



## **Barking and Dagenham**

### **Safeguarding Adults Review**

#### **Overview Report**

#### **'Drina'**

**Independent SAB Chair, Brian Parrott - Independent Author, David Byford**

**Barking and Dagenham Safeguarding Adults Board Commission**

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## Chapter 1

### Overview Report

#### Introduction and Executive Summary

##### Introduction

1. This Safeguarding Adults Review (SAR) Drina was commissioned by the Barking and Dagenham (B&D) Safeguarding Adults Board (SAB) into the apparent failure to safeguard Drina, a vulnerable 35 year old Romanian female with learning disabilities. Drina became known to LBBDD on the 17<sup>th</sup> November 2016 having been found when bailiffs attended a house in Dagenham, Address 1, regarding financial matters. Drina was seen in a dirty and unkempt condition in circumstances they believed she was being kept as a slave. They immediately reported their concerns to police. Drina was pushed into a van by occupants of the house before police arrived and taken away from the premises. Drina was later traced by police at a house in Walthamstow, Address 2, and taken to a place of safety. Drina was later determined by the UK Home Office (HO,) National Referral Mechanism (NRM) to be a victim of Modern Slavery. An Independent Overview Author (IOA) was commissioned to carry out the SAR as directed in the LBBDD Terms of Reference (TOR) outlined within Chapter 2 of this report. The review has identified safeguarding concerns of an extremely poor standard, no risk assessments and non-compliance with legislation and guidance by the Barking and Dagenham Community, Learning and Disability Team (CLDT) and a poor police investigation of Drina's case of Modern Slavery.

2. Drina was repatriated back to Romania on the 19<sup>th</sup> December 2016, by the Barking and Dagenham CLDT, a joint team of local authority social workers and staff from the North East London Foundation Trust (NELFT). She was accompanied back to Romania with her stepfather, whose care and involvement with Drina was not satisfactorily explored by agencies. The CLDT paid for the flight tickets and escorted Drina and her stepfather to the airport. The priority CLDT senior personnel gave to repatriate her was to ensure her 'best interest,' to be within her own community, rather than remain in the United Kingdom (UK.) The reason given was to look at the long term 'best interest' of Drina without putting the necessary safeguards in place, contravening legislation and guidance for addressing Human Trafficking and Modern Slavery, the rationale was seriously flawed. These failures have been acknowledged by key professionals within the SAR process. Significant learning for agencies has been identified, as outlined in the Findings and Recommendations of this report at Chapter 6 and Appendix 4.

3. Initial action taken by the Barking and Dagenham CLDT to protect her and apply the legislation was satisfactory and progressing. There was appropriate contact with the Metropolitan Police Service (MPS) Barking and Dagenham Borough Command Unit (BCU) now restructured as the East Area Command Unit (EA-CU) investigating Drina's case and the LBBDD Adult Social Care Solicitor regarding the next legal steps. CLDT senior management intervened, cancelled the identified action to be compliant to safeguard Drina and expedited her leaving the UK. The abruptness and concern of the repatriation with her stepfather, the quality of the police investigation, the failure to follow Care Act 2014, Modern Slavery Act 2015 and European Convention on Human Rights (ECHR)<sup>1</sup> and other

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<sup>1</sup> European Convention on Human Rights, Articles 3, 5 and 8

legislation is apparent. There was no forward safeguarding planning or consultation with the Romanian Social Services prior to her returning home to ensure her safety.

4. These concerns stimulated whistleblowing procedures enacted by a member of staff from CLDT. The disclosure questioned the action taken by CLDT, the police investigation and concerns with the stepfather's care of Drina and was the stimulus for the statutory Director of Adult Social Services (DASS) to seek the SAB to commission this SAR, to address any possible learning. Drina's repatriation affected morale within the CLDT who were unhappy and shocked how she was treated and not protected. This review has attempted to address all the questions of concern highlighted by the whistleblowing process and by key professionals spoken to during the SAR process. These are addressed within the analysis at Chapter 5 and the learning and recommendations at Appendix 4 of this report.

### **Purpose of the Review**

5. The purpose of the Safeguarding Adult Review is not to re-investigate or to apportion blame. It is:-

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work to safeguard adults at risk.
- To review the effectiveness of procedures.
- To inform and improve local inter agency practice.

### **Legislation, Guidance and Definitions**

6. The Prime Minister of Her Majesty's Government, together with a foreword by the Home Secretary in the 2016 Report of the Inter-Departmental Ministerial Group on Modern Slavery, outlined the priority and requirement to comply with the statutory legislation and to take action to improve, identify, challenge, prosecute offenders and safeguard victims or potential victims through enhance guidance of the National Referral Mechanism (NRM) developed for the purpose.

7. The Care Act 2014<sup>2</sup> defines the safeguarding duty as applying to any adult who:-

- Has needs for care and support (whether or not the local authority is meeting any of those needs.)
- Is experiencing, or at risk of, abuse or neglect.
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

8. The Care Act 2014 is significant legislation for adult social care and children and young people with special educational needs and disability (SEND.) There were changes made to the legislation in April 2015 that includes responsibilities for the promoting of wellbeing, a focus on prevention, personal budgets, eligibility criteria and support for carers, as well as Deprivation of Liberty Safeguards (DoLS) that is applicable to Drina's case.

9. Deprivation of Liberty Code of Practice (2015) is an amendment to the Mental Capacity Act 2005. The DoLS applies to persons who are in a care home or a hospital environment when it is necessary to deprive them of their liberty. This occurs where a resident or patient lacks capacity to consent to their care and treatment in order to keep them safe from harm. The Law Commission carried out a project on DoLS to consider a case for reform. The final report and draft Bill was published on the 13 March

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<sup>2</sup> The Care Act 2014 sets out in one place, local authorities' duties in relation to assessing people's needs and their eligibility for publicly funded care and support.

2017 and the outcome of the project findings and recommendations on DoLS awaits a response from Government. However the current guidance on DoLS applies in the case for Drina, for the purposes of this review.

**10.** The Modern Slavery Act 2015<sup>3</sup> states that an offence under that act has taken place where;

(1) A person commits an offence if:-

(a) The person holds another person in slavery or servitude and the circumstances are such that the person knows or ought to know that the other person is held in slavery or servitude, or

(b) The person requires another person to perform forced or compulsory labour and the circumstances are such that the person knows or ought to know that the other person is being required to perform forced or compulsory labour.

**11.** London Multi-Agency Adults Safeguarding Policy and Procedures, 2016<sup>4</sup> provides:-

- the legislative requirements and expectations on individual services to safeguard and promote the well-being of adults in the exercise of their respective functions, relating to adults with needs for care and support and carers, and
- A framework for SABs to monitor the effective implementation of policies and procedures.

## **Executive Summary**

### **Context**

**12.** Human Trafficking and Modern Slavery is an abhorrent crime to society which the UK through the Care Act 2014 and the implementation of The Modern Slavery Act 2015 have identified as a priority. The Modern Slavery and Human Trafficking Unit (MSHTU) administers the NRM on behalf of the Home Office. Where a potential victim (PV) such as Drina, is from a European Economic Area (EEA) country the decision making process is handled by the MSHTU. Where the PV is not from an EEA country, the decision is made by the UK Visa and Immigration Service as there is often an associated asylum claim.

**13.** The UK is a signatory to The Council of Europe Convention on Action against Trafficking in Human Beings. The implementation of this Convention led to the creation of the UK HO, NRM which is a victim identification and support process. It is designed to facilitate cooperation and information sharing between agencies. It assists PV's to access advice, accommodation and support.

**14.** Barking and Dagenham submitted a referral to the NRM, a 'Competent Authority' who having considered Drina's case, made an assessment for her against the definition of human trafficking as outlined in Article 4 of the Council of Europe Convention on Action against Trafficking in Human Beings.<sup>5</sup> It assessed her individual case against the definition of slavery, servitude and forced or compulsory labour as outlined in Article 4 of the European Convention on Human Rights as her case was identified in England and Wales.

**15.** The NRM on considering all available information, apply a 'Reasonable Grounds' test to consider if the statement "I suspect but cannot prove" that the individual may be a victim of modern slavery, holds true. Following a positive "Reasonable Grounds" decision, the Competent Authority will then

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<sup>3</sup> The Modern Slavery Act 2015 legislation.gov.uk

<sup>4</sup> London Multi-Agency Adult Safeguarding Policy and Procedures, August 2016, London ADASS.

<sup>5</sup> Council of Europe Convention on Action against Trafficking in Human Beings, Article 4.

make a second decision which conclusively decides if the individual is a victim of modern slavery based on the balance of probabilities.

**16.** These decisions and the information used to come to a decision, are reviewed by an NRM Senior Officer or Manager to ensure that the NRM decision has been made in line with the HO guidance entitled 'Victims of Modern Slavery – Competent Authority Guidance.'

**17.** Barking and Dagenham provided emergency accommodation for Drina and carried out eligibility assessments under the Care Act 2014, a Human Rights Assessment<sup>6</sup> (HRA) under the Human Rights Act 1998<sup>7</sup> and Mental Capacity Assessments (MCA) under the Mental Capacity Act 2005<sup>8</sup>. Drina was assessed as having 'Learning Difficulties.' LBBDD made a referral to the NRM<sup>9</sup> under the Councils duty to notify the Home Office of any potential victims of Modern Slavery.

**18.** In Drinas' case, she was assessed by the NRM as a victim of Modern Slavery and was entitled to 45 calendar day's reflection and recovery period. During this time Drina was able to access from the Barking and Dagenham, a range of support including safe and secure accommodation, emergency medical treatment, interpretive and translation services, information and counselling on legal rights, psychological assistance and subsistence support. It was these accesses and range of support that were not effectively applied in Drina's case.

## **Background**

**19.** As previously stated the Barking and Dagenham initial action to safeguard Drina was good with professionalism provided by an Enquiry Officer (EO1) and Safeguarding Adult Manager (SAM1) of the Barking and Dagenham CLDT appointed to represent her best interests and determine her case. The senior management within the CLDT however, (now merged with the Children Disability Service into a new Disability Service from April 2017) made decisions which overrode statutory and necessary actions required as identified by EO1. This resulted in Barking and Dagenham ultimately failing to put in place, safeguarding and protection for the consideration of Drina's 'best interest' and the possibility of her again becoming re-trafficked as a victim of modern slavery.

**20.** The significant failures have been acknowledged by relevant professionals in meetings with IMR Authors and with the IOA. Immediate action to ensure effective learning, knowledge and the protection and safeguarding of victims was put in place to guarantee that similar failures to comply with Modern Slavery guidance will not occur again. Senior management spoken to, acknowledge that Drina's basic rights, risk assessments and safeguarding protection fell unacceptably short of expectations, including a lack of legal safeguarding protection from a Court of Protection and a Deprivations of Safeguarding Liberties (DoLS) order. Drina's voice was not allowed to be heard, this would have been best served with a final MCA, the support of an Independent Mental Capacity Advocate (IMCA) and Romanian interpreter who could speak the distinct Roma dialect that she and

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<sup>6</sup> The Human Rights Assessment specifically follows Article 3 of the European Convention on Human Rights, prohibition of torture or inhuman or degrading treatment or punishment; and Article 8, the right to respect for private and family life.

<sup>7</sup> The Human Rights Act 1998 outlines the meaning that you can defend your rights in the UK courts and that public organisations (including the Government, the Police and local councils) must treat everyone equally, with fairness, dignity and respect.

<sup>8</sup> The Mental Capacity Act (MCA) 2005 is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment

<sup>9</sup> The National Referral Mechanism (NRM) is a framework for identifying victims of human trafficking and ensuring they receive the appropriate protection and support.

her stepfather used. These services were not provided when determining whether she should return in the custody and care of her stepfather at a meeting on the 16<sup>th</sup> December 2016 (with concerns having been raised against any decision to return her home with her stepfather to Romania, by CLDT staff at and previous to the meeting).

**21.** This SAR identified that the sharing of information between the CLDT and police was flawed. It is acknowledged that the police investigation was of a poor quality in relation to Drina being a victim of Modern Slavery. As a direct result of this SAR, the MPS are reviewing all aspects of their investigation to ensure failures are addressed and learning is appropriately promulgated with training on Human Trafficking and Modern Slavery to be implemented. (See Metropolitan Police Recommendation 1 and 2 in Appendix 4).

**21.** The action taken to return her at such short notice on the 19<sup>th</sup> December 2016 was met with consternation by other practitioners in the CLDT. On discovering that Drina with her stepfather were repatriated, staff as disclosed in meetings with the Independent Author, (see record of meetings with staff within the Analysis at Chapter 5,) were extremely concerned and ‘shocked’ particularly as other arrangements were still being made to effect a ‘best interest’ decision for her. As a result, the whistleblowing procedures within NELFT were escalated through their management chain and brought to the attention of the statutory Director of Adult Social Services (DASS). The DASS undertook an internal review and approached the Independent Chair of the SAB who agreed to recommend a SAR Panel be convened to consider whether to proceed with a SAR. These concerns are subject to further discussion and learning within the Analysis at Chapter 5 and Findings at Chapter 6 of this report.

### **Abstract of Findings**

**22.** This SAR has identified the following findings which are further developed within Chapter 5 Analysis of Professional Practice and Chapter 6, Findings and suggested Recommendations. The Barking and Dagenham SAR Overview Report Recommendations and Individual Agency Recommendations are detailed within Appendix 4 of this report.

#### **Finding 1.**

##### **Legal Services, consideration of advice, consultation and inclusion before sign off of complex cases:**

There is a need to ensure that in complex cases of Human Trafficking and Modern Slavery it requires an appropriate closure of a Multi-Agency Case Conference or Discharge Strategy Meeting with LBBB Adult Social Care Legal Services consultation and inclusion before sign off of the case that considers both National and Inter-National complexities that can arise. This is to guarantee the wellbeing of the victim and that legislation and guidelines are correctly applied. As outlined within the report conclusions (Chapter 7, Para 9), the Director of Adult Social Services makes the final decision as to case closures. In Drina’s case, if Legal Services had been maintained throughout the process, there may have been another outcome and the flawed decision to send Drina to Romania without the necessary safeguards being set in place to support her, may have been avoided.

#### **Finding 2.**

**Appropriate Use of IMCA’S and Interpreters to Hear the Voice of the Victim:** The Barking and Dagenham Safeguarding Adult Board must remind staff that the voice of a victim with learning disabilities needs to be heard by utilising the services an IMCA and appropriate interpreters if necessary, with a Mental Capacity Assessment completed by a suitably trained member of staff in all cases.

**Finding 3.**

Awareness of Human Trafficking and Modern Slavery: There is requirement for the enhancement of awareness, communication and the understanding of human trafficking and modern slavery for LBBB staff, agency partners and for the local community and businesses.

**Finding 4.**

Participants in Safeguarding Adult Meetings: Chairs of Safeguarding Adult meetings should ensure that potential suspects in a safeguarding case are not allowed to participate in meetings to preserve the integrity of the meeting and due process.

**Finding 5.**

LBBB Disability Service: There is a need for the recently merged Adult CLDT with the Children's Disability Service (April 2017) into the Disability Service that staff (and elsewhere in the service) have the awareness of the issues and how to address them, ensuring that knowledge of the legislation and the policy and procedures of Human Trafficking and Modern Slavery is disseminated to all key practitioners. This is to ensure a unilateral understanding, for a seamless approach, as staff had previously undertaken different roles and had other areas of experience as staff responsibilities will eventually be merged.

**Finding 6.**

Sharing of Information: There is a need to remind agencies of the requirement to ensure relevant information in relation to medical examinations and that victim's allegations are appropriately shared as this was evidently a failure identified in this review.

**Finding 7.**

Record Keeping: There is a need for Local Authority staff to ensure that documents, emails, decisions, actions and records are promptly uploaded onto the LBBB Electronic Social Care Record System (currently AIS, with a new system about to be introduced) in a timely manner to preserve integrity. There was a delay before updates were uploaded and the final case notes were not uploaded on to the relevant organisational record-keeping systems therefore the process to close the safeguarding enquiry was not completed.

**Finding 8.**

Metropolitan Police Service - Specialist Crime Review Group: There is a need for the MPS to review the criteria for the SCRG to carrying out SAR's in reported complex Human Trafficking and Modern Slavery cases under the Modern Slavery Act 2015 and the London Multi Agency Adults Safeguarding Policy and Procedures 2015. This will support the SAR process, as there was a significant delay before the MPS Individual Management Report (IMR) was received which, impacted on the timeframe for completing the SAR.

The identified poor police modern slavery investigation for Drina is being addressed (see MPS Agency Recommendation 1 at Appendix 4). Therefore, there is no further requirement for a Barking and Dagenham SAR Overview Report Recommendation at this juncture. The identified concerns are being addressed and the outcomes, any learning and action taken, will be reported to the SAB for the Barking and Dagenham Action Plan that follows this SAR. In particular, the review of the police investigation has added significance to our findings, as similar findings of police failures to investigate modern slavery cases were identified in a recent report published by the National Referral Mechanism.

**Finding 9.**

Medical Examination of Victims: There is a need to remind agencies of the requirement to ensure medical examinations are carried out when a resident in a care home or elsewhere shows signs of physical abuse in an adult safeguarding case that is subject to a police criminal investigation.

## Chapter 2

### Initiation of the Safeguarding Adult Review

#### Terms of Reference (Summarised)

The Terms of Reference (TOR) were set by the Barking and Dagenham SAB to be addressed by agencies participating in the Safeguarding Adults Review (SAR.) A summarised TOR as defined by the SAB is outlined below with additional information applied by the Independent Overview Author (IOA).

#### Timeframe for the review

To review the events and associated actions that occurred relating to the repatriation of Drina during the period of the 17<sup>th</sup> November 2016, when she first came to the attention of professionals and the 19<sup>th</sup> December 2016 when Drina returned to Romania.

Specifically:-

1. The review will establish the timeline of events and relevant actions of each agency, their inter-agency contact and the involvement of other people, e.g. family, friends.
2. Analyse all documentary records to enable an assessment of the efficiency and effectiveness of each contribution and considering whether all reasonable steps had been taken to manage the unfolding scenario and to safeguard Drina.
3. Assess the extent to which agencies followed relevant legislation, guidance, policy, procedure and recommended best practice emanating from formal reviews.
4. Establish what lessons are to be learned from Drina's case.
5. Identify how and within what timescales, lessons will be acted on and what is expected to change as a result.
6. Apply these lessons to service responses including changes to policies and procedures as appropriate.
7. To propose recommendations that may help to prevent a similar incident occurring and the further development of the way each agency works individually and in partnership.

It is not the remit of this review to reach a judgment on the performance of the social services function(s) of another EU member state but, it will be relevant to consider the extent to which appropriate supporting information was provided to them in order that they had the best opportunity to carry out their own safeguarding work within the framework that applies in Romania.

An Individual Management Review (IMR) template setting out the requirements for agencies to comply with in completing their submission to the SAR was developed.

#### SAR Panel

SAR Panel members are independent of the practitioners and have no involvement in Drina's case.

### **Independent SAR Author.**

Mr David Byford was commissioned as the IOA for SAR Drina on the 23<sup>rd</sup> February 2017. He has no previous involvement in the case or with any person or agency concerned within the SAR process for Drina.

### **Additional factors for completing the SAR (Independent Overview Author.)**

#### **Victim and other family details**

##### **Victim**

Drina – Female, born (restricted) Ethnic Origin – Roma/Romanian.

##### **Family**

LD – Stepfather. Ethnic Origin – Roma/Romanian.

##### **Other significant persons**

Not applicable.

#### **Involving Drina and her family**

This was not able to be completed as both Drina and her stepfather, the only confirmed family member, had returned to Romania.

#### **Scope and Agencies participating in the review**

The review will seek to establish lessons learned from Drina’s case so that partners can improve the response to vulnerable adults who are victims of Human Trafficking and Modern Slavery. The review will request information from each involved agency below:-

<b>Barking and Dagenham Adult Social Care</b>	<b>IMR and chronology</b>
<b>Metropolitan Police Service</b>	<b>IMR and chronology</b>
<b>Specialist Crime Review Group</b>	<b>Additional IMR requested and completed August 2017</b>
<b>NELFT</b>	<b>IMR and chronology</b>
<b>Modern Slavery and Human Trafficking Unit</b>	<b>IMR and chronology</b>

#### **Focus**

The review has focused on the key concerns raised by the whistle-blower policy that was enacted and from IMR submissions and interviews with key practitioners in the case. It aims to highlight any failures to identify learning in order to protect any victims or potential victims of Modern Slavery.

#### **Methodology**

The following methodology was used to complete this SAR:

- Consultation with the CLDT (subsequently part of the Disability Service), Metropolitan Police and NELFT, in order to identify key practitioners.

- Interview and communication with those key practitioners, as to their involvement and knowledge of Drina's case, in order to identify learning.
- A review of the response by each agency to the concerns raised in the terms of reference.
- Continually liaised and consulted with the SAR Drina Panel members with regular updates of progress.
- Carried out an analysis of the Individual Management Reports (IMR's) and monitored how the performance of each agency impacted on Drina.
- Reviewed and researched current legislation, guidance, policies and procedures for safeguarding adults with particular emphasis on victims of Human Trafficking and Modern Slavery.
- Attended a Human Trafficking and Modern Slavery seminar at City Hall (April 2017) regarding current policy and practice.
- Ensured that any learning identified during the course of completing this SAR was readily implemented or subject to implementation during the SAR process.
- Request made with the CLDT (Disability Service) to ensure no other person is at similar risk as in Drina's case of not being protected through compliance to legislation and policies.
- Requested a wellbeing check to be carried out on Drina with the Romanian Social Services (March 2017) who confirmed to the SAB in June 2017 that Drina and her stepfather have been missing from their home since April 2017. There was immediate liaison and information passed to East Area Command Unit (EA-CU) for their information and is outside the remit of the terms of reference.
- Completed a desk top review of LBBB, MPS and NELFT safeguarding policies and procedures to ensure compliance.
- Anonymised the SAR as it will be a matter for the SAB to agree the final publication of the review and how it is to be communicated.
- Reviewed recent Barking and Dagenham SAR's.

### **Inhibitors to the Review**

The MPS Specialist Crime Review Group (SCRG) were requested to complete an IMR for the SAR at the behest of the Barking and Dagenham SAB due to the complexity of the case and the identified concerns from the whistleblowing procedures. This was declined, as a result there was a significant delay of four months after the final date for submissions (March 2016) for IMR's which the EA-CU completed. Due to the complexity of Drina's case, the SCRG were approached by the IOA who assisted with the final MPS IMR (August). The delay, impacted on the timeline for the statutory requirement to complete a SAR (See Barking and Dagenham SAR Overview Report Recommendation 7).

## Chapter 3

### Details of the Investigation and Adult Safeguarding

1. On 17<sup>th</sup> November 2016, enforcement agents (acting as bailiffs) attended a residential property in Dagenham (Address 1). Upon arrival, the occupant's, one of whom was another Romanian female OD whose home it was, were immediately hostile and began making threats towards them. Whilst in the property the bailiffs could see a young female in the garden sitting on a chair, sheltering under a mattress. The female was subsequently identified as Drina, a Romanian national aged 35 years with learning disabilities. The bailiffs asked OS if Drina could come into the house as it was cold and they were concerned for her. OS who had managed to communicate with the bailiffs up to that point, stated she did not speak English. The bailiffs went into the garden tried to speak with Drina without success but she did not understand them. Drina presented as being dirty, dishevelled and smelling of human excrement. There was a garden shed that had a dirty mattress and a toilet with no plumbed sanitation. It smelt strongly of human faeces and urine. The shed door had a functioning lock with no key. Drina's condition was extremely concerning to the bailiffs who called the police as they believed she was being kept as a slave. OS walked up to Drina and got very close to her face and started to shout at her in her native language. She then allowed Drina into the kitchen. The bailiffs gave Drina a piece of cake which she ate with great haste and in their opinion, she appeared very hungry.

2. Whilst waiting for police to arrive, the bailiffs saw a van arrive and the occupants forced Drina into the van and drove her away. The bailiffs videoed the action. When police arrived at the scene they were given the details of the van that had quickly left with Drina. Police treated Drina as a 'high risk' missing person and managed to track the vehicle to a house in the Walthamstow area, (Address 2) where Drina was found. In the intervening period Drina had been placed in a change of clothing and appeared cleaner in appearance. Some of the people at the address were believed to be related in some way to Drina including her stepfather. Police made several arrests including OS and two Romanian youths, but those arrested did not include the stepfather. The police commenced a criminal investigation as Drina was initially suspected of being a victim of kidnap and false imprisonment before it was ascertained she was a victim of Modern Slavery.

3. OS told police officers whilst enquiries were ongoing to trace the van that it was her who lived in the shed. She was described as being incredibly obstructive to police questions, seemingly having no knowledge of Drina (however she attended a subsequent a LBBB family safeguarding meeting on the 24<sup>th</sup> November 2016 that contradicted this account.) After her arrest, she was searched and in her brassiere was found both Drina's and her own ID cards. A young 12 year old Romanian boy was detained at Address 1 after bringing a large bag of adult nappies which, it was believed were for Drina that OS later tried to insinuate were for her. It was however noticed that she used the toilet in the house whilst police were present which, again counters this explanation. A third young person, suspect CD who had the same surname as the stepfather, was arrested at Address 2 for false imprisonment.

4. Drina was taken to Fresh Wharf police station in Barking as a place of safety, where Police Officer 1 (PO1) the subsequent investigating officer met her. Police completed a Merlin, Come to Notice (CTN) form and referred her to the LBBB Access and Duty Intake Team (ADIT) as Drina appeared to have learning difficulties. The ADIT attended the police station with a Romanian interpreter who spoke a different dialect but determined that she spoke a Romanian, Roma dialect which was not easy to understand. At the time it was impossible to obtain an account from Drina and therefore she was not able to make any allegations. It was deemed that she had a learning disability and lacked mental capacity.

5. Drina was kept at the police station as being a possible victim of human trafficking and modern slavery until LBBB provided accommodation. Emergency accommodation was found at Kallar Lodge, a dementia care home for the elderly in the borough, authorised on the directions of the CLDT Group Manager (GM). This was not an ideal placement for her or for the residents of the care home but there were no other vacancies available in other placements at that time.

6. OS when interviewed at the police station with an interpreter, made a no comment interview but gave a prepared statement denying all allegations. She said it was her and her husband (the suspected driver of the van, required to be spoken to by police but never was) who had supported Drina for the last eight months when she came to the UK with her at Drina's own free will. She also stated that Drina went to the van and left her home of her own free will which, is contrary to the bailiffs and their video evidence. Also conflicting was the entry disclosure into the UK as it was later confirmed that she came to the UK with her stepfather in possibly October 2016. OS stated that Drina had a brother and sister in the UK who she visited but no details were given and it appears police and CLDT did not pursue this line of enquiry.

7. The two other younger suspects arrested had to be detained overnight as there was not an interpreter available that spoke their Roma dialect or an appropriate adult (AA) who, due to the lateness of the hour, had refused to attend the police station. They were interviewed the following morning, but did not disclose anything of significance. All three suspects were later bailed to return to the police station on the 11<sup>th</sup> January 2017 whilst enquiries were carried out. It is now known that there was not an effective police investigation carried out and the stepfather who was a potential suspect was never spoken to either as a witness or a suspect.

8. On the 18<sup>th</sup> November 2016, the ADIT duty manager liaised with the Kallar Lodge staff management. It was recorded that Drina had eaten well overnight and had accepted personal care from staff. The staff completed a body map and noted scarring, suggesting burns to her right side, leg and thigh. The CLDT social workers attended and undertook a social care assessment with the use of a Romanian Interpreter over the telephone. The social workers concluded she might have a cognitive impairment. The CLDT contact number was made available for any of Drina's family to contact if known and confirmed that an assessment will continue the following day, in the meantime she was to remain at the home.

**Comment: After the staff carried out a body mapping of Drina and found signs or potential abuse, they should have requested that a doctor attend to see Drina and medically examine her to assess the scarring and burn marks found on her body. This information was provided to the CLDT but as Kallar Lodge were aware, there was an ongoing police investigation and they should also have provided the information direct to police. PO1 was informed of this aspect by EO1. Police and the CLDT appear not to have acted on this evidence of possible physical abuse which was potential evidence for their investigation of Modern Slavery. (See Barking and Dagenham SAR Overview Report, NELFT and LBBB Recommendations at Appendix 4).**

9. Neighbours near to Address 1, who were old and frail had observed how Drina washed naked in the garden and believed Drina was made to sleep in the garden shed. She was seen to be allowed out to walk through to the front of the house to unload scrap metal vehicles that visited the address. The neighbours felt intimidated by the occupants and did not wish to make a statement to police.

10. On the 24<sup>th</sup> November 2016, a safeguarding meeting was held. It was an interview with family including Drina's step father, the suspect OS, believed to be Drina's step sister in law who was on police bail and a family friend who spoke English and was allowed to translate as no interpreter was

present. Attempts had been made to find a Romanian or Roma speaking interpreter but these had failed. Social Workers and police present gave an account of the circumstances in which Drina was found and also allowed OS, who was suspected of causing harm to Drina, to participate in the meeting. The family were keen to have Drina returned to them as the stepfather stated that he wanted to take Drina back to Romania. It was explained that as Drina had a learning disability, the CLDT would have to make an assessment to establish whether she is able to make her own decisions, the need to establish identities of family members or friends and that a police investigation was underway as criminal offences may have taken place. They were informed that they would not be facilitating contact with Drina at this stage until legal advice was sought. An appropriate Safeguarding Protection Plan was made that stated Drina would be staying in Kallar Lodge with 24 hour care and supervision.

**11.** As she was being deprived of her liberty and as she had been assessed with a learning disability this should have instigated a DoLS, as there is a Care Quality Commission (CQC) statutory notification required for an application to deprive a person of their liberty. Kallar Lodge should have applied for a DoLS in their own right for Drina.

**12.** In conversation to the Barking and Dagenham Adults' Care and Support IMR Author and the IOA, the Care Home Manager (CHM) said there were continual changing circumstances emanating from the CLDT that confused matters. Therefore a DoLS was not carried out but it was acknowledged by the CHM that whatever the ongoing situation in the future, Kallar Lodge would carry out their own DoLS for relevant residents when necessary. This is personal learning for the CHM.

**13.** On the 25<sup>th</sup> November 2016 the LBBB AIS record management systems reported that two Mental Capacity Assessments were undertaken, carried out on the 23<sup>rd</sup> November 2016. They were for 1) around her being able to make a decision on care and accommodation and 2) about any contact with family and associates. Drina was assessed to have a permanent impairment, underdeveloped language skills, poor memory for names of people (including family members), she could not count past 10 or name any colours, and she had limited awareness of geography (apart from mentioning England and Romania) and seemingly traumatised by her mother's death. Drina was not able to understand or retain information related to the decision or weigh up information about the decision making process on her behalf. She was able to communicate her views through an interpreter. The assessment stated that Drina was unlikely to regain capacity. The documentation contained the 'best interests' assessment for Drina.

**14.** An Enquiry Officer, EO1, was appropriately appointed with a Safeguarding Adult Manager. EO1 commenced and carried out ongoing enquiries, referred Drina to the NRM, arranged MCA's, liaised with police and attempted to obtain more suitable accommodation for Drina and was in contact with a LBBB Adult Social Care Solicitor regarding the options of making an application to the Court of Protection (COP) and applying for a DoLS.

**15.** On the 30<sup>th</sup> November 2016, an interview with Drina took place at Kallar Lodge with a social worker, Drina and an interpreter. Drina was shown photographs of family members taken at the safeguarding meeting. She could say the names of the people. She intimated that one of the men beat her and that two of them took her in the van on the day the bailiffs and one of them had a knife. The stepfather was identified as one of the men who took her away in the van from Address 1. Drina cried when she saw the photo of her stepfather and asked when she could be with him again. She stated that when her stepfather drinks, he hits her and that she most recently lived in England with him. The details of this information was shared with the police by email from EO1 and would seem to implicate the stepfather in the abuse of Drina.

16. On the 5<sup>th</sup> December 2016, whilst the EO1 was carrying out the safeguarding plan for Drina, he received an email from the CLDT TM to say he was removed from the case and informed to cancel the actions he was researching and carrying out. He was removed from the case as he was apparently successful in a promotion. There then proceeded to be a significant delay appointing another social worker EO2 to represent Drina's best interest and is subject to a LBBB Agency Recommendation at Appendix 4).

17. On either the 14<sup>th</sup> or 15<sup>th</sup> December 2016, the TM with the GM informed the Contracts Manager (CM) that they were looking to book airline tickets for Drina and her stepfather to return to Romania in the near future. The CM confirmed that he had no dealings with the service user clients of the CLDT but he holds a company credit card that would pay for any flights booked.

17. On Friday the 16<sup>th</sup> December 2016, there was a discussion between the TM, CLDT Consultant SW (CSW) and EO2 to hold a meeting for Drina and her stepfather to consider whether there were 'best interest' grounds to send Drina home, accompanied by her stepfather. The TM enquired with police, as it was the intention to repatriate her at that stage, as to whether there were concerns regarding the stepfather being a person of interest to police. It was confirmed by PO1 that neither Drina nor her stepfather were required for the ongoing investigation. The TM then made contact with the NRM case worker who, being informed of the police decision, stated that although there are reasonable grounds to suspect that Drina is a victim of Modern Slavery, Drina would be free to leave the UK.

18. A family meeting was arranged and held later that day at Civic Centre with Drina, and her stepfather. Present were CLDT staff including the TM, the new enquiry officer EO2, CSW and the Speech and Language Therapist (SALT). The SALT was asked to interpret at the meeting even though he had no formal training as an interpreter and did not speak the Roma dialect required to effect communication. He informed the CSW of this fact but was instructed to attend and translate in any case. The SALT assisted with the translation but described the interpretation as difficult as Drina and her stepfather were speaking in their Roma dialect.

19. The stepfather stated that he and Drina came to England on a six months visit to see his other children (Romanian Social Services informed the LBBB that they travelled to the UK in October 16). He couldn't recall his children's addresses. Drina had to accompany him, because there was no one to look after her in Romania, as he was her main carer and claims her monthly allowance that she receives from the Romanian Social Services. Drina used gestures to describe how she had been beaten, locked in a room and deprived of food and water. Her stepfather stated that she should not be listened to due to her disability. Drina also gestured she wanted to go home to Romania with her stepfather however there was no IMCA or appropriate interpreter present on behalf of Drina to represent and support her to capture her actual wishes. The SALT felt that although he couldn't interpret some of the things Drina was saying in Roma, he determined that she and her father were saying different things. Her stepfather wanted to use his own money to buy flights home but they were told that Social Services have a duty of care to ensure Drina is looked after. The stepfather also wanted Drina to stay with him whilst they sorted out flights but this was refused as he had no address to take her to. The EO2, CSW and the SALT were not convinced that the stepfather had Drina's best interests at heart and had concerns which they conveyed to the TM at the meeting (who was having phone communication with the GM). The minutes of the meeting described that LBBB needed to ensure that they were 1) not breaching Drina's human rights, 2) a Human Rights Assessment was required and 3) a further MCA was to be undertaken to ascertain Drina's ability to make decisions about her return to Romania.

**Comment: After the meeting the LBBB case notes record "Despite an ongoing safeguarding investigation, it was agreed between the GM and TM that Drina would be repatriated with her**

stepfather to Romania. It won't be possible to establish all the facts as Drina is not a reliable witness. Stepfather has been compliant with authorities. HRA required.” Clearly this decision overrode the decision and action plan from the meeting to rearrange for a follow up meeting on the 19<sup>th</sup> December 2016, with Drina and her stepfather, to carry out a MCA and further supported with an appropriate IMCA and Roma speaking interpreter to ensure effective communication with Drina.

20. It has now been established that over the weekend the TM in consultation with the GM, completed a HRA which EO2 believed she was to complete as Drina’s social worker. The HRA was signed off on Sunday 18<sup>th</sup> December 2016 by the GM who included the name of the Operational Director on the assessment. It was confirmed that the flight tickets were booked and paid for on the Saturday 17<sup>th</sup> December 2016.

21. On Monday the 19<sup>th</sup> December 2016 the TM with a staff member from Kallar Lodge escorted both Drina and her stepfather to Luton airport. They were assisted through customs and security for their flight home. Following Drina’s repatriation, a NELFT staff member on the CLDT implemented the NELFT whistleblowing procedures and correctly raised a number of concerns around how agencies and individuals worked together to safeguard Drina. NELFT senior management subsequently referred the matter to the Barking and Dagenham SAB. It pointed out the failures of the ‘best interest’ decision to repatriate her back to Romania in the care of her stepfather, the lack of forward safeguarding protection with the Romanian social services, concern about the police investigation and the involvement of the stepfather. It believed that Drina’s case was seriously flawed and actions taken were not in the best interest of Drina.

**Comment: Decisions around mental capacity are in this case, issue specific and a further MCA should have been conducted to determine whether Drina had the capacity to be able make the decision to return home to Romania with her stepfather.**

22. On the 6<sup>th</sup> January 2017, police made a decision to take no further action against the three suspects for false imprisonment. There was no consideration or evidence to suggest they were dealing with a case of Modern Slavery even though PO1 was conversant having been informed by the EO1 in the family meeting and within email communications. The closure states that following interview and after speaking further with the victim and adult social care it was clear that they had no involvement and there are no allegations made against them.

**Comment: This appears to be a closure with no apparent thorough investigation or satisfactory rationale. The victim had not been spoken to further by police as an IMCA and Roma speaking interpreter had not been engaged and no thought of an Achieving Best Evidence (ABE) video interview was considered or carried out. There were allegations made and the investigation displayed a distinct lack of supervision and challenge (see MPS Agency Recommendation 1 at Appendix 4).**

## **Victim**

### What did professionals know about Drina?

23. The information know to professionals are as recorded in the background above. LBBD CLDT requested background information translated by the SALT. They received an email from the Romanian Head of Social Services from her home town in response. A summary of the main points were:-

- Drina was born out of a causal relationship.

- Her biological father never looked after her.
- Her mother married her stepfather.
- In 2003, Drina was assessed by a Romanian medical team and was registered as having severe learning disabilities with an IQ of 23. It was recommended that she should be looked after by her family.
- According to the Romanian legislation Drina's mother was asked by the social services to act as her main carer (to look after her daughter with a severe learning disability). This lasted until Drina's mother passed away in December 2014.
- From January 2015, Drina has been entitled to a monthly allowance, designed to be paid for her main carer (She lives at the stepfathers address and he collects her monthly allowance on her behalf.)

Associated Family

**24.** Other than stated above, associated family members are not readily known or recorded.

## Chapter 4

### Chronology of Key Events within the Terms of Reference

#### Introduction

This section highlights the chronological events known to agencies within the UK about their interaction with Drina, together with a brief commentary. It outlines the significant key events and of professional practice during the period under review. The Barking and Dagenham SAB have completed an integrated record of the chronologies provided by agencies within their submissions to the SAR, for corporate memory. The analysis of these events are expanded in some circumstances within Chapter 5, Analysis of Practice and within Chapter 6, Findings.

#### Key Events

Date	Event
<b>2016</b>	
<b>17.11.16</b> Bailiffs located Drina and suspecting she was being kept as a slave and reported the concern to police. (B&D Safeguarding Meeting Minutes.)  Legislation – The Modern Slavery Act 2015.	Before police arrived the bailiffs witnessed Drina being bundled into a van and hurriedly taken away by two persons, from the premises. They videoed the event. The van was traced to an address in Walthamstow, Address 2. Drina was found at the location in different clothing and of a cleaner appearance.  Drina was taken to a police station where PO1 first met her. PO1 initially treated it as a case of kidnap and abduction with three suspects arrested by police.  Drina was believed to have learning difficulties. Police contacted the B&D Access and Duty Intake Team who found an emergency placement for her at Kallar Lodge.
<b>18.11.16</b>	A safeguarding concern was raised and Enquiry Officer EO1 appointed with a Safeguarding Adult Manager, SAM1 allocated on the 21.11.16.
<b>23.11.16</b> Two MCA's were carried out on Drina. Legislation - Mental Capacity Act 2005.	Two MCA's were undertaken in respect of 1) Drina being able to make a decision on her care and accommodation and 2) around her contact with family and associates. The assessment stated that Drina was unlikely to regain capacity and contained the 'best interests' assessment.
<b>24.11.16</b>	An interview took place with the family of Drina including Drina's stepfather. A family

<p>B&amp;D Safeguarding Meeting.</p> <p>A Safeguarding Protection Plan set out that Drina would be staying in Kallar Lodge with 24 hour care and supervision.</p> <p>Legislation - Care Act 2014 and Mental Capacity Act 2005.</p>	<p>friend who spoke English was there to translate. Attempts had been made to find a Romanian or Roma speaking interpreter but these had failed. A social worker and police were present and an account was given of how Drina was found. Drina's sister in law, OD suspected of causing harm to Drina was allowed at the meeting and who at that time was on police bail.</p>
<p><b>25.11.16</b></p> <p>NRM received a referral from the LBBB EO1.</p>	<p>LBBB AIS records that two MCA's were carried out on the 23.11.16 where Drina was deemed to have a permanent learning disability.</p>
<p><b>30.11.16</b></p> <p>Interview with Drina at Kallar Lodge.</p> <p>The information of physical abuse was shared by EO1 with PO1 as an email was sent to the police officer on the 02.12.16.</p> <p>The stepfather was identified as one of the men who took Drina away in the van to Address 2 and should have been treated as a possible suspect and his involvement and care of Drina explored. This information was shared with the NRM case worker who was informed of PO1 contact details.</p> <p>Legislation - Care Act 2014.</p>	<p>An interview with Drina took place at Kallar Lodge with her social work EO1 and an interpreter. Drina was shown photos of family members taken at the Safeguarding meeting. She could say the names of the people. She stated that one of the men beat her and that two of them took her in the van to on the day the bailiffs attended the property and that one of them had a knife. One of the men in the van was identified as Drina's stepfather. She stated that when her stepfather drinks he hits her and that she most recently lived in England with him <b>Comment: These allegations identify that the stepfather was a possible suspect in Drina's Modern Slavery case.</b></p>
<p><b>01.12.16</b></p> <p>EO1 liaises with LBBB Legal.</p>	<p>The EO1, emailed the LBBB Legal Team, Adult Social Care Solicitor as required by LBBB policy.</p>
<p><b>02.12.16</b></p> <p>An email from EO1 was sent to PO1 to notify him about the interview with Drina and was asked to provide scanned picture of Drina's Romanian ID card.</p> <p>NRM make a positive decision on Drina for 45 days reflection and recovery period and notified to EO1 on 5.12.16.</p>	<p>CLDT funding request made based on assessment of need and case briefing sent from EO1 to TM.</p>
<p><b>05.12.16</b></p> <p>EO1 informed by TM he will be taken off the case and took control of the Drina's case on the instructions of the GM.</p> <p>There was not a satisfactory handover to EO2 who was initially unaware of her allocated role.</p>	<p>EO1 completed a detailed case summary of action taken to date and what still needed to be undertaken for the TM. He was requested to stop his liaison with Legal Services in considering a Court of Protection Order and a DoLS and was asked to cancel an arranged IMCA appointment to see Drina.</p>
<p><b>12.12.16</b></p>	<p>TM telephoned the NRM case worker stating he is the new contact for information as EO1 was leaving the team.</p>

<p><b>14.12.16</b></p>	<p>The Contract Manager/Equipment and Adaptions was approached by the TM and GM on this day or the following day to ask about booking two flights for Drina and Stepfather. <b>Comment: It appears the decision was being taken earlier to repatriate Drina before the meeting on the 16<sup>th</sup> December.</b></p>
<p><b>15.12.16</b></p> <p>NRM made a reasonable grounds decision with 45 days discretionary leave. Legislation – The Modern Slavery Act 2015.</p>	<p>The details were sent to the TM as Drina was assessed as a victim of Modern Slavery.</p>
<p><b>15.12.16</b></p> <p>An email from the Romanian Social Services was received outlining their knowledge of Drina and the family.</p> <p>A home visit from family members seen by Romanian authorities’ state that the Stepfather and Drina left for the UK in October 2016.</p> <p>Legislation - Mental Capacity Act 2005.</p>	<p>Apparently Drina lived in the house in Romania that was owned by her stepfather. Romanian Social Services state that Drina lacks capacity to deal with finances but is entitled to a monthly allowance. She doesn't have a court appointee. Her stepfather collects and signs for her allowance.</p> <p><b>Comment: A possible diversity and cultural issue was identified via the Romanian authorities as the email stated that “these people belong to the Roma ethnic minority, they don't have education and refuse help. They are only interested in financial assistance without any commitments.”</b></p>
<p><b>16.12.16</b></p> <p>CLDT TM telephoned the NRM case worker to say that Drina wanted to return home as they had confirmed the stepfather’s details with the Romanian social services. The NRM had no objection as the safeguarding decision was for the local authority and police.</p> <p>The CLDT had previously contacted PO1 who stated that the stepfather was not of interest in the police investigation.</p>	<p>The HO NRM on being informed of the police situation stated although there are reasonable grounds to suspect that Drina is a victim of modern slavery Drina would be free to leave the UK.</p> <p><b>Comment: It is not clear what information or concerns were shared with or considered by police to make this judgement (see MPS Agency Recommendation 1).</b></p>
<p><b>16.12.16</b></p> <p>Meeting held at the LBBB Civic Centre with stepfather and Drina (minutes recorded and viewed.)</p> <p>No IMCA or appropriate interpreter was provided for Drina.</p> <p>Drina describes physical abuse which was not shared with police after the meeting.</p> <p>Outcome:- Arrangements made for a further meeting with Drina and stepfather on the 19.12.16 for an MCA to be carried out and to further organise that an IMCA and appropriate interpreter be present and an HRA to be</p>	<p>Present with Drina and her stepfather, were CLDT staff including the TM, EO2, CSW and the SALT. The SALT was asked to interpret but did not speak the Roma dialect which he informed them of prior to the meeting but was instructed to attend and translate in any case by the CSW. Interpretation was difficult. Drina used gestures to describe how she had been beaten, locked in a room and deprived of food and water. Her stepfather stated that she should not be listened to due to her disability. Regardless, the decision taken in the meeting was overridden later the same day.</p>

<p>completed to ensure a 'best interests' decision is made for Drina's care and welfare.</p>	<p><b>Comment: After the meeting the LBBB AIS record states the case notes record "Despite ongoing safeguarding investigation, it was agreed between the GM and TM that Drina would be repatriated with her stepfather to Romania. It won't be possible to establish all the facts as Drina is not a reliable witness. Stepfather has been compliant with authorities. HRA required."</b></p>
<p><b>17.12.16</b> Flight tickets booked.</p>	<p>Flights tickets were booked for both Drina and her stepfather to fly from Luton Airport to Romania for the 19.12.16.</p>
<p><b>18.12.16</b> HRA completed.</p>	<p>The TM completed the HRA over the weekend and it is shown being signed off by the GM and Operational Director (the latter is shown not to have signed the HRA off as discussed in Chapter 5 Analysis).</p>
<p><b>19.12.16</b> Drina and stepfather escorted to Luton airport and flew home to Romania.</p>	<p>TM with a Kallar Lodge member of staff escorted Drina and the stepfather to Luton Airport. The TM later sent an email updating CLDT colleagues that Drina and stepfather had travelled back to Romania that morning.</p>
<p><b>20.12.16</b> Email sent by the SALT on behalf of the CLDT TM informing the Romanian Social Services that Drina and her stepfather were on their way home.</p>	<p>The email sent and translated by the SALT to Romanian Social Services outlined that Drina and her stepfather were on their way home. It confirmed Drina was subject to a safeguarding enquiry and police investigation due to suspected trafficking. The email stated they were referring her to them to carry out an assessment and possible safeguarding enquiry to ensure she was not subject to similar circumstances again.</p> <p><b>Comment: This entry confirmed that the contact with Romanian authorities was after Drina was returned home and no prior knowledge or forward safeguarding planning was put in place by the CLDT.</b></p> <p>The Romanian Social Services subsequently confirmed that they had received a request from Drina's stepfather asking for her disability allowance to be reinstated.</p>
<p><b>2017</b></p>	
<p><b>January</b> Whistleblowing procedures enacted.  Police close investigation with no further evidence against the three persons arrested.</p>	<p>LBBB Director of Adult Social Services received information from NELFT colleagues through their whistleblowing processes that raised concerns around the case, Drina's repatriation to Romania with her stepfather and how agencies worked together to safeguard Drina. The points raised are addressed within Chapter 5 Analysis.</p>

## Chapter 5

### **Analysis of Key Events and Professional Practice**

1. The key events in Chapter 4 above, together with the input from the agencies and practitioners participating in this review, are further analysed within this section. It outlines the professional action taken, issues with guidance and decisions made that impacted on the final outcome for Drina. For transparency, it contains comprehensive details of meetings and discussions with relevant key practitioners conducted by IMR Authors and the IOA. The Findings and Lessons to be learnt, are detailed within Chapter 6, within the Barking and Dagenham SAR Overview Report and Agency Recommendations at Appendix 4 for the SAB to consider.

### **Initial steps and good practice**

2. Adult Care and Support Care (ACS) became aware that Drina was living in the borough after concerns were raised by a MPS Merlin report on the 17<sup>th</sup> November 2016. It appropriately triggered a Care Act 2014 assessment and emergency residential accommodation was provided on the 18<sup>th</sup> November 2016. The assessment commenced on this day and was concluded on the 24<sup>th</sup> November 2016. The action taken was within guidance timescales and demonstrated good practice.

3. Steps were also being taken to provide an appropriate placement as she should not have been placed in Kallar Lodge which, was contrary to Care Quality Commission (CQC) regulations. It was approved by the CLDT GM as an emergency placement, an appropriate decision at the time, notwithstanding that more care-appropriate options in the local independent sector were not explored, given the timescales available. Other more suitable in-house provisions were considered but there were no vacancies at the time. The action taken was to prevent further abuse and neglect in a safeguarding concern with significant risk factors and this was good practice.

4. An EO and SAM were appropriately allocated. EO1 completed a number of tasks including two MCA's on the 23<sup>rd</sup> November 2016, made a referral to the NRM, obtained an IMCA<sup>10</sup> and liaised with the police which, were all timely and appropriate.

5. The two initial MCA's that were carried out on Drina are factual documents. A Roma speaking interpreter was present, along with a Romanian SALT a member of the CLDT and social worker. These were completed in line with the MCA 2005 associated code of practice that meet the Care Act 2014 requirements around participation. They were completed as part of the safeguarding enquiry and determined that 1) Drina could not consent to having contact with her stepfather, who at the time, was a person of interest to the police in their enquiries and 2) she could not consent to moving to the emergency accommodation.

### **Enquiry Officer Handover and Safeguarding Adult Manager role**

6. EO1 was successful in applying for an acting up Cluster Managers, position. His involvement on Drina's case was terminated on the 5<sup>th</sup> December by the CLDT TM. SAM1 in a meeting with the LBB

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<sup>10</sup> The Mental Capacity Act 2005 introduced the role of the independent mental capacity advocate (IMCA). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.

IMR Author and the IOA states TM then assumed overall charge, as he was her manager. It appeared to SAM1 he was bypassing her and making the decisions in Drina's case. EO1 completed a detailed case closure summary outlining the action taken to date and what was still required in order to safeguard Drina and to ensure a smooth handover to another enquiry officer.

7. A new Enquiry Officer EO2 was allocated. There was however, an unsatisfactory period of over a week whilst Drina had no enquiry officer allocated and this was poor practice. Guidance is clear, there must be compliance as enquiry officers, SAM's and management should comply with the London Multi-Agency Adult Safeguarding Policy and Procedures. EO2 confirmed in a meeting with the LBBB IMR Author that she was not initially told that she was the enquiry officer and this is subject to LBBB Agency Recommendation 7.

8. The TM is shown as taking over the role of SAM on the 21<sup>st</sup> December which was two days after Drina and her stepfather were returned home. He had in any case, been making decisions for Drina on the instructions of the GM. Full case notes were provided regarding the decision to close the safeguarding of Drina. These case notes were not uploaded onto the LBBB AIS record management system, therefore the process to close the safeguarding enquiry was not completed. This was not good practice. (See Barking and Dagenham SAR Overview Report Recommendation 6, at Appendix 4 for record keeping).

#### **Deprivation of Liberty Safeguard and Court of Protection**

9. The Care Home Manager (CHM) at Kallar Lodge confirmed to the LBBB IMR Author in a meeting and to the IOA in a telephone discussion that a DoLS<sup>11</sup> should have been requested. An emergency DoLS was not put in place and no request was made by the managing authority during Drina's one month stay in the home. The CHM advised that this did not happen, as it was believed that Drina would be moving again once more appropriate accommodation was found. This resulted in a potentially unlawful deprivation of her liberty, which was also considered poor practice. The CHM acknowledges that her reason was due to continual changes in the action to take from the CLDT but will in the future immediately apply for a DoLS when the circumstances dictate and is personal learning. (See LBBB Agency Recommendation 5).

10. A Court of Protection application and the requirement for a DoLS was being considered by EO1 and the details were included in his case closure report. There was also previous communication between EO1 and the LBBB Adult Social Care Solicitor regarding the aspects of Drina's case. However these requirements were cancelled when EO1 was removed from the case and instructed by the TM to end contact with the legal department. EO1 was also informed to cancel an arranged IMCA meeting with Drina. The reason given by the TM and GM in their interview with the IOA was that the stepfather could advocate for Drina which is challenged and EO1 was removed from the case due to his forthcoming promotion. (The decision to remove him as EO was before the notification of his successful promotion was made).

#### **Safeguarding Meetings, participants and the use of IMCA's and interpreters**

11. There was difficulty throughout Drina's time being supported by LBBB in terms of finding an appropriate interpreter. However, one Roma dialect speaking interpreter was sourced for the two

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<sup>11</sup> The Deprivation of Liberty Safeguards is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

MCA's carried out on 23<sup>rd</sup> November 2016 (This should be read in conjunction with the MCA section that follows).

**12. 24<sup>th</sup> November 2016.** An interpreter was not used at the meeting with the extended family and the police. Inappropriately a family friend of those alleged to have caused harm is recorded as being the interpreter and concerns are noted regarding the accuracy of the interpretation. It is not recorded why the PO1 present at the meeting would have agreed to the family meeting taking place without an appropriate interpreter and more significantly allowing suspects present, one of whom OD was on police bail for Drina's case (See LBBB SAR Overview Report and MPS Agency Recommendations at Appendix 4).

**13. 30<sup>th</sup> November 2016.** A Roma interpreter was used during the safeguarding meeting but no IMCA was present to support Drina. It was disclosed that the stepfather hit her when he was drunk. This information was shared with PO1 by email as police were not present during the meeting.

**14. 16<sup>th</sup> December 2016.** There was no Roma speaking interpreter at the final meeting where the SALT, a Romanian staff member with no formal training in interpretation, was used, which should not have occurred. The minutes of the meeting record it was to determine both Drina and the stepfather's wishes to return to Romania. However, the SALT staff member advised that he could not translate much of what Drina was saying. During the meeting, Drina appeared to communicate through gestures, how she was beaten, had her arm twisted behind her back, had been locked in a room and deprived of food and water. Her stepfather attempted to suggest she was referring to what has happened in Kallar Lodge (in a ploy to shift the blame which was not the case). It was clear that effective communication was difficult and a Roma speaking interpreter could have significantly assisted with the communication to understand what she was saying and what she wanted to say. Furthermore an IMCA was not at the meeting to provide support for Drina. Actions from this meeting agreed that another meeting would be arranged for the forthcoming Monday 19<sup>th</sup> December 2016, to determine the best interest of Drina and whether she can return home with her stepfather. It was recorded that EO2 would arrange for an IMCA to take part in another MCA and complete a 'best interest' decision for Drina to return home to Romania with her stepfather, with an appropriate interpreter to be present at the meeting. It was understood that a HRA would be carried out but it appears there was confusion between the SALT, EO2 and CSW who all believed that the EO2 would complete the HRA. It is now known the TM completed Drina's HRA over the weekend with the assistance of the GM. (See LBBB SAR Overview Report Recommendation 1 and LBBB Agency Recommendation 1 at Appendix 4).

**15.** The view that the stepfather could advocate on Drina's behalf is undermined by the fact that the stepfather appears to have had little English language comprehension, and it is not known if he was fluent in Romanian or had no apparent understanding of safeguarding and what Drina's rights were under UK and European law. It is unlikely that he would have been able to effectively advocate on her behalf even if he was not involved in her neglect and abuse. This was a view stated to the TM at the meeting by the SALT, EO2 and CSW as they jointly believed the stepfather did not have Drina's best interests at heart.

**16.** In the early stages of Drina coming to the attention of the police and LBBB, the priority was to immediately protect Drina and preserve evidence for the police investigation. This necessity meant professionals had to do their best with what interpretation facilities were available to protect Drina. However, once a Roma speaking interpreter had been found, the failure not to arrange meetings with a Roma interpreter being present, was contrary to the principles of the Care Act 2014 and London Multi Agency Safeguarding Policy and Procedures, which the agencies participating in this SAR are

committed to. The LBBB IMR Author rightly indicates that Drina was in a place of safety therefore the meetings could and should have been delayed until an appropriate interpreter was available in line guidance which states:-

*'A requirement under the Equalities Act 2010 is for provision and adjustment to enable disabled people equal access to information and advice. Access to other services for example, translators should always be considered to ensure that the adults are afforded every opportunity to participate and be involved" (Para 3.2.2 LMASPP).'*

**17.** Significantly the CLDT after the meeting should have contacted the police to inform them of the allegations that Drina was attempting to disclose regarding physical abuse she suffered. The police investigating officer should have been invited to a properly convened meeting on the 19<sup>th</sup> December 2016 with a Roma interpreter and IMCA present to help facilitate and to hear Drina's voice in relation to these significant concerns. (See LBBB SAR Overview Report Recommendation 4).

### **Mental Capacity Assessments**

**18.** There were two initial MCA's completed. A further MCA should have been carried out as part of the actions at Drina's final meeting on the 16<sup>th</sup> December. It was to determine whether Drina had the capacity to be able to decide whether she wanted to return to Romania with her stepfather. This did not happen as Drina was repatriated on Monday 19<sup>th</sup> December 2016 before EO2 could complete the action on behalf of Drina.

The Care Act 2014 states:-

*'Where a person has substantial difficulties in participating in either a Care Act assessment (Section 67(2)) or a Safeguarding Enquiry (Section 68 (2) and there is no appropriate person available, an advocate or IMCA must be appointed.'*

**19.** Previously a further IMCA was requested for Drina by the EO1 on the 25<sup>th</sup> November 2016 due to the safeguarding concerns and the change of accommodation; this was good practice. The IMCA was allocated on the 30<sup>th</sup> November 2016. However, the IMCA was cancelled by EO1 on the instructions of the TM and GM. The TM advised that as Drina's stepfather was no longer of interest to the police he was deemed to be an appropriate person to speak on her behalf but, this was not confirmed until the TM spoke with police on the 16<sup>th</sup> December 2016.

**Comment: In a meeting with the IOA, the TM and GM agreed cancelling the IMCA was the wrong decision and acknowledge personal learning. The outcome led to Drina having no independent advocate throughout the whole of her time under LBBB's care and throughout the process with the Home Office with regards to her immigration status.**

### **Home Office and National Referral Mechanism**

**20.** After the LBBB referral to the NRM which should also have been considered by police to refer as a first responder<sup>12</sup>, the National Crime Agency, concluded:-

*'That there are reasonable grounds to believe that you (Drina) have been a victim of modern slavery (human trafficking).'*

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<sup>12</sup> The NCA is a first responder agency, as are, Police Forces, UK Border Force, Gangmasters Licensing Authority, Local Authorities, Health and Social Care Trusts etc.

Drina was given a 45 day recovery and reflection period to consider her options. The NRM goes on to state in the letter sent to the LBBB that:-

*'During this time, you (Drina) will be entitled to safe accommodation and support. At the end of the recovery and reflection period, the competent authority will make a conclusive grounds decision under the NRM and that an individual with a positive conclusive grounds decision under the NRM may be granted discretionary leave to remain due to 'compelling personal circumstance.'*

**21.** This opportunity was not afforded to Drina as she neither had the interpretation nor the independent advocacy support required that should have been made available to her.

### **Repatriation action taken by the CLDT over the weekend of 16<sup>th</sup> to 19<sup>th</sup> December 2016**

**22.** After the meeting at the Civic Centre on the 16<sup>th</sup> December 2016, the decision to reconvene a further meeting on the Monday 19<sup>th</sup> December 2016, was changed and ultimately, unknown to others in the meeting, cancelled. The TM on the instructions of the GM made arrangements to expedite the return of Drina with her stepfather which, was contrary to the arrangement made at the meeting that required another MCA to be completed and to provide adequate IMCA and interpreter services. It is known that the TM was looking at flights to Romania prior to this date and requested the CM to assist. The CM booked and paid for the flight tickets on Saturday 17<sup>th</sup> December 2016 as he held a company credit card. On the Sunday 18<sup>th</sup> December 2016 the HRA was completed and a 'best interest' decision was made to return Drina with her stepfather and the quality of the assessment is quantified at paragraph 29 below.

**23.** On the morning of Monday the 19<sup>th</sup> December 2016, the TM with a Kallar Lodge member of staff escorted Drina and her stepfather to Luton airport. They assisted them through security and customs and they flew home to Romania. On his arrival back at LBBB the TM sent out an email to staff within then CLDT to say that Drina and her stepfather had been repatriated to Romania that morning.

**24.** This affected the morale within the office, with professionals feeling that Drina had been badly let down and is a finding of this review. It was against advice that was previously given by CLDT personnel, both to the TM and GM. CLDT staff believed there had been no need to rush repatriation without carrying out the correct risk assessments and safeguarding for Drina, as she had been granted the 45 day period by the NRM. (See conclusions at Chapter 7).

### **Rationale for Repatriation**

**25.** When the GM was spoken to by the IOA he was asked about the rationale for the decision making process. The GM said that there was a positive relationship between Drina and her stepfather. He was of the opinion that it was in her best interest to return her home with him. He was concerned that failure to do so may breach Article 8 Right to Family Life, ECHR and this was discussed with the Operational Director – Adults' Care and Support. This aspect was further addressed within the meeting between the IOA and the CLDT TM, GM and Operational Director (See paragraph 29 for recorded rationale under HRA and also within interviews with practitioners below).

**26.** The reliability of the decision making process in Drina's case is compounded with the failures to share the information that Drina was describing physical abuse to herself and her stepfather hitting her when drunk, seems not to have been considered. It is further undermined by the lack of a decision specific MCA, a flawed HRA assessment and no IMCA or any other advocacy, no Roma speaking interpreter and no Legal Services involvement when there should have been. Both the TM and GM's view was that as Drina stepfather was no longer a person of interest to the police (this review believes

he should have been treated as a suspect or significant witness at the very least) he was an appropriate person to act on her behalf, is not accepted by this SAR.

**27.** The fact that police may not have considered the stepfather was a suspect in this case, as this SAR and the MPS IMR Author agree, the investigation was not of a satisfactory standard and fell short of the requirement to investigate and prosecute offenders for the heinous crime of human trafficking and modern slavery. Police have to be sure that the evidence and criminal threshold is 'beyond reasonable doubt' but there is still a requirement if they do not pursue an investigation against an individual that the CLDT still have a duty of care, as they have a lesser threshold of the 'balance of probability' to meet. It appears neither agency's enquiry rose to the level of professional inquisitiveness to consider thresholds for their enquiries. It is the view of this SAR that the 'best interest' decision taken by the TM and GM for Drina to return to Romania with her stepfather, was unsafe and the rationale flawed. Furthermore, the police investigation did not carry out an investigation into Modern Slavery in Drina's case, with a weak rationale given to close the investigation.

**28.** If the information of the physical abuse intimated in the meeting by Drina on the 16<sup>th</sup> December 2016 had been shared with police, there would have been an opportunity to have stimulated the police investigation that was still open at that stage. It may have delayed a decision to repatriate Drina and for CLDT to carry out further safeguarding enquiries.

### **Human Rights Assessment**

**29.** The HRA that was completed on the 18<sup>th</sup> December 2016 was uploaded onto LBBB AIS computer record system several days later. It records 'the HRA was undertaken and recorded that Drina and stepfather should be given financial and practical support to travel home including booking plane tickets and transfers to the airport. Drina expressed wishes to return home and was visibly relaxed and happy in her stepfather's company, intermittently holding his hand. Both Drina and father (sic) have agreed to this and UK authorities have been in touch with Romanian authorities to outline what has taken place. This decision was made in consultation with Operational Director and the CLDT GM. Police agreed they are free to leave as they are not required as part of the police investigation. Home Office states that she is unlikely to be allowed to remain in the UK. Concluded that human rights are not being contravened in allowing Drina to return to Romania. In balancing the risk it was concluded that Drina would be better off returning to her own country where local authorities can support her. Plan is for Drina and stepfather to return to Romania on Monday 19<sup>th</sup> December from Luton airport.'

**Comment: This entry and the contact with the Romanian authorities was after they arrived back in the country and not as intimated above. There was no formal risk assessment completed. The HRA contradicted that Drina did not have the ability to make a decision for herself but further records show that Drina said she wanted to go home with her stepfather.**

**30.** There is a confusion, as noted above, over who had the responsibility to carry out the HRA after the meeting on the 16<sup>th</sup> December. The EO2 thought it was her responsibility as well as organising an IMCA, this is confirmed by the SAM at the time, who recalls this discussion outside of the meeting.

**31.** The TM who chaired the meeting and who was described as constantly in phone communication with the GM, states that he was unaware of the social worker being tasked to carry out the HRA assessment and as he completed it over the weekend. He concluded it was in Drina's 'best interest' to return her home and flights were booked on the orders of the GM.

**Comment: The HRA was viewed by the IOA and it shows the HRA was both problematic and the overall assessment is contradictory to the facts. It appears not to understand the principles of the**

**MCA 2005 regarding precedence of Drina’s incapacitated wishes, particularly with her not having access to an appropriate interpreter and an IMCA, over a robust and thorough risk assessment of Drina. Furthermore it did not outline the apparent abuse that Drina had disclosed and the old injuries found on her after the home carried out a ‘body mapping’ examination which, was not followed up by a medical professional.**

**32.** This review concurs with the view of the LBBB IMR Author who records the failure of the assessment to make reference to Article 4 (No Slavery or Forced Labour) European Convention on Human Rights Act 1998. This is concerning as her stepfather may have been directly involved as a possible suspect for forcing her into labour and servitude or at the minimum being unable or unwilling to protect her from others in doing so. There was also no consideration in the assessment given to Article 14 of the ECHR 1998 (protection from discrimination) with the core principle that *“all of us, no matter who we are, enjoy the same human rights and should have equal access to them.”*

**33.** The HRA form was signed electronically by TM and GM with the wrong date of the 18<sup>th</sup> September instead of December 2016. The Operational Director was shown as also signing it off with the GM. It is understood that the TM had not completed a HRA before. He informed the IOA in interview (see interview of professionals below) that he was consulting and being advised by the GM over the weekend on how to complete the HRA, before finally completing it on the Sunday. Neither he nor EO2 had completed or had received training on the completion of HRA’s prior to the assessment (See LBBB Agency Recommendation 2).

### **Agencies Individual Management Reports**

#### **LBBB Commissioning, Adults’ Care and Support**

**34.** The IMR Author Quality Assurance and Safeguarding Adults Manager completed a concise report. It captured safeguarding failures as detailed in the agency recommendations in Appendix 4 and incorporated within the analysis of this report.

**35.** It was evident that training on modern slavery was imperative and steps have been put into place to enhance the online E-Learning with an additional SAB Training Plan that is in progress. Interviews with staff were carried out and where relevant are incorporated within the IOA interviews with participants below. The IMR author, when conducting meetings with individual staff members identified there was increasing concern who the decision makers were, with the allocated SAM1 feeling that more senior managers were making decisions rather than allowing the involved frontline staff to complete their enquiries and follow due process. This concern was evident when the IOA met with the key professionals as the outcome for Drina affected the morale of the team who, felt that Drina was not adequately protected. The IMR makes several recommendations that are supported and endorsed by this SAR (See LBBB IMR Agency Recommendations at Appendix 4).

**36.** It was suggested that financial constraint may have contributed to Drina being repatriated as a way of reducing cost. The SAM thought this might be the case but the budget holder, the GM was clear this was not the motivation in his meetings with the IMR Author and with the IOA. Enquiries made by the IOA ascertained however that the CLDT budget was considerably over budget. This question was raised by the IOA author with the Operational Director who confirmed that he maintains a contingency for overspends. There is no evidence to suggest therefore that financial constraints was the reason for Drina’s repatriation.

## **Metropolitan Police Service**

**37.** The criminal investigation was being conducted by the Barking and Dagenham East BCU which has subsequently been restructured into the Tri-Boroughs of Redbridge, Havering and Barking & Dagenham referred to as the EA-CU. It does not appear by PO1 or any supervisors that they sought independent advice in the complexity of investigating Modern Slavery as there is a MPS SO7 Human Trafficking Team and Borough SPOC's that could have been consulted. It is suggested that the stepfather should have been treated as a possible suspect for human trafficking for allowing or placing Drina, who was in his sole care, into slavery and servitude. He brought her to the UK a month or so earlier (exact date was never determined by police) to be kept in inhumane conditions. It is believed for her to be used as a slave and to beg on the streets. This was not investigated satisfactory in the professional opinion of the MPS IMR Author and the IOA who has an extensive police background, investigating serious allegation of crime (See Biography at Appendix 1).

**38.** Furthermore, organisational issues were identified by the IMR Author that the investigating officer PO1 did not consider Human Trafficking or Modern Slavery as part of the investigation and further consented to Drina being returned to Romania without completing a full investigation and ensuring her future safety (See MPA Agency Recommendations 1 and 2 at Appendix 4).

**39.** The IMR Author states that "the Criminal Investigation Department (CID) had taken primacy of the investigation and dealt with the suspects correctly. They liaised with Adult Social Care (ASC) (the term used by police for the ADIT) and ascertained that Drina would be assessed for mental capacity in the forthcoming days. Establishing her mental capacity would give police a better understanding of how she could be dealt with as a victim, as it was understood that victims are frequently targeted because of their vulnerabilities, such as learning difficulties. The fact that Drina was deemed to have learning disabilities would not have precluded her from being interviewed but it would have required a video interview with the use of an intermediary. There is no evidence of an investigation plan and no consideration given as to who forcibly removed Drina from the address and who managed her on a daily basis."

**40.** On 24<sup>th</sup> November 2016, the investigating officer attended the family safeguarding meeting for an interview with a family of an 'Adult at Risk.' The meeting was with family members including the stepfather, a family friend acting as interpreter and OS, a suspect who was on police bail in Drina's case for false imprisonment. PO1 should have obtained a Superintendent's authority to meet a suspect whilst on police bail. Police gave a precis of the events of the 17<sup>th</sup> November 2016. It was established in the meeting that the police recognised that the driver of the van was someone they needed to be speak with (known to be the husband of OS who was never seen by police). The family outlined the need to return Drina to Romania and it was explained that a court will need to make that decision. A safeguarding plan was put in place with a communication strategy.

**41.** On 1<sup>st</sup> February 2017, the police CRIS records that Drina was taken back to Romania by her stepfather and that Romanian Social Care were aware of her return. It stated that Drina made no allegations against anyone and there were no physical signs of abuse. The investigating officer commented that "she is a fairly large lady and therefore could be assumed that she is well fed." He stated that there were no witnesses, no CCTV, no photographs to assist a prosecution. The report conclusion stated "Drina is our main concern and the very best outcome is for her to return to Romania in a country that she fully understands and with people that understand her."

**42.** The IMR author further confirmed as well as no investigation plan, there was also no appropriate supervision or any consideration given to speaking to the stepfather with an interpreter, whether as a suspect or as the guardian of Drina. It was also not evident why it was concluded that Drina had not

made any allegations, as no consideration had been given to interviewing her and that is contrary to the information provided to this review. There was no reference to evidence secured by the Initial Investigating Officers (IIO) and the squalid conditions of the shed or no reference to the video footage of Drina taken by the bailiffs. There was never a consideration given for the offence of Modern Slavery and or kidnapping.

**43.** The IMR further challenges the closing entry that “Drina was not given the appropriate opportunity to speak to police. The police previously refer to her being hit by her step father when he was drunk. A comment to her size and being well fed are wholly inappropriate and have no evidential basis. There are witnesses who are afraid to assist police and there is photography and video footage seized of the incident. This closing summary is completely to the contrary of the evidence presented. It is a possibility that Drina could be re trafficked or harmed further.” The IMR Author believes that had Drina been treated by police as a victim of Modern Slavery, the outcome of the case may have been different.

**44.** The whistle-blower raised concerns around specific questions asked of police. These include why was the step father not investigated or charged?

- When he admitted taking her from the address in the van.
- When he lived at the property with Drina.
- When Drina stated he beat her when he had been drinking.

**45.** These questions are accepted by police as valid and raise concern as to the quality of the investigation, lack of understanding of the Modern Slavery Act 2015 and the safeguarding of vulnerable persons and appears Drina’s wellbeing was not considered.

**Comment: The IOA concurs with the IMR Author’s views and comments above. There is considerable learning for the MPS that has been identified from the analysis within this review. Overall, police acknowledge this was a very poor investigation and the concerns and action taken are subject to MPS Agency Recommendation 1 at Appendix 4.**

#### **NELFT**

**46.** NELFT provides an extensive range of integrated community mental health services for people living in the London Boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest and community health services for people living in the south West Essex areas of Basildon, Brentwood and Thurrock.

**47.** The NELFT IMR Author confirms that Kallar Lodge was a place of safety but was not an appropriate placement as she was assessed with a learning disability and a DoLS should have been considered.

**48.** On 18<sup>th</sup> November 2016 the staff at the care home on Drina’s admission, completed a body map and noted scarring, which was suggestive of burns to her right side, leg and thigh. The IMR challenges, given the condition she was found in, that no referral for a physical health check was considered.

**Comment: This review confirms that Drina during her time in the care of the Local Authority and during the police investigation was never seen by a medical practitioner to assess her physical wellbeing and is subject to recommendations within this review at Appendix 4.**

**49.** The concerns in Drina’s case after her return home to Romania was submitted by a CLDT member of staff through the NELFT Whistleblowing procedures and was subsequently raised with the Deputy Chief Executive and Strategic Director, Service Development and Integration, London Borough of

Barking & Dagenham by the Integrated Care Director, NELFT and captures the sequence of escalating the issue.

50. It was initially reviewed under the NELFT Serious Incident processes, with a 24 hour and 72 hour report completed. It was de-escalated as a NELFT Serious Incident as it was considered that any further investigation process should consider a SAR investigation under the Barking and Dagenham Safeguarding Adult Board policies and procedures. (See NELFT Agency Recommendations at Appendix 4).

### **Modern Slavery and Human Trafficking Unit**

51. The National Crime Agency leads the Modern Slavery Human Trafficking Unit who administers the NRM on behalf of the Home Office. As previously alluded to in Chapter 1, the UK is a signatory to The Council of Europe Convention on Action Against Trafficking in Human Beings and led to the creation of the UK NRM which is a victim identification and support process, designed to facilitate co-operation and information sharing between agencies, in order to assist potential victims to access advice, accommodation and support.

52. The NRM referral was first received on the 25<sup>th</sup> November 2016 from a first responder, EO1. There was effective communication with a NRM case worker by EO1 to discuss Drina's case with details of the MPS investigating officer shared. On the 2<sup>nd</sup> December 2016, a positive decision was made and notified to LBBD on the 5<sup>th</sup> December 2016 that support will be provided and Drina was allowed a 45 day recovery and reflection period. (When Drina was repatriated the 45 day period was still active). Following a positive 'Reasonable Ground' decision, the 'Competent Authority' will then make a second decision which conclusively decides if the individual is a victim of modern slavery based on the balance of probabilities that was confirmed in Drina's case.

53. It is noted within the chronology of events that the NRM later received an email from the TM stating he was the source of further information regarding any final conclusive decision and relevant safeguarding, as the contact for the NRM.

54. The TM telephoned the NRM case officer on the day of the meeting on the 16<sup>th</sup> December 2016 and informed the NRM case worker of the stepfathers' details confirmed by Romanian social services and that Drina wishes to go home to Romania, it will not impact on the police investigation and so this will be facilitated. The NRM agreed that Drina would be free to leave the UK.

**Comment: As the NRM is a civil process which makes decisions on an individual's status of Modern Slavery, it can postpone negative immigration decisions but, it cannot stop an individual from exiting the UK, as only safeguarding agencies (police or local authorities) can do this. When the TM spoke to the NRM they were not informed by TM that Drina was not in a position to consent as she required a MCA and support from an IMCA and Roma speaking interpreter to obtain her wishes. The NRM later requested and received confirmation of the repatriation on the 26 January 2017 for their records.**

55. The MSHTU do not interview potential victims or have any direct contact with them as all information is gained through submissions. It was explained that as Drina returned to Romania with her stepfather, as the rationale for this decision was supplied by a social worker and police, any action of a risk assessment is their responsibility. The MSHTU and NRM therefore take no view on this aspect. The case was left as a live case as the final conclusive grounds decision, as to status to either

leave the UK or remain had not been made which, does not impact on this review. The IMR made no recommendations.

### **Interviews and contact with key practitioners concerned in Drina's case**

**56.** The IOA carried out the following interviews and communication with key practitioners. Even though this review has identified significant failures to safeguard Drina as a victim of modern slavery, the key practitioners, acknowledged failings and fully accepted the need for lessons to be learnt. The participants were open and frank in their response and fully assisted the review process.

#### **Operational Director, Adults' Care and Support**

**57.** The Operational Director (OD) explained the restructuring of the Adult (CLDT) and Child Disability Services that had merged into the Disability Service and is subject to comment within Barking and Dagenham SAR Overview Report Recommendation 3. He had been kept apprised of the Drina case by the CLDT GM. He understood that a best interest decision and HRA had been completed for her to return home with the stepfather who, was considered suitable. He was of the opinion, suggested by the GM that Drina would be better with her own community rather than be a resident in a UK institution. He was reliant on the information provided by the GM and believes "you should allow your senior managers to make decisions." The OD was aware that the HRA was signed off by the GM but unaware his name was also appended on the document with the GM's. In hindsight he acknowledged personal learning to question such decisions in future.

**58.** It was discussed about the poor morale of the team which was impacted after the unsafe premature removal of Drina from the UK. The fact that staff were upset and shocked in conversation with both the LBBB IMR Author and IOA and to show that this SAR listened to CLDT staff who were participants to this SAR, the issue was raised with the OD. The requirement to promote empowerment of staff to challenge senior management decisions if necessary were also discussed to support the escalation of professional concerns. With credit to the OD, he agreed to hold a face to face meeting with the staff affected and fully supports the whistleblowing and escalation procedures for staff which he will promote. The Council has also subsequently agreed that if further organisational development support to the staff teams would be helpful after this meeting, in order to strengthen trust and confidence, it will be provided. The OD asked the IOA about any learning that could assist to stop the issues arising in the future. A recommendation was suggested and agreed that in such complex cases that there must be multi-agency case conference or discharge strategy meeting with Legal Services involvement to advise the Local Authority, as the responsibility for the final sign off sits with the Director of Adult Social Services. (See Barking and Dagenham SAR Overview Report Recommendation 1 at Appendix 4).

#### **CLDT Group Manager**

**59.** The GM gave a brief summary of the case and his CLDT teams' involvement. He confirmed his team liaised with the Home Office and NRM, who indicated that Drina would likely be repatriated to Romania at some point in the near future and was granted 45 days to stay in the UK. It was acknowledged that the work on the case started off well and he was aware that Drina was placed in an inappropriate placement as an emergency but had Drina been in the UK longer, she would have been moved into more appropriate accommodation.

**60.** With regards to the repatriation, he questioned whether prolonging the decision making on the case would have led to a better outcome for Drina. He stated that he and the team did consider the abuse Drina suffered but they also considered whether it would be in Drina's 'best interest' to stay in

UK longer than necessary, to be moved into different accommodation and to continue to be estranged from her family and stepfather. He confided that the team struggled with the decision. The Christmas period was approaching and he didn't feel it was right for Drina to be placed in alternative accommodation. He did not want work and decision making around the case to continue for longer than was necessary. It was pointed out that there was the failsafe, that after 45 day period Drina would be repatriated to Romanian under Home Office and immigration guidelines if satisfied.

**61.** The case was handed over to EO2 after EO1 left to take up a new role in another team. To put things into context, he explained that there were two tiers of managers below himself including the TM. Due to the complexities of the case, he was involved in making decisions around Drina. The SAM's role was taken over by the TM who was sharing information with him, as the SAM went on annual leave.

**62.** It was pointed out that the MCA's undertaken by EO1, clearly stated that Drina required a Roma speaking interpreter and support and at no stage was Drina provided with an IMCA or other advocate and this was acknowledged. He was asked that legal advice was being considered but this was not progressed and agreed that the DoLS application should have been requested by the manager of Kallar Lodge where Drina was staying. He acknowledged that they should always ensure that the correct interpreter is used and that staff members should not undertake interpretation and translation as was the case in using the SALT at the meeting on the 16<sup>th</sup> December 2016.

**63.** He was asked why an IMCA that had been previously arranged for Drina was cancelled at the request of the TM. The GM stated that they were satisfied that Drina's step father could advocate for Drina. His normal practice is that if there is a family member who can act as advocate for a person then this is what happens. (Participants in safeguarding meetings is subject to Barking and Dagenham SAR Overview Report Recommendation 4).

**64.** It was discussed that agencies did not arrange a medical examination for Drina after staff at Kallar Lodge carried out a body mapping of Drina and found scarring that looked like burns on her body. The GM was unsure if this information was shared with police. He however had a dilemma about referring Drina for a medical due to her issue with capacity. If she appeared to be fit and well he suggested, it could be interpreted as being abusive to undertake an examination and this could have complicated issues.

**Comment: Further enquiries whether to arrange a medical examination and the propriety of that decision were not explored. There was no professional medical expert sought to assist Drina's case to comment on the injuries and preserve the possible evidence of physical abuse of Drina.**

**65.** In respect of the meeting that took place on Friday 16<sup>th</sup> December, the GM was asked if he thought that sufficient risk assessments were undertaken to safeguard Drina from being in her stepfather's care. He stated that this was considered at the time but he can see, in hindsight, that a more robust risk assessment should have been undertaken along with a case conference. It was outlined that EO2 was in attendance at the meeting and took away some actions that included undertaking a HRA, an MCA and getting an advocate for Drina but he did not recall there being any actions around undertaking an MCA and getting an advocate (minutes confirm this was actioned). In his experience of MCA's, he believed they are fraught with complexities, when people are on the borderline, as he believed Drina did have some ability to communicate and could clearly state what she did and did not want. It was pointed out that was the role of the IMCA to support people with learning difficulties in order to understand and make decisions which, was accepted.

**66.** He was aware of the meeting but was not present but recalls agreeing that they needed to check out the position of the Home Office and the Police as he knew that Drina is likely to have been a victim of Modern Slavery.

**67.** The GM was asked what led to the decisions being made over the weekend, to repatriate Drina with her stepfather, to Romania on the morning of Monday 19<sup>th</sup> December 2016. He stated that they were trying to complete a piece of work before the Christmas period. He understood that the meeting on 16<sup>th</sup> December 2016, was to make arrangements for both Drina and her stepfather to return home. (This appears to contradict the view of the TM and EO1 and meeting participants). It was confirmed the flights were booked on Saturday 17<sup>th</sup> December 2016, the HRA was completed on 18<sup>th</sup> December 2016 and Drina and her step father were flown home on the 19<sup>th</sup> December 2016. The GM said the HRA was a culmination of thinking and preparation that had already been undertaken and he and the TM worked together to record this in writing, on the HRA form.

**68.** He feels that there are lessons to be learnt around the safeguarding work on the case. He stated that the Operational Director for Adult Care and Support was made aware of the situation, checked the plan and was in support of the decisions made. The IOA asked whether he would usually show the Operational Director on the HRA as a counter signatory which, he admitted he did not normally. The GM was unsure whether Drina would have been at risk in Romania, but Drina made it clear that she wanted to return with her stepfather and agrees that they should have taken steps to communicate the issues with Romanian authorities prior to her being sent home.

**69.** He felt that the TM was best placed to undertake the HRA at the time (his first HRA) and believes the whole team could benefit from having some on training on HRA's. He stated that it was a complex case and full of dilemmas. The GM's view was that had Drina not been sent home and was put into alternative accommodation, they may not be open to criticism but that this could have led to a worse outcome for Drina. He and his staff were genuinely concerned for Drina and her welfare concluding that Kallar Lodge was used as it was safe and was managed by the Council. They did not want to cause Drina unnecessary distress and upheaval in moving her and he was only interested in doing the best for her.

**70.** The GM was asked whether the decision to return Drina home was due to financial constraints. He confirmed that this was not the reason.

**71.** The GM agreed with the IOA that there was personal learning for him to take forward as follows:-

- The safeguarding process and recording.
- Lack of a case conference undertaken at the beginning of the process to enable more effective liaison with the police and other organisations.
- Consideration of a Court of Protection and putting in place the DoLS.
- More effective and timely communications with Romanian authorities.

#### **CLDT Team Manager**

**72.** He was the Team Manager in the CLDT, responsible for approximately thirteen staff including managers. When a safeguarding alert is received by the ADIT it is passed onto the CLDT and then allocated to an enquiry officer and a SAM which occurred in Drina's case. At the early stages he did not have an in-depth knowledge of the case but was aware of the safeguarding element and that Drina was possibly discovered living in a shed in a garden, as further enquiries would have been taken forward by the enquiry officer allocated to it. He said many staff in the office were aware of the case but it was too early at that point to know about the abuse and further details of Drina's situation.

**73.** The TM believes the decision was taken not to move Drina at the end of November 2016 or at the beginning of December 2016 because the GM wanted to prevent Drina being caught up in a lengthy process and at the same time acknowledged that the EO1 was carrying out a good job. The team however, did not consider referring Drina for a medical check at that stage and he was unsure whether he was aware earlier of the body map document recording the scars on Drina's body, undertaken by Kallar Lodge or if the police were aware of this information.

**74.** On the 5<sup>th</sup> December 2016, he told EO1 that he was no longer the enquiry officer as he would be moving into a new role. The TM was aware that the EO1 had started the communications with legal, attempted to get an IMCA for Drina and had researched alternative accommodation options. He felt it was not appropriate for him to get too involved in the case as he would be moving on, as the SAM was leading on the case. He believes the GM spoke with the Operational Director and plans started being made to send Drina home, in early December 2016. The cost for keeping her was the responsibility of LBB and the TM stated that there was a desire to avoid a lengthy complicated process and he followed instructions from more senior managers.

**75.** On the 12<sup>th</sup> December 2016, the case was allocated to EO2 as a social worker who was going to be looking at the issues of the case, not just the safeguarding elements. He confided there is a culture in the team that things can drift and they wanted to avoid this. If they had applied to the Court of Protection and for a DoLS, there was a risk that things would have gone on for longer than necessary, which the GM wanted to avoid. Drina was also expressing her wishes to return home and the police had stated that her stepfather was no longer a person of interest.

**76.** There was a pre-meeting on 16<sup>th</sup> December 2016 between the CSW, EO2 and GM on the phone with the TM regarding making arrangements for Drina to go home. He was aware there was no interpreter or IMCA present at the meeting with Drina and her stepfather that afternoon, so they could not have fully understood what the stepfather was saying to Drina. He says that the EO2 was not at any point asked to do a HRA. There may have been some miscommunication as EO2 stated this was one of her actions. When the CSW, EO2 and the SALT who was asked to interpret, told him they were not sure that the stepfather had Drina's best interests at heart. The TM asked them on what basis they felt this but he says they could not clarify. He said that the SALT was not happy with the stepfather but he could not be more specific. With hindsight, he now believes they should have made different decisions, however there was a push from his superiors to get Drina home.

**77.** He received instructions to book the flights on the 17<sup>th</sup> December 2016 by the GM and he asked the CM to carry out. He confirmed that he completed the HRA over the weekend in liaison with the GM, who provided supervision and advice. It was pointed out that the HRA is contradictory as it states that Drina wanted to return to Romania but also states that she does not have the capacity to make decisions about this. It also lacked the information of her injuries and details the body map information which should have changed the perspective on the safeguarding decisions to be made. He confirmed the HRA was signed off by the GM and Operational Director. He travelled to Luton airport with a member of staff from Kallar Lodge on Monday 19<sup>th</sup> December 2016 to escort Drina and the stepfather. There was a desire by GM to take her on the Friday night, but the TM advised this was too quick and it should wait until after the weekend. He was not sure why the management of the process fell to him and not the SAM.

**78.** He acknowledged there should have been a more robust communication with Romanian Social Services and the email sent to inform them that she was on her way home, was sent after they had boarded the plane (in fact it was two days later after translation). There was no forward safeguarding or support plan in place when she left which, he agreed was not good practice. He further stated that

there was lots of unsolicited advice from colleagues located in the office about the case which, he should have listened to. Some colleagues he explained expressed shock and felt uncomfortable about the decision that Drina had been repatriated.

**79.** At the beginning of the process the GM had instructed him to cancel the IMCA as they were not moving Drina from Kallar Lodge and fully agrees that they should have got an IMCA, interpreter and applied for a DoLS.

**80.** He identified some learning from the process which, are his personal view, as follows:

- Senior management should not interfere in safeguarding processes and work. The SAM should be left to manage the process.
- There should be a more robust handover between the enquiry officers and the SAM should manage this.
- EO2 was put in a difficult position but this was not done deliberately. She is a good worker and is resilient but there should have been a better handover to her.
- The Modern Slavery e-learning course is helpful but is more of an introduction. Classroom based training is required and would be well received by staff. (The LBBDD have already rolled our classroom based training on Modern Slavery with members of staff having received training for trainers to be disseminated and the SAB Training Policy has been updated).
- For some cases SAM's may need to provide more supervision and guidance. Each team needs group supervision to discuss blockages and complications on particular cases. (This will be addressed within the new modern slavery training programme).
- There is a distinct and unhealthy atmosphere of fear, communications and instructions from senior managers contribute to this and staff feel unable to challenge decisions. (Whilst this has not been widely expressed, this will be addressed by the OD with staff in a face to face meeting, to discuss learning from this review and to promote the empowerment of staff and their ability to escalate concerns and challenge management intervention).
- He feels he may have contributed to this culture by not challenging some of the decisions. He feels this could have been because he was on probation. On reflection, perhaps he should have challenged more and supported his staff to challenge also (as above).
- The TM stated that having learned from this review, he feels confident to challenge decisions in future and support staff to do the same.

#### **Care Home Manager (CHM) Kallar Lodge**

**81.** Drina arrived at the home with no belongings. Staff brought in clothes, provided necessities to make sure she was safe, clothed and fed. A body map was completed which is standard procedure for new admissions. Scars and marks were noted to be present but were not recent and did not require medical attention. Drina showed no apparent signs of pain. There were no immediate concerns for her health and no urgent medical advice was sought for this reason. Communication was an issue as she did not speak English but staff were able to get by, using verbal and gestural prompts.

**82.** CLDT team members were made aware of her body map by the CHM on her return from annual leave, as she was away when Drina was first placed at the home. Contact was made with CLDT to see what the long term plan was for Drina as Kallar Lodge was not an appropriate placement. Drina was under 65 years of age and though clearly vulnerable, did not have dementia. This was a breach of the homes registration with the CQC.<sup>13</sup>

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<sup>13</sup> The CQC are the independent regulator of health and adult social care in England.

**83.** Concern came to light where Drina was trying to help frail residents and it was becoming a problem with both Drina and the residents getting anxious. There was also some concern that Drina may have been tripping residents up when trying to help them. Risk assessments were completed with repeated calls made requesting urgent action as the CHM deemed it not to be in Drina's or other residents best interests for her to remain in Kallar Lodge environment.

**84.** On occasions Drina had entered the kitchen and ate things like a large piece of cheese. Drina did not look malnourished but food for some reason was something that was an issue for her. Also, Drina liked to have things and would take them to her room where it was then difficult to get them back. On one occasion, Drina took all the continence products to her room and then wasn't happy when they were asked to be returned.

**85.** It was difficult to establish her capacity due to language barriers alongside not fully knowing Drina's needs, to enable support for decision making to be provided. The CHM was considering a DOLS application and urgent authorisation. MCA's were completed, this took some time due to the limited number of interpreters able to speak the language. EO1 completed the MCA's and determined that Drina did not have capacity around accommodation. Representatives from another home visited on the same day to assess her and accepted Drina for accommodation. For this reason an urgent DOLS was not requested at that time. However instructions were received from CLDT management for her not to be moved. Contacts with the CLDT was initially EO1, then directly with the TM and GM. The CHM was under the impression that Drina would be moving fairly quickly as other accommodation had been identified for a potential placements.

**86.** The CHM was aware the CLDT were trying to get health appointments set up. A concern for the home as a provider was what medication she was on. CHM concluded that Drina was not on any medication, she was not registered with a GP and not showing any signs of health concerns. It is pointed out that it is very difficult to get a district nurse to come out and the GP will not come out if the patient is not registered. The CHM had no details or information to register her as temporary but there had been no need to seek emergency attention as no concerns were raised in this area.

**Comment:** There were clear issues regarding medical examinations, the sharing of information regarding the body mapping findings, lack of appropriate speaking interpreters and intervention by CLDT management that impacted on Kallar Lodge to comply with their CQC registration. The CHM acknowledged personal learning that regardless of delays or anticipated movement of residents, a DoLS would be applied for in every case in the future. The CLDT management failure to move Drina to another placement when concerns with Drina and her interaction with the other elderly residents were raised, left the home vulnerable to potential health and safety dangers.

#### **Interim Manager (IM) – Life Planning Team**

**87.** The IM raised concerns about Drina with both the GM and TM shortly before she went on leave. She spoke to GM and told him that it was her opinion that either the TM or SAM1 should act as SAM and made it clear that it may not be safe to immediately return Drina to Romania. She explained to the GM that she had concerns that Drina may have been a victim of both neglect and exploitation and this should be dealt with under safeguarding. At that stage the IM had no knowledge that there was any plan to send her home. On returning from holiday and learning of what happened with Drina, she states there was an atmosphere and she spoke with the TM to offer advice that this was premature and believes he may have been put under pressure by his line manager the GM, as he was a new manager under probation. The IM was going to escalate the concerns but held back as she was aware that NELFT were going to raise whistleblowing procedures. The IM remains concerned for the

wellbeing of Drina and considered it likely that she had not been safeguarded and that she may be at risk of further abuse and neglect. The IM was on vacation when the care plan for Drina was changed and EO 1 taken off the enquiry.

### **Consultant Social Worker (CSW) Cluster Manager**

**88.** The CSW had minimal involvement in the Drina case. On Friday 16<sup>th</sup> December 2016 she was allocated to the case and was told that a meeting with Drina and her stepfather had been arranged for that afternoon. The CSW had a pre-meeting with TM and EO2 with TM communicating with the GM on the telephone. She asked if there was a need for an IMCA and interpreter for the meeting and was told that she did not need to know too much for the meeting and just to observe. She was told the meeting was concerning Drina returning home to Romania with her stepfather. The CSW questioned why they were rushing to have the meeting without this support as they had 45 days allocated from the Home Office. Apparently she was told the GM stated that the meeting had to go ahead and the CSW asked the SALT to interpret at the meeting.

**89.** CSW discussed the HRA with EO2 and discussed the need for an interpreter and advocate to be present when the assessment was undertaken. At the meeting with Drina that afternoon, she did not show signs of being scared of her stepfather, although she did gesture at being beaten. CSW told the meeting they needed to have another meeting to clarify further issues on the Monday. TM spoke to the GM on the phone and the CSW recommended they wait and put all measures in place before making any final decisions.

**90.** When the CSW arrived at work early on Monday 19<sup>th</sup> December 2016, she had a brief meeting with EO2 to plan the work to be undertaken. She was shocked to find out that Drina had returned to Romania. TM confirmed to her that the HRA had been undertaken over the weekend. The CSW's view was that Drina could not make a judgement at that time and she did not know Drina's full background but she would have used the 45 day period to make a proper assessment with an advocate and interpreter, carried out a full risk assessment and had onward communication with Romanian Social Services. She believed if Drina was to be repatriated after the 45 day period, the Home Office and Immigration Service would arrange the plans to return her home as it was not the social worker's role to book flights and take people to the airport.

**91.** CSW stated that people are aware of whistleblowing policy. She feels she did challenge TM at the time and made clear that he and the GM needed to take responsibility for the decisions taken. (Both the TM and GM within this SAR accepted responsibility for the decisions they took).

### **Enquiry Officer - Social Worker EO2**

**92.** EO2<sup>14</sup> was allocated the case after EO1 left the team, in the week beginning 12<sup>th</sup> December. Her involvement in the case was very short at less than a week, as there was a delay with no proper handover from EO1. She received a call from a friend of the family saying that the stepfather wanted to meet with Drina. EO2 arranged this meeting at the Civic Centre on the afternoon of Friday 16<sup>th</sup> December 2016. She, CSW and the CLDT TM met previously and later joined the SALT, Drina and the stepfather at the Civic Centre for the meeting.

**93.** The stepfather stated that he wanted to return to Romania with Drina and had the money to go immediately as he could no longer stay with friends or family and would not share the address of where he had been staying. He was given an opportunity to stay in a hotel until at least the Monday,

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<sup>14</sup> An enquiry officer is a member of staff who undertakes and co-ordinates the actions under S42 Care Act 2015.

when things could be reviewed but, he declined offer. It was explained to him that Drina could not leave straight away and will stay at Kallar Lodge over the weekend. The stepfather stated that he was in the UK to visit his children but he could not remember their names. No one expressed any concerns about the stepfather's involvement in Drina's abuse. She got the impression that he might have also been a victim (this view was not further pursued or considered).

**94.** EO2 suggested at the meeting that an IMCA was required in order to fully understand Drina's wishes. Clear actions were agreed between TM, CSW and EO2 that she would arrange for an IMCA, a Roma speaking translator and undertake a MCA around the decision to return to Romania and undertake a HRA. TM stated the action for EO2 to carry out a HRA was not agreed but the other participants believed this was the agreement. The minutes of the meeting also did not reflect this and there is a lack of clarity of the notes of the meeting taken by the EO2. (They were not completed until after the repatriation). EO2 was going to be supported by the CSW through the HRA process for Drina and was planning to request the translator and IMCA for a follow up meeting agreed for on the 19<sup>th</sup> December 2016, as by the time the meeting ended on the Friday, it was around 6pm.

**95.** When she came into work on Monday 19<sup>th</sup> December 2016, she received information that the CLDT had already repatriated Drina and her stepfather to Romania. EO2 was not aware that this was going to happen and called the CHM to check that this information was correct. She then received an email from TM stating the HRA was undertaken at the weekend and they had returned home on a flight that morning. EO2 was surprised at this as she was aware that an MCA had not been done as required. There was no rationale explained as to why this decision had been made or why they did not wait for her to undertake the actions that had been agreed, as Drina' was in a place of safety at Kallar Lodge. She was surprised that the repatriation had happened so fast. She felt it was vital to get an IMCA and translator to move forward with the case and in order to undertake the MCA. She had made initial enquires to see whether an IMCA was allocated or available for Drina.

**96.** EO2 feels there may have been discrimination from other family members but it didn't seem like there was discrimination towards Drina from the stepfather and she did not feel that discrimination played a role in Drina's repatriation.

**97.** She was not aware of budget pressures that would affect the provision of care to Drina. Within the team she described there is a good relationship between staff and managers with a small shortage of staff at the time. Overall there was some pressure but the staff coped well and supported each other by talking through issues. EO2 did not feel the workload would impact on decision making around the case as the team are used to managing large caseloads. She felt that this was a straight forward case for her and EO1 had already done a lot of the work that was helpful to her.

#### **NELFT Speech and Language Therapist (SALT)**

**98.** The SALT explained that his role was dealing with clients with communication, eating and drinking problems and is employed by NELFT within the CLDT. His first contact with Drina was with EO1 when they carried out a joint MCA on her, using his professional opinion whilst she was at Kallar Lodge with a Roma interpreter and an IMCA on the day. Symbolically he deals with vulnerable persons and Drina was assessed as having a significant learning disability.

**99.** It was good practice that EO1 also used the services of the IMCA and a Roma speaking interpreter as the SALT, although from Romania he could not interpret the dialect that both Drina and the stepfather who he later met, used. There were two MCA's carried out for Drina, one regarding her lack of capacity and the other a decision of no contact with the family at that time. To understand, it

was imperative he believed that contact communication should only be made with the services of these professionals to best serve and understand Drina.

**100.** He was later aware that the TM had cancelled the service of an IMCA for a 'best interest' meeting that had been arranged by EO1 on the 5<sup>th</sup> December 2016 and told to delete the appointment from his diary. There appears no rationale to this request and he believed *"This action denies any rights to the individual who is left with her disability."*

**101.** He was aware there were safeguarding meetings for Drina and the family but he was not invited to attend. He was asked to transcribe and translate an email to the Romanian Social Services to find out the background on Drina and her family. In response it was reported that she was known and registered with severe learning disability, they replied with a derogatory comment that *"Roma do not want to accept services but only wanted financial assistance."* It transpired that she was in receipt of a monthly allowance that the stepfather collected on her behalf (See Culture and Diversity, paragraph 116).

**102.** On Friday 16<sup>th</sup> December 2016, he was approached by the CSW his Cluster Manager and told to attend a family meeting at the Civic Centre to act as interpreter that afternoon. He told her that he cannot speak or understand Drina's and the stepfathers Roma dialect but was instructed to attend and do as he was told. He was aware that there had been an earlier meeting with the TM, CSW and EO2 and communication with the GM on the telephone with the TM. This information was recorded on the LBBB AIS system on the 21<sup>st</sup> December 2016 and was an agreement to set up a family meeting that day between Drina and her father (not recorded as stepfather) to establish if they still wished to return to Romania.

**103.** The SALT attended the arranged meeting on the 16<sup>th</sup> December and Drina was collected from Kallar Lodge. At the Civic Centre Drina and stepfather embraced. She started talking to her stepfather but the SALT could not interpret. Drina apparently intimated she wanted to go home and with gestures described how she was beaten, how her hand was twisted behind her back, how she was locked in a room, beaten on the head and deprived of food. (Food was clearly an issue for her as during the meeting she removed some biscuits that she had concealed on her person and offered them to those present).

**104.** The stepfather stated that Drina had never been beaten up while in his care, stating that she is referring to her current placement (Kallar Lodge). The SALT stated that listening to them both, they were saying completely different things. The stepfather kept saying that they should not listen to what Drina is saying as she is *'handicapped.'* The SALT stated that to get a more accurate information from Drina it would be better to have a Roma interpreter to translate, to understand what Drina was trying to say. Drina kept saying her mother was dead and kept repeating that she was beaten up and forced into a room.

**105.** They discussed the allowance that the stepfather collected on her behalf and he confirmed he was the main carer of Drina. He was willing to travel back to Romania with Drina the following day with his own funds, which was declined. The CSW said she would have to liaise with the Romanian Social Services to follow up Drina's case and a referral would be made to ask them to support Drina. The stepfather did not know where he was currently staying and could not remember the names of his family in the UK.

**106.** The SALT confirmed as indicated above that he, CSW and EO2 told the TM they were not satisfied that the stepfather had Drina's best interest at heart and felt that letting him have Drina back into his care, it was likely that they will remain in the UK and disappear from the local authority radar. They

told the TM, they needed to ensure that Drina does have an opportunity to express her choices and feelings and to establish whether she had the capacity to make a decision to return to Romania.

**107.** During this meeting, the TM went out of the room to speak with the GM on the phone. He came back and stated that the local authority had to satisfy themselves that by sending Drina back to Romania her human rights will not be breached and that an HRA is required. The meeting concluded and the stepfather was told that there would be another meeting on Monday 19<sup>th</sup> December 2016 and Drina was to return to Kallar Lodge.

**108.** He recalls the action was to complete an MCA to ascertain Drina's capacity to make a decision to return to Romania and with the assistance of an IMCA and Roma interpreter. He believed EO2 was going to complete the HRA as she was now Drina's social worker. (He was later made aware that TM completed the HRA over the weekend).

**109.** On Monday 19<sup>th</sup> December 2016, he and others within the office were shocked when they received an email from the TM saying that Drina and her stepfather were repatriated that morning to Romania. Kallar Lodge were contacted and confirmed that Drina had left the home that morning. He was concerned that the action taken to repatriate her and the previous worries expressed in the meeting, did not best meet the interests or safety and protection of Drina which, was a distressing outcome.

**110.** His last dealings with Drina's case was translating an email informing the Romanian Social Services that Drina and her stepfather were returning home, completed after they had already left the UK.

#### **Safeguarding Adult Manager (SAM 1)**

**111.** The SAM's role is the person that manages, makes decisions, provides guidance and has oversight of safeguarding concerns that are raised to the local authority. She was at the time a CLDT Lead Nurse (NELFT) and became the appointed SAM on the 21<sup>st</sup> November 2016 after Drina was accommodated. She was aware there was a police investigation and they were struggling to obtain the services of a Roma speaking interpreter. It was apparent to her in the family safeguarding meeting held that some of the family could understand more of the conversation than they were letting on. PO1 made a comment on this, the exception being the stepfather who, appeared not to understand much of what was said. It was stated that Drina indicated being used for begging at the family meeting.

**112.** On the 7<sup>th</sup> December 2016, she was emailed to say that EO1 was being taken off of Drina's case as he was moving to a new post. The SAM noted the decision to move the EO off the case was before he was offered the new role. She states there was a time lapse before EO2 was appointed to the case for Drina. She was unaware whether arrangements had been made by anybody regarding a medical check on Drina and presumed the police would have carried this out. It was her view that in a complex case, EO1 should have been allowed to continue with the case within his new role so as to provide continuity; he was knowledgeable of the action he had taken and what was further required. She was informed, having never met her that Drina could articulate through gesture.

**113.** Concerns were raised with the TM, he was warned about following due process as Drina had a 45 day reflection and recovery period. She was not aware of any rationale that arrangements were being made over the weekend of the 17<sup>th</sup> and 18<sup>th</sup> December 2016, to send Drina home. TM and GM had been in constant communication and she knew that the GM believed that Drina should not be kept away from her stepfather. She felt however, they needed to ensure that it was safe for Drina to return home. The TM took over the decision making and had contacted the police and the NRM on

the 16<sup>th</sup> December 2016. After Drina had returned home, the TM sent SAM1 an email to say he was taking over the role of SAM. (This was presumably for him to write up the case closure). She was of the opinion that Drina did not have the capacity to agree on the action proposed, as she had not invoked her treaty rights and it was likely at the end of the process she would have been returned home in any case.

**114.** The LBBB IMR author asked whether there was any discrimination from the family towards Drina which, she felt there might have been. She did not believe there was any discrimination by the Romanian authorities as Drina had been assessed by them and in relation to the UK authorities, she felt there was no discrimination in the decision making process, it was a rushed repatriation and due to finances (finances are discussed within the conclusions at Chapter 7 of the report). She did not think there was any discrimination from TM or GM. Her opinion was that if a frontline worker been allowed to get on with the case, it would have been completed with due process. They may well have come to the same conclusion about sending her home but, this would have been after all enquiries and safeguarding was considered which did not happen and left a sense of unease.

#### **Contract Manager (CM)**

**115.** Communication was by email exchange with the IOA. The CM said there was a discussion on the 14<sup>th</sup> or 15<sup>th</sup> December 2016 about repatriation of Drina. The CM was heard to say in the CLDT, “This is good I am booking flights, Brexit is good.” The IOA communicated with CM to confirm the date of booking the flight tickets and questioned the ‘Brexit’ comment as some staff thought the comment was inappropriate, considering there was a CLDT colleague who was of Romanian descent. He recalls that he was approached in the office by both the TM and GM and asked if he could book airline tickets to Europe as he held the company credit card. He believes his exact words were “Are you Brexiting?” He meant nothing by the remark and it was not directed at anyone as he was not aware of the specifics of Drina and her case and is personal learning for the future. (See comment at paragraph 116). The CM later obtained confirmation with the accounts department so he could use the credit card for flights tickets. He was then requested by the TM to book the flight home for Drina and her stepfather. The tickets were bought and paid for on the Saturday the 17<sup>th</sup> December 2016 for a flight from Luton airport to Romania on Monday 19<sup>th</sup> December 2016.

**Comment:** - The fact that both the TM and GM approached him in the office confirms that both had made the decision to book repatriation flights before the late afternoon meeting with Drina and her stepfather on Friday 16<sup>th</sup> December 2016. The actions recorded or understood by the other attendees at the meeting was that a further decision would be made on the following Monday as previously referred to above. The action taken by the TM over the weekend to expedite their removal from the UK and the hurriedly completed HRA, confirms the decision of action to be taken in the meeting to obtain a ‘best interest’ decision to repatriate Drina and her stepfather, was regardless of what had been agreed in the meeting.

#### **Culture and Diversity**

**116.** There are three comments regarding culture and diversity that the SAR has identified within the information and documentation provided and analysed for this report.

1. The first is an earlier communication between the LBBB and the Romanian Social Services when they were requesting background information on Drina. The Romanian authorities responded and confirmed that Drina was known and was assessed many years previously with a severe learning disorder and that she was in receipt of a monthly allowance that the stepfather, who has the sole care of her collects. The emails states words to the effect “these

people belong to the Roma ethnic minority, they don't have education and refuse help. They are only interested in financial assistance without any commitments." The reason behind this comment is outside the remit of this SAR.

2. The Contract Manager who was booking the flights for Drina and her stepfather to return home, was heard to say in the office "This is good, Brexit works." In communication for the purposes of this review, as mentioned above, he states he said "Are we Brexiting?" The IOA asked the CM to account for this comment. He stated that he is not client facing and does not know the clients. He admits saying the comment and it was said in jest with no malice in the comment. He appreciates that such a comment, when others are dealing with clients such as Drina that it might not come over as such and accepts this as professional learning and he will be more aware in future which, I suggest is acceptable at this juncture.
3. Although there is no evidence to suggest this is widespread, the culture within the previous CLDT, now the Disability Service, alluded within some interviews with key practitioners, will be explored by the OD in meetings with staff, to discuss the findings and learning from this SAR. It will be kept under review and if any concerns are later identified, organisational develop and support to staff teams will be provided.

**117.** There was no other evidence to suggest that culture or diversity was the reason for the expedited return of Drina to Romania.

### **Voice of Drina**

**118.** The fact that two MCA's were carried out and Drina was assessed with learning difficulties should have ensured compliance to ascertain her thoughts and views by using the appropriate advocacy on all occasions whilst dealing with her situation. However, the earlier good practice was not consistent with the later failure to provide an IMCA and Roma speaking interpreter, particularly when making a 'best interest' decision on Drina's behalf. The allocation of an IMCA, a further MCA and a Roma speaking interpreter was not afforded to her as was recommended at the meeting with her and the stepfather on the Friday before she returned home. The voice of Drina was not effectively heard particularly with regards to her comment about her stepfather hitting her when drunk and at the meeting on the 16<sup>th</sup> December 2016 when she was intimating to professionals, gesturing how she was kept in a room, restrained and physically abused was not listened to, explored and the allegations of abuse was not shared with police, which is unacceptable.

### **Whistleblowing**

**119.** Gov.UK<sup>15</sup> describes a whistleblower as a worker who reports certain types of wrongdoing usually something seen at work. The wrongdoing disclosed must be in the public interest. This means it must affect others, e.g. the general public. A whistleblower is protected by law and should not be treated unfairly or lose their job because they 'blow the whistle'. A concern can be raised at any time about an incident that happened in the past, is happening now, or will happen in the near future.

**120.** The term 'worker' include police, local authority and NHS and others who are protected by law if they report a criminal offence, where someone's health and safety is in danger, there is a risk or actual

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<sup>15</sup> Whistleblowing for employees Gov.UK

damage to the environment, a miscarriage of justice, a company is breaking the law or the worker believes someone is covering up wrongdoing.

**121.** A CLDT colleague correctly enacted whistleblowing policy and procedures within NELFT, called 'Freedom to Speak Up: Raising Concerns (Whistleblowing Policy) regarding Drina's case, after her repatriation. The whistleblower was spoken to by the IOA for the purposes of completing this review. The whistleblowing report was received by the LBBB via NELFT in January 2017. It disclosed the following concerns which stimulated the commissioning of this SAR, as follows:-

1. The video taken by bailiff's shows Drina's stepfather putting Drina in the van. The stepfather also disclosed this information at the Safeguarding meeting. Why was he not investigated/charged by the Police? (This was a question posed to the MPS to consider in their IMR response to this review and subject to MPS Agency Recommendation 1).
2. It was also stated that Drina's stepfather lived at the property where Drina was found. (This was never confirmed but suggested in submissions to the review. As police failed to speak to the stepfather it cannot be confirmed and subject to an MPS recommendation as above).
3. Drina states that her stepfather beats her when he has been drinking. (This was stated when there was a meeting with Drina. Police were asked to consider this information and action taken by the investigating officer. The police investigation fails to address this issue or confirm whether they were aware and is again subject to a recommendation as aforesaid).
4. The final advocacy and IMCA request was cancelled. (This is addressed within the narrative of this report and is subject to comment within the Analysis at Chapter 5 and within the Findings at Chapter 6).
5. The Home Office states that it is acceptable for Drina to leave as she consents to this but the MCA states she lacks capacity to make decisions. (The CLDT TM having obtained the information that police were not treating the stepfather as a person of interest contacted the NRM case worker and agreed in the circumstances Drina was free to leave. This is further discussed in the narrative in Chapter 5 of the MSHTU).
6. Poor use of interpreters, no Roma speaking interpreters was used. (This was a finding and subject to recommendations at Appendix 4).
7. There was no medical check on Drina by a doctor at any point even though staff at Kallar Lodge noticed burn marks and scars on her body. (This is subject to recommendations at Appendix 4).
8. Social Worker advises on 24th and 30th November 2016 that Drina would not be able to see her family without an application to the Court of Protection but a meeting was facilitated between Drina and her stepfather on 16th December. (This was a failure also identified in this SAR and confirmed within this report).
9. It is possible that Drina's stepfather was threatening Drina in the meeting in Roma dialect but there was no Roma interpreter to translate this. (This is subject to comment within the report and subject to the Findings and Recommendations at Chapter 6).
10. No MCA was carried out on Drina's ability to establish whether she could make decisions on her return to Romania with her stepfather. (This is addressed within the narrative of the analysis in this chapter and subject to LBBB SAR Overview Report and Agency Recommendation at Appendix 4).
11. Social Workers did not pass on information to the Police about Drina's gestures of abuse in the presence of her stepfather only that she wanted to return home with him but how did she have capacity to consent and an IMCA was not provided. (This issue was addressed and subject

to comment in the Findings at Chapter 6 and Recommendations within the report at Appendix 4).

12. Drina was placed at Kallar Lodge which was against CQC regulations. (This has been acknowledged and answered within the narrative in Chapter 5).
13. Noticed feelings of helplessness amongst staff when suggestions and advice was ignored. (This concern and the impact on morale was addressed by the IOA who met with the Operational Director. An agreement was made for the Operational Director to meet with the staff and to ensure their empowerment to challenge senior management in future cases within the newly merged Disability Service that has encompassed the Adult CLDT with Children's Disability Services).
14. By returning a vulnerable person with a learning disability, without capacity to consent, with the stepfather (alleged abuser) we have put her at further risk of abuse and slavery. (Practitioners have been seen and have acknowledged that were significant failures to protect Drina. This has been subject to comment within the narrative at Chapter 5 and the Findings at Chapter 6 and the Recommendations at Appendix 4).
15. We should have followed the normal safeguarding and MCA processes and safeguard her until Romanian authorities could find an alternative place of safety, then repatriated her after joint work with the Romanian authorities. (This statement is agreed and the processes should have been followed. This concern is subject to a recommendation regarding IMCA, MCA, the use of appropriate interpreters and forward planning, joint working and communication with the accepting authority. (See LBBB SAR Overview Report and Agency Recommendation at Appendix 4).

122. The SAR has attempted to address all the concerns detailed above, to ensure that all available learning is captured and disseminated in order to protect future LBBB victims of Human Trafficking and Modern Slavery. The whistleblowing procedure was effective and correctly identified the concerns highlighted above that have been endorsed by this SAR.

### **Safeguarding Adult Priorities**

123. Safeguarding priorities as defined within the London Multi- Agency Adult Safeguarding Policy and Procedures and subject to comment within the narrative and Findings at Chapter 6, will be captured within the SAB training on Modern Slavery as defined within the LBBB and NELFT Agency Recommendation at Appendix 4.

### **Previous Barking and Dagenham SARs**

124. Previous Barking and Dagenham SARs were viewed for the purposes of completing this SAR. It was noted there were recommendations regarding MCA's and surrounding features that have formed part of a SAB action plan to address the learning. Although MCA's featured in this SAR, two were carried out effectively and the decision to carry out a third was cancelled. A further MCA to obtain a best interest decision for Drina whether she could make the decision to return home with her stepfather, was not carried out. MCA's are further discussed in the narrative above.

### **Specified Question from the Terms of Reference**

125. The TOR asks to what extent was appropriate supporting information provided to the Romanian authorities in order that they had the best opportunity to carry out their own safeguarding work within the framework that applies in Romania.

**126.** This overview report confirms that no information was provided to the Romanian Social Service to ensure forward safeguarding planning on her return. Both Drina and the stepfather had left the UK and it was not until the following day that a translated email was completed and later sent to notify them of her return to Romania. A recommendation to guarantee this does not occur again has been made (See LBBD Agency Recommendation 4).

## Chapter 6

### FINDINGS – LESSONS LEARNT AND SUGGESTED RECOMMENDATIONS FOR THE CONSIDERATION OF THE SAFEGUARDING ADULTS BOARD

This chapter outlines the findings identified from the analysis of the key events and analysis of professional practice. They are produced for the consideration of the Barking and Dagenham Safeguarding Adults Board to reflect and implement any learning from this SAR. There is an expectation that SAR overview reports should have recommendations that are concise and smart. Therefore the findings contain suggested Barking and Dagenham SAB Overview Report Recommendations that overarch, encompass and support Agency Recommendations that have been set in Appendix 4. The following findings and recommendations identified from the SAR are:-

**FINDING 1 – LEGAL SERVICES CONSIDERATION OF ADVICE, CONSULTATION AND INCLUSION BEFORE SIGN OFF OF COMPLEX CASES:** Does the LBBD Safeguarding Adults Board agree there is a need to ensure that in complex cases of Human Trafficking and Modern Slavery it requires for an appropriate closure Multi Agency Case Conference or Discharge Meeting with Legal Services consultation and signed off by the Local Authority having considered both National and Inter-National complexities that can arise, to guarantee the wellbeing of the victim and that legislation and guidelines are correctly followed?

**What are the issues?**

- 1) All human trafficking and modern slavery and other complex cases should only be signed off by the local authority legal department after a multi-agency case conference or closure meeting as in Drina's case as there were a catalogue of infringements and non-compliance with the Modern Slavery Act 2015, the Care Act 2014 and the London Multi Agency Adults Safeguarding Policy and Procedures.
- 2) Encourage and empower staff to support whistleblowing procedures and to escalate concern in order to address issues of the morale of LBBD CLDT that staff felt of Drina's case, Support to be given to challenge senior management intervention in cases to allow SAM's, EO's and frontline staff to carry out the due process that was not allowed in this case.
- 3) A safeguarding plan was not followed and there was no case conference or multi-agency discharge meeting.
- 3) Appropriate risk assessments were not carried out.
- 4) Repatriation of Drina was carried out without any international communication and forward planning with the receiving country.
- 5) Court of Protection and DoLS were not requested having been initially considered but subsequently cancelled by CLDT senior management. DoLS must be applied for to avoid adults with care and support needs being unlawfully deprived or their liberty.
- 6) Human Rights Assessments should be carried out by appropriately trained personnel. Drina's HRA was completed by the CLDT TM with the assistance of the CLDT GM but was unsatisfactory. It omitted to include the physical abuse alleged, it was contradictory stating that Drina was requesting to return home with her stepfather and then stating she did not have the capacity to make that decision.

7) Handover of cases. In this case there was not an effective handover from EO1 to EO2 with a significant period in excess of one week where no one was appointed to support Drina's best interests.

**What should be considered?**

By having a closure Multi-Agency Case Conference or Strategy Discharge meeting on Modern Slavery or other complex cases with a consideration of consultation and advice from the Adults' Safeguarding Legal Service before any final sign off, will ensure compliance to statutory legislation and guidance requirements. The seven identified concerns above will be addressed by the suggested recommendation and Agency Recommendations at Appendix 4. This will preserve the wellbeing of the victim, reputation of the local authority and key practitioners decision making and rationales have been scrutinised. Final sign off of such cases must be subject to the Council's legal team's advice and clearance, to ensure the integrity and transparency of the decision making process is compliant particularly if the outcome for the subject is repatriation. By failing to adequately provide onward safeguarding may also reflect poorly on the local authority and also the UK Government. By providing this insurance, will fundamentally help to protect the subject from being further abused or made subject of Modern Slavery again.

**Point 2)** above has been addressed with the Operational Director. Escalation and whistleblowing in Drina's case provided vital information that disclosed the failures in this case and must be encouraged. Empowerment to escalate and challenge in future cases including senior management involvement and interference will hopefully be negated if this recommendation is implemented. It is appreciated that it takes great courage to challenge as it can be difficult for personal or other reasons to do so. In order to support the findings, the Operational Director will speak personally with the Disability Service staff members to show support in order to empower them regarding whistleblowing procedures and the assurance they will be supported to escalate and challenge concerns to intervention in cases where necessary.

The overarching Barking and Dagenham SAR Overview Report Recommendation 1 below, will encompass and address the collective concerns that have been identified and will address all the seven points above and other findings below and supports the Agency Recommendations set at Appendix 4 that also identified these issues for learning:

**Suggested Barking and Dagenham SAR Overview Report Recommendation (1) for the Barking and Dagenham Safeguarding Adults Board**

**It is recommended that the Barking and Dagenham, Safeguarding Adult Board require that in Human Trafficking and Modern Slavery cases, there is a closure Multi-Agency Case Conference or Strategy Discharge meeting with legal oversight to ensure that the governance, legislation, guidelines and the best interest of the victim have been followed.**

**FINDING 2 – APPROPRIATE USE OF IMCA'S AND INTERPRETERS TO HEAR THE VICTIMS VOICE.** Does the Barking and Dagenham Safeguarding Adults Board agree there is a need to remind staff that the voice of a victim with learning disabilities needs to be heard by utilising an IMCA and appropriate interpreter and a Mental Capacity Assessment completed by a suitably trained member of staff where necessary?

**What are the issues?**

1) Drina had identified learning difficulties. There was not an appropriate use of an IMCA or interpreter engaged to understand and support Drina, in order to hear her voice. There was no opportunity afforded to support her to express by comment or gesture, her view as to whether she could return home safely to Romania with her stepfather.

2) In the family meeting, a family friend was allowed to translate and there was concern how effective and reliable the translation was.

3) Two initial MCA's were effectively carried out in accordance with the Care Act 2014 however a third MCA was required to be completed before the decision to repatriate Drina was made. This final MCA was vital to ensure Drina's views to safeguard her that was not carried out, as Drina was returned home before it could be arranged by an appropriately trained staff member.

#### **What should be considered?**

1) On all occasions where a victim has been assessed with a learning disability, the victim must be appointed an IMCA to support the victims best interests and where required an appropriate interpreter supplied. No meeting or discussion with the victim should be allowed to go ahead without these necessary safeguards in place.

2) Only officially vetted translators should be allowed to be used in meetings with victims and family to ensure transparency and effective communication.

3) MCA's must be completed by a competent practitioner prior to any decision to close a Modern Slavery case or where repatriation to another country is being considered to ensure the 'best interest' of the victim is captured and supported. This can be monitored for compliance by Recommendation and Finding 1 above.

#### **Suggested Barking and Dagenham SAR Overview Report Recommendation (2) for the Barking and Dagenham Safeguarding Adults Board**

It is recommended that the Barking and Dagenham, Safeguarding Adult Board, require that in Human Trafficking and Modern Slavery cases and other relevant safeguarding adult cases, when a victim is assessed as having a learning disability it is incumbent on the Local Authority to ensure compliance with legislation and guidance. A Mental Capacity Assessment must be carried out for the victim, supported by the appointment of an IMCA and suitable interpreter if required to support and be present at meetings to ensure that the 'best interest' to protect and understand the victim, is determined.

**FINDING 3 – AWARENESS OF HUMAN TRAFFICKING AND MODERN SLAVERY.** Does the LBBB Safeguarding Adults Board agree there is requirement for the need for the enhancement of the awareness, communication and understanding of Human Trafficking and Modern Slavery for the local community, LBBB staff and agency partners?

#### **What is the issue?**

Barking and Dagenham SAB should consider the enhance communication, promotion and awareness of human trafficking and modern slavery, to the local community, LBBB staff and agency partners. There is a requirement to deliver current information and guidance as part of a communication strategy.

### **What should be considered?**

Barking and Dagenham have already implemented Modern Slavery training and developed classroom and E-learning courses for staff. Barking and Dagenham staff have been trained in Modern Slavery and the SAB Business Manager is a nominated SPOC. (See Barking and Dagenham and NELFT Agency Recommendations).

Barking and Dagenham SAB should review their policy, procedures and guidance to ensure that human trafficking and victims of modern slavery is current and effectively encompassed within all Safeguarding Adults practice, including the Barking and Dagenham, Communication Strategy, ICare campaign and SAB Annual Report. This is further expanded upon within the conclusions in Chapter 7:

### **Suggested Barking and Dagenham SAR Overview Report Recommendation (3) for the Barking and Dagenham LBBB Safeguarding Adults Board**

It is recommended that the Barking and Dagenham, Safeguarding Adult Board review communication strategies, Safeguarding Adult Policy and Procedures and guidance within the Local Authority regarding Human Trafficking and Modern Slavery to ensure:-

1) They are current and incorporate awareness and guidance of legislation encompassed within all LBBB Safeguarding Adults practice, including the LBBB ICare campaign and SAB Annual Reports and Communication strategies.

2) Promote the awareness of Human Trafficking and Modern Slavery to the community and key practitioners of the legislation, to ensure it is understood in order to enable individuals the ability to recognise and report possible allegations of crime. This is to protect victims and assist in the apprehension of offenders in Human Trafficking and Modern Slavery.

**FINDING 4 – PARTICIPANTS IN SAFEGUARDING ADULTS MEETINGS.** Does the Barking and Dagenham Safeguarding Adults Board agree that Chairs of Safeguarding Adults meetings should ensure that potential suspects in a safeguarding case are not allowed to participate in meetings to preserve the integrity of the meeting?

### **What is the issue?**

At the family safeguarding meeting on the 24<sup>th</sup> November 2016 potential suspects and one participant who was on police bail was allowed to participate in the meeting

### **What should be considered?**

Professionals both LBBB and police should not allow potential suspects and those on police bail to participate in a multi-agency family meetings. This finding also supports Recommendation 2 above regarding the appropriate use of IMCA's and interpreters at meetings.

### **Suggested LBBB SAR Overview Report Recommendation (4) for the LBBB Safeguarding Adults Board**

It is recommended that the Barking and Dagenham, Safeguarding Adult Board remind key practitioners as to the integrity required when conducting all safeguarding adult meetings that potential suspects or persons on police bail for the case under discussion, should not be allowed to participate and chairs of meetings must apply strict compliance.

**FINDING 5 – LBBB DISABILITY SERVICE.** Does the Barking and Dagenham Safeguarding Adults Board agree there is a need for a specific piece of work, required to ensure that the newly formed Disability Service has procedures in place to support staff in implementing the legislation on Human Trafficking and Modern Slavery?

**What is the issue?**

The Disability Service has merged Adults and Children Disability Teams into one Service with staff who have had different levels of knowledge and experience in separate fields. This will need to be monitored to ensure safeguarding is not prejudiced, providing a consistent approach with cases and interaction with other agencies. After restructuring there will eventually be a merging of staff roles and there is a need to ensure that knowledge is promulgated to all staff in compliance with the Care Act 2014 and the Modern Slavery Act 2015.

**What should be considered?**

It is imperative, considering the restructuring where staff roles were distinctly different that learning is captured for a unilateral response. The LBBB have commenced E-Learning and have completed a classroom based SAB Training Programme (2017) and LBBB personnel have been trained in ‘Trainer training’ on Modern Slavery that is currently being rolled out to key practitioners. **There is no requirement to make a Barking and Dagenham SAR Overview Report Recommendation as the LBBB Agency Recommendations at Appendix 4 has identified and commenced training of the legislation that can monitor this finding.**

**FINDING 6 – SHARING OF INFORMATION.** Does the Barking and Dagenham Safeguarding Adults Board agree there is a need to remind agencies of the requirement to ensure relevant information in relation to medical examinations and victim’s allegations are appropriately shared?

**What is the issue?**

There were failures to share information in relation to the injuries found on Drina at Kallar Lodge and from safeguarding meetings where Drina intimated allegations of physical abuse against others and her stepfather that needed to be investigated, particularly at the meeting held on the 16<sup>th</sup> December 2016 that was not shared with police.

**What should be considered?**

Professionals should share information that is pertinent to any Human Trafficking and Modern Slavery or other case which in Drina’s case related to the injuries found on Drina at Kallar Lodge, the CHM confirmed that they shared the information directly with the CLDT and but should have considered sharing it with the police who were conducting a criminal investigation. This is personal learning and no recommendation is required. However, the allegations of abuse that Drina was gesturing at the meeting held on the 16<sup>th</sup> December 2016 should have been shared with police which may have 1) Ensured that the revised meeting to carry out an MCA, obtain an IMCA and appropriate interpreter, set for the 19<sup>th</sup> December would stop the repatriation until police had been informed, and 2) Possibly reignited police to further review their Modern Slavery investigation.

**Suggested LBBB SAR Overview Report Recommendation (5) for the Barking and Dagenham Safeguarding Adults Board**

It is recommended that the Barking and Dagenham, Safeguarding Adult Board remind care home staff and LBBB Disability Service practitioners of the requirement to promptly share relevant information relating to victims to police when there is an ongoing police investigation.

**FINDING 7 – RECORD KEEPING.** Does the Barking and Dagenham Safeguarding Adults Board agree there is a need to remind LBBB staff of the requirement for all uploads onto the LBBB AIS record management system are completed promptly to preserve integrity of the information?

**What is the issue?**

The LBBB AIS computer management, records and retains staff entries and documentation but is often not entered expeditiously as in Drina's case. This does not uphold the transparency of the decisions and actions taken. Entries were made by the CLDT Team Manager of the rationale for decisions made in Drina's case and repatriation with delayed entries. The final case notes were not uploaded on the computer system and the process to close the safeguarding enquiry was not completed.

**What should be considered?**

All LBBB staff should be instructed to upload documents, information, actions taken and the rationale for decisions made on the LBBB AIS as soon as reasonably possible, with a reason for any delay recorded. This will preserve the integrity and transparency of the information as far as possible, both for the staff member and the LBBB.

**Suggested Barking and Dagenham SAR Overview Report Recommendation (6) for the Barking and Dagenham Safeguarding Adults Board**

It is recommended that the Barking and Dagenham, Safeguarding Adult Board remind staff to upload information on the LBBB AIS (record management) for Safeguarding Adult cases as soon as reasonably possible, with a reason for any delay recorded, in order to preserve the integrity and timeliness of the information.

**FINDING 8 – METROPOLITAN POLICE SERVICE - SPECIALIST CRIME REVIEW GROUP.** Does the Barking and Dagenham Safeguarding Adults Board agree there is a need for the Metropolitan Police Service to review the criteria for the Specialist Crime Review Group (SCRG) to carrying out SAR's in reported complex Human Trafficking and Modern Slavery cases under the Modern Slavery Act 2015 and the London Multi Agency Adults Safeguarding Policy and Procedures 2015, in support of the SAR process?

**What are the issues?**

The SCRG were requested to complete an IMR for the SAR at the behest of the Barking and Dagenham SAB due to the complexity of the case and the identified concerns from the whistleblowing procedures. This was declined, as a result there was a significant delay of four months after the final date for submissions (March 2016) for IMR's which the EA-CU completed. However, due to the complexity of Drina's case, the SCRG assisted with the finalisation of the IMR (August) and this delay impacted on the timeline of the statutory requirement to complete a SAR.

The police investigation was identified in this review and by the MPS IMR author, as poor and is subject to a full review (see MPS Recommendation1 at Appendix 4). It is not subject to a Barking and Dagenham SAR Overview Report Recommendation as the concerns are being addressed.

**What should be considered?**

The SCRG should consider the completion of SAR's in Modern Slavery cases that are reported to be them as significantly complex by Local Authority SAB's. This will support the SAR process and allow for the scrutiny of police actions as Borough police should not be asked to review their own practice ensuring transparency, continuity of quality and support to the review process where identified concerns of the agency are apparent at the outset.

**Suggested Barking and Dagenham SAR Overview Report Recommendation (7) for the Metropolitan Police Service**

**It is recommended that the MPS Specialist Crime Review Group review the threshold criteria for conducting Safeguarding Adult Reviews in cases such as Modern Slavery, where clear information is supplied of the complexity and concern identified, if requested by a Local Safeguarding Adult Board.**

**FINDING 9 – MEDICAL EXAMINATIONS OF VICTIMS.** Does the Barking and Dagenham Safeguarding Adults Board agree there is a need to remind agencies of the requirement to ensure medical examinations are carried out and medical professionals called when a resident in a home shows signs of physical abuse regardless of the age of the injury?

**What is the issue?**

In Drina's case, staff at Kallar Lodge carried out a body map examination and found old scars and burn marks. The information was referred to the CLDT but not directly to the police who were investigating a possible criminal offence against Drina. The care home, CLDT and police, all failed to follow up this concern, tantamount to possible evidence of physical abuse. and did not request an examination by a medical professional or attempt to gain an account from Drina on how and by whom the injuries were inflicted. The London Multi Agency Adult Safeguarding Policy and Procedures states there is a duty to preserve evidence to ensure that adults are no longer in danger. If another agency does not call for a medical examination it should not deter another agency to carry out the request for a medical examination on their own behalf.

**What should be considered?**

Kallar Lodge notified CLDT who later informed police of the findings of signs of burn marks and scars on Drina's body. A full medical examination should be carried out to determine the cause, age and who inflicted the injuries in support of the victim and to obtain and preserve evidence in any potential criminal investigation.

Both the LBB and NELFT have made recommendations for their respective agencies in respect of this issue (See LBB and NELFT Agency Recommendations at Appendix 4). In support of the MPS Agency Recommendation 1, this also should be considered for the MPS East Area Command Unit (EA-CU) to also comply with.

**Suggested Barking and Dagenham SAR Overview Report Recommendation (8) For the MPS East Area Command Unit**

**It is recommended that the MPS East Area Command Unit remind staff that where a victim of modern slavery (or any relevant case) shows signs of possible physical abuse, the causation must be investigated and appropriate expert medical advice sought in order to obtain and preserve evidence in any potential criminal investigation.**

## Chapter 7

### Conclusions

1. This SAR Overview Report is the Barking and Dagenham Safeguarding Adults Board's response to the safeguarding failures to protect Drina, a victim of Modern Slavery with learning difficulties. It is hopeful that the outcomes from this review will enhance and sustain support for all victims and potential victims against the abhorrent criminal offence of Human Trafficking and Modern Slavery. Lessons learnt from the findings and suggested recommendations will be monitored for compliance and implementation by the SAB Action Plan that will follow this report.

### **Moving forward to address Human Trafficking and Modern Slavery**

2. The Anti-Slavery Working Group (LWG) is coordinated by the Human Trafficking Foundation (HTF) and includes NGO's, the MPS Modern Slavery Unit, the Home Office and the NHS, are producing a practical best practice guidance for frontline staff in local authorities and a pan-London Directory of services.

3. Furthermore, the Local Government Association (LGA), in partnership with the Independent Anti-Slavery Commissioner (IASC), is to publish in the autumn, high level guidance for Councils about their role in fighting Modern Slavery.

4. An NCA press release on the 10<sup>th</sup> August 2017, launched a national campaign, an initiative led by the NCA and supported by the City of London Police and other police forces across the country. It aims to help people to interpret the signs of Human Trafficking and Modern Slavery which is reported to be 'in every UK town and city.' It is a growing problem with more suspected cases than previous estimates of 10,000 to 13,000 victims believed in the UK which, it suggests is the "tip of the iceberg." Therefore LBBB and agency partners should ensure learning from this review are taken forward, as it is an emerging challenge to society. The Barking and Dagenham SAR Overview Report Recommendation 3, identified this aspect and is further discussed in the following paragraph.

### **Awareness of the Modern Slavery Act 2015**

5. A vital element required to ensure learning and knowledge is the communication and awareness of Human Trafficking and Modern Slavery that is effectively and regularly shared with practitioners, key agencies, the general community and local businesses by revising the current Barking and Dagenham Communication Strategy 2016 and other current Modern Slavery guidance (See Recommendations at Appendix 4).

6. This would provide a more robust and knowledgeable community, able to identify and respond by reporting more offences. Whereby appropriate services, support and safety advice can be provided for victims or potential victim and supports a commitment to the six priorities of Accountability, Empowerment, Protection, Prevention, Proportionality and Partnership. It will further assist the

national requirement, ensuring cases of adult safeguarding concerns of abuse of Human Trafficking and Modern Slavery are effectively identified, recorded, criminals investigated and prosecuted with the utmost vigour, through the criminal justice system.

**7.** There will be a need to communicate in plain English and translate into other languages as a high proportion of victims are foreign nationals. A dedicated website with contact details for self-referral should be considered. A further consideration is for every business to be leafleted, completed over a timely period with Barking and Dagenham interaction with press and free newspapers. Businesses have been highlighted in research as likely areas of significant concern and should be targeted to identify any exploitation of Human Trafficking and Modern Slavery victims. This could be a joint commitment both locally and nationally, possibly using local enforcement officers, police safer neighbourhood teams and volunteers that could ensure that a named business proprietor or manager receives a copy of the legislation, so there is no excuse for not knowing the law and their legal obligations.

**8.** Locally the LBBB have trained Modern Slavery trainers and the SAB Business Manager is the Council's SPOC for Modern Slavery. Online and classroom training has been implemented and is in an advance stage with training sessions being rolled out. The LBBB and agency partners through this SAR process have recognised that learning from the failures of this review are necessary in order to support victims and identify potential victims from being placed into slavery and servitude.

### **Legal Services Inclusion**

**9.** By implementing the suggested recommendation for legal services inclusion in the process for complex cases (Barking and Dagenham SAR Overview Report Recommendation 1) particularly on emotive and complex Modern Slavery cases, may maintain and preserve LBBB's reputation. Case closure must be subject to the Local Authority's Safeguarding Adults Legal Services for scrutiny and advice for the information of the DASS who has the responsibility for closure, to ensure the integrity and transparency of the decision making process is followed, particularly if the consideration and outcome for the subject is repatriation. By failing to adequately provide onward safeguarding plans for a victim which, occurred in Drina's case, will reflect poorly on the Local Authority and also the UK Government.

**10.** This recommendation will insure that the fundamental priority has been assessed to help and protect the subject from being further abused or made a subject of modern slavery again, providing an overarching insurance that all governance, legislation and guidance is compliant.

### **Police Investigation and CLDT Closure of Drina's case.**

**11.** This SAR has established that the police investigation of Drina, as a victim of Modern Slavery was below acceptable standards, as confirmed within the MPS IMR and through their Agency Recommendation 1. Regardless whether the police failed to pursue an allegation of Modern Slavery where police have to be sure that the evidence is 'beyond reasonable doubt' which the investigation appears not to have considered, social workers still have a duty of care, to carry out an effective risk assessment, as they work on a lower threshold on the 'balance of probability' which, again in Drina's case, did not occur.

**12.** Ultimately services failed to ensure her protection and this should never be allowed to happen again. There can be no excuse for any key professional to say that they did not know about Modern Slavery. It is their professional duty to familiarise themselves with the legislation, guidance and information available on the subject and to partake in the training programmes that are readily available within the Barking and Dagenham, their agencies and elsewhere.

### **Whistleblowing**

**13.** Whistleblowing provided vital information that disclosed the failures in this case and must be encouraged. Morale issues and concerns by staff to ensure empowerment to escalate is encouraged which this SAR attempts to address, supported by senior officials of the Local Authority.

**14.** It is hoped that there will not be a need to invoke whistleblowing procedures in a similar situation if the preceding Legal Services recommendation for consideration and consultation in cases such as Drina's. This would guarantee compliance as stated above, that the victim is protected, legislation and guidance followed and will provide assurances to support or challenge the decision making processes of professionals and be a surety to the reputation of key workers and of Barking and Dagenham.

### **Predictability and Preventability**

**15.** When Drina was discovered in a position of slavery and servitude, it was neither predictable nor preventable, as she was unknown to safeguarding agencies. Once she became known to professionals however, the steps taken to ensure she was appropriately safeguarded so she was free from further exploitation was preventable, if and only if, guidance was appropriately applied. In the present case, Drina was not sufficiently supported, this can be seen through non-compliance of legislation, an absence of a thorough police investigation against potential modern slavery traffickers and a failure to carry out satisfactory risk assessments for her future care. The outlook for Drina in considering these factors is likely to be both poor and predictable.

### **Outcome and current wellbeing of Victim**

**16.** The IOA on being commissioned, requested the Barking and Dagenham SAB to contact the Romanian Social Services to check on the wellbeing and care of Drina. A reply was not received until June 2017 when it was confirmed that Drina and her stepfather had not been seen at their home since April 2017 and their present whereabouts are unknown. As a result, the authorities have stopped Drina's monthly allowance and therefore she is no longer in receipt of any financial assistance. There is a presumption that Drina could have been trafficked again to become a victim of modern slavery. This information was promptly shared with the MPS EA-CU for their information and consideration.

### **In Conclusion**

**17.** The intervention of senior management from CLDT in Drina's case, overruled the necessary action, previously identified to be conducted, to protect Drina in order to complete a full risk assessment with appropriate safeguarding actions carried out. The expediency of the decisions taken to circumvent the correct action required, was a significant failure. During the course of completing this SAR, a living document, as alluded to above, Modern Slavery awareness training has been put in place by the SAB. Similarly the awareness with key professionals was apparent within interviews with the IOA which gives confidence that learning has been learnt to ensure such action will not be repeated as other CLDT personnel, were not in agreement with the decisions and action taken for Drina. Practitioners

spoken to, have acknowledged learning and where appropriate, accepted responsibility for their decisions and the action taken. It was also ascertained during the SAR process that there were no similar Human Trafficking and Modern Slavery cases known within Barking and Dagenham requiring immediate action to be taken.

**18.** There is the strong possibility that the Immigration Service may have repatriated Drina after the NRM 45 day period allowed. This period however, should have been fully utilised to conduct a thorough risk assessment ensuring the safety of Drina, with onward communication and consultation with the Romanian Social Services, to confirm that appropriate safeguarding support processes were in place.

**19.** Another significant concern was the stepfather who was never formally spoken to by police or considered as a possible suspect for placing Drina into slavery and servitude. Considering he had sole care of her, he brought her to the UK, he was aware of the condition she was found in at Address 1, he was in the van that took her away and aware she had been cleaned up before being found safe by police at Address 2, the fact Drina had declared that her stepfather hit her when drunk and she had old injuries on her person, it would not be unreasonable to expect that the police investigation should have immediately considered him as a possible suspect, as answers were needed to be ascertained as to his involvement in Drina's exploitation and abuse.

**20.** Furthermore, the allegations of physical abuse that Drina was gesturing in the final meeting with CLDT staff and the significant concerns of professionals present at the meeting that had been raised regarding the stepfather, were not reported to police. This may have been an opportunity to reconsider the information for their investigation and for an opportunity to stop any repatriation.

**21.** Safeguarding agencies action was unacceptable for the care and protection of Drina, a vulnerable adult with learning disabilities. She should have benefited from all the help and resources that was and are available to prevent and protect a person who has been or is likely to become a victim of Modern Slavery which, in Drina's case was not availed to her. LBBD and agencies involved in her case have seriously failed Drina, whose current whereabouts are unknown after her return to Romania and remains a concern. Legislation, guidance, safeguarding policies and procedure in accordance with the Modern Slavery Act, 2015 in Drina's 'best interest' was not best served.

**22.** This SAR Overview Report is submitted to the Barking and Dagenham SAB to consider the findings and recommendations and to promulgate necessary learning through the Barking and Dagenham SAR Action Plan that accompanies this report. The SAB should ensure that individual learning is personally shared with the key professionals who participated within this SAR with their respective agencies to ensure learning has been acknowledged and understood.

## Appendix 1 - Biography

### The Independent Overview Author of the SAR

David Byford is a Safeguarding Expert and Managing Director of his own Safeguarding Consultancy. He retired in September 2014 after 40 years within the Metropolitan Police Service (MPS) including over 25 years' experience in Child Protection. He was a Senior Investigating Officer responsible for investigating serious crimes against children, young people and adults. In 2003, he developed the serious case review (SCR) process for the MPS.

After retirement as a serving Police officer (2006,) he was again employed by the MPS as an expert Senior Review Officer, responsible for the MPS SCR responses for all 32 London Boroughs. He has acted as an adviser on SCRs' to the MPS, Association of Chief Police Officers (ACPO) now the National Police Chiefs Council (NPCC), CEOP's, police forces nationally, local authorities, independent schools and LSCB's. He was personally selected to carry out national sensitive and bespoke reviews, including for the Attorney General, Lord Goldsmith regarding *Regina V Sally Clark* and for the Director of Public Prosecutions who identified experts to research and write the CPS Disclosure Manual for expert witnesses. In 2010 he conducted an ACPO National Review for CEOP's, identifying how the Police Service should conduct SCRs'. He has presented nationally on conducting SCR parallel criminal and coronial processes and has effected strategic change.

David has completed the DfE sponsored training "Improving the Quality of SCR's" and he was asked to participate in the DfE funded NSPCC and SCIE led "Learning into Practice Project (LiPP) for Improving SCR's (2016) to look at quality markers for Lead Reviewers. He was invited as part of a small selected group of SCR Authors by the DfE, to meet with Alan Wood so he could consult prior to concluding his "Wood Report into LSCB's" (2016.) David is an Independent Chair and Author for Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews. His name is on the Association of Independent LSCB Chairs, National Directory as an SCR Lead Reviewer/Author which includes his detailed biography.

### Acknowledgements

The Independent Overview Author would like to take the opportunity to thank the LBBB SAB and participating agencies and key professionals who contributed to the SAR. The review could not have been completed without the valued assistance of the Independent SAB Chair, Business Manager and the SAR panel members.

The Bailiffs, must be congratulated on their observation and professionalism in locating and recognising that Drina was being kept as a slave. They showed humility within the face of challenge from the hostile occupants of Address 1. They quickly and appropriately reported the matter to police, ultimately assisting in the safe recovery of Drina who had been forcefully taken away in a van and video recorded the events as they occurred, for evidential purposes.

The Whistleblower, must be congratulated for raising the undoubted safeguarding concerns of Drina. The professionalism displayed to challenge wrongdoing should empower others to do likewise in the future, if such circumstances were to happen again which, the learning from this SAR hopes to negate.

## **Appendix 2 - Bibliography**

**The following legislation, documentation and guidance was consulted for the process of completing this SAR:**

*A Safer City for All Londoners, Police and Crime Plan 2017-2021, Mayor of London*

*Care Quality Commission (2010) Guidance about compliance: Essential standards of quality and safety. What providers should do to comply with the section 20 regulations of the Health and Social Care Act 2008, London: CQC*

*Care Act 2004, 2014*

*Council of Europe Convention against Trafficking in Human Beings*

*Equalities Act 2010*

*European Convention on Human Rights (ECHR)*

*Human Rights Act 1998*

*Identifying and supporting victims of modern slavery: Guidance for health staff, 27 November 2015*

*Inter- departmental Ministerial Group on Modern Slavery, September 2016*

*Barking and Dagenham Communication Strategy 2016*

*Barking and Dagenham SAB, Communication Protocol, July 2016*

*Barking and Dagenham Previous SAR's*

*Barking and Dagenham SAR Safeguarding Adult Policy*

*London Multi-Agency Adults Safeguarding Policy and Procedures. December 2015*

*Mental Capacity Act (MCA) 2005*

*Modern Slavery Act 2015*

*Victims of Modern Slavery – Competent Authority Guidance, Home Office*

### Appendix 3 – Glossary of terms

Access and Duty Intake Team	ADIT
Adult Care and Support.	ADS
Appropriate Adult	AA
Adult Social Care	ASC (Term used by police for ADIT)
Anti-Slavery London Working Group	ASLWG
Barking and Dagenham	B&D
Care Home Manager	CHM
Care Quality Commission	CQC
Community and Learning Disability Team	CLDT
Contract Manager	CM
Consultant Social Worker	CSW
Court of Protection	COP
Criminal Investigation Department	CID
Crown Prosecution Service	CPS
Director of Adults Social Services	DASS
Deprivation of Liberty Safeguards	DoLS
Disability Team	DT
Enquiry Officer	EO
General Practitioner	GP
Group Manager	GM
Home Office	HO
Human Rights Assessment	HRA
Independent Anti-Slavery Commissioner	IASC
Independent Chair LBBD SAB	IC
Independent Mental Capacity Advocate	IMCA
Independent Overview Author	IOA
Initial Investigating Officer	IIO
Interim Manager – Life Support Team	IM
Local Authority	LA
London Borough of Barking and Dagenham	LBBD
Local Government Association	LGA
London Multi Agency Safeguarding Policy and Procedures	LMASPP

Nation Referral Mechanism	NRM
North East London Foundation Trust	NELFT
Mental Capacity Assessment	MCA
Metropolitan Police Service	MPS
Modern Slavery and Human Trafficking Unit	MSHTU
MPS come to notice form	Merlin
National Crime Agency	NCA
Operational Director	OD
Police Officer	PO
Potential Victim	PV
Safeguarding Adults Board	SAB
Safeguarding Adults Manager	SAM
Safeguarding Adults Review	SAR
Senior Leadership Team	SLT
Social Worker	SW
Specialist Crime Review Group	SCRG
Speech and Language Therapist	SALT
Team Manager	TM
Terms of Reference	TOR
<b>Address1</b>	Known to Barking and Dagenham SAB and the MPS
<b>Address2</b>	Known to Barking and Dagenham SAB and the MPS

## **Appendix 4 – SAR Overview Report and Agency Recommendations**

Listed below are the suggested Barking and Dagenham SAB Overview Review Report Recommendations, together with individual agencies recommendations and implementations that have been reviewed and quality assured within their respective agencies. All the findings and recommendations have been considered and accepted after consultation by the Barking and Dagenham SAR Panel. The measurability, action taken by the agencies and timeliness for the completion of all recommendations and learning are contained within the SAB Action Plan that will accompany this report. The suggested report recommendations for the Barking and Dagenham SAR Overview Report and individual agencies involved are as follows:-

### **Suggested Barking and Dagenham SAR Overview Report Recommendations:**

Findings at Chapter 6 detail the rationale for the following recommendations which concurs with and supports Agency Recommendations that are set out below.

#### **Barking and Dagenham SAR Overview Report Recommendation (1) for Barking and Dagenham Safeguarding Adults Board**

**Legal Services consideration of advice, consultation and inclusion before sign off of complex cases.**

It is recommended that the Barking and Dagenham, Safeguarding Adults Board require that in Human Trafficking and Modern Slavery cases, there is a closure Multi-Agency Case Conference or Strategy Discharge meeting with the consideration of legal services consultation to ensure that the governance, legislation, guidelines and the best interest of the victim have been followed.

**Comment: This is an overriding recommendation that will ensure that the failures and non-compliance identified during the SAR process and by Agency IMR Authors will be addressed with legal oversight and supports the Agency Recommendations below.**

#### **Barking and Dagenham SAR Overview Report Recommendation (2) for the Barking and Dagenham Safeguarding Adults Board**

**Appropriate use of IMCA's and interpreters to hear victims voice.**

It is recommended that the Barking and Dagenham, Safeguarding Adult Board, require that in Human Trafficking and Modern Slavery cases and other relevant safeguarding adult cases, when a victim is assessed as having a learning disability it is incumbent on the Local Authority to ensure compliance with legislation and guidance. A Mental Capacity Assessment must be carried out for the victim, supported by the appointment of an IMCA and suitable interpreter if required to support and be present at meetings to ensure that the 'best interest' to protect and understand the victim, is determined.

#### **Barking and Dagenham SAR Overview Report Recommendation (3) for the Barking and Dagenham Safeguarding Adults Board**

**Awareness and Communication of Human Trafficking and Modern Slavery.**

It is recommended that the Barking and Dagenham, Safeguarding Adults Board review communication strategies, Safeguarding Adult Policy and Procedures and guidance within the local authority regarding Human Trafficking and Modern Slavery to ensure:

- They are current and incorporate awareness and guidance of legislation encompassed within all Barking and Dagenham Safeguarding Adults practice, including the Barking and Dagenham ICare campaign and SAB Annual Reports and Communication strategies.
- Promote the awareness of Human Trafficking and Modern Slavery to the community and key practitioners of the legislation, to ensure it is understood in order to enable individuals the ability to recognise and report possible allegations of crime, thereby protecting victims and assisting in the apprehension of offenders in Human Trafficking and Modern Slavery.

**Barking and Dagenham SAR Overview Report Recommendation (4) for the Barking and Dagenham Safeguarding Adults Board**

**Participants in safeguarding adult meetings.**

It is recommended that the Barking and Dagenham, Safeguarding Adults Board remind key practitioners as to the integrity required when conducting all safeguarding adult meetings that potential suspects or persons on police bail for the case under discussion, should not be allowed to participate and Chairs of meetings must apply strict compliance.

**Barking and Dagenham SAR Overview Report Recommendation (5) for the Barking and Dagenham Safeguarding Adults Board**

**Sharing information.**

It is recommended that the Barking and Dagenham, Safeguarding Adults Board remind care home staff and Barking and Dagenham Disability Service practitioners of the requirement to promptly share relevant information relating to victims to police when there is an ongoing police investigation.

**Barking and Dagenham SAR Overview Report Recommendation (6) for the Barking and Dagenham Safeguarding Adults Board**

**Record keeping.**

It is recommended that the Barking and Dagenham, Safeguarding Adults Board remind staff to upload information on the Barking and Dagenham AIS (record management) for Safeguarding Adults cases as soon as reasonably possible, with a reason for any delay recorded, in order to preserve the integrity and timeliness of the information.

**Barking and Dagenham SAR Overview Report Recommendation (7) for the Metropolitan Police Service**

**Specialist Crime Review Group.**

It is recommended that the MPS Specialist Crime Review Group review the threshold criteria for conducting Safeguarding Adult Reviews in cases such as Modern Slavery, where clear information is supplied of the complexity and concern identified, if requested by a Local Safeguarding Adult Board.

**Barking and Dagenham SAR Overview Report Recommendation (8) for the Metropolitan Police Service, East Area Command Unit**

**Medical examinations of victims.**

It is recommended that the MPS East Area Command Unit remind staff that where a victim of modern slavery (or any relevant case) shows signs of possible physical abuse, the causation must be

investigated and appropriate expert medical advice sought in order to obtain and preserve evidence in any potential criminal investigation.

### **Individual Agencies Recommendations**

The following identified agency recommendations have been agreed by their respective senior management for the process of completing this SAR. They are either being or are in the process of being implemented. The Barking and Dagenham SAR Overview Report Recommendations confirm and supports the agency recommendations for learning and where relevant encompasses and overarches the agency recommendations in support of the individual agency findings.

### **NELFT**

**Recommendation 1. Training around the use of the Human Rights Act and Human Trafficking** (See also the Barking and Dagenham Recommendation 9 below. Modern Slavery training is currently being carried out by Barking and Dagenham, available to all staff and agencies and supplements an online eLearning training package).

**Recommendation 2. Support to gain access to comprehensive medical assessment in such cases** (See also the Barking and Dagenham Recommendation 6 below which supports this agency recommendation and findings at Chapter 6 and Barking and Dagenham SAR Overview Report Recommendations at Appendix 4).

**Recommendation 3. Support in the formal role of Safeguarding Adults in relation to conducting enquiries, holding discussions, the role of the SAM and advocating** (This will be addressed within the Modern Slavery training and the intervention within cases is noted actioned within the narrative above with the LBBB Operational Director).

**Recommendation 4. Understanding the deprivation of liberty functions** (As 1 above, this will be captured in the Modern Slavery training).

**Recommendation 5. Multi-Agency Challenge** (This has been addressed within the narrative above as point 3, with the LBBB Operational Director – Adults’ Care and Support).

### **Barking and Dagenham Adults’ Care and Support**

**Recommendation 1. Mental Capacity Assessments** - to be completed by trained competent workers where there is doubt about an adult’s capacity:-

- MCA training for frontline staff is already included in the training offer for 2017/8 which all frontline workers can access. All frontline workers and managers to undertake MCA training every three years.
- Proactive communication and a management focus (appraisal, one to one practice supervision and professional development) is needed in order to raise consistently the importance of MCA. This would benefit from a partnership-wide emphasis.

**Recommendation 2. Human Rights Assessments** - to be completed by trained competent workers:-

Training to be developed for frontline workers and resources developed and added to the SAB website resources for staff. All frontline workers and managers to undertake HRA training every 3 years.

**Recommendation 3. Risk assessments** - Robust risk assessments should always be carried out in line with the Care Act 2014 and the London Multi Agency Adults Safeguarding Policy and Procedure. Consideration of coercive and controlling behaviour should be included:-

- Training is already planned by the Council for front line workers and resources have been developed under the SAB website for professionals to access. These will be reissued to all staff.

**Recommendation 4. Interagency/national cooperation** - Nobody should be repatriated without a clear understanding and agreement from the receiving authority or country that they have in place a robust plan to support the adult on their return, insofar as the procedures of the receiving state allow, and in line with the outcome of the Human Rights Assessment :-

- All workers to be emailed to remind them of the need for robust planning in the transfer of cases between agencies and between countries.
- As part of the development of online procedural resources for all social care staff, LBBD should ensure that modern slavery, human trafficking and repatriation are all covered, so that staff can have access to clear guidance.

**Recommendation 5. DoLS must be applied for in a timely manner** - to avoid adults with care and support needs being unlawfully deprived of their liberty:-

- An audit of placements at Council services has been conducted and it has been confirmed that there are no outstanding DoLS requests by the homes. External providers have been reminded to ensure that requests are current.

**Recommendation 6. Medical Examinations** - The London Multi Agency Adults Safeguarding Policy and Procedures is clear that there is a duty to preserve evidence and to ensure the adult is no longer in immediate danger. If the MPS did not request a medical examination then one should have been requested by Kallar Lodge:-

- Kallar Lodge has confirmed that this will be policy going forward.

(See NELFT Recommendation 2 above, which supports this recommendation).

**Recommendation 7. Safeguarding Enquiries** - All Enquiry Officers, SAMs and managers must follow the London Multi Agency Adult Safeguarding Policy and Procedure at all times:-

- Training around the London Safeguarding Policy is planned and currently taking place.

**Recommendation 8. Advocacy** - This is a duty under the Care Act 2014 and all workers of LBBD must ensure their practice is Care Act compliant:-

- The role of advocacy must be incorporated into frontline practice and all workers must be aware of the requirements of the Care Act 2014 and the London Multi Agency Adult Safeguarding Policy and Procedures. This will be discussed in staff meetings and individual supervisions and recorded in notes. Information on advocacy and how to book it will also be attached to the SAB pages for professionals.

**Recommendation 9. Modern Slavery** - This case has highlighted the complexity of cases involving trafficking and modern slavery, and the partnership should ensure that workers have access to development tools to ensure that they are able to reflect and prepare for encountering such cases:-

- Development programmes for social work and related disciplines should include training, events, masterclasses and other practice development options around modern slavery and trafficking of vulnerable adults.

(See NELFT Recommendation 1 above, which supports this recommendation).

### **Metropolitan Police Service**

#### **Recommendation 1. MPS East Area Command Unit (EA-CU) – Supervision and Training**

It is recommended that the EA-CU Senior Leadership Team (SLT) review decisions taken at each step of the investigation and conduct a thorough debrief of individuals to address any identified failings or the need for further training.

#### **Recommendation 2. MPS East Area Command Unit (EA-CU) – Modern Slavery**

It is recommended that officers on the EA-CU are sufficiently trained to identify and deal with Modern Slavery.