Harrow Safeguarding Adults Board (HSAB)

Newsletter – issue number 25

(Summer 2019)

Welcome from the chair of the HSAB (Chris Miller)

Dear Colleagues, welcome to the Summer 2019 edition of the HSAB's quarterly newsletter. This is my first foreword to the regular HSAB newsletter as chair of the HSAB. I have already been working alongside some of you in the past two years because of my role as chair of the Harrow Safeguarding Children's Board (HSCB). I am pleased to have been offered this new opportunity to work with you. My experience in the HSCB role is that the partners in Harrow are cooperative, open to change and challenge and most of all determined to do their very best to promote the welfare of those who are vulnerable. Having one person to chair both the children and adults' boards makes a lot of sense as we develop more ways of working together across both areas of safeguarding. Partners at the recent planning day for the future priorities of HSAB identified a set of priorities for the next two years which are described later in this newsletter. I very much look forward to working with the HSAB as we develop our approach to these priority matters. At the end of our business cycle we want to be able to say with confidence that our partnership has made things better for Harrow's vulnerable residents. Suggestions for the newsletter can be sent to either Sue Spurlock (sue.spurlock@harrow.gov.uk) or Seamus Doherty seamus.doherty@harrow.gov.uk).

Learning from Safeguarding Adults Reviews (SARs): "Mr B and Mr C" (Suffolk)

Mr B, aged 61, who had a mild learning disability, died at home from smoke inhalation during a house fire in the early hours of the morning. His friend Mr C, who lived with him, also died in the fire. A Fire Investigation Report concluded that the fire resulted from electrical failure of a toaster. The property in which the men died was Mr B's family home, where he had lived with his parents until their death. At some point (it is not known when) he was befriended by Mr C and his dogs and the property deteriorated to a filthy and soiled state and the dogs were removed by the RSPCA. Subsequently Mr B had a stroke, which affected his mobility, speech and ability to process information. Although he still slept upstairs, he used a wheelchair when downstairs and outside. After Mr B's stroke, Mr C remained and became his carer. Mr B's personal care and hygiene, however, were severely neglected and he presented as dirty, severely soiled and unkempt. The house was similarly neglected; it was very dirty, the carpets were soaked with urine and faeces and there were large volumes of clutter, including festering household waste and hoarded objects. The two men had a complex relationship in which both at times were witnessed to be verbally abusive to the other, but with a degree of mutual loyalty and dependency that enabled their arrangements to endure. They were both reluctant to engage with services and consistently refused support with clearance and cleaning.

Mr B and Mr C were well known to services and had contact with the Police, the Fire Service, RSPCA, environmental health, occupational therapy, primary health, physiotherapy, community nursing and local authority adult social care and safeguarding services. Professional concerns during the period under review focused primarily on Mr B's personal care and on the state of the property.

Until shortly before the fire the professional view was that Mr B had mental capacity to make choices about his care, treatment and living conditions. However the final assessment found he lacked capacity to manage his financial affairs and to make decisions about his personal care and living conditions. However efforts continued to seek his agreement to intervention, focusing on building a relationship of trust through which improvements could be achieved by negotiation rather than the imposition of a solution. When he died, the local authority was considering application to the Court of Protection for appointment of a Deputy to make decisions on his behalf.

Key review findings

- there were a number of missed opportunities in early contacts with Mr B to conduct a comprehensive assessment of his needs, thus missing opportunities to intervene, particularly after his stroke when his situation may have been more amenable to change

- insufficient attention was paid to mental capacity. Reliance appears to have been placed in early contacts on a presumption of capacity, rather than upon formal process of assessment, despite knowledge of Mr B's condition that could have called his capacity into question earlier
- for a few year's, practitioners took at face value Mr B's assurance that he did not need support. Allied to the absence of mental capacity assessment about such decisions and failure to identify his mental health needs, this demonstrates an absence of ***professional curiosity*** and a failure to pursue the proactive engagement that was warranted by the level of risk

Q: Do you or your Team know anyone in similar situations that might be at higher risk from these issues? Are you confident that all relevant assessments have taken place?

Guardian article on hoarding

(now classified by the World Health organisation as a medical disorder)

https://www.theguardian.com/society/2018/aug/18/it-looks-like-youre-a-lazy-idiot-hoarders-welcome-medical-classification?CMP=Share_iOSApp_Other

Safe Recruitment Practice

The HSAB Prevention Strategy recognises that safe recruitment practice is a key part of ensuring that the best possible staff are employed to look after/support vulnerable people. One element of the process (alongside the need for references) includes DBS checks. There is often confusion about which staff need a DBS check and which type of check should be undertaken. The Home Office has published guidance (updated 3 April 2019) for employers about ***Disclosure and Barring Service (DBS)*** checks, including how to apply. An employer may request a criminal record check as part of their recruitment process. These checks are processed by the DBS. For certain roles, the check will also include information held on the DBS children's and adults' barred lists, alongside any information held by local police forces that is considered to be relevant to the applied-for post.

More information is available on the ***Government website***. Please also see: ***The code of practice for registered persons and other recipients of DBS check*** *and* ***Changes to the enhanced disclosure application process*** (published 02 April 2019).

DBS Checks – New Leaflets

The Government has also produced two new leaflets providing information related to eligibility and other Disclosure and Barring Service products and services

DBS Checks: Working with Adults in the Charity Sector

DBS Checks: Working with Children in the Charity Sector

HSAB plans for 2019/2020

The HSAB held its annual business planning event on 28th June which was facilitated by Dr Adi Cooper OBE. The priorities agreed for this year and next included: more community safety work with a special focus on elderly people living in their own homes; a focus on supported housing so that there are the same safeguards and protection for vulnerable people in these settings as for those in regulated services; a refocus on self neglect and hoarding; and any actions needed from learning disability mortality reviews. The Board's Annual Report for 2018/2019 will be published at the end of August on the Council and partner agency websites.

Thank You!!

The HSAB would like to say a big **"Thank You!"** to Harrow Mencap and Mind in Harrow whose users attended the Board meeting on 28th June as "experts by experience" to raise their issues about keeping safe and to challenge the Board about what it will be doing this year. ☺

The Safe Car Wash App:

The Safe Car Wash app has been developed to allow the general public to engage with the problem of modern day slavery. It is a new tool that will enable the largest community intelligence gathering attempted in the United Kingdom.

Download the free app onto your smartphone and then when you are using a hand car wash, simply open the app and complete a short survey about the working conditions of the car wash.

https://www.theclewerinitiative.org/s/mtvsff1nyye8wdvqjoh89uekfali57