SAFEGUARDING ADULTS

Cath Erine – Board Manager

People in Positions of Trust

- Legal requirement (Care Act 2014 – S14) to respond to allegations against anyone who works (paid or unpaid) with adults with care and support needs
- The Safeguarding Adults Board is required to seek assurance that all organisations can evidence appropriate structures in place to deal with allegations against workers or volunteers
- Barnsley Safeguarding Adults Board has a policy - https://www.barnsley.gov.uk/media/15368/protocol-for-procedures.pdf
- PIPOT concerns can be managed via safeguarding, employment processes/law and/or criminal enquiries

PIPOT processes do not replace

- Health and social care's responsibility to provide safe and high quality care and support
- Commissioners role in seeking assurances that all services are safe and effective
- CQC's responsibility to regulate services and if necessary take enforcement actions
- High quality recruitment and supervision processes

What does this mean for Barnsley Safeguarding Board and its members

- All BSAB members, including any services they commission, must provide assurances that their arrangements to respond to PIPOT concerns are robust and functioning effectively
- All organisations dealing with PIPOT must comply with the Care Act guidance and other relevant legislation (GDPR etc.)
- Historical and current concerns must be addressed.

PIPOT criteria. The worker or volunteer will have

- Behaved in a way that has harmed, or may have harmed an adult or child
- Suspected of a criminal offence against, or related to, an adult or child or other relevant offence (supplying and using illegal drugs etc)
- Behaved towards an adult or child in a way that indicates they may pose a risk of harm to adults with care and support needs.

Examples of PIPOT concerns

- The PiPoT's own work / voluntary activity with Adults (and/or children)
- Examples

1. A worker is suspended for alleged financial abuse of an adult with learning disabilities

- The PiPoT's life outside work i.e. concerning adults with care and support needs in their family or social circle
- Examples

1. A son is accused of physically and financially abusing his mother and he works as a domiciliary care worker with adults with care and support needs.
2. A woman is convicted of grievous bodily harm against a neighbor; she works in a residential home for people with learning disabilities.

Additional examples

- The PiPoT's life outside work (family life)
- Example

1. A woman is employed in a day centre for people with learning disabilities but her children are subject to child protection procedures; including a criminal investigation into neglect and physical harm
2. A male worker in a care home for adults with dementia is discussed at MARAC, (violence against his female partner)

What should I do

- Whistleblowing to a senior manager within the organisation – if appropriate
- Contact Human Resources if the concerns relate to a paid employee
- Contact the police if a crime has been committed or is suspected
- If an adult who has care and support needs is involved send an adult safeguarding concern into adult social care, this can be done without their consent in a PIPOT case. https://www.barnsley.gov.uk/services/children-families-and-education/safeguarding-families-in-barnsley/safeguarding-adults-in-barnsley/for-professionals-and-volunteers/ (adult concern form)

Safeguarding Adults Reviews

The criteria are met when:

- An adult at risk dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death; or
- An adult has sustained a potentially life threatening injury through abuse, neglect, serious sexual abuse or sustained serious and permanent impairment of health or development through abuse or neglect;

SAR – definition continued

- **and one of the following:**
- Where procedures may have failed and the case gives rise to serious concerns about the way in which local professionals and/or services worked together to safeguard adults at risk;
- Serious or apparently systematic abuse that takes place in an institution or when multiple abusers are involved. Such reviews are likely to be more complex, on a larger scale and may require more time;
- Where circumstances give rise to serious public concern or adverse media interest in relation to an adult/adults at risk

Learning from local SAR's

- "Jack" – man who died in a house fire, self- neglected and hoarded. Struggled to maintain relationship with people after death of his mum. Highly intelligent, had previously worked as a teacher. Owner occupier. History of mental ill health
- **Learning**
- Identification of fire risks and referral to SYFR by all agencies
- Recognising impact of "bereavement" and its links to self neglect and hoarding
- Developing and maintaining relationships with the adult; consider why family are speaking for them?
- Training for all staff to use the self neglect and hoarding policy and guidance.
- What do we do when adults do not attend appointments?
- Examine how we share information to inform risk assessments

Learning from local SAR's

- Mr G (68) – died as a result of liver cirrhosis. Mr G struggled to maintain tenancies – history of self neglect/hoarding and anti-social behaviour. Inappropriate and often sexualised behaviour with females. His behaviour deteriorated after the death of his mother. Had multiple medications, which were not taken as prescribed and often combined with alcohol.

Learning

- No effective information sharing between agencies to assess risk as the self neglect policy not used to provide a framework for sharing.
- Absence of a fire risk assessment or contact with SYFR
- Sexualised behaviour towards female workers not appropriately managed
- Mental health/learning disabilities not fully explored

Learning from local SAR's

- Mrs T (86) died in a house fire. Mrs T had impaired mobility, early dementia and her legs were dressed with paraffin based emollients. Her home had a coal fire/coal bucket near the sofa (where she often slept). History of mental ill-health and domestic violence from her husband. Reliance on her son, who lived out of area, but visited daily

Learning

- Fire risk assessment not completed
- Capacity assessments not considered
- Role of son not fully explored – force for good or not? (he cancelled the agreed and social care funded care package). Mrs T's view or not?

Clive – published 2020

- Clive was 59 when he died at home in a sleeping bag on the living room floor, where he had slept since a fire in the property in 2014. He weighed 6 stones due to his self neglect
- Clive lived alone in the Berneslai Homes tenancy since the death of his mother in 2012. He had lived with his family for the bulk of his adult life.
- Clive had obsessive compulsive behaviour which limited his ability to leave the house. His parents ”looked after” him, cooking meals, washing his clothes, organising appointments
- Clive had longstanding issues with anxiety, (from the age of 16)
- Clive had 2 sisters who tried to support him, without success
- Clive had long periods without income – he struggled to attend DWP appointments and was not aware he could request a home visit. Rent arrears a feature

Clive – published 2020

- Clive was an avid reader, loved football and music.
- Clive was very sensitive to noise and “germs” evidenced by repeated handwashing, reluctance to touch door handles, travel on buses etc
- Clive liked structure – regular meal times etc.
- Clive did not have any relationships outside the family
- Clive confirmed to professionals who had contact with him that he was “very lonely” but was unable to access support to address this and said he had “burnt his bridges” with his sisters.
- At the time of his death, CLIVE was in receipt of support from the mental health tenancy support and a housing management worker employed by Berneslai homes; a small care package funded by Adult Social Care to assist with meals and personal hygiene for the six weeks prior to his death

What did we learn?

- Lack of shared information about his inability to attend appointments impacted on organisation's responses
- Bereavement services not accessible
- Lack of family mediation = no access to family support
- Staff not aware of home visiting options offered by organisations
- Lessons not learnt from previous SARs (policy not used) and risk assessment not completed

What did we learn

- Family concerns not acted upon – contact made with GP, Mental Health and Adult Social Care. (consent)
- His ability to care for himself not fully explored
- Questions about his functional/Executive capacity not addressed
- Suitability of the accommodation (emotionally) not addressed , post fire.
- Would psychological support have helped – if accepted?

Questions for practice?

- How do you manage DNA's for adults who have a history of DNA/mental ill health/bereaved
- Would you be confident to make a referral into Adult Social Care on the grounds of self neglect and/or hoarding
- Would you be able to arrange a home visit to a man like Clive – would you know which other organisations could offer this service?
- How do you manage contact from concerned family members? Would this result in a safeguarding referral
- Do you know how to find the self neglect and hoarding policy and summary guidance

Resources

- https://www.barnsley.gov.uk/media/14951/sn-and-hoarding-policy-summary-approved-july-2020.pdf

- https://www.barnsley.gov.uk/media/14480/self-neglect-and-hoarding-policy-approved-bsab-may-2020.pdf - Full policy
- https://www.scie.org.uk/self-neglect - suite of resources produced by Social Care Institute for Excellence
- https://www.barnsley.gov.uk/services/children-families-and-education/safeguarding-families-in-barnsley/safeguarding-adults-in-barnsley/barnsley-safeguarding-adults-board/safeguarding-adult-reviews-sars/ - CLIVE and other SAR reports