Shropshire Partners in Care
The Care Workforce Development Partnership

Safeguarding Adults Forum

April 2018

NHS Telford and Wrekin Clinical Commissioning Group
a co-operative council
Telford & Wrekin Council
NHS Shropshire Clinical Commissioning Group
Shropshire Council

Agenda

Introduction from safeguarding adults forum organisers *(Karen Littleford)*

Deprivation of Liberty Safeguards (DoLS) in Telford and Wrekin *(Ian Francis and Lorna Rice)*

Referring an Individual to the DBS – Good Safeguarding Practice *(Karen Littleford)*

MCA, G.P.'s and covert medication *(Marion Kelly)*

The Learning Disabilities Mortality Review (LeDeR) Programme *(Kathy George)*

Forum Meeting Evaluation

The **purpose of the Safeguarding Adults Forum** is to promote awareness of good practice concerning safeguarding adults, including the application of the Mental Capacity Act, the Deprivation of Liberty Safeguards and the Prevent agenda

(SA Forum ToR, 2018)

Ground Rules for Forum Meetings and Engagement with the Forum

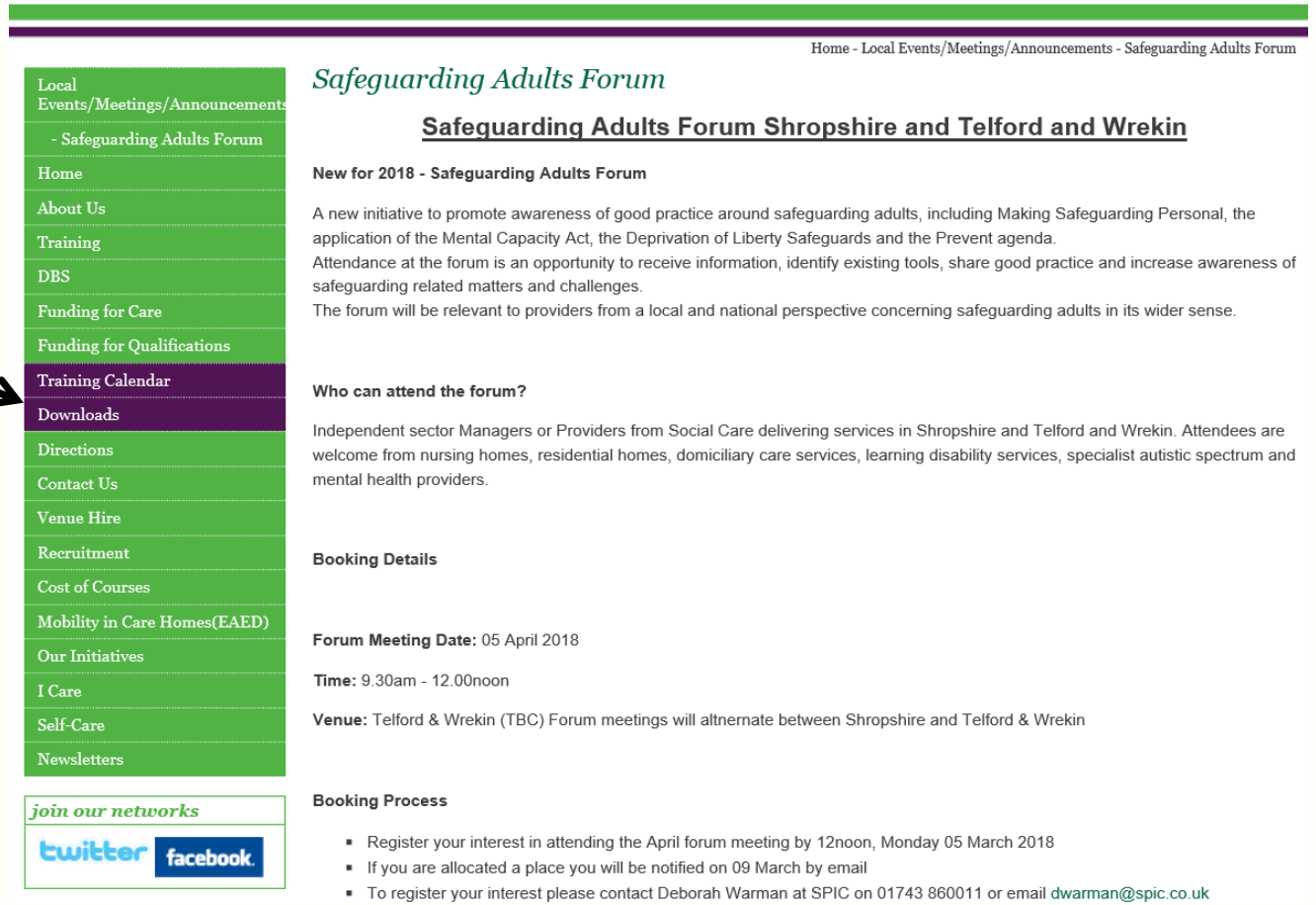
Applicable during forum meetings and in any subsequent communication, including electronic:

- Language (appropriate)
- Maintain individuals confidentiality
- Respect other forum members right to voice their opinions
- Acknowledge differences in opinions
- Contribute to requests for future agendas
- Work to the forum Confidentiality Agreement
- Commit to partnership working in order to improve the experience of adults with care and support needs
- Commit to engage, share good practice and take appropriate action
- Be open to suggestions ‘open, engaged and involved’
- Evaluate individual forum meetings in order to contribute to overall project evaluation
- Cascade information within your organisation

Ground Rules for Forum Meetings and Engagement with the Forum

Communication outside of forum meetings:

Visit the SPiC website to access signposting materials



Forum Questions

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Deprivation of Liberty Safeguards (DoLS) in Telford and Wrekin

Ian Francis and Lorna Rice

Telford and Wrekin Council

Referring an Individual to the DBS – Good Safeguarding Practice

Karen Littleford

Safeguarding Adults Lead, Shropshire Partners in Care

Role of DBS

The DBS's role is to help prevent unsuitable people from working (or volunteering) in Regulated Activity with children and adults.

The Disclosure and Barring Service (DBS) established under Protection of Freedoms Act 2012 combines criminal record & barring functions

DBS Vetting and Barring Service

Vetting –
DBS Disclosures - Background checks on an individuals 'criminal history' & 'soft intelligence' if enhanced check

Purpose – Allows an employer to make an informed decision

Barring – DBS operate two barred lists

DBS **Adults** Barred List

DBS **Children's** Barred List

Those in '**Regulated Activity**' (adults) need to be checked against the DBS Adults Barred list. And referred to DBS if they **harm** or **risk harm &** you **remove them from regulated activity role**

Criminal Offences to work or volunteer (or seek work) in **Regulated Activity** whilst **barred**

1. **Providing healthcare**
2. **Providing personal care**
3. **Providing social work**
4. **Assistance with cash, bills and/or shopping**
5. **Assistance in the conduct of a persons own affairs**
6. **Conveying**

Vetting and Barring Legislation

Protection of Freedoms Act 2012, Part 5

Established the Disclosure and Barring Service (DBS)

Safeguarding Vulnerable Groups Act 2006

Set out the scope and operation of the Vetting and Barring Scheme

Police Act 1997, Part V

Established Criminal Records Bureau (CRB)

Other Legislation and Guidance

Health and Social Care Act (2008) Regulated Activities) Regulations 2014 (part 3)

Care Quality Commission (Registration) Regulations 2009 (part 4)

Care Quality Commission Guidance for providers on meeting the regulations - see Regulation 19 Fit and Proper Persons Employed 19(2)

Human Rights Act (1998) Article 6 (right to a fair trial) Article 8 (right to private and family life)

What is harm in relation to a DBS Referral?

This is not defined in legislation. *DBS view harm as its common understanding or the definition you may find in a dictionary.* **Harm is considered in its widest context** and may include:

- sexual harm
- physical harm
- financial harm
- neglect
- emotional harm
- psychological harm
- verbal harm

This is not a fully comprehensive list, harm can take many different forms.

Examples of Harm to an adult:

Examples of harm in relation to vulnerable adults

This list gives you some examples of harm. It isn't a definitive list of every possible example of harm but will help you to understand types of potential situations.

Type of harm to vulnerable adult	Meaning	Example
Emotional / Psychological	Action or inaction by others that causes mental anguish	Inflexible regimes and lack of choice. Mocking, coercing, denying privacy, threatening behaviour, bullying, intimidation, harassment, deliberate isolation, deprivation.
Financial	Usually associated with the misuse of money, valuables or property.	Unauthorised withdrawals from vulnerable adult's account, theft, fraud, exploitation, pressure in connection with wills or inheritance.
Physical	Any physical contact that results in discomfort, pain or injury	Hitting, slapping, pushing, shaking, bruising, failing to treat sores or wounds, under or overuse of medication, un-prescribed or inappropriate medication, use of restraint or inappropriate restraint, inappropriate sanctions.
Sexual	Coercion or force to take part in sexual acts	Inappropriate touching. Causing bruising or injury to the anal, genital or abdominal area, forcing an individual to watch sexual acts. Transmission of STD.
Neglect	Failure to identify and/or meet care needs	Untreated weight loss, failing to administer reasonable care resulting in pressure sores or uncharacteristic problems with continence. Poor hygiene, soiled clothes not changed, insufficient food or drink, ignoring resident's requests, unmet social or care needs.
Verbal	Any remark or comment by others that causes distress	Demeaning, disrespectful, humiliating, racist, sexist or sarcastic comments. Excessive or unwanted familiarity, shouting, swearing, name-calling.

DBS (2016)

Click here to access

Legal Duty to Refer

If you engaged a person to work in regulated activity, you have a legal duty to refer where the **relevant** conditions are met.

The duty to refer applies even when a report has been made to another body such as a local authority safeguarding team.

The duty to refer applies irrespective of whether another body has made a referral to the DBS in relation to the same person.

(DBS, 2017)

A person who is under a duty to refer and fails to refer to the DBS without **reasonable justification** is committing an offence. If convicted they may be subject to a fine up to £5,000.

(DBS, 2017)

Do you refer to DBS when an allegation is made or when you suspend?

NO – you need to carry out your investigations first and establish if it has foundation.

If you dismiss or remove the person from working in regulated activity then you should refer to the DBS.

You should complete your investigations and disciplinary processes even when the individual has resigned and left your employment.

(DBS, 2017)

When to Refer to DBS

When two main conditions have been met:

ONE: Withdraw permission to engage in regulated activity

- Dismissed
- Redeployed
- Retired / Redundant
- Resigned

(DBS, 2017)

TWO: Referring party thinks that the person has either:

- Engaged in relevant conduct or
- Satisfied the harm test or
- Received a caution for, or been convicted of a relevant offence For most cases, the DBS only has the power to bar a person who **is, has been** or **might in future** engage in regulated activity

(DBS, 2017)

Relevant Conduct

Put simply, relevant conduct is an action or inaction that has harmed or placed a child or vulnerable adult at risk of harm (DBS, 2012:5)

Relevant conduct in relation to vulnerable adults

- Endangers a vulnerable adult or is likely to endanger a vulnerable adult
- If repeated against or in relation to a vulnerable adult, would endanger an adult or would be likely to endanger them
- Involves **sexual material relating to children** (including possession of such material)
- Involves **sexually explicit images depicting violence against a person** (including possession of such images), if it appears to DBS that the conduct is inappropriate
- Is of a sexual nature involving a vulnerable adult, if it appears to DBS that the conduct is inappropriate.

A person's conduct endangers a vulnerable adult if they:

a. Harm a vulnerable adult,

b. Cause a vulnerable adult to be harmed,

c. Put a vulnerable adult at risk of harm,

d. Attempt to harm a vulnerable adult, or

e. Incite another to harm a vulnerable adult.

DBS, 2012:5

What is the Harm Test?

There are occasions where a person may not have engaged in relevant conduct but there are still serious concerns which satisfy the harm test.

To satisfy the harm test there needs to be **credible evidence** of a risk of harm to children or vulnerable adults such as statements made by an individual regarding conduct/behaviour, etc.

For a case to be considered as a risk of harm, relevant conduct would not have occurred but there must be tangible evidence rather than a “feeling” that a person represents a risk to children and / or vulnerable adults.

For example, a teacher who confides in their head teacher that they are sexually attracted to children (but who had not engaged in ‘relevant conduct’) would satisfy the harm test.

Disclosure and Barring Service (2012)

At What Point Do You Refer to DBS?

The DBS has **no investigatory powers** and relies upon the evidence provided with referrals/any other evidence gathered.

A referral should **not be** made when an allegation is first made.

You are referring when you have gathered evidence and decided on the relevant action

The employer must carry out an investigation and gather evidence to establish if the allegation has foundation.

You are providing the information from your disciplinary investigation to the DBS, HR input is therefore critical

Without evidence or information for the DBS to consider, the allegation may be closed as there is no basis on which the DBS can proceed.

A premature referral to the DBS may result in no action.

Power to Refer to DBS

The **power to refer** may be used when a **local authority** or **regulatory body** is acting in a role other than as a regulated activity provider, ***for example when undertaking a safeguarding role.***

Refer when these two conditions are met:

Condition 1: the organisation thinks a person has either:

- harmed or poses a risk of harm to a child or vulnerable adult;
- satisfied the harm test; or
- received a caution or conviction for a relevant offence

Condition 2: the organisation thinks that:

- the person they are referring is or has been, or might in the future be working in regulated activity; and
- the DBS may consider it appropriate for the person to be included in a barred list

DBS, 2016a

Local Authority Power to Refer to DBS

Scenario

An enquiry identified that a member of staff working at a privately run care home carried out emotional and physical abuse of older people. The member of staff left during the investigation.

The investigation concluded that if they had not left, the care home would have dismissed them from the role (Disclosure and Barring Service, 2016a).

Can I make a referral to the DBS if the legal conditions are not met?

There could be times when you consider that you should make a referral in the **interests of safeguarding adults** even if you have not removed the person from working in regulated activity.

- acting on advice of the police or a safeguarding professional
- situations where you don't have enough evidence to dismiss or remove a person from working with vulnerable groups

(DBS, 2017)

The DBS is required by law to consider any and all information sent to it from any source.

An employer may wish to seek their own legal advice in relation to these cases.

(DBS, 2017)

The duty to refer applies irrespective of whether another body has made a referral to the DBS in relation to the same person.

A person who is under a duty to refer and fails to refer to the DBS without reasonable justification is committing an offence. If convicted they may be subject to a fine up to £5,000.

(DBS, 2017)

Referring Individuals to the DBS

An allegation has been made that a member of staff harmed an adult.

The allegation was that the individual mocked an adult using the service.

The staff member hands in their notice and leaves the organisation as you are preparing to commence an investigation which may result in disciplinary action.

Referral Criteria - When two main conditions have been met:

ONE: Withdraw permission to engage in regulated activity

Dismissed
Redeployed
Retired / Redundant
Resigned

TWO: Engaged in **relevant conduct**

or

Satisfied the **harm test**

or

Received a caution for, or been convicted of a relevant offence For most cases, the DBS only has the power to bar a person who is, has been or might in future engage in regulated activity

Is a referral to the DBS required?

Other Considerations

You are asked to complete a reference request asking if you would re-employ the worker – how do you respond?

What will your insurers or legal advisers suggest?

How Does Appropriate Referral to DBS Constitute Good Safeguarding Practice?

- ✓ Protects the people you support
- ✓ Protects your business and reputation
- ✓ Supports other care providers by preventing unsuitable individuals from moving around
- ✓ Ensures you are meeting your legal duties
- ✓ Compliance with contracts, commissioning and regulations
- ✓ Upholds the human rights of both staff and clients (Article 3 Prohibition of torture, Article 6 Right to a fair trial, Article 8 Right to respect for private and family life)
- ✓ Is the **RIGHT** thing to do *as well as a duty*
- ✓ When all providers understand & act on the legal duty this makes Shropshire & Telford and Wrekin a *safer* place to receive care and support

DBS Referral Resources

DBS Barring Referral Guidance – click here

Guidance - Making barring referrals to the DBS

Click here

Disclosure and Barring Service (2012) *Referral Guidance: Frequently asked questions.*
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/143692/dbs-referral-faq.pdf

Help with DBS Referrals call 03000 200 190.

National Audit Office (2018) *Home Office: Disclosure and Barring Service Investigation into the Disclosure and Barring Service.* London: National Audit Office.

https://www.nao.org.uk/wp-content/uploads/2018/02/Investigation-into-the-Disclosure-and-Barring-Service.pdf

DBS References

Disclosure and Barring Service (2012) *Referral Guidance: Frequently asked questions.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/143692/dbs-referral-faq.pdf

Disclosure and Barring Service (2017) *Guidance - Making barring referrals to the DBS*. London: Disclosure and Barring Service. https://www.gov.uk/guidance/making-barring-referrals-to-the-dbs#legal-duty-to-refer-the-two-conditions-that-must-be-met

Disclosure and Barring Service (2016) *Examples of harm in relation to vulnerable adults.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/500137/Examples_of_harm_in_relation_to_adults.pdf

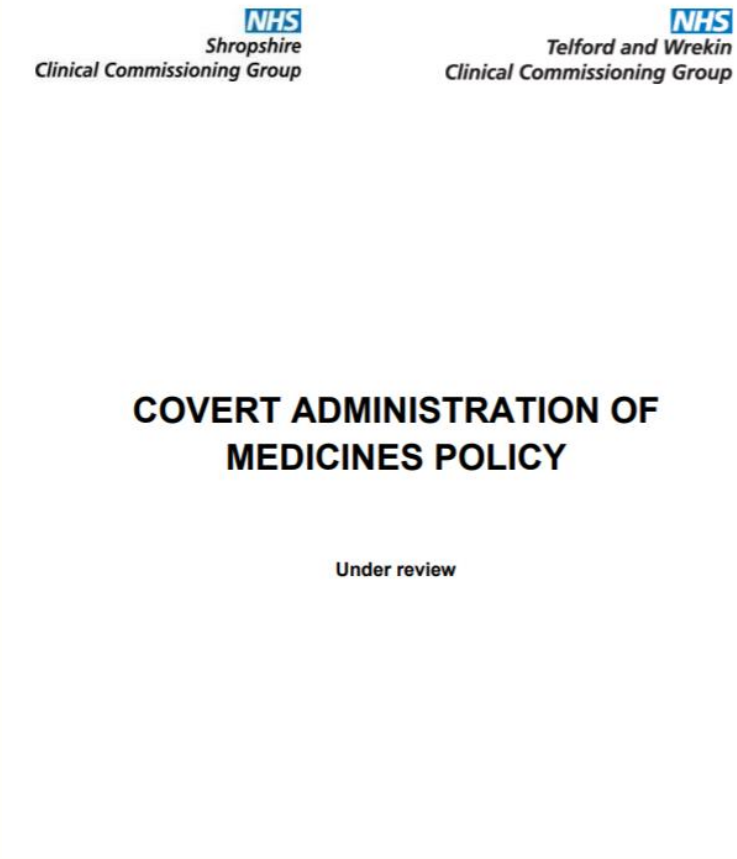
Disclosure and Barring Service (2016a) *Guidance Referral duty and power for local authorities and regulatory bodies*. Updated 4 March 2016. London: DBS.
https://www.gov.uk/government/publications/dbs-barring-referrals-local-authority-referral-duty-and-power/referral-duty-and-power-for-local-authorities-and-regulatory-bodies

Disclosure and Barring Service (2015) *Meeting your Legal Duty to Refe*r. Presented by: Lyn Gavin. January 2015 – Sandwell.

MCA, G.P.'s and Covert Medication

Marion Kelly

Trainer and Development Officer
Shropshire Partners in Care



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COVERT ADMINISTRATION OF MEDICINES POLICY

Under review

Link to Policy - http://www.telfordccg.nhs.uk/your-health/medicines-management/care-homes/1263-covert-administration-of-medicines-policy-may-2015/file

Shropshire Partners in Care
The Care Workforce Development Partnership

The Learning Disabilities Mortality Review (LeDeR) Programme

Kathy George

Named Nurse, Adult Safeguarding
Telford and Wrekin CCG

Learning Disabilities Mortality Review (LeDeR) Programme

Background

‘Death by Indifference’ Mencap (2007)

Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD) (2013)

An independent review of deaths of people with a Learning Disability or Mental Health problems in contact with Southern Health NHS Foundation Trust MAZARS (2015)

The Learning Disabilities Mortality Review (LeDeR) Programme was established as a result of one of the key recommendations of the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD).

CIPOLD reported that some people with learning disabilities were dying sooner than they should. Some of the reasons for this were related to the standard of health and social care that they received.

The LeDeR Programme aims to make improvements to the quality of health and social care for people with learning disabilities.

‘Entirely Preventable’

Connor Sparrowhawk - an NHS trust has been fined a record £2m after admitting "systemic failures" following the deaths of two vulnerable patients.

Southern Health pleaded guilty last year to breaching health and safety laws following the deaths of Teresa Colvin and Connor Sparrowhawk, an epileptic teenager with autism who drowned in a bath at an NHS care unit.

On Monday, a judge at Oxford crown court described each death as an "unnecessary human tragedy" as he issued the biggest fine of an NHS trust following a prosecution by the Health and Safety Executive (HSE).

Halliday, J. (2018) *NHS trust fined £2m for Connor Sparrowhawk and Teresa Colvin deaths.* The Guardian. https://www.theguardian.com/society/2018/mar/26/nhs-trust-fined-2m-over-death-of-teenager-connor-sparrowhawk

Richard Handley – ‘A "missed opportunity" for potentially life-saving treatment contributed to the death of a man from constipation complications, an inquest has found.

Richard Handley, 33, who had Down's syndrome, died at Ipswich Hospital on 17 November 2012.

Some 10kg (22lb) of faeces were removed from his body two days before.

Coroner Dr Peter Dean said there were "gross failures" in spotting Mr Handley was in a critical state after the surgery.

After an 11-day inquest at Ipswich Coroners' Court, Dr Dean said an overall care co-ordinator "would have prevented this from happening" as there were a number of agencies involved in looking after Mr Handley.

Mr Handley's mother Sheila, who gave evidence during the inquest, said outside court she was "disappointed" after the coroner's verdict.

"It feels to me, having heard all the evidence, that the level of the failures was such that Richard died because he was neglected. He wasn't given the care he needed to keep him safe.”

BBC News (2018) *Richard Handley: 'Gross failures' in constipation death*. http://www.bbc.co.uk/news/uk-england-suffolk-42989091

Jeremy Hunt – Secretary of State for Heath December 2016

'*We will ensure that the NHS reviews and learns from all deaths of people with learning disabilities in all settings*'

'*The LeDeR programme will provide support to both families and local NHS areas to enable reporting and independent standardised review of all learning disability deaths*'

Definition of Learning Disability from '*Valuing people*'

Learning Disability includes the presence of:

A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence),with

A reduced ability to cope independently (impaired social functioning)

Which started before adulthood with a lasting effect on development

NHS Definition - Learning Disability

www.nhs.uk/livewell/childrenwithalearningdisability/pages/whatislearningdisability.aspx

A learning disability happens when a person's brain development is affected, either before they are born, during their birth or in early childhood.

Several factors can affect brain development, including:

- the mother becoming ill in pregnancy
- problems during the birth that stop enough oxygen getting to the brain
- the unborn baby developing certain genes
- the parents passing certain genes to the unborn baby that make having a learning disability more likely (known as inherited learning disability)
- illness, such as meningitis, or injury in early childhood

Aims of the LeDeR Programme

To drive improvement in the **quality** of health and social care service delivery

To reduce **Premature Mortality** and **Health inequalities**

To influence **practice** at service, individual practice and professional level

Local Reviews of Deaths

Identify the potentially avoidable contributory factors related to deaths of people with learning disabilities

Identify variation and best practice in preventing premature mortality of people with learning disabilities

Develop action plans to make any necessary changes to health and social care service delivery for people with learning disabilities

Reviews to Include

All notified deaths of people with a learning disability aged over 4 years

All deaths of those aged 4-17 years reviewed by Child Death Overview Panel (CDOP).

Priority Themed Reviews

Deaths of young people aged 18-24 years, or from Black and Minority Ethnic Communities

Notification of Death to the LeDeR Programme

Deaths of people with learning disabilities will be notified to a single point of contact by anyone (family member, advocate, GP, residential care worker or other) who is aware of the death of a person with learning disabilities.

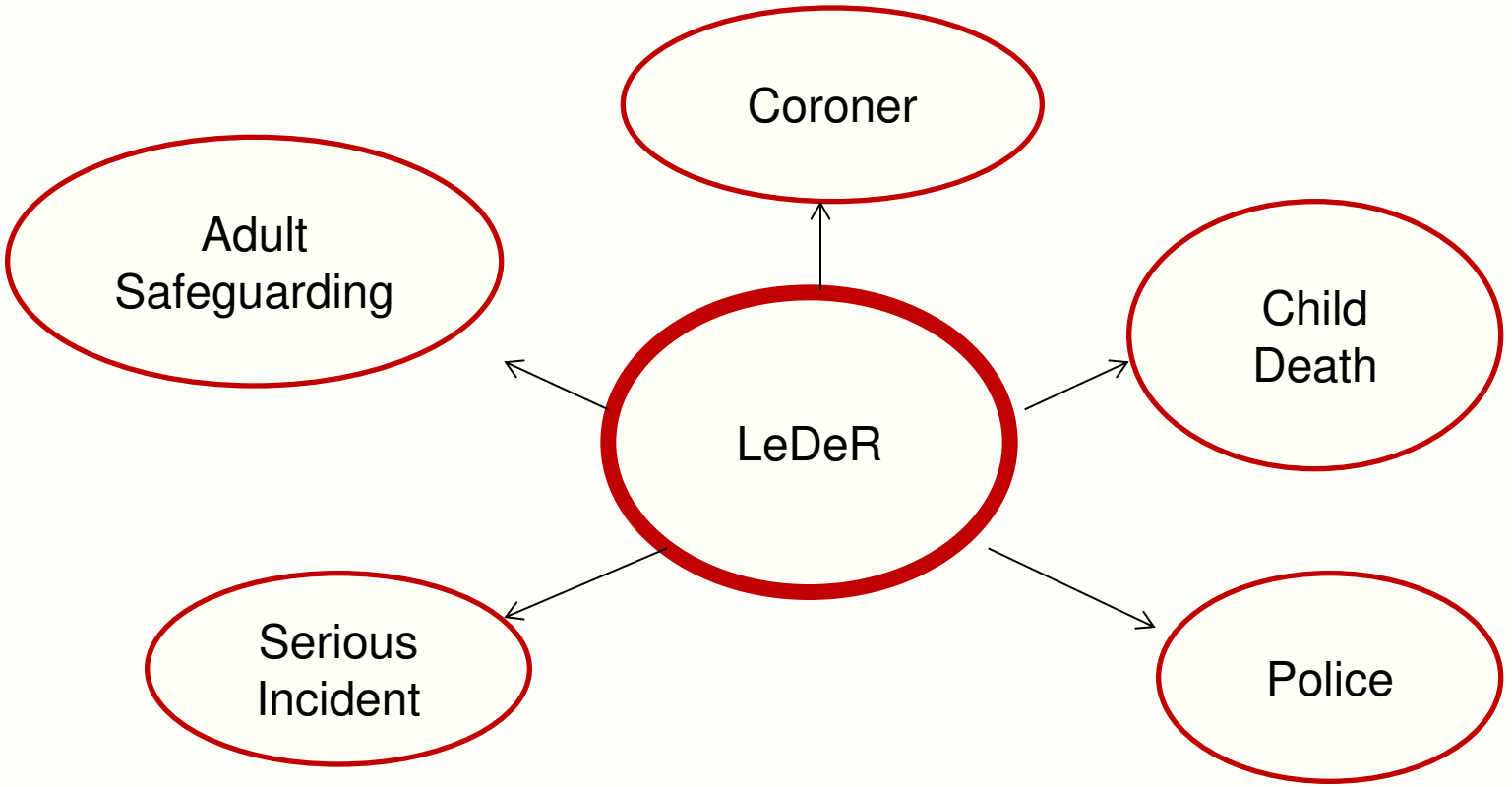
Reporting a death of someone with learning disabilities can be done in a number of ways: via **0300 7774 774** directly to a member of the LeDeR team, or via the Programme's secure web-based portal, which can be accessed through the LeDeR website.

This will direct them to a standard questionnaire which asks for details of the person with a learning disability who has died, the contact details of a person who knew them well, known health conditions and cause of death if known. People reporting the death will be asked to complete as much of the death notification information as possible.

The information will be checked by the LeDeR team to ensure that the death meets the inclusion criteria for the Programme; i.e. that the person is aged 4 years or over and has learning disabilities.

Once confirmed, the person's death will be allocated a Programme ID number and reported to the Local Area Contact - The Local Area Contact will be responsible for nominating a local reviewer to undertake the review of the death. Once a local reviewer has been nominated, the LeDeR Programme team will allocate the case to this reviewer.

How does LeDeR work with other Reviews



Potentially Avoidable Deaths

‘Potentially avoidable deaths are those where there are aspects of care and support that, had they been identified and addressed, may have changed the outcome and on balance of probability the person may have lived for another year or more’

The Reviews

Initial reviews

For each death there is an initial review. The purpose of this is to collect information that establishes if there are any concerns relating to the care of the person who has died or if any further learning could be gained from a more in-depth review of the death that would contribute to improving the health and social care provided to people with learning disabilities.

For the initial review someone who knew the person well, such as a family member, is invited to contribute their views. The reviewer will ask them about the person who has died and the circumstances leading to their death. The reviewer will also look at relevant case notes relating to the person who has died, including GP records and care records

The Reviews

In-depth or multiagency reviews

If there are any areas of concern identified about the death, or if it is felt that a fuller review could lead to improved practice, a more in-depth or multiagency review takes place. This involves the range of agencies that have been supporting the person who has died, (e.g. health and social care staff).

The review looks at three levels of care:

a) Initial diagnosis and management of the condition.

b) Ongoing management of the condition from initial diagnosis to critical illness.

c) Management and care received during final illness.

The reviewer will ask about any examples of best practice in relation to the care of the person, if there are any potentially avoidable contributory factors related to their death and whether it is thought that anything could have been done differently.

Good Practice for Care Providers

Health Passports – ensure updated and available (ensure transfers with the service user)

Annual Learning Disability Health Checks - to include medication reviews

DNACPR - Learning Disability is not a valid reason to consider DNACPR.,……..Challenge!

Involve families/advocates. Promote regular and meaningful reviews.

Capacity Assessments/DoLs/ Best Interest Decisions

Make reasonable adjustments

LeDeR Resources

LeDeR - http://www.bristol.ac.uk/sps/leder/

Notify a death - http://www.bristol.ac.uk/sps/leder/notify-a-death/

Frequently Asked Questions - http://www.bristol.ac.uk/sps/leder/frequently-asked-questions/

Repository - http://www.bristol.ac.uk/sps/leder/repository/

LeDeR Social Media

- Twitter
  https://twitter.com/leder_team

- Facebook
  https://www.facebook.com/lederteam

Safeguarding Adults Forum 18th July 2018, 9:30 – 12noon (Shropshire Venue TBC)

Booking Process

- Register your interest in attending the July Forum meeting by 12noon, Monday 4th June 2018
- If you are allocated a place you will be notified on 8th June 2018 by email
- To register your interest please contact Deborah Warman at SPIC on 01743 860011 or email dwarman@spic.co.uk
- **Safeguarding Adults Forum Questions?** Contact Karen Littleford, Safeguarding Adults Lead, Shropshire Partners in Care, 01743 860011 klittleford@spic.co.uk