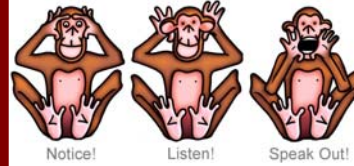


Bradford Safeguarding Adults Board Newsletter - Issue 5 - October 2007



Hello and welcome to this 5th issue of our newsletter!

Firstly some news from the Adult Protection Unit....

Kate Higgins the Units MARAC (Multi Agency Risk Assessment Conference) Co-ordinator joined the team in July 2007; Kate previously worked as a Domestic Violence Co-ordinator for the Police. Welcome Kate!

Helen Nelson has now joined the Adult Protection Unit as an MARAC Administrator, Helen will be working full days from Wednesdays to Fridays until her job share partner is appointed. Welcome Helen!

Catherine Stobart who is currently part of the Health in Mind team will be on a short term contract with the Adult Protection Unit until 16th December 2007. Catherine will be providing administration support to the Unit in the afternoons. Welcome Catherine!

Neena Punnu has finally returned back from her maternity leave. She is very pleased to be back at work!

Farewell to... Susan Kendrick left the Unit on Friday 26th October – she writes....After two years (almost to the day!) with the APU, I am leaving to work in the Council's Corporate Procurement department. I have enjoyed working with the Safeguarding Adults Board and will no doubt hear about the continuing good work of everyone through the Council grapevine. Best wishes to everyone. Sue

She will be truly missed! Thank you Sue for all your good work!

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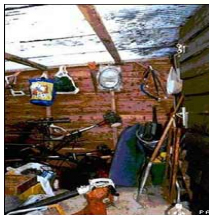
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AP Murder – Three jailed over shed imprisonment



Three people who kept an epileptic man prisoner in a garden shed in Gloucestershire for four months have been given lengthy jail sentences.

Kevin Davies, 29, was a victim of a truly appalling systematic torture and abuse where he was repeatedly beaten, burned and humiliated. He was held hostage over a minor debt that was claimed he owed.

He was found dead by paramedics at a house in Gloucestershire, on September 26 2006, where he had been locked away in David Lehane and Amanda Baggus's shed since May 27.

A diary was kept; recording the punishments they had meted out to the **vulnerable victim** and scornfully noted his cries for help. They also made a hostage style video of him in which they forced him to say he was being 'fed perfectly' but in fact he was being fed only scraps. He was

bullied into saying he was there voluntarily and was being treated well.

The court was told that Mr Davies had been treated like an animal he suffered from severe epilepsy and had been described as **'gullible' and 'vulnerable'**.

Amanda Baggus felt Kevin Davies owed her money and that was a good enough reason to keep him at their address where she helped herself to his social security money to pay household bills and debts.

It was said 'What emerged from the investigation into Kevin Davies' death was that he had been held captive at the home for nearly four months. That he had been abused for that period of time. He had been assaulted, he had been beaten and he had effectively been kept like a dog in a locked garden shed at night. The last few months of this man's life must have been utterly miserable and inhumane.

The couple, along with a second man, Scott Andrews, all pleaded guilty in May to false imprisonment and assault occasioning actual bodily harm.

Four face nursing abuse charges

Four people appeared in court charged with neglecting elderly residents at a Gloucester care home. The allegations surrounding Newsham House in Stroud Road are said to include mouldy faeces found in one of the rooms, filthy toilets, and the lack of any stimulating activity for the patients.



There was a general hygiene risk. In one case faeces with mould growing on it was found. There was no plan to address the patients' social needs, nor was there any stimulation or diversion therapy. Thought was given to closing the home, but the service provider ADL Ltd gave assurances that the problem was being managed.

The court was presented a 52 page dossier of evidence, saying that a number of complaints were made relating to the ill-treatment and neglect of residents at Newsham House. The complaints were lodged in relation to the in-patient care at the home, which caters for 41 adults with mental disorders, such as dementia. Given the level of complaint an operation was launched between Gloucester police and the Commission for Social Care Inspectorate.

There was a joint inspection on 26 July 2005. It was found lack of information regarding care plans and in many cases the non-existence of care plans. Photographs revealed the disgusting state of toilets in residents' rooms. They were old, damaged and there was penetrative moisture.

William Davies Managing Director, Pearl Jackson Operations Director, Derek Youds Manager and Heather Bolton Deputy Manager - It was said that all four were in a position to act to improve the state of the home but failed to do so. **ADL Ltd is a Yorkshire based company also operating two homes in the Bradford District.** ADL faces nine charges of neglect and/or ill-treatment in its own right. Its lawyer indicated no pleas to the charges.

The magistrates granted all four unconditional bails until November 27 when they will return to Gloucester Magistrates' Court for Committal Proceedings.

MCA – Update October 2007

On Monday 1st October 2007 the Mental Capacity Act will be fully implemented in England and Wales, *which includes the creation of the Office of the Public Guardian (OPG), the new Court of Protection, Lasting Power of Attorneys and the IMCA service in Wales.* Some parts of the Act came into operation in April 2007, namely the creation of a new criminal offence of wilful neglect or ill treatment, the provision of Independent Mental Capacity Advocates (IMCAs) in England, and the Code of Practice.

NEW Office of the Public Guardian Launched

The implementation of the Act means the Public Guardianship Office (PGO) will be replaced by Office of the Public Guardian (OPG). The Public Guardian is

a new statutory office holder with specific powers and duties to supervise and regulate those appointed to make decisions on behalf of those who cannot do so themselves.

The Public Guardian will be the registering authority for Lasting Powers of Attorney. These are similar to the current Enduring Power of Attorney, but allow people to choose an attorney to make health and welfare decisions. In addition the Public Guardian will supervise deputies appointed by the Court and provide information to help the Court make decisions.

The OPG will work with appointed decision makers and provide support and guidance that will emphasise the need to always act in the best interests of the client.

NEW The new Court of Protection Launched

On 1st October 2007 the new Court of Protection as created under the Act became fully operational. The new Court of Protection is a superior court of record and will have jurisdiction covering health and welfare and finance and property decisions.

NEW IMCA Service in Wales Launched

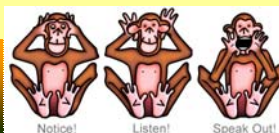
On the 1st October 2007, the IMCA service became operational in Wales.

NEW MCIP Programme Handover

The Mental Capacity Implementation Programme (MCIP) closed on the 28th September 2007. The Office of the Public Guardian (OPG) will now handle all queries relating to the Act and its operation.

Find out more on

www.publicguardian.gov.uk



Bradford's IMCA Protocol for Safeguarding Adults Agreed here's a summary..

Safeguarding Adults Use of an IMCA's

The Local Authority or NHS body have the power to instruct an IMCA to represent the person concerned if it is satisfied that it would be of benefit for the person to do so:

- Where safeguarding measures are being put in place in relation to the protection of vulnerable adults from abuse; and
- Where the person lacks capacity

In safeguarding adults cases **only**, access to IMCAs is not restricted to people who have no one else to support or represent them. Therefore, people who lack capacity who have family and friends can still have an IMCA to support them through the safeguarding process

The regulations equally apply to a person:

- Who may have been abused,
- Who has been neglected and
- Who is alleged to be the abuser

Where the qualifying criteria are met, it would be unlawful for the Local Authority or the NHS not to consider the exercise of their power to instruct an IMCA for safeguarding adults cases

IMCA role is to assist the **decision maker** who is making **the decision** on behalf of the person who does not have mental capacity

Referrals Criteria

For someone who may have been abused or neglected

- Where there is a serious exposure to
 - risk of death
 - risk of serious physical injury or illness
 - risk of serious deterioration in physical or mental health
 - risk of serious emotional distress

- Where a life changing decision is involved and consulting family or friends is compromised by the reasonable belief that they would not have the person's best interests at heart

- Where there is a conflict of views between the decision makers regarding the best interests of the person

For someone who is alleged to be the abuser

- Where a life changing decision is involved and consulting family or friends is compromised by the reasonable belief that they would not have the person's best interests at heart

- Where there is a conflict of views between the decision makers regarding the best interests of the person

Referrals to an IMCA

PROTOCOL AGREED IN BRADFORD

The APRAC is the decision maker

Referrals **MUST** be made/ **WILL ONLY** be accepted if they are made as part of a multi-agency adult protection procedure

Referrals

AP Situations 2 and 4

Duty to consider whether an IMCA should be consulted with reference to decisions *for the alleged victim and perhaps for the alleged perpetrator*

AP Situations 1 and 3

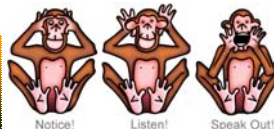
perhaps for the alleged perpetrator

When is an IMCA Needed

- Strategy Discussion /Meeting stage?
This would need to happen for cases where the wishes/decisions made by the individual would have a significant impact on the risk assessment process or where the immediate protection plan involves making decisions on behalf of the alleged victim

- Protection planning stage?
So that they can provide input into the decisions needed as part of the safeguarding plan

For more information contact Neena at the APU



Notice!

Listen!

Speak Out!

Poor handling of clostridium difficile the superbug that claims 90 lives at Maidstone hospitals – is this an adult protection issue?

You have probably heard a lot about this situation already but it is interesting to read it with “adult protection eyes”. The causes of these deaths lie in systemic failures and poor practice and in that way are very similar to those we have found when we have tackled neglect and abuse in care settings. Should this case be seen as “neglect”? Were the patients “abused”? What ever the answer hopefully the lessons learnt will protect patients from all forms of neglect, not only hospital acquired infections.

It has already been known that clostridium difficile is a major problem across the country. There were 55,634 cases of C. difficile in patients aged 65 and over, and in England the Health Protection Agency reported an increase of seven per cent in 2006.

One of the most shocking chapters in NHS history can be put down to the **poor handling** of the infection C. difficile which has resulted in 90 deaths at hospitals in Kent Maidstone and Tunbridge Wells.

A total of 1,176 people contracted C. difficile over two-and-a-half years, between April 2004 and September 2006, at the three hospitals in Kent run by the Maidstone and Tunbridge Wells NHS Trust. They are now at the centre of the worst

superbug scandal in British history.

Most of the wards at Maidstone Hospital were dreadful, but there was one in particular that patients feared the most. No one wanted to end up on Whatman. It was here that the C. difficile patients were all heaped together to try to keep them away from other patients, in an attempt to prevent the dangerous superbug spreading.

For four months, patients who did not have C. difficile continued to be placed in Whatman ward, surrounded on all sides by those who did. Patients with C. difficile were placed in open wards with nothing but a trolley between them and patients who were not infected. In these conditions, the bug quickly spread.

It was found that patients suffering from diarrhoea who rang the bell because they needed to be helped to the toilet were told to “go in the bed”.

They could be left lying in their own excrement for hours afterwards. In other examples of horrendous practice, excrement was not washed away from bedpans, there were blood stains on trolleys, needles overflowing out of bins and buckets full of filthy water.

Half the staff were not even aware of the basic rule that to kill C. difficile spores you have to use soap and water, and used alcohol wipes instead. In this appalling environment of filth the bug thrived.

A report by the Healthcare Commission has revealed that of 345 patients who died after being infected with C. difficile, in around 90 cases it was most likely the main cause of death.

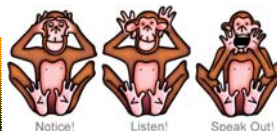


Countless examples of dirt were found



Commodores were not properly cleaned after use

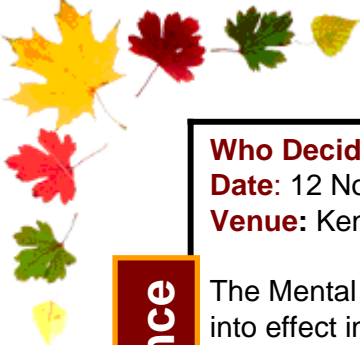
This lack of competent handling of the virus combined with a lack of basic training for staff, lack of basic care for the patients, lack of basic hygiene and lack of quality control have all contributed to the escalated number of deaths at the hospitals.



Notice!

Listen!

Speak Out!



Conference

Who Decides Now?

Date: 12 November 2007

Venue: Kent

The Mental Capacity Act 2005 came into effect in April 2007. This conference will help understand the implications of the Act on your work with vulnerable people, and gain essential guidance and practical advice on the implementation of the Act direct from policy makers and practitioners.

To book call: 0870 890 1080

Ann Craft Trust - Is it abuse or just Poor practice?

Date: 20 November 2007

Venue: Nottingham

Looking at how we define crime, abuse and poor practice. Recent inquiries will be reviewed and discussed and there will be an emphasis on everyday abuse that can become culturally acceptable within health care and residential services for vulnerable adults.

To book call: 0115 9515400

Conference

Conference

Improving Dementia Services: Meeting the challenges of fulfilling the national dementia strategy

Date: 27 November 2007

Venue: Central London

Explore the Government's national dementia strategy in detail, discussing best practice in dementia care, to improve service design and delivery.

To book call: 020 7347 3575

Pathways into Social Inclusion for Adults with Complex Needs

Date: 11 December 2007

Venue: Central London

Focus on solutions to complex needs – the closely allied problems of drugs, mental health, personality disorder and homelessness – with the aim of charting a course out of social exclusion.

To book call: 0207 347 3575

Conference

Mark your diaries... Safeguarding Adults Board meetings for 2008

Wednesday 16 Jan 2008
Wednesday 16 April 2008
Wednesday 16 July 2008
Wednesday 15 Oct 2008

Venues all booked to be held at: Olicana House, Conference Room

Commence at 13:00 to 15:00

ADULT PROTECTION UNIT THE TEAM...

Adult Protection Co-ordinator:
Ruth Ingram

Assistant Co-ordinators:
**Bernadette Gallagher, Lesley Latham,
& Jayne Morrell**

MARAC Co-ordinator:
Kate Higgins

Information & Administration Officers:
Magdalena Myrcha & Neena Punnu

Administration:
**Theresa McKay, Catherine Stobbart &
Helen Nelson**



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