DRAFT MINUTES OF THE SAFEGUARDING ADULTS BOARD
Wednesday 16th October 2024 at 15:00-17:00
Virtual Meeting via MS Teams

MEMBERSHIP & ATTENDANCE:

AGENCY	NAME	Initials	ATTENDANCE
Safeguarding Adults Board	Dr Adi Cooper, Chair	AC	
	Rebecca Waggett, Governance & Improvement **(Minutes)**	RW	
	Ashraf Sahebdin, Governance & Improvement	AS	
	Farzad Fazilat, Haringey Safeguarding Adults Board Manager	FF	
Volunteer Lay Member	Lauritz Hansen-Bay	LHB	Apologies
Adult Services	Beverley Tarka, Director of Adults, Health and Communities	BT	Apologies
	Jo Baty, Service Director, Adult Social Care	JB	
	Chris Atherton, Head of Assurance and Principal Social Worker	CA	Apologies
	Marianne Ecker, Workforce Development Manager	ME	Apologies
	Ajibola Awogboro, Head of Assessment and Safeguarding	**AA**	
	Andrea Kelly, Head of Service Learning Disabilities	**AK**	
Commissioning	Rebecca Cribb, Head of Service for Commissioning	RC	
	Louise Daniels, Senior Performance Officer	LD	
	Richmond Kessie, Specialist Commissioning Officer	RK	
Children's Services	Dionne Thomas, Assistant Director Children's Safeguarding and Social Care	DT	Apologies
Public Health/ Community Safety	Dr Will Maimaris Interim Director of Public Health	WM	Apologies
	Abigail Wycherley, VAWG Programme Lead	AW	
Legal Services	Haydee Nunes De Souza, Head of Legal	HNS	
Cabinet Member for Adults and Health	Councillor Lucia das Neves, Cabinet Member for Health, Social Care and Well-Being	LON	Apologies
North Central London ICB	David Pennington, Director of Safeguarding	DP	
	Rosie Peregrine-Jones, AD Quality Assurance	RPJ	Apologies
	Victor Nene, Haringey Safeguarding Adults Designated Professional	VN	

	Dr Lionel Sherman, Adult Safeguarding Lead	LS	
Whittington	Sarah Wilding	SW	
	Maameyaa Adabie	MA	
	Theresa Renwick, Safeguarding Adults Lead	TR	
	Toby Kent, Adult Safeguarding Lead	TK	
NMUH	Sarah Hayes, Chief Nurse	SH	Apologies
	Shahida Trayling, Deputy Chief Nurse	ST	Apologies
	Sian Carter-Jones, Associate Director for Safeguarding	SC-J	
North London Mental Health Partners	Amanda Pithouse, Executive Director of Nursing, Quality and Governance	AP	Apologies
	Graeme McAndrew, Head of Safeguarding	GM	
Haringey Police	DCI Elsa Mak, North Area BCU	EM	
Housing	Sara Sutton, AD, Partnerships and Communities & Interim AD Housing Demand	SS	
	Maddie Watkins, Head of Housing Related Support	MW	
	Monika Zerbin, Rough Sleeping Programme Lead	MZ	
Housing Provider	Phil Johnson, Housing Services Manager, Homsey Housing Trust	PJ	Apologies
London Fire Brigade	Keith Wilson, Borough Commander	KW	Apologies
	Peter Shaw, Tottenham Station Manager	PS	Apologies
Healthwatch	Sharon Grant, Chair	SG	
DWP	Archibald Okolie, Senior Safeguarding Lead	AO	Apologies
Probation	Shirley Kennerson, Assistant Chief Officer	SK	Apologies
	Russell Symons, Deputy Head of Service	RS	

In attendance (guests)

Michael Preston-Shoot	Item 2.3 (a) ASPC SAR report	MPS	
John Goldup	Item 2.3 (b) Victoria SAR report	JG	

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1.	**WELCOME AND INTRODUCTIONS/APOLOGIES:** AC welcomed everyone to the meeting. Apologies for absence were received from those listed above and accepted by the meeting.
1.1	**MINUTES OF LAST MEETING AND MATTERS ARISING (17.04.24)** The minutes of the July meeting were reviewed and agreed as an accurate reflection of the meeting. EM explained that the Met Police utilise the Haringey Children's Social Care escalation protocol for partnership escalations. AC noted that an update on the MASH review is included in the Board Management report.

2	**PRESENTATIONS and REPORTS**
2.1	Alcohol Related Deaths in Haringey This item has been deferred to January 2025 SAB meeting.
2.2	**Homelessness and Rough Sleeping Annual Report 23/24** • MW presented the Homelessness and Rough Sleeping Annual Report for 2023/24. • She noted a recent issue with housing benefits decisions leading to an increase in evictions from supported exempt accommodation and an associated rise in homeless applications. • SS explained that there is a cross-Council project board in place to manage the risks associated with this issue, including colleagues from Housing Benefit, Housing Needs and Licensing. Work is being undertaken with Adult Social Care to identify any impact on people receiving care and support. • Government guidance around regulations and funding in this area is expected in early 2025. • MW highlighted work undertaken around language barriers in homeless healthcare, which highlights that the technology and translation services being used are not meeting the needs of people who are homeless. • MW noted that approximately 75% of the service is grant funded and the funding comes to an end in March 2025. This funding has enabled significant developments in health inclusion and safeguarding within the rough sleeping programme. A funding announcement is expected in the October budget. • MPS noted that the Museum of Homelessness has published powerful research into homeless deaths in 2023: https://museumofhomelessness.org/dhp • MPS highlighted that the National Network for SAB Chairs is conducting a survey on how SABs have responded to the joint ministerial letter on homelessness and rough sleeping, which should provide national comparative data. **ACTIONS:** 1. **MW** to share thematic review of language barriers in homeless healthcare. 2. **MW** to liaise with AS around timing of the next update to **SAB.**
2.3 (a)	Adult Safeguarding and Provider Concerns Thematic SAR • MPS presented the thematic SAR report concerning Adult Safeguarding and Provider Concerns. This review looked at the deaths of Rosemarie and Mearl. • MPS noted that he had received excellent support with the SAR from RW and good engagement from the services involved. • The report is organised around the four key lines of enquiry set out by the SAB in the terms of reference for the SAR. • The CQC provided really useful data to the SAR, comparing the care setting with comparable settings. • The cooperation of the care provider was acknowledged; they have engaged positively with two SARs in a short space of time and met with MPS and AC. • MPS noted that there were some commonalities between Rosemarie and Mearl's cases, and with the previous Paulette SAR: o Comorbidities and complexities of health care o Pressure ulcer care (hospital and care home) o Complex hospital discharge and lack of placement options o Missed opportunities for mental capacity assessment/review o Missed opportunities to refer, escalate and/or review concerns o Lack of multi-agency meetings o Concern about care standards and available resources in the setting o When concerns translate into section 42 enquiries and/or provider concern procedures • MPS set out the recommendations of the review, noting that these align with the recommendations of the previous Paulette SAR.

	• A publication meeting is scheduled for early November. It is recommended that the report in published in full in early 2025. • AC thanked MPS for undertaking this review and noted that it was helpful that he had been able to build on the insight and knowledge from the Paulette SAR. She noted that the SAR presents some challenges for SAB partners to work together to respond the recommendations. • SW suggested that it may be challenging to implement the ICB leading on improving the monitoring of pressure ulcers in hospitals and the community. • MPS cited examples of community and hospital pressure ulcer panels chaired by the ICB designated professional in Greenwich and Lewisham. This strategic oversight has led to a reduction in the incidence of pressure ulcers. • TR noted that the Whittington has existing mechanisms to monitor pressure ulcers. AC suggested that the SAR Implementation Group should consider how the recommendation is best taken forward, in the context of existing practices. • JB expressed her support for taking the recommendations forward, and focusing on what can be achieved, rather than the constraints. • The **HSAB** agreed to the recommendations outlined in the cover report: i. It is recommended that the HSAB agrees the content, findings and recommendations in the Adult Safeguarding and Provider Concerns Thematic SAR report. ii. It is recommended that the HSAB supports the families' wishes to refer to Rosemarie and Mearl by their own names in the SAR report. iii. It isrecommended that the HSAB record its thanks to the participating agencies and independent reviewer. **iv.** It is recommended that the SAR report is published in full on the HSAB's webpage on the Haringey Council website in early 2025. v. It is recommended that a SAR publication meeting is arranged to follow the HSAB meeting to agree the arrangements for publication. **vi.** It is recommended that the SAR report is circulated to HSAB partners upon publication, together with a ?-minute briefing, with a request to disseminate the learning widely across each partner agency. **vii.** It is recommended that a SAR action plan is developed, and the SAR Implementation Group tasked to coordinate relevant partners to progress the recommendations of the SAR until completion. **viii.** It is recommended that the SAR report is made available to the national SAR library to enable wider learning from this review.
2.3 (b)	**Victoria SAR** • JG introduced himself; he was previously Director of Adult Services at Tower Hamlets, first National Director of Social Care at Ofsted, has chaired adults and children's safeguarding boards and undertakes SARs and other consultancy work. • JG presented the Victoria SAR report. He noted that he had received excellent support from RW and a good response from all agencies involved in the review. • Victoria's cousin was involved in the SAR and is keen for Victoria's real name to be used in the report. • Key aspects of Victoria's story were: o Born in UK in 1984 to Greek Cypriot parents. Died in June 2022. Cause of death - sepsis, with cardiac failure, type 2 diabetes, obesity, and liver cirrhosis as contributory themes. o Diagnosed in adolescence as having a mild learning disability and in adulthood with an emotionally unstable personality disorder. o Multiple physical health problems, extremely obese, below the knee amputation in 2017. o Lived alone with mother as sole carer until mother's death in November 2018.

- Confined to grossly unsuitable and unsafe housing after mother's death but not rehoused until March 2020.
- Care package put in place after mother's death.
- Described as chronically self-neglecting from 2016 but seriousness of risk never escalated.
- Ongoing and serious concerns raised about quality and competence of agency care, with carers said to be colluding with self-neglect.
- Nine safeguarding concerns raised between August 2016 and June 2022. Five of these included concerns about quality of care, but these were not shared with the Quality Assurance Team.
- Victoria was referred twice by her GP to adult mental health services. On both occasions she was referred back to the Learning Disability Partnership.
- Multiple hospital admissions in last six months of her life.

- The community learning disability nurse tried extraordinarily hard to help Victoria over a 10-year period but there did not appear to be any coordinated plan across organisational boundaries to help Victoria.
- JG set out the recommendations of the review, in response to these findings.
- AC thanked JG for his thorough analysis of this case.
- TR suggested that Haringey are included in the universal care plan pilot project with Camden and Islington. DP agreed to ensure that Haringey is part of these discussions.
- JG clarified that the carers colluded in Victoria's self-neglect by buying her chocolate in exchange for her buying them chocolate. He also explained that the application for tenancy succession did not reach the appropriate housing team for 7 months and this delay could not be explained.
- SG and TK noted their recognition and support for the recommendation around feedback to referrers of safeguarding concerns and establishing a baseline, to ensure that people are not deterred from referring their concerns. AK noted the importance of defining expectations.
- SG noted her concern about the advocacy and support provided to vulnerable people when they are re-housed.
- DP and AK noted their support for a coordinated approach to reviewing current self-neglect and mental capacity policy, guidance and training.
- SS noted that this SAR would be used as a case study for pathway and customer journey mapping as part of ongoing improvement within Housing.
- TK suggested that this case would have benefited from being referred to the MASP or the weekly GP MDT teleconference.
- VN noted that the ICB will now prioritise a SAR over a LeDeR review.

- The **HSAB** agreed to the recommendations outlined in the cover report:
  i. It is recommended that the HSAB agrees the content, findings and recommendations in the Victoria SAR report.
  ii. It is recommended that the HSAB supports the family's wishes to refer to Victoria by her own name in the SAR report.
  iii. It is recommended that the HSAB record its thanks to the participating agencies and independent reviewer.
  iv. It is recommended that the SAR report is published in full on the HSAB's webpage on the Haringey Council website in late 2024.
  v. It is recommended that a SAR publication meeting is arranged to follow the HSAB meeting to agree the arrangements for publication.
  vi. It is recommended that the SAR report is circulated to HSAB partners upon publication, together with a ?-minute briefing, with a request to disseminate the learning widely across each partner agency.
  vii. It is recommended that a SAR action plan is developed, and the SAR Implementation Group tasked to coordinate relevant partners to progress the recommendations of the SAR until completion.

	viii. It is recommended that the SAR report is made available to the national SAR library to enable wider learning from this review.
3.	**STANDING ITEMS**
3.1	**Performance Safeguarding Data** • Higher number of safeguarding concerns for self-neglect reported in Quarter 2. • Fewer concerns reported involving financial abuse than in Quarter 1. • An increased number of concerns (59%) involved women in Quarter 2. • The gap between concerns for people from White backgrounds and Black backgrounds has narrowed, with an increased number of concerns reported for people from a Black background in Quarter 2 (23.6%). • There was an increased level of concerns reported in September as the backlog of referrals was dealt with. • Following the last meeting, LD found that larger concern circles on the heat map correlate with provider locations. This information will be routinely shared with ASC Commissioning to inform the provider risk register. • LD noted that information on the referrals from specific hospitals cannot be provided retrospectively but will be included in the report going forward. **ACTION:** 3. LD to follow-up on the detailed recording of referrals from hospitals in the data.
3.2	Joint Providers Monitoring Report • [redacted]
3.3	**HSAB** Management Report • A virtual SAR learning event led by Professor Michael Preston-Shoot has been planned for Wednesday 29th January 2025, covering learning from recent Haringey SARs - the Paulette SAR and the Adult Safeguarding and Provider Concerns Thematic SAR - and the Second National SAR Analysis. • The SAR Implementation Group repeated its recommendation that the SAB consider including short descriptions of multi-professional high-risk panels within the MASP documentation alongside the existing descriptions of MAPPA, MARAC and CMARAC, so that agencies are aware of the possible routes for multi-agency discussion and referral into the MASP. • The Engagement and Prevention Subgroup convened to discuss preparations for National Adult Safeguarding Week, including the financial abuse poster initiative. A subgroup led by Farzad Fazilat has met three times to organise a financial abuse event scheduled for November 19th at Winkfield Resource Centre. Six to eight tables have been reserved for participants, with confirmation received from several individuals and organisations. A guest speaker has been invited, and the event will focus on providing key safeguarding information to attendees.

	• The report details national and local events being held for National Adult Safeguarding Week. • The MASH review has been developing terms of reference and a joint protocol to respond to a safeguarding concern between the Met and ASC. These are in the final stages of sign off and will be circulated once agreed. • Details of safeguarding training available to SAB partners are included in the report; please ensure staff within your agencies are aware of this. • TR/AA noted that there is a difference in opinion on timescales for DoLS authorisation and holding the supervisory meeting. AA has sought advice from Haringey Legal Services and is awaiting a response. • The HSAB has recently approved new guidance related to People in Positions of Trust (PIPOT), as required under the Care Act 2014. A session has been arranged in November to share the guidance with voluntary sector partners and explain what is required. **ACTIONS:** 4. Board members to promote and share the invitation to the virtual SAR learning event widely with anyone in their organisation who may find this a useful learning opportunity. 5. Board members to provide a short description of any internal multi-professional high-risk panels for inclusion in **MASP** documentation.
4.	**BUSINESS ITEMS**
4.1	**HSAB** Escalation Policy This item has been deferred to January 2025 SAB meeting.
4.2	National Safeguarding Adults Board Chairs Network Priorities and Recommendations for **SABs** & Improvement Priorities from the Second **National Analysis of Safeguarding Reviews** • The National Safeguarding Adults Board Chairs and Managers Networks has set out a proforma for SABs to respond to, which includes some priorities from the SAB Chairs annual report. • FF presented an update on the draft response which is currently being worked on. • The December SAR Subgroup meeting has been extended to review the SAB's response to the recommendations of the second SAR analysis.
4.3	**Engagement & Prevention Strategy and Communication Plan 2024** This item has been deferred to January 2025 SAB meeting.
5	**FOR INFORMATION**
5.1	**HSAB Forward Plan 2024/25 and Meeting Dates** • AC highlighted upcoming items and invited colleagues to propose additional agenda items for future meetings. **ACTION:** **6. Board members to note the next HSAB meeting is on 22nd January 2025 and** to liaise with AS to propose additional agenda items for future meetings.
6.	**AOB**
6.1	SAR Learning • AC noted that the CQC inspection regime recognises the importance of frontline staff being aware of SAR learning. The learning from SARs is relevant to all local agencies, not just those directly involved in the SAR. AC therefore asked that

	Board members pick up the SAR reports and learning briefings, once published and circulated, and use all internal mechanisms possible to ensure that staff and volunteers are aware of those stories since they are a powerful resource for learning and driving improvement. **ACTION:** 7. **Board members to share SAR learning widely across their organisations once the two SAR reports are published and circulated.**
	CLOSE