Putting Safety First:

Governing body member assurance

Chartered Institute of Housing Scotland

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ASSOCIATION OF LOCAL AUTHORITY CHIEF HOUSING OFFICERS

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Background

This briefing is the second in our series "Putting Safety First". It has been developed by the Scottish Federation of Housing Associations (SFHA), working with consultancy Campbell Tickell.

The SFHA gratefully acknowledges input to the report from the Chartered Institute of Housing (CIH) and Association of Local Authority Chief Housing Officers (ALACHO) and the support for this work from the Scottish Housing Regulator (SHR). This paper expands on a webinar Campbell Tickell delivered in March 2023 which was aimed at governing body members of SFHA members.

SFHA will conduct a short review of its Self-Assurance Toolkit (concluding in June 2023) and will take account of the issues highlighted within this briefing as part of the process. The toolkit, which was developed in conjunction with the SHR, is available to all social landlords.

The previous briefing in the "Putting Safety First" series was aimed at housing practitioners and is available here: Putting safety first: a briefing note on damp and mould for social housing practitioners (Feb 2023).

Who is this briefing for?

This briefing is aimed at two main audiences:

- The board/committee members of RSLs in Scotland, and
- Elected councillors in Scottish local authorities which own and manage social housing.

Although the legal position of these two audiences is not identical, as regards the subjects of this briefing their responsibilities are broadly similar. This means that the document will be of interest to those who govern both RSLs and local authorities.

For sake of brevity, the briefing uses the term 'governing body member' (or 'GBM') to cover both groups. The governing body of an RSL will be the board, (sometimes called committee). In terms of local authorities, the governing body is the full council. In both cases, those are the entities where ultimate responsibility for safety matters must rest.

Both RSLs and councils will of course delegate certain responsibilities to staff and to committees, and we discuss this in the briefing. Elected members who serve on housing committees may find it to be of particular interest, as will many board/committee members of RSLs.

It should also be noted that most of the examples that form the context for the briefing relate to events that have taken place in England, which has different legislative and regulatory frameworks. Housing associations, co-operatives and local authorities provide safe, warm affordable housing for people all across Scotland, but it is crucial not to become complacent.

Throughout the briefing, short case studies (including some extreme scenarios) are included to provide examples of how things can go wrong. The key aim of this briefing is to ensure GBMs ask the question: "Could it happen here?" and seek necessary assurance from their staff.

Context

This briefing is not a comprehensive guide to what is a highly complex area of legislation and regulation, but it aims to give GBMs the background knowledge and perspective they need to discharge their responsibilities. It suggests key areas where GBMs should be focusing their scrutiny, and the questions they could be asking.

Being a GBM brings many rewards, but it also carries much responsibility. These include areas related to health and safety, and this briefing aims to support GBMs in carrying out their main responsibilities of that kind. Ultimately, GBMs are responsible for the safety of tenants, residents, service users and employees, in some cases vulnerable adults, and all those who may be in their properties or working for their organisation.

GBMs are not expected to be experts in all matters, but they do need to know which questions to ask and when they can take assurance from the answers that they receive. They also need to be familiar with the main risks their organisation may face, as well as the resources, policies and reporting that apply to them. They must be assured that the reports and advice they are receiving are accurate and evidence-based from the staff team and their other advisors, internal or external.

In a handful of extreme cases, governing bodies of different kinds of organisations have been fined large sums of money for certain failings leading to the harm of residents or employees, and there have been cases of prosecutions for corporate homicide (known as corporate manslaughter in England).

Two recent incidents in England – that resulted in tragic loss of life – are noted below to provide further context.

The shocking death of Awaab Ishak

Awaab Ishak, a two-year-old boy, died of a cardiac arrest after exposure to toxic fungal mould in a dangerous flat in Rochdale, England. His parents had raised the issue with Rochdale Boroughwide Homes (RBH) on frequent occasions, and had been ignored, with the father being told to 'paint over' the mould.

NHS staff had also raised the case with RBH, although they too hadn't taken certain actions that may have helped. The role of claims solicitors in blocking RBH's access to the property may also have been an issue. There was no evidence that the family was in any way at fault. A coroner's report[1] was highly critical of RBH and the case has had a huge media profile. The CEO was replaced with an interim, and a new Chair has recently been appointed.

Grenfell Tower fire (2017)

In 2017, the disastrous fire at Grenfell Tower in London meant 72 people tragically lost their lives. This rightly raised the issue of unsafe cladding on blocks across all the countries of the UK. This focused attention on landlord fire safety procedures and guidance and lead to a review of materials used for cladding.

Equality, diversity and inclusion

Although this briefing focuses on health and safety, GBMs should always be aware that certain risks may affect some groups in society more than others due to their protected characteristics. These are set out in the Equality Act 2010 as age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. Combatting all forms of prejudice and discrimination is a key role for GBMs.

[1] Ms Joanne Kearsley, HM Senior Coroner, North Manchester (Nov 2022) Inquest into the Death of Awaab Ishak

Quick reminder: the role of governing bodies

RSLs

The governing body of an RSL (housing association) is a corporate entity, or 'legal person'. The organisation as a separate legal entity is thus subject to statutory controls. Directors (sometimes known as trustees or committee members) are responsible for ensuring that the company complies with statutory controls. Non-executive governing body members have no specific legal duties under H&S legislation as individuals. However, the governing body as a 'corporate person[2]' does.

Local authority members

The legal position of a local authority elected member is significantly different to that of a company director, trustee or RSL GBM. The legal framework here is complex, but elected members normally enjoy statutory immunity from civil liability where they act within the powers of the authority in good faith and without negligence.

This immunity does not apply where they exceed the statutory powers of the authority, act in bad faith or act in a way that is negligent. It does not protect them from criminal liability, for example for corporate homicide in the (unusual) case where they exercise managerial responsibilities.

In practice though, elected members will wish to act in a responsible and diligent manner, and this briefing will be relevant to them, and to how they discharge their responsibilities in relation to local authority housing. As noted above, this briefing may be of particular interest to elected members who serve on a housing committee (or equivalent).

Elected members who need further advice on their legal responsibilities and liabilities should in the first instance refer to the Head of Legal Service (or equivalent) in their local authority.

Corporate homicide

All GBMs have a range of legal responsibilities. However, in the context of safety, it is important for all to be aware of the Corporate Manslaughter & Corporate Homicide Act 2007[3].

It sets out that companies can be guilty of corporate homicide. This is defined as "where serious management failures result in a gross breach of the duty of care owed to the company's employees or members of the public, which results in death.". Prosecutions will be of the corporate body (but directors may be individually liable under other H&S laws). In the event, prosecutions are rare, however – maybe one or two each year on average.

Three examples from England are given at Appendix A, by way of cautionary tales.

[2] MUK Government (2016) Definition of legal person

[3] UK Government (2007) Corporate Manslaughter and Corporate Homicide Act

Where responsibilities may lie

Responsibilities may lie in different places with each organisation, hopefully well documented in key procedures and policies, but the buck always stops at the top, namely with the board or Full Council. Other key people or entities may include:

- RSL subsidiary board/committees(s) if any
- Council committees such as Housing Committee or equivalent
- RSL Audit and Risk Committee
- Safeguarding Committee
- Other sub-committees of the governing body
- The Chief Executive or Director of Housing
- LA Head of Housing
- Other Executive Directors
- Other employees
- Contractors, sub-contractors, agents, advisors and partner organisations

All roles need to be properly documented and understood, whether in terms of reference, policies and procedures or scheme of delegated authority.

Robust systems and processes

The systems and processes developed by social landlords play a major part in all service delivery. Where process is weak or data collected is not accurate, it can result in poor outcomes for tenants. For example, these kinds of examples must be guarded against:

- A gas service visit was not recorded, or even worse, a visit was recorded that never took place
- A few dozen properties somehow dropped off the database
- Everyone knew that Mr A. at number 17 was a hoarder, but nobody made a note of the problem
- A new computer system was introduced, and old data didn't come across in full.

A specific area of risk can be when sub-contractors are responsible for filling in data fields, as they may be less assiduous in doing so. Cyber sabotage and hacking are also a constant worry and could seriously undermine safety at worst.

Another key aspect is that GBMs must have confidence about the how the organisation is capturing, reporting and responding to customer complaints and queries. This requires robust and well understood processes that tenants, practitioners and GBMs all understand and have confidence in.

Governing bodies must consider all these issues until they are given appropriate and satisfactory assurance.

The vital role of organisational culture

One important theme throughout this briefing is the need to focus on behaviours within an organisation. If practitioners have got into the habit of cutting corners there is a risk of bad outcomes for tenants. Equally if someone who sees a problem is frightened or reluctant to raise it, the same is true.

Governing bodies therefore need to 'own' the culture of their organisation, understand it, and work with the senior team to create the required culture. This means review of systems, processes, skills and training requirements in the organisation. GBMs must champion any required change in culture and attitudes, and appropriate mechanisms – such as clear whistleblowing arrangements – must be in place to ensure that everyone in the organisation is comfortable in raising issues as required.

The 'Chronic Unease Model'

'Chronic unease' is shorthand to describe the eternal vigilance that is required of GBMs. The concept (in relation to safety) was originally developed by Shell[4] and has been adopted in a range of safety critical industries such as mining, quarrying, deep sea diving and flying.

The five key features of chronic unease can be set out as:

- A tendency to **worry** about health and safety
- **Vigilance** - awareness of near misses, local failures
- Resisting **complacency**
- **Imagination** to visualise unfavourable scenarios
- **Flexibility**, systems thinking, not jumping to conclusions.

The lessons here are:

- Don't necessarily believe all that you are told by officers
- Understand what the risks are, and don't be afraid to ask questions
- Ask yourself what else could be done, or what might be overlooked. Just because things have worked so far, doesn't mean they'll work going forward – very few systems are 100% reliable
- Learn from mistakes and near misses, whether your own or those of others
- Even when things seem to be going well, keep an eye on the tell-tale minor issues.

[4] Centre for Safety, the U. of Western Australia (sponsored by Royal Dutch Shell and based on research of Dr Laura Fruhen and Prof Rhona Flin (2015) Chronic Unease: A State of Mind for Managing Safety

Chronic unease: a case study

In 1998, at Lassing in Austria, ten miners died in a mine collapse. Afterwards, it became apparent that the men had been sent to near-certain death for purely economic reasons by the mine owners, Rio Tinto, at that time the largest mining company in the world. People with local expertise were ignored, offers of valuable assistance declined, and a corporate cover-up got under way. The disaster's aftermath saw Rio Tinto's share price dropping by some 30%, with compensation and rescue costs as high as $30m.

But this event acted as the positive catalyst for major change at the company, with health and safety becoming a top corporate priority, under the banner of "Zero Harm by Choice". Employees with good records on health and safety were promoted, others conversely left the company. Using Rio Tinto's own version of chronic unease, a massive overhaul of culture, processes, accountability, performance management and reporting was undertaken. Reportable incidents dropped by 80% in the 8 years that followed, and continued to drop thereafter.

Rio Tinto now has the best safety record of any major mining company in the world.

What do we mean by assurance?

GBMs may be familiar with the 'three lines of defence' model, which is a useful tool to evaluate the ways in which they receive assurance on a whole range of areas:

First line of defence: operational. This is the information gathered from operational staff and systems: front line staff, line managers; internal controls; performance reporting, staff training, clear policies and procedures, incident reporting.

Second line: internal. This is assurance from the internal oversight functions, quality oversight, IT security, specialist H&S staff, executive oversight, committee and governing body oversight, oversight of contractors, whistleblowing, case reports from specialist advisors and assessors, analysis of tenant complaints, spot checks, analysis of incident reports.

Third line: external. This is assurance received from internal audit, independent oversight reports by external advisors, benchmarking, specialist audits, case investigations, input from regulators and authorities and of course in terms of finance, the external auditors.

How things go wrong

Despite seemingly good assurance, things still can and sometimes do go wrong, and here is a summary list of some ways in which that can happen:

- Some procedures may be incomplete or ambiguous
- People may take 'short cuts' to demonstrate compliance
- There may be uncertainty about what the compliance standards actually mean in practice
- Issues may fall between two or more teams in an organisation
- Poor systems and inaccurate data collection
- Weak organisational culture
- Weak contract management & oversight
- Governing bodies mistaking well-meaning reassurance for actual assurance.

Questions to ask

Each organisation will be different, but here are some prompts below. GBMs don't necessarily need to know answers to these, but they need assurance that someone does. They need to know too where responsibility for each area lies within the staff and (if any) group structures. All GBMs will need some familiarity with key documents, starting with the Health and Safety Policy and its associated procedures.

Probing questions from GBMs to officers might include:

- How confident are we in our data integrity?
- How do we know that our own Health & Safety lead and all of our advisors/surveyors are competent and qualified? Do we encourage honesty & challenge in our brief?
- Are we meeting our inspection/cyclical targets?
- How are outstanding actions tracked and closed out?
- What assurance do we have that safety is well managed and resourced day-to-day?
- What should we be getting external validation for?
- Is the governing body hearing about incidents (and near misses) in a timely manner?
- Have any notices have been served on us? How many if so?
- Do we have a range of mitigations for if something goes wrong?
- Are our policies and procedures regularly reviewed and up to date?
- What do we know about the organisational culture in our organisation?
- How can we get better at prevention rather than cure?
- How were the standards we follow set? Do we have confidence in their timeliness, independence & rigour?

A checklist for governing body members

All GBMs need to be:

- Clear about their responsibilities and accountability, particularly in any group structure context
- Generally aware of current issues and legal frameworks
- Familiar with their own main policies and procedures
- Able to review and learn from data & trends – within their organisation & beyond
- Well placed to scrutinise, support and challenge, ask the right questions, whether at governing body or sub-committee level
- With solid assurance on key areas with appropriate level of evidence, in some cases independently verified
- Modelling leadership
- Nurturing a positive culture of compliance and learning.

Three case studies are given at Appendix B – that might help you to consider questions to be asking in your role as a GBM and the checklist provided above. You may wish to consider whether something similar could happen in your association, and what you could do to reduce the risks.

Building safety

Building safety has always been important for social landlords, for obvious reasons. The main areas of concern have been identified as:

- Fire safety – alarm systems, evacuation measures, flammability of certain materials, fire doors and so on
- Gas servicing and general gas safety
- Electrical safety, including alarm systems
- Damp and mould
- Asbestos
- Legionella virus in water systems
- Lifts
- For some, trees, play areas etc.

For reasons that will be well understood, damp and mould are now higher up the agenda than they have been in the past.

Regulation and enforcement

In terms of building safety more generally, different parties are involved in terms of oversight and regulation:

- The Health and Safety Executive
- Local authorities
- The Care Inspectorate
- The Fire Service
- Scottish Public Services Ombudsman
- Scottish Housing Regulator
- OSCR.

Their respective roles and powers are not spelt out in this briefing but should be evident from your own policies and procedures. It is worth mentioning here one new piece of legislation, namely the Scottish Fire Safety Regulations 2022[5], now in force and summarised below.

From February 2022, every home in Scotland should have:

- One smoke alarm in the living room (or the room you use the most)
- One smoke alarm in every hallway or landing
- One heat alarm in the kitchen
- A carbon monoxide detector in rooms with a carbon-fuelled appliance

These alarms need to comply with the following standards:

- Smoke alarms – BS EN14604:2005
- Heat alarms – BS 5446-2:2003
- Carbon monoxide detector – British Kitemark EN 50291-1

All smoke and heat alarms should be wired in, interlinked and mounted on the ceiling.

[5] Scottish Government (Feb 2022) Fire and smoke alarms: changes to the law

Damp and mould

Social landlords have taken a number of actions regarding damp and mould, including:

- Full assessment of all reported cases
- Prompt mould removal, and installation of anti-mould shielding
- Installation of internet-enabled humidity sensors
- Advice & assistance offered to affected residents, including translation
- Better information place on website for tenants and residents
- Increased staffing levels
- Technical and awareness training – focus on culture
- New partnerships with specialist contractors
- Accelerated timescales for referral of tricky cases to contractors
- Review and streamlining of internal processes
- Creation of new data fields in property records
- Enhanced reporting to executive, sub-committees and governing body.

More guidance is offered as part of the first briefing in our Putting Safety First series, which is aimed at staff working for social landlords.

Some more building safety questions

Here are some further examples of the kinds of questions GBMs could be asking about building safety:

- Do our processes/policies conform with the law and do they work in reality?
- How do we perform compared to our peers?
- Where are incident reports considered?
- How do we learn from the examples of other organisations?
- How is learning embedded?
- Are there any mission critical supply chain or labour market issues?
- Are our contractors and agents compliant?
- Are all the risks being evaluated and mitigated?

And in terms of contractors:

- Do our contractors (and sub-contractors) take the safety of their own employees seriously?
- Have our contractors reported any serious incidents to us or to the Health and Safety Executive? Are their reporting systems robust?
- Have we followed good due diligence in appointing and monitoring our contractors?
- Are our contractor management processes robust?
- Are we using accredited or certified third parties for specialist works where that would be desirable or indeed necessary?

Employee safety

This is a complex area and should be covered in internal procedures and processes in detail. Employees – including agency staff – have extensive rights, and some obligations.

The health and safety of staff is a key consideration for governing bodies – and they must take reasonable steps to ensure compliance. GBMs can't all be experts, but they do need to be aware of any issues and risks and exercise their independent judgement.

The kinds of issues that might arise include:

- Lone working
- Bullying, discrimination
- Stress
- Lifting, working at height
- Eye strain, back strain from VDU usage
- Overwork
- Accident in company or private vehicle on work business
- Assault by an aggrieved customer or member of the public
- Post-pandemic mental ill-health.

Many employers are increasingly concerned about mental ill-health manifesting itself in the workplace. It may also be exacerbated by the cost-of-living crisis, and inflation in food and energy prices, not to mention transport and childcare. Many governing bodies have been giving active consideration to more active measures to support their employees at this difficult time in history.

Three semi fictional scenarios are included at Appendix C regarding employee safety. You may wish to consider whether anything similar could happen in your workplace and what you could do to minimise this possibility.

Questions for GBMs to ask regarding employee safety

Employee safety is clearly linked to organisational culture. Appropriate processes, policies and procedures will help to create the desired culture. There should also be training programmes, refresher courses and other forms of organisational development.

Here are some examples of the kinds of questions that governing body members may wish to ask in this area:

- Are the various documents fit for purpose, clear, easy to use?
- Are they up to date, reflecting the latest legislation and good practice?
- Do they reflect the learning from recent cases both in the organisation concerned and more widely?
- Have staff been trained in the meaning and application of the documents?
- When were they last reviewed?
- Above all, are they being followed?

Safeguarding vulnerable individuals

It is important for all landlords to consider the need for protection of vulnerable individuals. As well as those living in more specialist provision, there may be vulnerable people living in general needs homes. The consequences are particularly severe if things go wrong, therefore it is important that landlords consider the following:

- The risk of abuse or neglect of vulnerable individuals, with older people, disabled people and those with mental health issues more at risk
- For specialist providers, those with dementia, learning disability, substance abuse, or unmet care and support needs need particular care
- Post-pandemic and cost of living pressures
- Bullying, harassment and anti-social behaviour on estates
- "Cuckooing" of vulnerable or isolated tenants; Issues within housing developments or projects
- Ill health due to poor living conditions
- Mobility issues affecting ability of individuals to evacuate if fire breaks out[6]

Two further scenarios are included at Appendix D regarding safeguarding vulnerable individuals that you may wish to consider. In particular, you may wish to think about: what should have happened differently? What questions would you be asking if something similar was reported to the governing body?

Safeguarding checklist

The Charity Commission in England has published a helpful list of reminders for charity trustees[7] about how best to get safeguarding up the governance agenda. We reproduce it below with thanks, and with the minor amendments needed for the Scottish housing situation:

1) Ensure that your organisation has an adequate safeguarding policy, code of conduct and any other safeguarding procedures. Regularly review and update the policy and procedures to ensure that they are fit for purpose
2) Identify possible risks, including risks to your service users, residents or anyone else connected, and any emerging risks on the horizon
3) Consider how to improve the safeguarding culture within your organisation
4) Ensure that everyone involved with the organisation knows how to recognise, respond to, report and record a safeguarding concern
5) Ensure that all involved know how to raise a safeguarding concern
6) Regularly evaluate any safeguarding training provided, ensuring it is current and relevant;
7) Review which posts within the organisation can and must have a BDC check from Disclosure Scotland
8) Have a risk assessment process in place for posts which do not qualify for a BDC check, but which still have or may have contact with children or adults at risk
9) Periodically review your safeguarding policy and procedures, learning from any serious incidents or 'near misses' in your own organisation and more widely
10) If you work in more than one country, find out what different checks and due diligence you need to carry out in different areas of operation.

[6] The Scottish Government (Feb 2022) has published detailed guidance to assist those who have responsibility under the Fire (Scotland) Act 2005 for ensuring fire safety in care homes in Scotland: Fire safety guidance in care homes

[7] Charity Commission (Nov 2021) Safeguarding for charities and trustees

Top ten points for the way forward

To conclude, ten key points from this briefing are summarised below.

(1) Responsibility sits with each governing body on health and safety matters, and it has significant legal responsibilities as a corporate body, or 'legal person'.

(2) The culture of an organisation is set by the governing body and leadership team. Only with appropriate, robust systems and the right checks and balances can an organisation have confidence it is ensuring a safe and happy environment for its residents, employees, and all others with whom it comes in contact.

(3) Good data integrity is also a vital bedrock for building top performance, particularly in terms of building safety.

(4) Damp and mould should be considered alongside other major areas of building safety, such as gas, electricity, asbestos and others.

(5) Social landlords are making rapid changes to how they deal swiftly and effectively with damp and mould cases, and ensuring that they do not fall into the trap of 'tenant blaming'.

(6) The safety of employees remains a top priority for governing bodies, and must be given regular attention.

(7) The safety of vulnerable tenants is likewise a top priority, in which partnership working with statutory authorities and others is a vital 'must'.

(8) GBMs don't need to be experts in health and safety matters, but they do need to be aware of the legal and regulatory frameworks, and of their own corporate responsibilities, as well as being familiar with their own key policies and procedures.

(9) GBMs must feel free to ask leading questions on health and safety matters, particularly around risks, and to keep on asking until they can be sure they have the robust assurance that they need. The equality and diversity angle to health and safety should always be kept in mind.

(10) Robust assurance for each board on health and safety is key. It needs to be built systematically across a range of areas, using operational information, internal oversight, and external advice and validation where needed.

Disclaimer

Please note that this briefing does not represent legal advice and should not be taken as such; reference to a legal firm, advocate or barrister will always be required in connection with the interpretation of law, statute, regulations or contracts. As regards building safety, Campbell Tickell are not qualified to certify whether or not a particular building or building material is or is not safe in terms of fire or general safety. Accordingly, no formal or legal reliance may be placed on this briefing in relation to these or other similar matters without additional reference to an appropriately qualified person or firm, such as a valuer, lawyer, or safety professional.

Further reading

- Chartered Institute of Housing, Scottish Federation of Housing Associations; Association of Local Authority Chief Housing Officers & Scottish Housing Regulator (Feb 2023) Putting safety first: a briefing note on damp and mould for social housing practitioners.
- Scottish Federation of Housing Associations (June 2022) Self-Assurance Toolkit

Appendix A – Worst case scenarios

Corporate homicide

A care provider in England was convicted of corporate manslaughter after a vulnerable woman suffered burns while being bathed. She was bathed by carers who failed to check the water temperature. She sustained burns across 12 per cent of her body and died 3 days later. The investigation revealed that the home had longstanding problems in regulating the hot water supply. The care provider pleaded guilty to corporate manslaughter and was fined £1.04 million. The care home manager was sentenced to 9 months in prison, suspended for 18 months. The company chose to ignore repeated problems and warnings with the hot water system with the consequence that the resident suffered extensive burns. This was a gross breach in their duty of care.

An avoidable death

A worker at a housing association gave a disabled service user an unsuitable snack, which sadly caused her to choke, and die three days later. The resident's dietary needs had been well documented. The worker concerned had not been given adequate training. Under the circumstances, the death was considered entirely foreseeable and avoidable. The organisation was fined £100,000, although not prosecuted for corporate homicide.

Highest ever UK fine for fire safety failings

A care home provider was fined nearly £1m after a wheelchair using resident who was smoking unsupervised in a garden shelter was burned to death. The resident had been using paraffin based creams on his skin, and this had not been taken into account in his smoking risk assessment. There was also evidence that he had previously had minor accidents of a similar nature, from burn marks found on other items of his clothing. Staff had not been properly instructed in fire safety matters.

Appendix B – Case studies for GBMs to consider

The risks of hoarding

A tenant in an upstairs flat is a hoarder, and the entire floor is covered in piles of newspapers and other accumulated debris. The ceiling below has been cracked and bowed for a while, and your contractors have mended it a couple of times, but without checking the cause.

The ceiling eventually collapses and both tenants are seriously injured, and both flats left uninhabitable. Although a gas contractor's employee had been aware of the hoarding, this was never escalated or recorded, hence you did not realise there was a problem.

Fire damage

Because an employee of an electrical contractor becomes seriously unwell onsite on a Friday afternoon, a faulty fire alarm system in a housing development for people with learning disabilities hasn't been repaired. A fire breaks out over the weekend, and a number of residents end up in hospital suffering from smoke inhalation, because of delays in evacuating. The development is closed for repairs and redecoration.

Damp and mould

A vulnerable person dies as a result of damp and mould in one of your homes. The case was long-standing, and had been attributed largely to 'lifestyle issues' by those dealing with repairs in your organisation. Various contractors and colleagues were aware, but the case had not been escalated to senior/governing body level. The local and national media, and politicians, have taken up the case, and there is a national furore. Could it happen to you?

Appendix C – Case studies to consider concerning employee safety

A case of bullying

Following an experience of workplace harassment and intimidation, one of your employees attempts to take their own life and is hospitalised. It turns out that there have been various complaints and grievances within that team, none however suggesting really serious concerns, which have been dealt with informally, and which didn't set major alarm bells ringing.

The long distance driver

After attending a meeting in a regional office, a colleague is seriously injured in a late-night car crash on a 150 mile journey home, apparently having fallen asleep at the wheel, as no other vehicle was involved. He was in his own car, and only had social/domestic/

/pleasure insurance. His manager and other colleagues were aware that he had made similar journeys in the past.

Use of power tools

Between 2009 and 2014, five employees of a large housing association group used vibrating powered tools to carry out grounds maintenance. An investigation by the Health and Safety Executive found that the employer failed to assess or manage the risks associated with vibrating tools. It also failed to provide suitable training or health surveillance for its workers and failed to maintain and replace tools which increased vibration levels. The employer was fined £600,000 plus costs.

Appendix D – Scenarios to consider relating to vulnerable individuals

Cuckooing

An elderly tenant living on her own has been "befriended" by the daughter of a member of your staff. When the tenant's son visits, he discovers that she has been making sporadic cash payments to the staff member's daughter for reasons that are not clear. The tenant is also cold and malnourished, as she has less money from her pension for food and heating, and is admitted to convalescent home to recover. Local newspapers are aware of the case and adverse publicity is likely.

Community harassment

An elderly man living on his own has wrongly and for no reason been accused of paedophilia. His windows are all broken, and he is afraid to leave the building to do his shopping, or to go and see his family a bus-ride away. He has now received death threats and there have been attempts at arson, luckily failed to date. He doesn't wish to be rehoused, and there are no suitable vacant properties nearby in any case. The police have not been as responsive as desirable, and the way forward is far from clear.

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