B&NES, Swindon & Wiltshire (BSW) Self-Neglect Virtual Conference

"Don't judge me by the chapter you have walked in on. I have a past and a future and not defined by my current situation".
Quote from Swindon Experts by Experience.

Please put your name and role in the chat

BCSSP
Bath & North East Somerset
Community Safety & Safeguarding Partnership

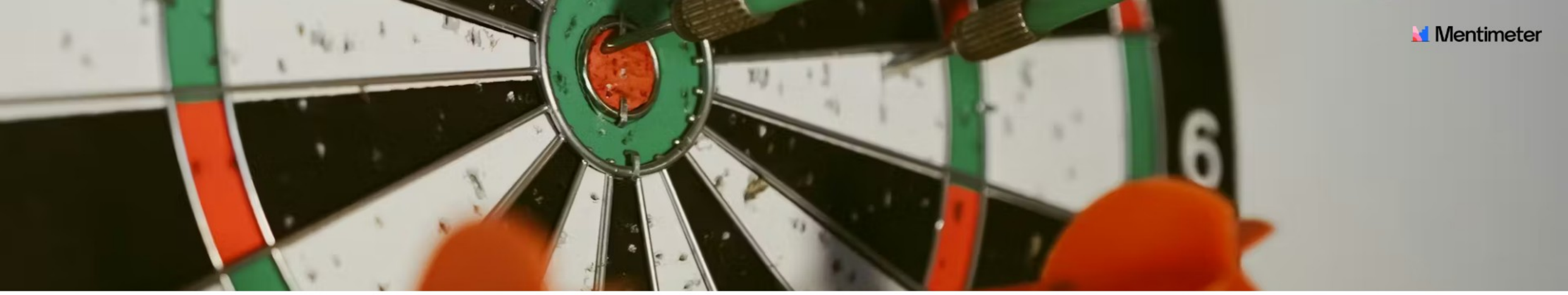
Swindon
Safeguarding
Partnership

Wiltshire
Safeguarding
Vulnerable
People Partnership

Instructions

Housekeeping

- Please keep your camera off and mirophone muted.
- This webinar is being recorded and uploaded to your local partnership website as a learning resource
- If you can't see slides, or they freeze, try logging out then back in
- Please ask questions in the chat box or as dedicated question spaces
- Confidentiality
- Evaluation
- Certificated
- Please put your name, role and organisation in the chat



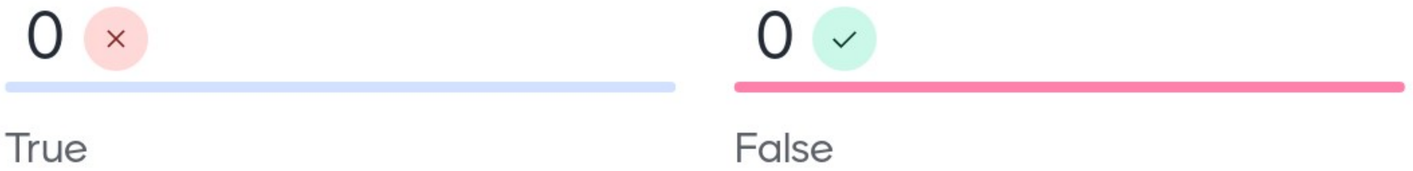
Aims of the day:

- To understand the national and BSW picture of Safeguarding Adults in relation to self-neglect
- To have the opportunity to hear from an expert by experience
- To challenge ourselves
- Consider what we, our organisations and systems can to do differently to enable better outcomes for people
- Practical skills to assist when working with people with hoarding behaviour.
- Look at resources to assess and evidence self-neglect concerns when working with an individual and their support network
- Legal Literacy - Mental Capacity Act
- Look at a health led case study

Agenda

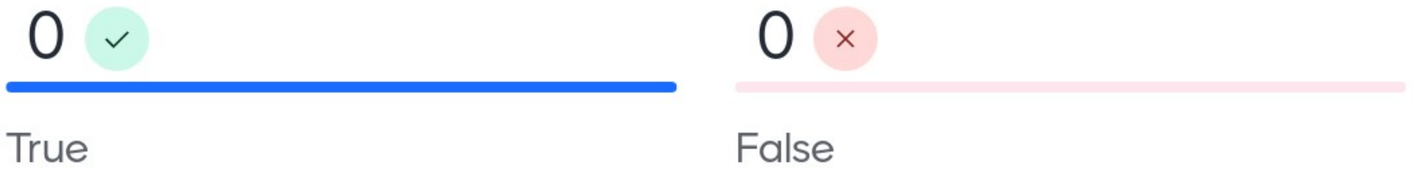
- 9:30 - Start and scene setting
- 9:55 - Ian Porter: Hoarders Helping Hoarders
- 11:15 - Break
- 11:30 - James Sawford: BSW SAR Analysis
- 12:30 - Lunch break
- 13:15 - Dr Sharma: SAR Robert
- 14:00 - 'Emily', Kati Wood & Faith Margle: Voice of expert by experience and Welfare and Safety Plan Resource
- 14:45 - Break
- 15:00 - Leona McCalla & Tim Shearn: Legal Literacy - Mental Capacity Act
- 16:45 - Finish

Self-neglect is usually a lifestyle choice. True or false?

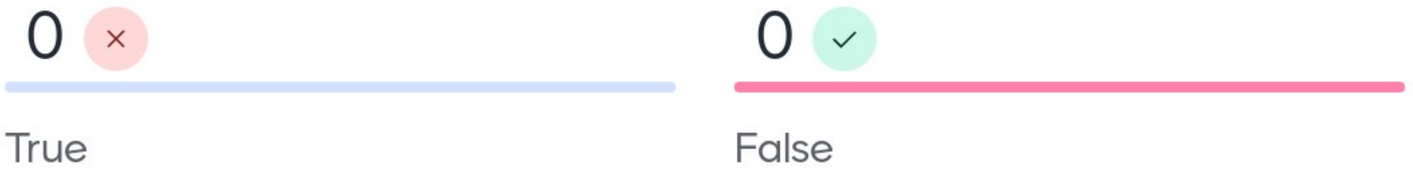


Mentimeter

Self-neglect doesn't always have to be the subject of a safeguarding enquiry. True or false?

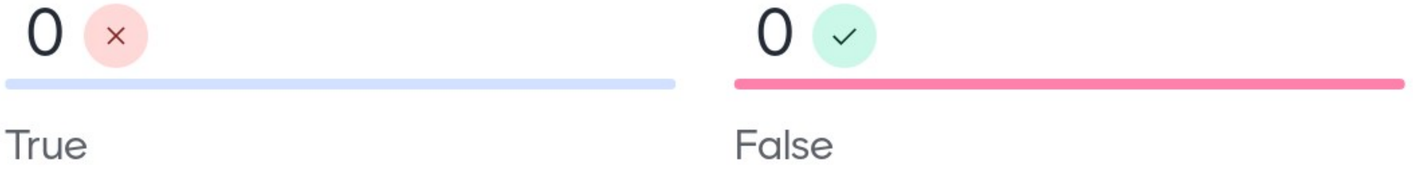


If someone who is self-neglecting has mental capacity and refuses to engage in intervention, there is nothing that can be done to impose a solution.

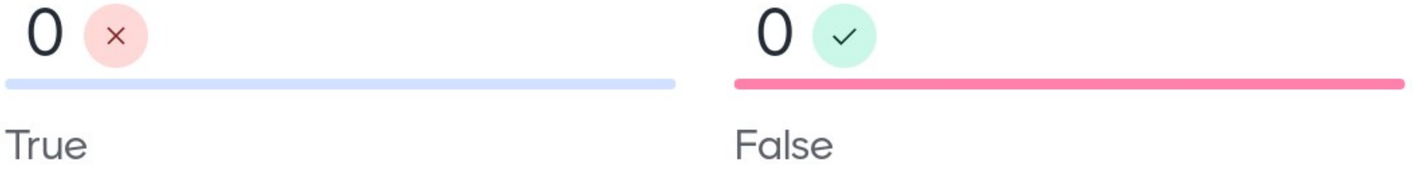


Mentimeter

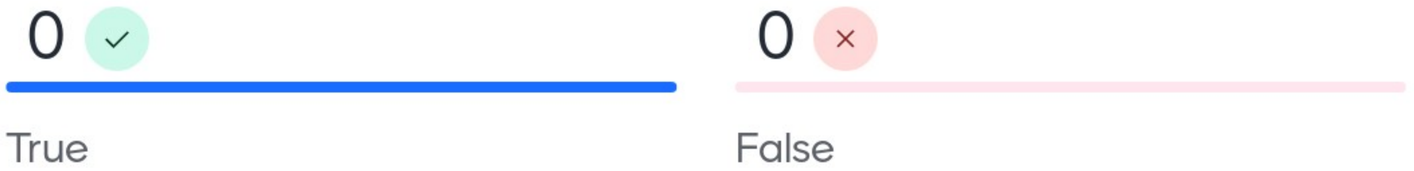
Making safeguarding personal means you can only do what the person will allow you to do. We have to respect autonomy.



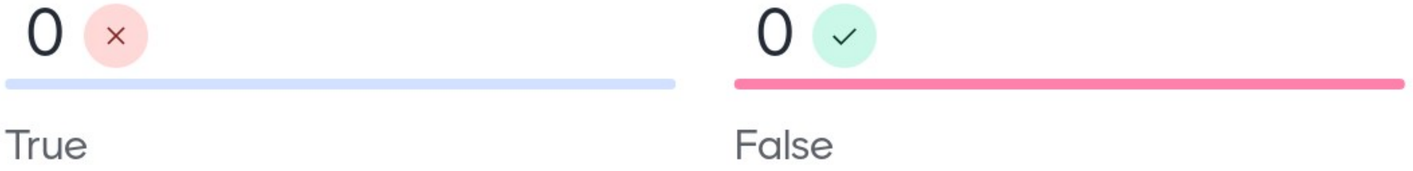
Making safeguarding personal takes too long – we don't have time we need to find quick solutions.



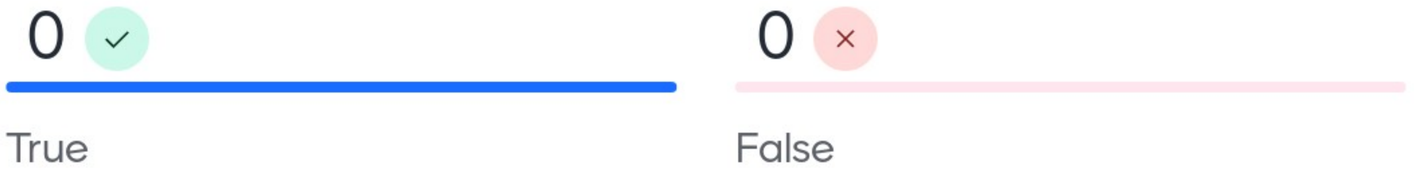
Environmental health have power of entry, with police presence, to properties under certain laws – true or false?



Emergency services (police, fire, etc) are solely responsible for ensuring long term social care support is in place for adults who self-neglect?



Adult social care can conduct assessments and support individuals who are self-neglecting with their day-to-day living – true or false?




Mentimeter
Ian Porter
Hoarders Helping Hoarders

Any Questions:

Coffee Break

15minute break

BSW SAR Analysis

James Sawford
Head of Adults Safeguarding, Quality Assurance and Practice
Bath and North East Somerset Council

Mentimeter

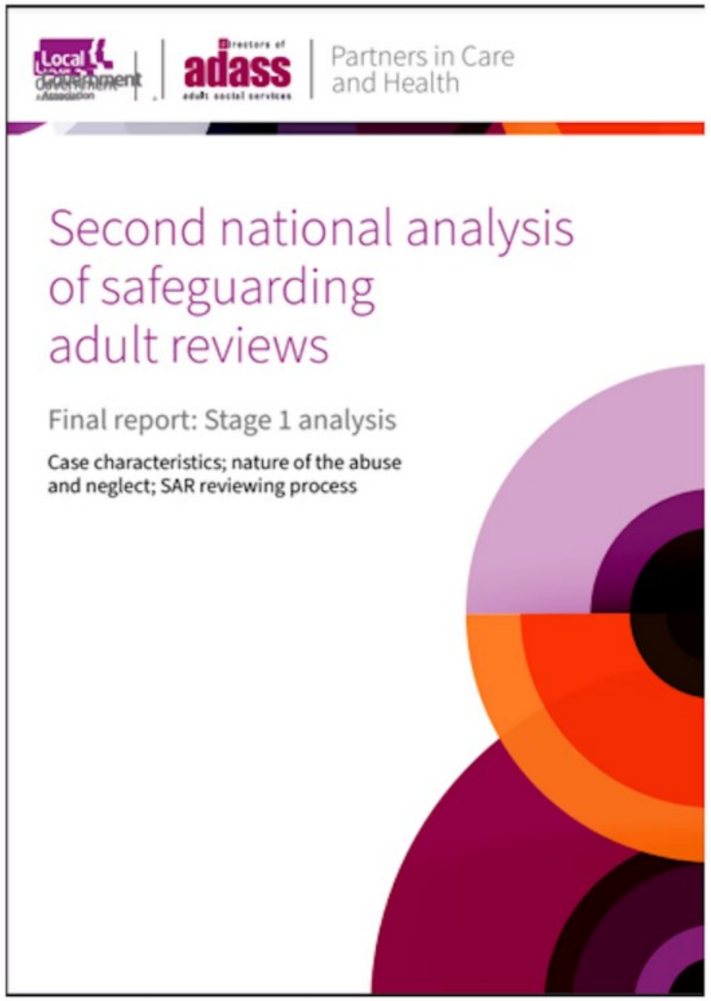
"A single tree cannot make a forest."

"Just as a forest is made up of many trees working together, so too can we achieve great things when we work together towards a common goal."

Aims

You will have been given a handout with comprehensive information that informs this learning event. This event:

- ✗ Will **not** give you a blow-by-blow commentary on what Safeguarding Adult Reviews (SAR's) are telling us, your handout will provide this information to you.
- ✓ **Will** provide you the themes identified in national, regional and local SAR's
- ✓ **Will** give you a **map** to help avoid the pitfalls & practice gaps that were present in **all** SAR's



https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023

National SAR

This second national analysis of Safeguarding Adult Reviews (SARs) in England was funded by Partners in Care and Health, supported by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS).

This study analysed the findings of 652 SARs completed over the 4-year period, drawing out common learning themes.

The analysis showed self-neglect to be the type of abuse most commonly reviewed, featuring in 60 per cent of reviews,

https://nationalnetwork.org.uk/search.html

National SAR cont...

National Network for Chairs of Adult Safeguarding Boards

Observations on Direct practice?

✓ **good practice**

- **risk assessment and management** (in 31 per cent of cases)
- **applying the principles of Making Safeguarding Personal** (29 per cent).
- **good attention to mental capacity** (11 per cent),
- Others 'think family' approach (8 per cent), use of advocacy (7 per cent), legal literacy (6 per cent), understanding of personal history (4 per cent), work with unpaid carers (4 per cent) and hospital discharge (4 per cent). Very occasional positive mention was made of recording (3 per cent), transition planning (3 per cent), use of professional curiosity (3 per cent) and attention to protected characteristics (1 per cent).

✕ **Arears of risk/ improvement "practice shortcomings"**

- poor **risk assessment/risk management** (noted in 82 per cent of cases),
- shortcomings in **mental capacity assessment** (58 per cent),
- lack of recognition of abuse/neglect (56 per cent).
- shortcomings in **making safeguarding personal** (50 per cent),
- **absence of professional curiosity** (44 per cent)
- **attention to people's care and support needs** (43 per cent),
- **mental health needs** (41 per cent) **and physical health** (37 per cent).
- Other commonly found shortcomings included **absence of legal literacy** (40 per cent), **superficial acceptance of individuals' apparent reluctance to engage** (38 per cent), absence of a **'think family' approach** (37 per cent). **Poor recording, poor attention to unpaid carers, lack of understanding of personal history, absence of trauma-informed practice,** shortcomings in **hospital discharge** and poor attention to **living conditions** were each found in around a quarter of cases. Observed less frequently but nonetheless having a negative impact were a lack of perseverance (21 per cent), poor **access to advocacy** (21 per cent), lack of attention to **substance use** (20 per cent), **poor transition planning** (15 per cent), poor attention to **protected characteristics** (12 per cent) and absence of **relationship-based practice** (10 per cent).

National SAR cont...

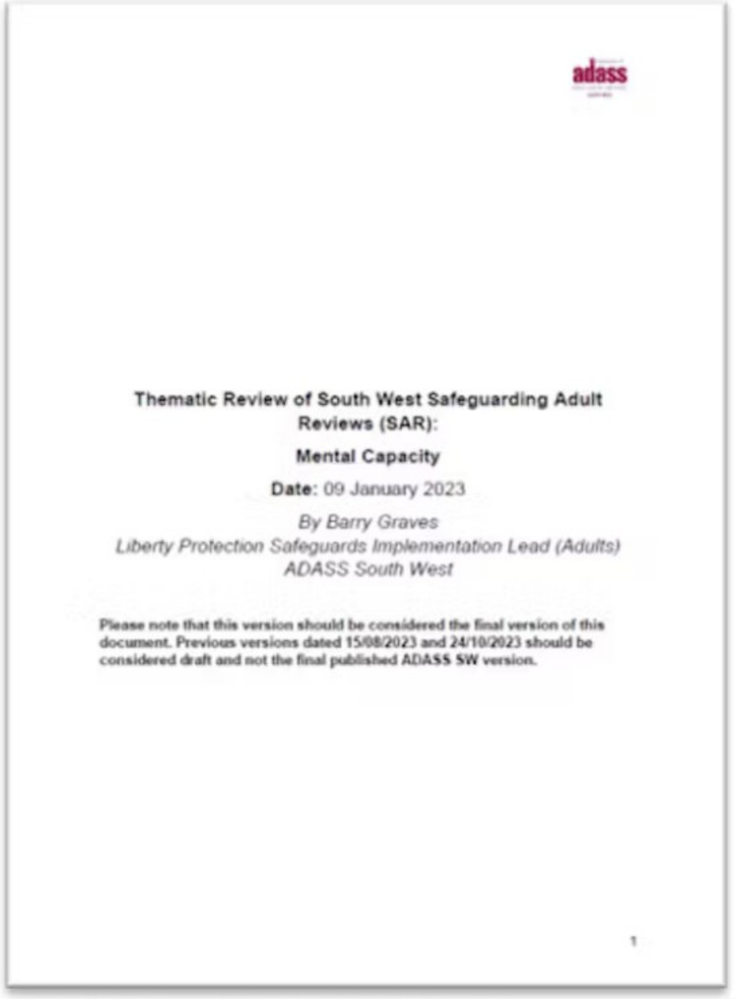
National Network for Chairs of Adult Safeguarding Boards

Observations on wider systemic factors that impact upon direct practice?

✓ While good interagency practice was noted in around a fifth of cases, shortcomings were more widely noted

✕ **Arears of risk/ improvement "practice shortcomings"**

- There was **poor information-sharing**
- an **absence of case coordination** present in almost three-quarters of cases.
- There were **Shortcomings in use of the Care Act 2014 section 42 safeguarding provision and of multi-agency (risk management) meetings** were each noted in around 38 per cent of cases.
- concerns about the **quality of recording, how agencies understood their roles and responsibilities,** and how **services communicated across local authority and other boundaries**.
- lack **of management oversight, poor provision or use of policies and procedures, and press**
- The most frequently mentioned organisational features were **pressures on staffing and workloads**, each present in over a quarter of cases. Failure to provide training and concerns about commissioning practice, including **quality assurance of provider services** and communication about 'out of authority' placements, were also noted, along with an **absence of suitable, sometimes specialist, resources.**



adass

Thematic Review of South West Safeguarding Adult Reviews (SAR):

Mental Capacity

Date: 09 January 2023

By Barry Graves
Liberty Protection Safeguards Implementation Lead (Adults)
ADASS South West

Please note that this version should be considered the final version of this document. Previous versions dated 15/08/2023 and 24/10/2023 should be considered draft and not the final published ADASS SW version.

1

https://sites.southglos.gov.uk/safeguarding/wp-content/uploads/sites/221/2015/05/SAR-Thematic-Review-Final-Version-Jan24.pdf

Regional SAR

directors of adass adult social services South West

This thematic review of South West Safeguarding Adult Reviews (SAR) did not specifically focus on self neglect but looked at *"practice issues identified in relation to the Mental Capacity Act 2005".*

62 published and publicly available documents informed this review covering all 12 Safeguarding Adult Boards (SAB) from the region.

Over-arching themes were identified in relation to omission of completing mental capacity assessments and sub themes discuss various examples of practice concerns identified, including one being:

> *"One of the biggest, if not the largest area of practice concern, is practitioners finding it difficult to work with and understand executive function and how to assess mental capacity with individuals with potential executive dysfunction. This includes the specific impacts that some contexts and conditions have on executive function such as self-neglect and substance misuse."*

Executive Function & Fluctuating Mental Capacity: Areas of risk/ improvement "Practice Shortcomings"

SAR 1 –

-No **mental capacity** assessment

-**Absence of a documented assessment** & **legal decision-making framework**

-Lack of **exploration with others** & via best interests to support **management of risks**.

-Lack of **challenges to unwise decisions**

SAR 2 –

-**Over-reliance** on a misinterpretation of the MCA's **principle three** by professionals

-Believing individual had a **right to make unwise decisions.**

-The **repeated unwise decisions** should have in this instance triggered a mental capacity assessment

-Lack of exploration of **executive function.**

Executive Function & Fluctuating Mental Capacity: Areas of risk/ improvement "Practice Shortcomings" cont...

SAR 3 –

-Lack of **curiosity** around **compliance & non-compliance**, also the presence of compulsive behaviours.

-Lack of **conversations to discuss unwise decisions** that may be indicative of **impaired executive functioning** were not held by any professionals working with him

Risk Formulation and Management: Arears of risk/ improvement "practice shortcomings"

- Multiple SARs commented on the need for practitioners to be more curious around mental capacity in their consideration of risk.

- Gaps in engagement or compliance were taken **at face value** by practitioners and potentially considered 'unwise' decisions **without the completion of a mental capacity assessment or reflecting on executive function** (see section 2).

- An **over simplified model of mental capacity** meant that the legal framework that stems from a documented assessment and offers protection to the individual and practitioners **was not put into place**.

- Critically there was **no evidence of a mental capacity assessment around taking/refusing medication** despite the GP reporting that not taking medication will likely result in a decline of mental capacity.

Risk Formulation and Management: Arears of risk/ improvement "practice shortcomings" cont...

- There were **missed opportunity of professionals from different backgrounds coming together to discuss risk**

- Examples of **not sharing information and/or formulating risk management plans** based around mental capacity.

- Despite the individual's mental capacity for decisions relating to the areas of risk being tested, this was **not formally recorded nor included in the risk management plan.**

- An individual lacked the mental capacity to make relevant decisions around accepting support and therefore a **risk management plan** should have been in **place to pre-empt and provide contingencies for future refusals** to help minimise harm.

Bath & North East Somerset Community Safety & Safeguarding Partnership

Swindon Safeguarding Partnership

Wiltshire Safeguarding Vulnerable People Partnership

B&NES, Swindon & Wiltshire (BSW) SARs

B&NES - 6 SAR's relating to self-neglect, since 2018
https://bcssp.bathnes.gov.uk/safeguarding-adult-reviews

Swindon - 10 SAR's relating to self-neglect, since 2019
https://safeguardingpartnership.swindon.gov.uk/info/18/for_professionals/64/safeguarding_adult_reviews_sars

Wiltshire - 7 SAR's relating to self-neglect, since 2018
https://www.wiltshiresvpp.org.uk/p/adults/safeguarding-adults-reviews-1

B&NES SARs:

Adult C pg.11

Adult C describes herself as 'happy' and having a 'normal family life' and a 'successful' career prior to becoming unwell. She left employment dye to mental ill health & physical health. Adult C is married, and both she and her husband participated in this review, along with her mother and sister-in-law.

Levi Swaby pg.12

Levi a 36 year old man of Black African Caribbean heritage, died unexpectedly on 19th November 2019 following a cardiac arrest. He left family including his mother, who was involved in his support, and a sister. He also had children with whom contact was variable over the years

B&NES SARs:

Angus (2022) pg.13
History of alcohol abuse & self-neglect. He had been resident in a care home under a DoLS in 2019. Angus returned to the community with a support package, a pattern of self-neglect, alcohol abuse & regular falls in his home followed. Angus developed an infected leg and pressure sores. Angus died in hospital, aged 72 years.

Martin (2021) pg.14
Martin died at 36 years. He had a long history of MH & alcohol use. He was unresponsive at home & couldn't be resuscitated. Martin was known as a 'high risk' drinker. He lived alone with self-neglect. He wished to become alcohol free & was described as a 'gentle giant', with the exception of times of anger & frustration, was polite & always as asked for help. He said he hated being a burden to his father

B&NES SARs:

Mark [2020] pg.16
Mark was 63 years when he died. He was diagnosed with OCD. He understood it's manifestations. At times he sought support, at others, became depressed, withdrew or obscured symptoms by drinking alcohol. His OCD impacted on management of his diabetes; diet & medication. He feared throwing anything away as he was concerned he may lose something valuable, including parts of his own body. there were ongoing concerns on hoarding behaviour.

Elley (2018) pg.18
Elley was a 93 year old woman. Cause of death; sepsis of unknown cause, frailty of old age, dementia & heart disease. Elley self-funded care, a befriender & the District Nursing. Concerns about her managing at home and reluctance to accept care or increasing her care calls. Legal options to support were not explored.

B&NES Analysis - See pg.19 in handout

- **Engaging with and the voice of the person**
- It is our responsibility to engage the person, not the person to engage with us
- **Mental capacity**
- Over-reliance on assumed capacity and an absence of formal assessment
- **Information sharing and Holistic Assessment of needs, vulnerability and risks.**
- There is a need to include all people involved with the person, inclusion the person, carer & others [think family]
- **Care planning and Resources to meet needs**
- Care plans should describe the support the person requires and how/by whom that will be provided
- **Tools and resources to support practice**
- Legal literacy knowledge, what are the "signs" of escalating risk & a shared commitment and curiosity

Swindon SARs:

Sally (2024) pg.21
Sally was aged 48. Experiencing domestic abuse, history of drug & alcohol dependency, exploitation (including cuckooing) & self-neglect including her health needs. She was deceased in her home in Feb'24. She was known to service.

Ethan (2024) pg.22
Ethan was a 62 years. He had two adult children with his long-term partner. This relationship ended about 10 years ago. Ethan was his fathers carer, prior to his death in 2018. Ethan had a stroke some years previously and this may have had an impact on his self-care & pattern of self-neglect. Ethan was found deceased at home in Jan'24. Ethan often declined support adult social care.

Richard (2024) pg.25
Richard 70 years & lived alone. He was a Physicist. With a diagnosis of schizophrenia and his property was known to be unkempt.

Swindon SARs:

Wendy (2024) pg. 26
Wendy was 60 years, previously a Nurse. She had MH needs incl depression & anxiety. Wendy lived in a sheltered housing, with District Nursing, carers, Housing and MH services. Wendy's self neglect was closely related to her MH.

Robert (2024) pg.26
IT was Robert's vocation when he died at 53. He experienced significant issues with alcohol. He attempted suicide by overdosing. He was known to emergency services. Between Aug'22 and his death in Jan'23, AWP, GWH, the police, SWAS, and Turning Point all had contact with him.

Andrew (2022) pg.29
Andrew was a 77 years found next to his adult son, who was deceased. The coroner ruled both deaths as suicide. Andrew's wife died in 2017 & since this was treated for depression & low mood. Andrew showed signs of self-neglect.

Swindon SARs:

Alison (2022) pg.21
Alison was 49 years who committed suicide. With a history of trauma, MH & alcohol misuse. Known to MH for 25 years; anxiety, depression, emotionally unstable personality disorder, self-harm, alcohol & drug use, chronic liver disease (hep C+) & asthma & experienced exploitation.

Kieran (2022) pg.33
Kieran died at his home following illness. He had mild learning disabilities, contact with MH following his father's death. He lived with his Mother until she died. Kieran experienced self–neglect, hoarding, MH & exploitation.

Brian (2021) pg.25
Brian was 43, with MH and drug use. He lived alone & died in a fire in Feb'21. Brian was in contact with several agencies incl police, SWAS, mental and physical health services & drug services. Self-neglect and drug use.

Swindon SARs:

Brenda (2021) pg.37
Brenda was 75 years who died Feb'21. A safeguarding was raised in Jan'21 with concerns for not eating, history of depression & self-neglect. Brenda lived alone & was estranged from her son. Brenda had multiple health needs (heart & kidney disease, Sjogren's syndrome, anaemia) & depression. Weekly Community nurses visits for Eprex injection, Advanced Clinical Practitioner, GP, Adult Safeguarding Team and Initial Contact Team.

Terry (2019) pg.39
Terry died in hospital in Jun'19 aged 71 from liver cirrhosis & Hep C. Terry experienced self-neglect, financial exploitation & alcohol dependency.

Swindon Analysis - See pg.41 in handout

- **Engaging with and the voice of the person**
- Practitioners burdened with an overwhelming workload may inadvertently or deliberately "dispose" of cases
- **Mental capacity**
- Duty of care vs. Autonomy - inconsistent approaches and an assumption of capacity
- **Information sharing and Holistic Assessment of needs, vulnerability and risks.**
- Lack of making contact with families, lack of life history sharing, minimisation of risks
- **Care planning and Resources to meet needs**
- absence of an agreed lead professional, leading to communication and information sharing to "dropping off"
- **Tools and resources to support practice**
- "repetitive behaviour" not explored & "presence of this pattern of characteristics" could support identifying future risks

Wiltshire SARs:

Adult A (2016) pg.44
Adult A was found at home with serious self-neglect, it was cold, dark & she was severely hypothermic. No fresh food in the flat and Adult A had not been taking her medication. Adult A died the following day.

Adult B pg.46
Diagnosed with Alzheimer's. Nov'16, Adult B was found 10 miles from his home, inappropriately dressed for the cold weather. He was taken home & after getting very distressed, to the police station. His care package was increased, but he was not in for some of them. On 27th November 2016, Adult B was struck by a vehicle whilst walking alone on an unlit road & later died from his injuries.

Wiltshire SARs:

Adult C pg.48

Aged 74, diagnosed with Paranoid Schizophrenia. Reluctant to engage with professionals and CTO ensured that he received anti-psychotic medication. Due to concerns for presentation he was recalled for assessment and found emaciated and starved and died 8 days later in hospital.

Adult M pg.50

Learning disability, complex physical & MH needs. She died because of 'Inanition', death by exhaustion due to lack of nourishment. The case had been subject to a LEDER review that identified delays in referrals to dietetic services and quality of annual health checks. This case did not meet the threshold for a SAR the SVPP wanted to learn from this case to explore our ability as a system to be alert to risks associated with complex needs.

Wiltshire Analysis - See pg.52 in handout

- **Engaging with and the voice of the person**
- Large caseloads and the case's long-term nature
- **Mental capacity**
- Duty of care vs. Autonomy
- **Information sharing and Holistic Assessment of needs, vulnerability and risks.**
- Overreliance and assumptions on informal carers meeting needs and risks
- **Care planning and Resources to meet needs**
- We saw a number of factors adversely impacting on both resource allocation and care planning
- **Tools and resources to support practice**
- Again, we saw reference to "trauma histories"

What do these tell us - 8 steps

- Legal literacy – MCA balancing rights and risks
- MDT working and leadership
- Unconscious bias
- Trauma informed
- Information gathering and sharing
- Engagement – assertive outreach
- Assessment of needs and risks – mental health Vs physical health
- Action must be taken to address risks

Legal Literacy - Balancing rights to autonomy Vs the rights to protection?

Human Rights

Article 3 imposes a **positive obligation** on public authorities to protect adults from "*torture, or inhuman or degrading treatment or punishment*".

This is an absolute right

Article 5 Everyone has the "*right to liberty and security of person*".

Article 8 Everyone has the "*right to respect for his private and family life, his home and his correspondence*".

These are not absolute rights, these are qualifiable rights.

Legal Literacy - Balancing rights to autonomy Vs the rights to protection? cont...

Public bodies can interfere with people's rights to respect for private and family life, but they must be able to show that such action is lawful, necessary and proportionate in order to protect national security, public safety, the economy, health or morals, prevent disorder or crime or protect the rights and freedoms of other people.

Furthermore, Public bodies can interfere with people's rights to liberty and security, if they have a mental health condition which makes it necessary to detain them or have a mental health impairment that is sufficiently serious to warrant detention or intervention/ this is where wither the Mental Capacity act or mental Health Act will provide a framework.

Legal Literacy - Balancing rights to autonomy Vs the rights to protection? cont...

Duty to protect:

Public authorities have a **proactive duty** towards Adults at Risk to take "*reasonable steps to prevent ill-treatment of which the authorities had or ought to have had knowledge.*"

Public authorities may be considered to be responsible for the Harm and therefore will be in breach of Article 3 even where they have merely failed to prevent degrading treatment, rather than caused it. People whose disabilities make them critically dependent on the help of others are entitled to enhanced protection....

This does include abuse and..... abuse does include self-neglect!

“Don’t judge, use judgement”
“I'm the leader, I’m the leader”

Judgment

Make sure unconscious Bias is checked for and if present, it is not left unchallenged

Don’t make excuses or be risk blind, due to preconceived, unevidenced beliefs.

Don’t hide behind “Unwise decision making” and check for:

- Whether there is **over-reliance** on a misinterpretation of the Mental Capacity Act’s **principle three** Is
- Whether you are they have a **right to make unwise decisions,** despite information leading to reasonable cause to doubt capacity .
- Whether **repeated unwise decisions** have been assessed and have triggered a mental capacity assessment
- Whether they are talking the talk, but can they walk the work - exploration of **executive function.**

Remember the MCA is there to protect and uphold the person rights, not prevent you for intervening

Leadership and escalation

Multiple commissioning arrangements can lead to **disjointed working** – coordination is key!

Leadership and management are not the same thing:

- There needs to be a **leader** coordinating an MDT approach. They are not there to instruct but are there to **direct and support**.
- **Leadership** is about leading the MDT and supporting others to **manage** thing; whether this is risk or professional anxiety

Challenge and escalation help us grow!!

Make sure there is a culture within the MDTR for respectful challenge. If action is not being taken by an agency…….. Challenge! and if you are not provided with a clear rational as to the inaction, escalate escalate escalate!!

Be Professionally Curious & Trauma Informed

Caring, compassionate, empathetic...**GIVE A DAMN**!!!

Curiosity
Gather Information
Verify Information
Evaluate Information

[*What information?*]
Anecdotal/ antecedent

Trauma aware and informed
Data
Assessment
Major Event
Needs and risk

Gathering information vs sharing information

Gather information
Don't let GDPR stand in the way!
Think family, think network!

Sharing information

Caldicott Principle Seven says:
"**The duty to share information for individual care is as important as the duty to protect patient confidentiality** Health and social care professionals should have the confidence to share confidential information in the best interests of patients and service users within the framework set out by these principles."

ICO states:
"When sharing information to the appropriate authorities seeks to address a perceived risk of harm to that individual, practitioners should consider whether the sharing is necessary for the exercise of their statutory function"

Set in Stone

We have to assess and act upon:

Needs - Mental health, physical health, environmental, social....
Risks – Mental/Psychological, physical, environmental, social.....

Within the context of the adults Capacity

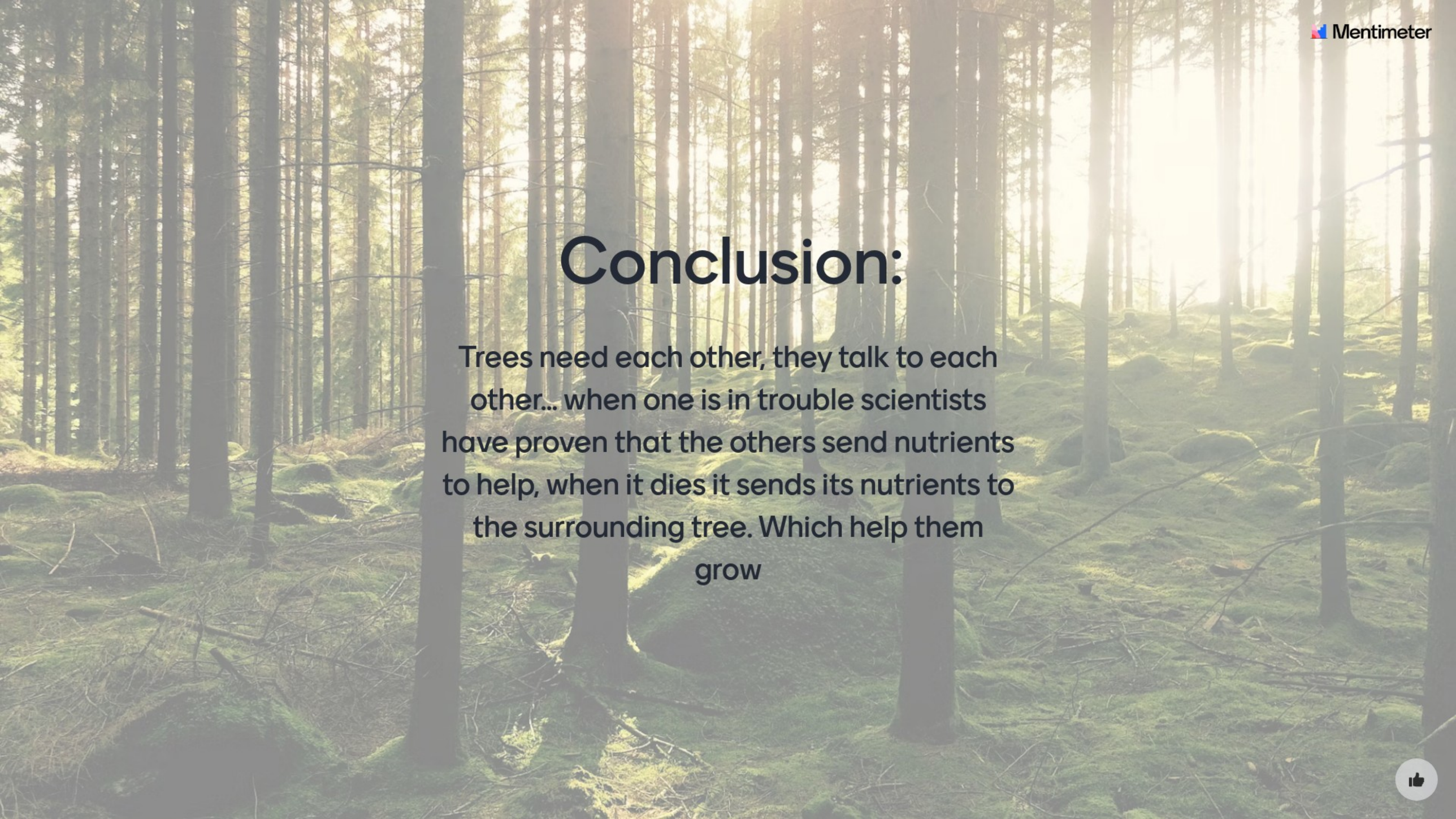
Overwhelming workload may inadvertently or deliberately "dispose" of cases utilising capacity as a means to do so.

We can only do this effectively, if everyone is involved, including the person

"**but they won't engage?**"

- Team around the adult
- Relational practice
- Assertive outreach

Remember sharing is not only caring... It is essential!!


Mentimeter
Conclusion:
Trees need each other, they talk to each other... when one is in trouble scientists have proven that the others send nutrients to help, when it dies it sends its nutrients to the surrounding tree. Which help them grow

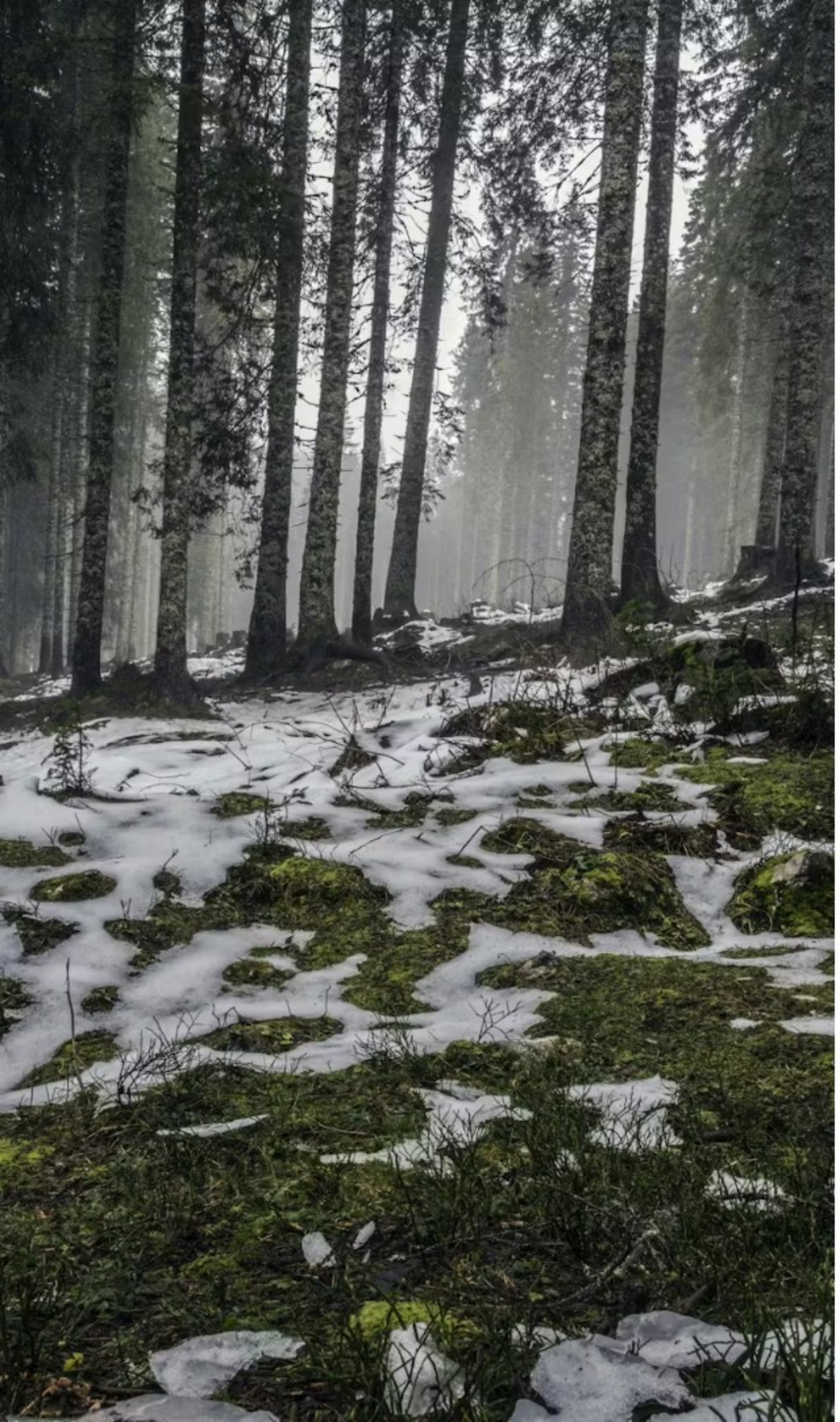
Conclusion:

Poor Assessment of needs and risk – assessment of need and risk are fundamental to good therapeutic, risks management intervention, balancing rights and risks

Lack of information sharing or gathering - Assessment need information, gathered and shared
Lack of evaluation - Be kind…. give yourself time – evaluate information and the intervention(s), use data to identify themes, trend

Lack of risk intervention – An Assessment alone is just words on a page, unless judgment is used, and actions are taken

Lack of legal Literacy - Rights and risks are not mutually exclusive, if the risks dictate, then rights can be interfered with… risk management is upholding the persons rights… the law is there to protect the person and you!



Conclusion:

Not accurately applying mental capacity act - Unwise decision making need to be explored within the context of executive functioning ..... they may be able to talk the talk, but can they walk the walk. Remember the MCA is there to protect the adults' rights, but not applying correctly we are not protecting their rights or them from the self-neglect abuse .

Not trauma informed – we all live within the context of some form of trauma, some more than others. Has something(s) major happened in the adult life... this may inform your think and/or approach .... The only way to find out is to get their story

Conclusion:

Lack of professional curiosity and being bias –
remember GIVE A DAMN

Lack of MDT, coordination, leadership and escalation -
Team work makes the dream, but action and leadership turn dreams into realties.... Lead people, manage things - escalate when needed

Professionally and respectfully challenge each other. Remember without external stress our roots can't grow, and we won't withstand the storm!

Any Questions:

Lunch Break

30 minute lunch break