West Sussex Safeguarding Adults Board

Learning Review: Adult J

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Introduction

Adult 'J' is a person who wanted to live independently and to make decisions about life generally and day to day living that although not necessarily seen as always in Adult 'J' best interests, were nonetheless decisions Adult 'J' on the face of the case history, was able to make.

However, fire deaths are always traumatic and harrowing, whenever they occur, learning from cases such as this is essential. It helps all agencies understand what has happened and identify necessary steps, across all organisations, to reduce risk and improve services.

This specific case, in the context of a review of learning elsewhere, helps identify key actions to make a difference in West Sussex.

It demonstrates the vital importance of working across all agencies engaged with those who use services, respecting their independence and assessing risk. It identifies the vital role frequently played by our colleagues in the voluntary sector, who may know service users well.

All agencies involved in Adult 'J' life have committed to making changes to improve services through better communication and working more closely together.

The implementation of the Action Plan following this case review, will be monitored through reporting progress to the SAR Sub Group of the Safeguarding Adults Board.

Annie Callanan
Independent Chair
West Sussex Safeguarding Adults Board

1. Overview

1.1. A Safeguarding Adults Review referral for Adult J (name changed) was received by the Safeguarding Adults Review subgroup of the Safeguarding Adults Board in June 2017. The referral was made by West Sussex Fire and Rescue Service.

1.2. The referral described Adult J as a grandparent and parent who had a significant history of psychological illness, and a diagnosis of Motor Neurone Disease. The referral described how on the 4 January 2017; Adult J had been involved in an incident where lighting a cigarette on the cooker resulted in Adult J being set alight. Adult J received severe burns (20%) mainly to the left side of the torso, head and arms. Adult J was admitted to Queen Victoria Hospital in East Grinstead, and then transferred to Chelsea and Westminster NHS Foundation Trust specialist Burns Unit in London. Unfortunately Adult J died as a result of the injuries sustained.

1.3. The Safeguarding Adults Review referral was made to identify any learning in terms of the following:

- Adult J's capacity to make decisions in relation to receiving support and adaptive technologies.
- Whether agencies could have done more to prevent the incident?

2. Family involvement

2.1. Contact with families, including offering relatives the opportunity to be involved in the review process and share their experiences and concerns with the Learning Review Author and a representative of the Safeguarding Adults Board is fundamental to ensuring the transparency of the review. It is also an opportunity to build up a clear impression of the person at the centre of the review, their character, and personality.

2.2. Relatives were contacted via letter at the start of the review process and again in January; both informing them of the review and offering an opportunity to contribute. The Safeguarding Adults Board received acknowledgement that communications had been received, but no further information relating to their wishes to participate in the review.

2.3. The Safeguarding Adults Board Safeguarding Adults Review subgroup chair and the Board Manager feel that proportionate steps have been taken to seek engagement, and the anonymised version of the report should be published to share and capture the effectiveness of Multi-Agency learning.

3. The learning review threshold

3.1. The Safeguarding Adults Review subgroup requested Summaries of Involvement from all agencies to identify their contact with Adult J from 1 January 2016 until the day of death on 21 April 2017. This was intended to give the subgroup an

indication as to which agencies had been involved in supporting Adult J and what support was given. Within the Summaries of involvement agencies are also asked to identify actions and learning that had already taken place within their own organisation to reduce the likelihood of the situation happening in the future.

3.2. The responses were analysed by the Safeguarding Adults Review subgroup and linked in with the learning identified from other fire deaths that had occurred within England (identified from other Safeguarding Adults Boards. On this occasion it was felt by the subgroup that there was limited additional learning to be found from this incident, so did not warrant a full Safeguarding Adults Review.

3.3. The SAR subgroup recommended that a report be written to detail the actions that agencies had implemented following learning from this and other nationally known cases. This could then be shared with other agencies within West Sussex.

4. National learning

4.1. Agencies who had been involved with Adult J were asked to consider any learning that had previously been identified with the following nationally known cases:

Previous SARs	Key findings/ root cause	Actions/Recommendations/learning
Gloucestershire SAB – SJ – Fire Fatality	Health and Social Care providers did not appreciate the fire risk to SJ in her environment when she had been housebound since 2012 with implications for her to exit the accommodation in an emergency.	• Risk assessments must include consideration of whether if someone has a smoke alarm fitted and if this is sufficient protection. To also include assessment of person's ability to escape from the property in the event of a fire. • If the risk assessment indicates that the person may not be sufficiently protected from a fire then a referral must be made for a formal Fire and Safety Assessment. • In cases where there is more than one agency involved in a person's care, a multi-agency/review meeting should be carried out to a specified schedule to ensure all relevant and proportionate information is shared. This must include gathering information from front line carers and family to inform a review processes and ongoing management of risk. • Any training needs that are identified in successfully applying the above 3 recommendations should to be forwarded onto the GSAB Workforce Development Lead.
Bristol SAB – Mr C – Fire Fatality	The key outcome for the review was that people in Bristol who self-neglect would be safer in	• That the Bristol SAB should develop a joint protocol to be followed when working with individuals who self-neglect. • That the Bristol SAB should assure itself that partner agencies have adequate policies and training plans in place to ensure improved practice

Previous SARs	Key findings/ root cause	Actions/Recommendations/learning
	future, because of the learning from Mr C's death and the circumstances, both longer term and more immediate, leading up to it.	in matters relating to Mental Capacity Assessments • Bristol SAB should draw up a local agreement identifying how agencies can flag concerns about escalating problems, and what responses are required. • The Bristol SAB should seek assurances from AWP that policies and practice guidelines in relation to engaging with individuals with co-morbid mental health and drug misuse issues have been reviewed in the light of learning from this case. • Bristol SAB should assure itself that the relevant agencies are robustly recording and tracking any individuals who are subject to S117MHA. • Given that there are lessons to be learnt from this case for all agencies involved in Mr C's life, Bristol SAB should accept this report; disseminate its findings to all SAB partner agencies and assure itself that individual action plans are being implemented.
C of London and Hackney - BC	Mr BC, aged 72 died in a fire at his home in Nov 2014. He did not always easily engage with services or attend appointments and refused personal care (aggressively at times). Findings were similar to WSSAB Mr W Learning review	• Placed in an environment that was not entirely suited to his support needs. • Lack of over-all Risk Management strategy clearly evident in the way that agencies responded to needs and to the risks he posed. • No single agency took the initiative to convene the interagency system – leading to a fragmented response to mitigate risks. • Disconnected interface between safeguarding and ASC responsibilities/Care Management. Also a disconnect between Health and Social Care. • No comprehensive attention given to Fire Safety Measures • Similar strategies were tried over and over to mitigate risk without appropriate escalation. • ASC focussed on practical care without looking at a relationship based approach to build trust within a professionally bound relationship. • Uncertain processes around MCA application. • Inadequate recording in a number of agencies hampering the work of IMR authors.
Tower Hamlets – Mr X and Mr Y	Father and son (son had a history of Arson) – both identified as Adults at risk.	• Lack of safeguarding awareness in all of the agencies involved with Mr Y and Mr X, including the LA. No challenge from Board member agencies or others that should have pressed for appropriate escalation in the form of a MA strategy meeting. • Communication between teams was poor and this was replicated between agencies. Most mistakes within the SAR were founded on assumption. Written records and communication also poorly managed.

Previous SARs	Key findings/ root cause	Actions/Recommendations/learning
		• Incident occurred just prior to the procedures for DHRs – strong parallels to domestic violence patterns were not spotted and those who did have information were not able to share. • Misunderstanding of MCA and DoLS legislation particularly by LA and local hospital Trusts. • Historical information not included as part of decision making or opportunity for review of longer term work. • Risk assessments did not happen – or were based on inaccurate information or not updated. • MA working – failed primarily due to lack of coordination of individual agency responses.

5. Key themes

5.1. Several key themes are consistent throughout all the cases that were reviewed. The SARs reviewed brought up issues of problems in multi-agency working, lack of information sharing, poor internal policies and procedures, lack of understanding around the Mental Capacity Act, and failure to escalate serious concerns. These key themes also appeared as areas for local agency learning from the incident of Adult J:

5.2. Multi-agency working

5.2.1. A need to improve referral pathways and provide more detailed information for West Sussex Fire and Rescue Service (WSFRS) to identify the level of risks for individuals. They explained that there was a 'training and partnership need to improve our knowledge and understanding of the whole person.'

5.2.2. WSFRS have offered to work with adult services and agencies in providing risk assessment for those with care and support needs to reduce the risk of injury and death where there are fire safety issues.

5.2.3. The GP identified the importance of working closely with colleagues within MND support and Macmillan nursing teams and have stated that they will continue to include all multidisciplinary staff involved in supporting patients in all relevant meetings. The requirement for improved communication has been identified as a key learning outcome.

5.3. Information sharing

5.3.1. There was a lack of clarity in communication between Continuing Health Care and Sussex Communities Foundation NHS Trust. Follow up meetings have taken place and action has been agreed to ensure that 'accurate

records of referrals and telephone conversations will be recorded regarding contact with other specialist teams to ensure an audit trail is available.'

5.3.2. Western Sussex Hospitals Foundation NHS Trust (WSHT) and Queen Victoria Hospital identified a lack of clarity relating to agreed protocols for the management of burns patients who are re-patriated back to WSHT from Queen Victoria Hospital. Communication processes between WSHT and the Burns Outreach team were not clearly documented within medical records. Internal Root Cause Analysis investigation has been completed and communication and proactive information sharing procedures have been implemented to ensure that information about safeguarding/support is shared prior to transitions between hospitals.

5.4. Internal procedures

5.4.1. WSFRS have improved processes within their own referral process to ask for more details about risk and managing safely – including cooking, smoking, substance use, and hoarding level. WSCC have reviewed the Sussex Hoarding Procedures for Multi-Agencies which should receive Safeguarding Adults Board assent in September 2018.

5.4.2. WSFRS have also reviewed their management information systems and introduced a new system called CFRMIS. This system is more robust in monitoring the workflow of cases and highlights vulnerabilities within the rollout of 'Safe and Well' visits. A Safe and Well Visit is a free service carried out by West Sussex Fire & Rescue Service. It involves a pre-arranged visit to your home to offer advice on how to make it safer and, where appropriate, fit smoke alarms or other specialist fire detection equipment free of charge.

5.4.3. Sussex Partnership Foundation Trust (SPFT) identified that an annual review of Adult J should have taken place, even though the care from SPFT was acknowledged to have been stable for some years. A previous SAR identified a need for the Trust to look at its 'Care Programme Approach' processes and therefore SPFT will ensure that the frequency of review periods is also considered in this ongoing work.

5.4.4. The importance of ensuring documentation is well recorded, defensible and clear was also identified as a learning point in multiple agencies.

5.5. Mental Capacity Act (MCA)

5.5.1. It was a clear professional judgement from a number of agencies working with Adult J that they had capacity in relation to smoking within the home, in spite of being aware of the potential risks, and that Adult J was described as 'a fiercely independent adult who was determined to remain living in the property despite mounting physical difficulties', documentation would have benefited from being more robust in documenting decisions made.

5.5.2. Recent Safeguarding Adults Reviews undertaken by the Safeguarding Adults Board in West Sussex and other reviews nationally have highlighted the

importance of ensuring that all workers understand their role in line with MCA.

5.6. Confidence in escalating concerns

5.6.1. Both the GP and GoZone Care (the Home Care service who supported Adult J), felt that they were unclear as to how to escalate concerns to other agencies. The Safeguarding Adults Board has an Escalation process in place (developed following the Alan Safeguarding Adults Review). It is important that this is further shared to all agencies supporting adults with Care and Support needs in West Sussex to ensure all workers know the clear route of escalation of concerns.

6. Further actions and work for the Safeguarding Adults Board

6.1. The Safeguarding Adults Review subgroup agreed this report on the 26 April 2019, and a Learning briefing will be prepared for sign-off at the Safeguarding Adults Board meeting on 13 June 2019.

6.2. The report will be shared with Board Partners for wider learning and registered with the RiPfA/SCIE National SAR Library for reference and identification of key themes.