Cornwall and Isles of Scilly Safeguarding Adults Board

Safeguarding Adult Review
Executive Summary

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As with all cases where we seek to learn from circumstances prior to the death of a person it is important that we recognise the human cost involved. The loss of a family member, friend, member of the community or person we are seeking to help and support can bring sadness and a number of other emotions. As the lead reviewer I would like to offer my sincere condolences to anyone who has been touched by this case.

A Safeguarding Adult Review (SAR) was commissioned by the Cornwall and Isles of Scilly Safeguarding Adults Board (SAB) following the death of CT a 64-year-old man in January 2021. CT died having suffered significant burns and smoke inhalation during a fire at his home address. There was a significant history of contact with agencies over a prolonged period prior to his death, these included adult social care, health professionals and care providers.

The review found evidence that CT was independent and active prior to suffering a stroke in 2010. His family have described the coastal walks he would enjoy and his love for the outdoors. CT was a smoker, and he drank alcohol, the extent of his drinking is unclear but there is no evidence that it had a direct impact on his cause of death. The fact that he smoked is significant and impacts on many of the issues considered in this review.

The review focuses on a period from May 2010 to the date of CT's death in January 2021. This period was selected because this covers the period where agencies had significant contact with him.

A hybrid approach was adopted seeking information from agencies through written reports (chronologies and individual management review reports, practitioner events and one-to-one interviews which explored process, policy and key practice events. The review engaged with CT's family, and this provided significant information.

The review has examined key practice episodes across all agencies, concentrating on professional practice, multi-agency working and impact. This has afforded the review the opportunity to maximize reflection and learning for individual agencies and the wider partnership.

Following examination of the key practice episodes six key findings were identified.

- ***The benefits of early engagement with vulnerable adults:***

  CT suffered his first stroke when he was in his 50's. Prior to this he was a fit, active, independent man. Evidence from his family pointed to the fact that the stroke had impacted on his ability to look after himself. Early intervention and support in cases such as this is vital if opportunities to improve individual's quality of life and reduce the risk of further deterioration in circumstances that will require increased intervention at a later stage.

- ***Multi-agency planning and risk assessment:***

  There was a lack of multi-agency planning and risk assessment in this case. Multi-agency risk assessment based on good information exchange is vital to produce effective plans for individual's care. Recommendations regarding existing systems are made in the review.

- ***Developing trusting relationships with vulnerable adults:***

  Affording professionals time to develop trusting relationships with vulnerable adults is key to providing the best care and outcomes for that person. The review found that carers for CT were varied in their skill level and approach. This is compounded by increased demand and reduced capacity.

- ***Recognising the impact of significant events in a vulnerable adult's life:***

  The impact that significant events can have on an individual's life must be recognised and mitigated against. In this case these events coincided with increased safeguarding referrals and contacts to adult social care. There is no evidence that the significance and impact were recognised, discussed or plans made to support him. Whilst some events including significant medical issues are easily recognisable others are perhaps more subtle but can be traumatic and impact on a person. Change of allocated social worker or the inability of a family member to visit through illness were significant in this case but went unnoticed.

- ***Information sharing and responses to agency referral:***

  Information exchange is a consistent theme across several Safeguarding Adult Reviews (SAR's). This review has found that whilst there was some exchange of information, particularly between Adult Social Care and single agencies there was a complete lack of multi-agency information sharing. These single agency exchanges limited understanding and context. There were a number of missed opportunities to bring agencies together so a full understanding of the individual's circumstances could be gained, and multi-agency plans put in place.

- ***The heightened risk of fires whilst using emollient creams:***

  CT used emollient creams for a significant time. This, together with his smoking and restricted movement created a heightened fire risk that was not appropriately addressed.

Conclusion

The review made eight recommendations that seek to help the Safeguarding adults board embed learning and improve multi-agency practice. It is important to respect CT as an individual and learn lessons from his death, but it is also incumbent on the Safeguarding adults board to recognise that there may be a significant number of vulnerable adults in very similar circumstances. Therefore, lessons learned from this review should be disseminated and action plans developed to deal with longer term solutions. The Safeguarding adults board may wish to consider the findings regarding the heightened risk of fires whilst using emollient cream as being worthy of National consideration.

Recommendation 1 – The Safeguarding Adults Board seeks assurance from all partners that they recognise the positive impact of early intervention and support when vulnerable adults suffer life changing illness or injury. This should include recognition of risk, how to seek and create a multi-agency response, pathways to support and advice to individuals/families. Where there are gaps in this provision the Safeguarding adults board should challenge and support partners to develop robust systems.
Recommendation 2 – The Safeguarding adults board should assure itself that multi-agency planning takes place to support vulnerable people who wish to return to or remain at home and have capacity to do so. It is important that this planning includes all aspects of the person's life and goes beyond physical risks. All aspects of mental well-being should be considered, and the plan should include consultation with all key stakeholders, family and the person involved. The role of the key worker is critical and consistent key worker support is best practice.
Recommendation 3 – The Safeguarding adults board undertakes an audit of all Adult Risk Management meetings called in the last twelve months. The audit should consider who calls the meeting and the adherence to policy. It should also consider the outcome for the individual concerned. This will inform the Safeguarding adults board of who is using the Adult Risk Management procedure, its impact and gaps in its application.
Recommendation 4 –The Safeguarding adults board should review the current Adult Risk Management policy and guidance. They should ensure Adult Risk Management meetings are used to deal with self-neglect issues. This review would suggest that the policy should encourage all agencies to call Adult Risk Management meetings rather than rely on adult social care. Meeting requests should include a rationale and detail any agencies who decline with their rationale.
Recommendation 5 – The Safeguarding adults board should review its self-neglect policy and best practice guidance (last reviewed July 2019) to ensure it is up to date and fit for purpose. This review should include a practice and outcomes impact assessment. This would afford the Safeguarding adults board the opportunity to consider the effectiveness of the policy. It would also allow the Safeguarding adults board to consider the benefits of promoting the document, particularly in terms of partners that should be targeted.
Recommendation 6 –The Safeguarding adults board should seek assurance from all agencies that when referrals are made information is checked via a number of sources. They should provide assurance that input is sought from the individual, family, carers (subject to consent) and other partners who can assist in the assessment and provide the best possible context so appropriate decisions are made. A dip sample should take place and results reported back to the Safeguarding adult's board.

Recommendation 7 - The Safeguarding adults board should use this case to promote the Medicines & Healthcare products Regulatory Agency (MHRA) & National Fire Chiefs Council (NFCC) messages and toolkit regarding the management of risks using emollients. The material available should be cascaded across all partner agencies so professionals, volunteers and families are aware of potential fire risks.
Recommendation 8 – The Safeguarding adults board should seek reassurance from the Integrated Care Board, all General Practitioners and dispensing chemists that they are aware of Medicines and Healthcare products Regulatory Agency advice on emollient creams. This case should be used to remind those that prescribe and dispense creams that they should consider the circumstances of the patient in terms of movement, capacity and smoking habits, giving appropriate warnings and advice to those who use these creams.