Safeguarding Adults Review into the death of SJ

Fatal Fire

Incident Date: 8 June 2015

Commissioned by: Gloucestershire Safeguarding Adult Board

Author; Trust Risk Manager,
Gloucestershire Hospitals NHS Foundation Trust

Report Date: April 2016

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EXECUTIVE SUMMARY

1.1 Introduction

SJ, a 68 year woman, lived alone in a semi-detached bungalow with communal entrance owned by a housing agency. She had a daily care package for personal hygiene needs arranged by the Health and Social Care agencies and a network of friends and family members who visited at varying frequencies. SJ was able to mobilise in her bungalow with the use of aids and was independent for preparation and cooking of her meals as well as transfers between bed, chair and between rooms.

On 8 June 2015 passers-by noticed smoke coming from the bungalow and unfortunately SJ was found inside having been overcome by the smoke. The source of the fire has been confirmed as the television in the lounge. An inquest undertaken on 15 November 2015 confirmed cause of death as smoke inhalation.

The Gloucestershire Safeguarding Adults Board (GSAB), following an initial information sharing briefing that included all agencies accessed by SJ, commissioned a more detailed review to identify any learning from the events. This review is outside of Her Majesty's Coroners Inquest process but may be shared with the Coroner.

1.2

Incident date:	8 June 2015
Incident type:	Fire
Agencies involved:	Health, Fire and Social Care
Actual severity of the incident:	Catastrophic

1.3 Involvement and support of relatives.

The Independent Chair of the GSAB contacted the relatives of SJ informing them of the review and inviting them to be involved. As a result the Chair of the GSAB, the GSAB Business Manager and the Independent Review Author met with family members and were able to learn of SJ's lifestyle and their understanding of services provided to her.

1.4 Involvement and Support of staff

All staff involved with SJ have been supported by their individual organisations' line management processes and through debriefs.

The Chair of the GSAB, the GSAB Business Manager and the Independent Reviewer described the process for the Review when meeting with staff, explaining that this was about shared learning and not about blame, inviting all staff to contribute to the review aiming to prevent recurrence

1.5 Rationale for GSAB Safeguarding Adults Review.

GSAB Safeguarding Adults Review sub group (SAR) commissioned the review following the recommendations of the Multiagency Information Sharing meeting 11 June 2015.

1.6 Care and Service Delivery Problems / Contributory Factors

- SJ expressed her concerns to all involved that if she made comments about her accommodation she would be moved into accommodation that did not allow cats
- SJ had an ability to divert conversations which made it difficult to have meaningful discussions about her accommodation and the risks associated with entering and exiting the property. While Health and Social Care providers made attempts to engage SJ in discussions with the risks associated with the space limitations, she expressed reluctance for another move which was a possible option
- Planned adaptations were in place to install handrails at the rear of the property at a later date. It is understood that there were conversations starting about adapting the access to the lounge with the Disabled Adaptations Surveyor

- Systems, while in place to ensure nursing staff employed by the community healthcare provider complete Safeguarding training, this is not so robust for other professional teams (therapists) and for staff employed by Social Care

1.7 Root Cause

- 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.

1.8 Main actions

- 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 persons 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

MAIN REPORT – FATAL FIRE

2. INCIDENT DESCRIPTION AND CONSEQUENCES

2.1 **Summary**

SJ, a 68 year woman, lived alone in a semi-detached bungalow with communal entrance owned by a housing agency. She had a daily care package for personal hygiene needs arranged by the Health and Social Care agencies and a network of friends and family members who visited at varying frequencies. SJ was able to mobilise in her bungalow with the use of aids and was independent for preparation and cooking of her meals as well as transfers between bed, chair and between rooms.

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2.2 Incident Date 8 June 2015
Incident type: Fire
Agencies involved Health, Fire and Social services:
Actual severity of the incident: Catastrophic

3.0 PRE INVESTIGATION RISK ASSESSMENT

SJ's Safety associated with potential for	Potential severity	Likelihood of recurrence	Risk rating
Fire based on use of open fire and deep fat fryer	Catastrophic (5)	Unlikely (2)	**Moderate Risk (10)**
Falls due to deteriorating mobility based on evidence provided by Daily Carers	Moderate (3)	Possible (3)	**Moderate Risk (9)**
Ability to exit property in an emergency without support	Catastrophic (5)	Unlikely (2)	**Moderate Risk (10)**

Assessment based on criteria contained in Model Matrix (see para 16. References)

4. BACKGROUND AND CONTEXT

4.1 Details of Support Services involved

- **Housing**

SJ lived in a semi detached bungalow owned by a Housing Agency. She had moved there in 2007 and was reportedly happy with that location as she lived with her cats. Access to the house was by steps at the front and back

- **Daily Care**

SJ received daily assistance with her personal hygiene from carers funded and arranged by the local County Council following assessment by the Local Authority's Health and Social Care Integrated Team at that time. This included ongoing input and assessment to meet her changing needs from Therapy Services (occupational therapy and physiotherapy) employed by the Community Healthcare Trust

- **Health needs as required**

SJ regularly accessed her General Practitioner and district nurse service for care of her skin. Other contacts with her General Practitioner involved consultations by telephone call or by home visit as SJ could not get to the surgery.

- **Social networks**

SJ was well known in the community with a network of neighbours and friends visiting and helping with shopping, maintaining the coal fire, the local vicar visiting to give communion, the vet visiting for her cats if required. Her brother and sister-in-law visited on a weekly / fortnightly basis delivering their sister food shopping for her and her cats.

4.2 Context

The review involved the above groups, learning of their interactions with SJ and each other in enabling SJ to maintain her independence in her preferred domestic setting.

5. REVIEW PROCESS

5.1 Terms of reference for the Review

- To establish an accurate timeline of the involvement of Health and Social Care with SJ and with each other
- To inform the GSAB of any issues arising from the review
- To identify any learning and agree actions based on the findings of the review if appropriate and to monitor its implementation
- To feed back to all Health and Social Care providers involved in the care and support of SJ in her own home
- To feed back to SJ's family on the findings of the Safeguarding Adults Review
- To agree learning points for wider cascade

5.2 The Review Schedule

- **Gloucestershire Safeguarding Adults Review Sub Group** (SAR) commissioned the review following the recommendations of the Multiagency Information Sharing meeting 11 June 2015. The GSAB identified an Independent Reviewer, employed by the Acute Trust as SJ had had no episodes of care with that Provider.

Timeline for review

Date	Activity
11 June	Multiagency information sharing meeting
24 July	Chair of Safeguarding Board / Head of Safeguarding Adults met with Independent Reviewer
August / September	Contact made with SJs family advising of plan to carry out review Request made to all Agencies to provide timeline of their involvement with SJ between 2011 – 2015
September / October	Meetings arranged with – Family members – Integrated Care Team (Health and Social Care) – Daily Care Providers

	Summary of conversation provided to participants and Investigator lead
November 2015	Inquest confirmed cause of death as smoke inhalation, accidental death
December2015/ January 2016	Drafting report
April 2016	Presentation of Report to GSAB

- **Independent Reviewer / Author of Report**

Trust Risk Manager (Gloucestershire Hospitals NHS Foundation Trust)

5.3 Scope and level of review

The Review aimed to understand processes for assessment of needs and communication channels between all service providers in the support of SJ.

The Review also aimed to confirm that staff employed by all providers involved with SJ had rigorous policies /protocols in place which were aligned with the Multi Agency Safeguarding Adults Policy & Procedures for staff to follow with appropriate training provided.

5.4 Investigation type, process and methods used

Preparation for review

- An initial information sharing meeting with representatives from agencies involved with SJ to learn of the extent of their involvement
- Appointment of an Independent Reviewer to undertake the review and provide a briefing to them
- Identification of staff involved in the provision of both social services and health care and gain their recollections of the situation prior to the event

Review

- Preparation of timeline for SJ and provider agencies' involvement since 2011
- Review of Countywide and Service Provider policy/procedures associated with the care of adults with care and support needs as well as specific to the care needs of the SJ
- Meet with key providers to appreciate processes for providers' involvement with SJ

Analysis of review

- Identification of any red flags/missed opportunities for the Service Providers involved with SJ
- Confirm the role of the SJ/Provider in the contributory factors associated with the learning from the review

6.0 INVOLVEMENT AND SUPPORT OF RELATIVES

6.1 The Chair of the GSAB contacted the relatives of SJ in September 2015 informing them of the planned review and inviting them to be involved. As a result, the Chair of the GSAB, the GSAB Business Manager and the Independent Reviewer met with family members and were able to learn of SJ's lifestyle and their understanding of services provided to her.

6.2 The GSAB and Independent Reviewer were made aware that a formal complaint had been made by the family of SJ and this has been investigated with a response provided through the County Council's complaints process. Details do not feature in this report

7.0 INVOLVEMENT AND SUPPORT PROVIDED FOR STAFF INVOLVED

7.1 All staff involved with SJ have been supported by their individual organisations' line management processes and through debriefs.

7.2 The Chair of the GSAB, GSAB Business Manager and the Independent Reviewer described the process for the Review when meeting with Service Providers, explaining that this was about shared learning, inviting all staff to contribute to the review.

8.0 INFORMATION AND EVIDENCE GATHERED

8.1 Timelines

The GSAB Business Manager requested providers involved with SJ to provide a timeline of their involvement since January 2011. Summary entries were requested for 2011 – 2014, with a detailed account provided for 2015. Timelines were provided by

- Housing Provider
- Gloucestershire County Council
- Primary Care – General Practitioner
- Village and Community Agents
- North Cotswolds Integrated Care Team (Gloucestershire Care Services/Gloucestershire County Council)
- Daily Care providers

The Fire and Rescue Service and Gloucestershire Care Services' Telecare Service had no contact with SJ.

A floor plan of the bungalow was also obtained from the housing provider to illustrate the layout of the Service User's property.

8.2 Council Based shared information system (ERIC)

Gloucestershire County Council provided the Independent Reviewer with a copy of the electronic record of contacts between SJ and the Integrated Care Team (Health and Social Care)

8.3 Transcriptions of meeting with key service providers

The GSAB Business Manager prepared transcripts of discussion with the following service providers

- Daily Care providers
- North Cotswolds Integrated Care team (Gloucestershire Care Services/Gloucestershire County Council

8.4 Transcription of meeting with SJ's immediate family

The GSAB Business Manager prepared transcripts of discussion with SJ's brother and sister-in-law

8.5 Policies/ Procedures/ Reports

The Independent Reviewer had access to organisations' and countywide Safeguarding policies and external reports (Care Quality Commission)

9.0 DETECTION AND ESCALATION OF CONCERN

A Safeguarding Adults Multiagency Information Sharing Meeting was held on 11 June 2015 chaired by the Prevention Strategy Manager for Gloucestershire Fire and Rescue Service. At this meeting all agencies were expected to provide an overview of their involvement with SJ. As an outcome of the meeting it was recommended that the event be referred to the GSAB Safeguarding Adults Review (SAR) Sub Group for consideration of a review aiming to identify any learning.

This recommendation was actioned by the Independent Chair of the Gloucestershire Safeguarding Adult Board

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10.0 CHRONOLOGY OF INVOLVEMENT OF HEALTH AND SOCIAL CARE PROVIDERS

Summary
SJ was a 68 year old female, registered disabled and living alone in semi-detached bungalow. A care package was implemented in 2007 – focusing on supporting daily personal hygiene needs. SJ had requested rehousing in 2007 following issues with a neighbour hence relocation to current address. Initially able to mobilise in and out of the bungalow with assistance and driving a car, however following a non health and social care incident while driving she ceased this activity. Becoming house bound with increasing immobility due to weight gain, leg ulcers, and access / mobility issues. Cleaning services was arranged privately by SJ with Guideposts, however arrangement broke down in 2013

Health needs included long term management of urinary incontinence and leg ulcers. District nurses visited to attend to leg ulcers.

Physio/ OT involved to assess for mobility aids supporting living at home

Date	Provider	Summary of involvement	Comments
2011			
	Housing Provider	Service of gas central heating by contracted engineer	
	Provider of Daily Care Package	Visiting daily in the morning to assist with personal hygiene. It was noted that on occasion SJ was more receptive to some carers than others. This led to refusals of showers etc. Noted that brother and sister-in-law visit weekly with shopping	
	GP/District Nurse	DN attended for leg dressings with courses of antibiotics prescribed for associated local infections. Calls made to Out of Hours (GWAS) and home visits made by GP for infected legs and anxiety state brought on by death of her cat	
	Gloucestershire County Council (ERIC report)	Daily Care provider advises that SJ wishes to reduce care package Telephone call requesting OT assessment to support charity application for replacement riser/ recliner chair – referral actioned	Rationale for request - see entry below
	Integrated Community Team (Social and Occupational therapists)	Request for reduction of care package due to costs, continues as funded but SJ requests daily carers to attend later in morning Request for new chair as transfer difficult and needs to elevate legs. OT assessment required Feedback from DN – visiting alternate days – recent increase in weight and leg wounds. Encouraged to rest in bed but has declined hospital bed. Difficulties in resourcing alternative chair to assist in raising legs. OT assessments made to support identifying suitable chair. SJ able to mobilise slowly and with difficulty around home using kitchen trolley. Having difficulty getting in and out of chair. Self reporting she is independent for washing and dressing although had help from carers. Able to transfer in/out of bed, use the toilet and manage	Chair takes 5 months to be replaced as difficulties with funding and needing assessment for height of chair due to stature

		continence aids independently. Does not go out of doors without assistance and uses wheelchair. Charitable funding sought Riser/recliner chair delivered with pressure relief on seat and legs. SJ to arrange ongoing service	
2012			
	Village/ Community agents	SJ requested assistance about her Disability Living Allowance. Agent also contacted Healthwatch Gloucestershire for information about grants and charities to help the service user financially. No other help required as other services involved and relatives in the area	Relatives also elderly and live more than 20 miles away – non direct route
	Housing Provider	Service of gas central heating by contracted engineer and repair of minor faults reported by SJ. These were – Repair to sliding doors serving her and her neighbour's bungalows – Clearing of blocked drain – Fixing of smoke alarm	Smoke alarm fitted in hall of bungalow See appendix
	GP/District Nurse	Telephone call with GP – chest infection for antibiotics. Contacted after 3 days, antibiotics made SJ feel sick however improving anyway SJ develops dental abscess but cannot find dentist with wheelchair access	Increasing immobility outside of the home environment
	Gloucestershire County Council (ERIC report)	Telephone call requesting OT assessment for replacing perching stools in kitchen and bedroom and also for toilet seat. Mobility aids for SJ listed as – trolley with wheels – walking stick – recliner chair – wheelchair – handrail by toilet – perching stool to guide self in bathroom Reported SJ not able to go out unless by ambulance so unable to attend clinics – referrals actioned	
June	**Integrated Community Team (Social and Occupational therapists)**	Request to review financial arrangements from Village Agent as SJ now over 65. Referral for replacement perching stool – **Proportionate Assessment** concludes moderate impairment of mobility using walking stick or wheeled trolley. Poor skin on legs, prone to weight gain due to limited mobility. Independent with bed chair and toilet transfers. Able to dress/undress with help only for lower limbs. Able to access shower, assistance to wash hair, dry lower body and apply creams. Able to prepare drinks and meals sitting on perching stool, assistance required for housework, cleaning and shopping. Unable to access garden	Timeline provided by ICT includes '*your mobility has reduced; you struggle with access at front and rear of property and say you are at risk of falling here' ….you are able to get access the front {of*

November		due to steep steps. In relation to falls SJ reported a fear of falling. Able to get in and out of brother's car Deep step in the front door to access (once inside the porch). Brother and wife take SJ shopping; friend lays fire and tends garden, carers support for personal care and some household routines. Identified as being able to call for help in an emergency. Perch stool provided for kitchen and bathroom Recliner chair broken - ?repair under SJ's insurance	*the bungalow} but have to hang on to the rail. You get exerted and anxious when doing it'* **Calling for help by use of telephone in house – landline placed next to chair in lounge**
2013			
	Housing Provider	Service of gas central heating by contracted engineer and repair of minor faults reported by SJ. These were – Repairing of heating – Fixing a dripping tap – Repairing a leak to overflow	
	Provider of Daily Care Package	SJ found on floor, paramedic called, no injury SJ's chair broken	The mention of a fall should have triggered a discussion related to Lifeline/ Telecare.
February March/ April/ May/ June December	**GP/District Nurse**	Telephone reviews and home visits – congestion, ear symptoms persist but otherwise no signs of infection. Hearing buzzing noises – contacted GP, OOH with same symptoms. Becoming anxious about becoming deaf. GP suggested visit surgery for audiogram – SJ unsure she would be able to attend- domiciliary audiogram only available privately funded. Telephone call with suspected UTI. Unable to get to surgery – so medication prescribed based on antibiotic history	
January	**Gloucestershire County Council (ERIC report)**	Self referral requesting OT assessment for replacement riser/ recliner chair - SJ will not have anywhere to sit once chair removed to be repaired. She is unable to get off sofa and will only have use of perching stool which does not have a back. SJ worried she will have to stay in bed while it is being repaired. She has poor mobility and uses trolley and walking stick in the home and a wheelchair when going out. Able to get in and out of bed independently and can make meals and drinks. Sister-in-law and friend take her food shopping. No reported problems with cleaning and laundry Referral actioned	
January	**Integrated Community Team (Social and Occupational**	Referral for replacement of recliner chair, SJ refuses raising of sofa / use of wheelchair as interim measure	

	therapists)		
2014			
	Housing Provider	Service of gas central heating by contracted engineer and repair of minor faults reported by SJ. These were – Replacing fire basket (after sweeping chimney) – Unblocking drains – Repairing shower – Asbestos survey undertaken	
January August	**Provider of Daily Care Package**	SJ's stick is broken – felt to be grabber stick as SJ does not use walking stick. Unable to obtain replacement from Pharmacy, awaiting OT Unable to access SJ who was in bedroom as fireguard in way of door	
	GP/District Nurse	Telephone call – dental abscess needs domiciliary dentist as housebound but off sick, needs antibiotics Telephone call – low back pain ? urinary tract infection as similar to before – treat this as 'carer too busy to attend'	
February November	**Gloucestershire County Council (ERIC report)/**	Self referral - requesting assessment for replacement perching stools SJ was sitting in kitchen when handle snapped off nearly causing her to fall. This has happened previously resulting in SJ dislocating her shoulder Bathroom stool needs replacing as hole in seat. Self referral – requesting OT assessment as Housing Provider is arranging a kitchen refurbishment	The mention of a fall should have triggered a discussion related to Lifeline/ Telecare.
February	**Integrated Community Team (Social and Occupational therapists)**	**Annual review of care package** - identified the following needs- assistance with daily showering, maintaining personal hygiene, changing bedding as required, monitoring of pressure areas, removing food from cupboards and keeping kitchen hygienically clean after meal preparation. SJ unable to attend to household tasks – support required to find cleaner. Noted that SJ needs support in completing paperwork as can get muddled, referred to Village Agent for support in form filling. Able to prepare drinks and meals sitting on perch stool, transfer and mobilise around the bungalow independently. Recognised as needing assistance to get out of bungalow as has difficulty with steps and only able to walk a few steps as becomes fatigued, then requiring a wheelchair. Would like to get out to go shopping but needs someone to help her out of the accommodation and wheel her round supermarket. **SJ was identified as able to phone for help in an emergency but would need support to get out of the property if needed**.	

June November-December		Replacement of 2 broken perch stools and provision of handy reacher **Assessment of personal care with carer –** documented 1 deep step into front door, SJ requires assistance to get in and out of property. Unable to maintain hygiene in kitchen, carers tidy up and mop floor to reduce risk of falls. SJ only mobilising short distances with kitchen trolley/ walking stick **Findings –** access to property by keysafe as SJ unable to answer door due to poor mobility. Able to stand from riser recliner chair and mobilise with stick and trolley. Urinary continence note. Fall assistance required for showering drying and dressing to maintain skin integrity. Only showers weekly with carer assisting in strip washes on other days. OT noted property unkempt, carers noted to have mopped floor due to grease on floor. SJ recorded to be at high risk of falls due to limited space in kitchen and items on floor. Discussed cleaners but SJ had lost phone number of Age UK. Rail provided by sink in bathroom to aid transfer from perching stool and referred to Housing Agency re thermostat for shower OT involved in plans for kitchen modification. Also noted that rotten wooden rails on steps at rear door. 2x 5inch steps at front with grab rail but SJ has difficulty managing step. Record indicates 'mobilises with trolley indoors and transit chair outdoors'	Risk of falls should have been a trigger for possible referral to telecare involvement
2015			
February March May	**Housing Provider**	Pull handle renewed on door As part of kitchen replacement programme Building and Disabled Adaptations Surveyors with OT met with SJ to discuss design of kitchen and incorporate her requirements Suggested that OT review assessment of bathroom and access. SJ advised she received care in the morning and she did not wish to move from the bungalow. She felt she had plenty of help and could manage SJ reviewed plans with Disabled Adaptations surveyor – SJ again states she is happy in her bungalow and does not wish to move	No mention of repair to rear handrails
March	**Provider of Daily Care Package**	Discussed with OT re ability to access shower for personal hygiene needs as lot of clutter in bathroom. Confirmed that the ability to assist SJ for showering depended on the carer attending Also requesting information about skin integrity – informed that historically SJ's skin had never been good and that the District Nurse visited regularly. Also confirmed that mobility had declined with difficulties accessing the toilet and that often the toilet seat was broken. Aware of plans to refurbish the kitchen	

April June		Private cleaning call put in place at SJ's request OT arranges to observe carer delivering care to assess mobility and accessing of bathroom. Planned for 9 June	
January	**GP/District Nurse**	Dental abscess – trying to get domiciliary dentist to visit. Antibiotics prescribed	
June	**Gloucestershire County Council (ERIC report)**	Nil prior to notification of fire in accommodation resulting in SJ's death	
February March May 08.June	**Integrated Community Team (Social and Occupational therapists)**	Contact made with Housing to repair rotten rails at back door and also requesting details of kitchen upgrade Meeting with housing provider to confirm details of kitchen upgrade with SJ Telephone to Daily Care providers for information about personal care routine as shower/ bathroom cluttered by household objects. Informed by Care Providers that SJ is supported to have a shower by carers when she wishes but that the SJ's mobility had deteriorated over the last 12 months. OT visit planned for next day. **OT assessment** – SJ has difficulties managing activities of daily living in current home environment. Discussion with SJ acknowledges current housing is not ideal but clear she does not want to move. Difficulties in leaving premises - but unable to install ramp due to space restriction. Request review of ramping at rear of property. SJ categorical about not moving, options discussed but she indicates she could not face another move and would not like to move away from village where she has lived most of her life. Concerns confirmed about increasingly poor mobility and access via front door Confirmation of replacement rails ordered for rear of property – potential for new access where window is in lounge to improve accessibility in / out of property Plans made to undertake joint visit with agency to assess SJ's personal care and issues with shower – unable to confirm with SJ as no answer	

11.0 FINDINGS

11.1 Findings arising from the investigation – Specific to SJ

11.1.1 SJ

SJ, a 68 year old woman, was born with spina bifida. She had enjoyed an active and independent life, managing associated continence problems throughout her life. In 2007, reduced mobility and skin integrity concerns contributed to the arrangement of a daily care package arranged by the Local Integrated Care Team (Health and Social Care) to support her personal hygiene needs (washing and dressing). SJ used different aids to assist her mobility around her property i.e. trolley on wheels, walking/ grabber stick etc. and was independent for getting in and out of bed and for preparation of meals.

SJ was known to many people in the village having lived in the location since 1986, attending church and singing in a choir as well as carrying out her own shopping until her mobility decreased, limiting her ability to leave her bungalow. SJ then relied on others to help her with cleaning her bungalow, minor gardening, setting and cleaning the open fire as well as shopping for her and her cats. Physically, partly due to her reduced mobility, this had led to weight gain and her skin had suffered so she received regular visits from district nurses for leg ulcers although her sacrum retained its integrity. SJ had pet cats and their welfare was a main focus for her on a daily basis. She was concerned that if she made any comment about her lifestyle / accommodation then she would be transferred to another accommodation that did not allow residents to keep pets and her cats could be destroyed. This concern was also reported by SJ's family members, daily care providers and the integrated care team.

SJ had an ability to divert conversations which made it difficult to have meaningful discussions about her accommodation and the risks associated with entering and exiting the property. Health and Social Care providers did attempt to discuss these limitations and explore the option of moving, SJ however confirmed she could not face another move. The situation with regard to SJ's cats if she moved however seems not to have been discussed specifically and this was felt to be main stream to SJ reluctance to engage.

11.1.2 Feedback from SJ's family

The family members confirmed that their sister cared deeply for her cats and was anxious that if she raised any concerns about her accommodation or other difficulties then her cats would be taken off her and she would be re-housed in accommodation that did not allow cats.

The family members indicated that initially on moving to the address, their sister had been able to leave her bungalow which has 2 steps (depth 5 inches approx.) at the front entrance to use her car to visit people, shopping or other errands as she wished. This had ceased though and she had become housebound due to her reduced mobility and difficulties getting in and of the house as there was no ramp or grab rail. They reported that they had encouraged their sister to ask for adaptations to the entrance however she was reluctant to do this because of her cats. The family questioned why the professionals visiting SJ did not initiate these adaptations.

The family confirmed that they visited their sister regularly (between weekly and fortnightly) to bring her shopping for the cats and herself and between times they were aware neighbours would help with getting milk, bread etc. from local shops, tidying the garden or laying the open fire.
The understanding of the family members was that the carers came in daily and supervised her shower in case she fell (she had apparently fallen previously near the shower) and helping dry her lower limbs. The family members were also under the impression that the carers would 'tidy and hoover the bungalow, put washing on and clean the kitchen floor' believing that the carers were there for 45 minutes each day during the hours of 7 – 11 am although the time of arrival varied.

11.1.3 Recollections from SJ's Daily Care Providers

The Daily Care Provider confirmed they had been the provider for day to day care for SJ since 2007 and since she was at that address. The care they provided was for assistance with washing and

dressing in the morning – initially carried out late morning but then rearranged based on SJs request to change the time to about 09.00am. They reported that SJ was nearly always up when they arrived and they had access to the accommodation by a key kept in a key safe outside the property. A retrospective review of records confirmed that SJ had fallen in the property over the years (at least once a year approx.) however she did not want to finance a telecare resource and did not want to report it as she felt she may be hospitalised and then not be able to return home to her cats.

It was confirmed that SJ spent most of the day in her lounge watching television. The lounge had an open fire which was kept 'small' and tended by the neighbour's son on a daily basis. There was a telephone in the lounge by her chair and also one in the bedroom. The recollections of the carers was that there was a smoke alarm in the lounge - this is at variance with the recollections of the family who place it in the hall way between lounge/ kitchen and bedroom

The carers describe the property as small and containing a lot paperwork and they were sometimes asked to move piles if she was expecting a visit from the Integrated Care Team – however next day the items would be back in place. They were also led to believe that the family visited weekly and took SJ shopping however questioned this in retrospect as the shopping would be left in the kitchen waiting for them to unpack and put in cupboards. They never met family members.

The carers did not feel that SJ felt socially isolated as she had several daily visitors and with her television this provided topics for conversation. The Carers describe SJ as a person who always ensured she was clean and well presented and giving no indication of dissatisfaction with her surroundings, but her main focus was caring for her pet cats

11.1.4 Recollections from the Integrated Care Team

The Physiotherapy, Occupational Therapy and Social Care staff involved with SJ have indicated that they found her to be a proud woman who valued her independence. She did have some difficulties with thought processing when dealing with financial matters and following appropriate assistance made decisions whether to carry forward or not. They remember that if SJ was asked about specific issues that she did not want to discuss, then she would divert the conversation along another pathway indicating that the earlier topic was not for discussion.

As can be seen from the time line – members of the Integrated Care Team recognised SJ's difficulties and were moving along the pathway aiming to try an improve access however acknowledged that this was slow due to difficulties with engagement from SJ. An example being when requested to review how SJ exited the property, she indicated that they could do that later and it did not take place. The Integrated Team had also been led to believe that the family members visited weekly and either bought her shopping or took her out shopping. They never saw the family members and as SJ was deemed to have mental capacity (see para 11.1) they had no remit to include them in discussions for ongoing adjustments/assessment to support SJ living independently.

Based on the difficulties in engaging SJ about her ability to access the accommodation, the Integrated Care Team were asked if this should have been escalated to senior members in their organisation – they did not feel this was needed as gentle progress was being made and the plan for modification of the kitchen in June/July may have demonstrated how life could have been made easier for SJ.

11.1.5 Mental Capacity and communications between the teams/Family

SJ was perceived by all those involved with her to have mental capacity although no formal assessment was carried out. (*The national guidance for Mental Capacity states that a person must be assumed to have capacity unless it is proved otherwise, therefore this would be the reason for an assessment to have not been appropriate*). Indeed there is no evidence that she did not have capacity and this was an underlying theme arising from discussions with the carers and Integrated Care Team preventing them from engaging with the family members etc. to realise a more complete picture of SJ's lifestyle and concerns. An example of this is described by the perception of the

ICT/carers that the family visited weekly on a Friday and took SJ shopping and the family believed that the carers provided a cleaning service for the accommodation.

The company providing the daily carers use a system whereby SJ was left with hand held notes for the daily carers to add their comments based on care provided. The ICT would also access these notes, the family members however were not made aware of this 'journal' by SJ and it was destroyed in the fire. While it is recognised it is the service user prerogative to share or not to share the contents with relatives this may be an area to encourage with other service users to enable a more holistic understanding for all parties involved. It may need sensitive discussion with a service user involved to gain their permission for increased sharing of information and possibly the journal could include the consent of the service user to share with family as well as encouragement for them to do so inside the cover. There is no record of any such discussion with SJ.

11.1.6 Ability to get in and out of home

SJ's accommodation was a semi detached bungalow with access at the front by two steps and sliding door leading into a communal porch for both bungalows. As mentioned in 11.1.2 – there was no ramp or handrail in place for SJ to access to help with leaving or entering the property. The rear door to the property had 5 steps which were described as 'steep' and again without an effective hand rail.

Family members, carers and the ICT as well as visitors all appreciated SJ's difficulties in exiting and entering her bungalow and the ICT in their feedback indicated that the housing provider was trying to resolve this issue. This is not backed up by information received by the housing agent.

The carers and ICT were led to believe that the family members visited regularly (weekly) and assisted SJ down the steps and into their car to go shopping. This activity did not happen and when SJ was asked to demonstrate how she got out of the bungalow supporting mobility assessments, she side stepped the issue by changing the subject.

The GP notes also document that the patient was not able to attend the surgery for audiometry as housebound, and there were several failed attendances for screening. All consultation with the GP was by telephone or by home visits.

Members of the Occupational Therapy team were concerned at the inability of SJ to leave the property in an emergency however were dealing with this by themselves by gentle persuasion and had not escalated to their seniors at this stage. This was a missed opportunity to put in place means for alerting services / key contacts in an emergency

Recent ICT records demonstrate plans for improved access via the rear of the property and discussions focussing on a new access into the lounge had been suggested to SJ with involvement of the Disabled Adaptations Surveyor. There had been confirmation of the ordering for hand rails for the rear of the property.

11.1.7 Fire Risk Assessment

No fire risk assessment was undertaken of SJ's property although several service providers recognised SJ would have difficulty exiting the premises in an emergency. The providers also described several triggers that could contribute to a fire should it start, including an open fire (used on a daily basis), frequent use of a deep fat fryer and piles of flammable material (papers) in close location to the open fire as well as obstacles on the floor.

This was a missed opportunity for all Service Providers visiting the home to suggest to SJ that the Fire and Rescue Service visit to provide advice on fire prevention. The Fire and Rescue Service have indicated that they are developing an advertising campaign for staff and public so that this can be dovetailed into agency awareness training. They have also met with the Care Providers to advice on assessing premises.

11.1.10 Access to emergency helplines e.g. Telecare

Gloucestershire County council operates a Telecare helpline service supporting people with issues about '*general safety, medication management, falls, purposeful walking, health, memory concerns, carers stress'*. This service provides a 24 hour monitoring centre where on contact they will call named family, friends, carers or 999 to ensure the patient is safe and well. This service is provided free or self financed based on a risk assessment basis (see para 16 References). The Independent Reviewer has not been able to access any documentation of the formal risk assessment for SJ for this resource however carers, family and the ICT all indicate she would have had to provide contributions as she did not fall under any of the categories listed above and SJ was concerned about the ability to fund this. It is questioned whether complete information was available when making these assumptions as the Care Provider reported she had fallen on an annual basis at least and had suffered injuries and the Integrated Care team assessed her as at high risk of falling in June 2014.

The ICT and Social Care team recognised that from their knowledge of SJ frequency of falls, she did not meet the criteria for a funded Careline. However an exception should have been explored given the documented concerns about mobility and access. It is noted that for Careline to have been installed, 2 emergency responders living locally would have had to be identified and while family members may not have been appropriate (as outside the locality); other contacts may have been identified within the village. These options were not explored and at this time there were no other alternatives and this had been identified as a gap in provision. The fire occurred in June 2015, the same week the Gloucestershire Fire and Rescue Service started a pilot in the Cotswolds of them being named as one emergency responder.

Referral to this service is an area for review for the professionals involved with caring for vulnerable adults who are housebound, however it is unsure whether this would have prevented the outcome.

11.2 Findings Arising from the Investigation – Safeguarding Awareness

11.2.1 Daily Care Provider

- **Safeguarding Awareness and Training**
  The company providing the daily carers confirm that all staff complete safeguarding training on induction and then on an annual basis. This is monitored by a central training database and flagged to individuals when updates are required. Following the event, the company invited the Fire Service to meet with staff and guidance has been developed using flash cards to guide staff on the fire risk based on the level of contents, and presence of possible sources of fire so supporting request to them to carry out Fire Risk assessments for service users. This may be of use for other providers.

- **Communication**
  The Provider commented that they had minimal feedback on the progress of ongoing issues for SJ escalated to the Local Authority and were reviewing ways to improve this.

11.2.2 Locality Provider (Integrated Care Team)

- **Safeguarding Awareness and Training**
  It was confirmed that while systems are in place to ensure nursing staff in the community healthcare provider complete Safeguarding training, this is not so robust for other professional teams (therapists) who have an increased level of involvement with more vulnerable adults in their own homes. A recent Care Quality Commission Inspection for the Community HealthCare Provider commented on this in their report for the organisation and an action plan has been agreed with its implementation monitored by the Gloucestershire Clinical Commissioning Group and NHS England.

  It was confirmed that while systems are in place to ensure nursing staff in the community healthcare provider complete Safeguarding training, this is not so robust for other professional teams (therapists/ social services) who have an increased level of involvement with more

vulnerable adults in their own and a formal audit around 'practice, process and standards' is to be undertaken.

11.3 Missed Red Flags

- **Deteriorating mobility**
  All health and social care providers recognised that SJ's mobility was deteriorating. However while adaptations to the accommodation were made for the interior through provision of grabber stick, trolley on wheels and perch stool and plans for a refurbishment for the kitchen, no adaptations had been carried out specifically to ensure SJ was able to enter and leave the property in an emergency or for normal day to day activities.

  While the ICT records demonstrate plans for improved access via the rear of the property and discussions focussing on a new access into the lounge had been shared with SJ with involvement of the Disabled Adaptations Surveyor. This may be seen as delayed in recognition of a person's deteriorating mobility

- **Inability to exit / access the property**
  The Health and Social Care Providers were informed that SJ was leaving the accommodation to go shopping with her family. However this is against a documented background of inability to attend dental appointments, GP or hospital appointments since 2012 because she was housebound.

- **Sharing of information/ assessments between Health and Social Care Providers**
  The maintenance of separate records for each provider without triangulating concerns or issues has contributed to all organisations working without complete details so not fully appreciating the extent of the issues with SJ's ability to exit or access her property.

- **Difficulty in engaging SJ in conversations about her accommodation**
  SJ chose to not discuss issues she was uncomfortable with for whatever reason i.e. cats, finance etc., and diverted conversations to a more acceptable topic.

- **Recognition of potential Fire Risks**
  Several sources for fire were recognised, open fire, clutter, deep fat frying in the chronology but not acted upon to refer or carry out a fire risk assessment either locally or by referring to the fire service for prevention.

11.4 Notable practice

- The demonstration of care for SJ by her daily carers
- Neighbours in their support of SJ on a daily basis

11.5 Care and Service Delivery Problems / Contributory Factors / Potential Root Causes/ Recommendations

Table 1 – Relationship between Care and Service Delivery Problems / Contributory Factors / Potential Root Causes/ Recommendations

Care and Service Delivery problems	Contributory factor	Root Cause	Recommendation
SJ was concerned that if she made comments about her accommodation she would be moved into accommodation that did not allow cats	**SJ – interpersonal relationships - engagement with services –** SJ diverted conversations whenever she felt it may have a negative effect	**SJ's belief that her pets were more important to her than other issues**	
Health and Social Care providers did not proactively take forward issues with accessing/ exiting accommodation due to SJ's ability to divert conversations	**Communication management - lack of effective communication with Users about risks –** staff did not pursue concerns about access/exit of accommodation when diverted **Team factors – failure to seek support** from seniors when faced with difficulties to progress with SJ		Explore as scenarios in training
Appreciation of number of times patient had fallen making her at a higher risk for recurrence and possibly reducing the need for the SJ to contribute to the funding of Telecare etc.	**Communication – written communication – all records not stored together and available when required –** different providers kept separate records and there was no facility to easily search to identify falls from documentation **SJ - engagement with services –** SJ unwilling to contribute to Telecare Service herself	**Multiagency working with separate documentation requirements**	review potential for handheld records to list key risk and dates occurring i.e. Falls
Red flags for fire risk not acted upon	**Task factors – decision making aids - aids not available -**	**Staff did not refer to Fire Service for review based on observations of accommodation for SJ**	Fire Service has provided guidance for referral for Fire Service review based on picture flash cards on clutter or other risk factors
Staff not completing training on safeguarding awareness	**Tasks guidelines – guidelines not followed –** staff non compliant with undertaking organisations training on Safeguarding awareness in line with National requirements – **Organisational – safety culture -**		Action plan developed by organisations to improve compliance

Care and Service Delivery problems	Contributory factor	Root Cause	Recommendation
	ineffective monitoring of compliance with attendance at Safeguarding training		

11.6 Root Cause

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.

11.7 Lessons learned

- Guidance and increased awareness for referral for formal Fire Safety Assessment for Health and Social Care Providers
- If service users are avoiding discussion about aspects of living these need pursuing to understand detail
- Aim to involve family members if they are involved in a service user's ability to maintain independence recognising mental capacity limitations but working with the service user for a wider discussion to reduce misunderstanding/misinterpretations

12. CONCLUSIONS

SJ had experienced increasing difficulties with mobilising around her accommodation having become housebound. She was reluctant to raise any issues with Health and Social Care providers who were proactively supporting her in maintaining her independent lifestyle as she was worried that if it was agreed she be re-accommodated then the new accommodation may not agree to pets.

Health and Social Care providers, while aware of SJ's difficulties in mobilising, had been prevented in taking these concerns forward by her limited engagement with the providers and her primary concern for her cats' welfare. However this should have triggered further safety assessments to reduce the risk of falls, potential for fire etc.

13.0 ACTIONS

- 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 persons 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

14.0 ARRANGEMENTS FOR SHARED LEARNING

Future opportunities are afforded through the Fire Safety Development Sub-Group

15.0 DISTRIBUTION LIST

- Gloucestershire Safeguarding Adults Board

16.0 REFERENCES

Care Quality Commission

- Gloucestershire Care Services NHS Trust http://www.cqc.org.uk/provider/R1J

Policies and procedures reviewed

Countywide

- Gloucestershire Safeguarding Adults Board – Adult Case Review Protocol February 2014
- Gloucestershire Multi Agency Safeguarding Adults Policy & Procedures - January 2011

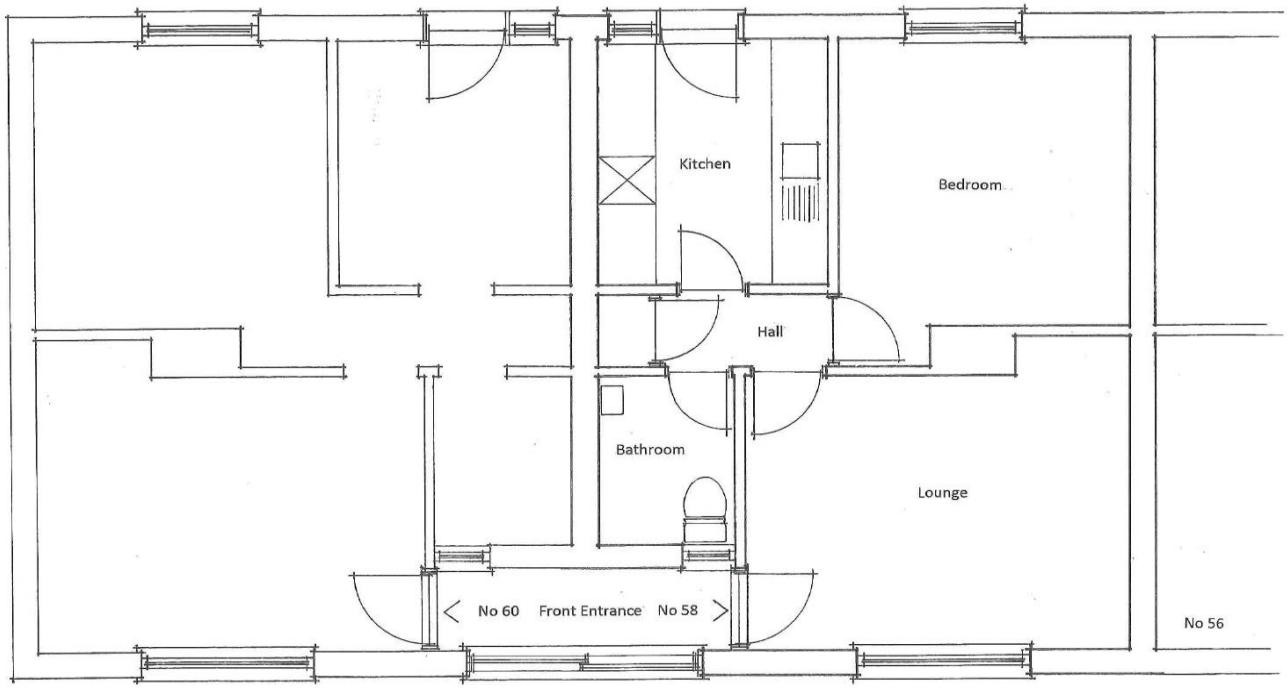
Additional Documents/ information

- Minutes of Safeguarding Adults Multiagency Information Sharing Meetings
- Electronic Record of Service User contacts completed by Gloucestershire County Council, Integrated Care Team (ERIC)

Gloucestershire Telecare http://www.gloucestershire.gov.uk/telecare/home

Model Matrix

Contributory Factors Classification Framework



EXISTING FLOOR PLAN