Safeguarding Adults Review of the circumstances concerning Mr BC

Executive Summary

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CITY & HACKNEY SAFEGUARDING ADULTS BOARD
SAFEGUARDING ADULTS REVIEW OF THE CIRCUMSTANCES CONCERNING MR BC

EXECUTIVE SUMMARY

1. INTRODUCTION

1.1. Mr BC, aged 72, who was born in Guyana, died in a fire at his home on 7th November 2014. He lived as an assured tenant in a flat in sheltered housing, receiving housing-related support from staff at the scheme and a personal care and support package from a care agency commissioned by London Borough of Hackney Adult Social Care. His adult sons and daughters were actively involved in supporting him. Mr BC was a heavy smoker who routinely drank large amounts of alcohol. He had a number of complex health problems including high blood pressure and strokes, arthritis, a hip replacement, diabetes, sickle cell anaemia, and cataracts; his condition resulted in poor mobility and balance and incontinence, and he neglected his diet, personal hygiene and home conditions. Emergency services were alerted on a number of occasions: the police to deal with repeated verbal and physical abuse of Mr BC by a neighbour, and theft from Mr BC by visitors to the building; the ambulance service when he had falls; the fire brigade when smoke alarms were activated. On a number of occasions safeguarding referrals were made.

1.2. Mr BC did not always easily engage with all the services that sought to help and support him. He did not always attend routine appointments, and although after emergency calls he did sometimes agree to go to hospital, he sometimes refused this, against ambulance crew advice. He would sometimes refuse personal care from his care staff, and could at times behave aggressively towards them. Although he was offered specialist advice about smoking and drinking, he did not make use of the services that were offered. He received fire safety advice from his family, from professional staff and from the Fire Brigade, but it seems that his behaviour did not change in response, even though he appeared to acknowledge the risks. It was believed that he had mental capacity to make decisions about his living situation, care and support needs.

1.3. Early on the morning of 7th November 2014, fire broke out in Mr BC's flat, the seat of the fire being on his bed. All emergency services attended, and ambulance personnel treated Mr BC, but he was pronounced dead at the scene. At a post-mortem on 10th November 2014 the cause of his death was identified as smoke inhalation. The Coroner's Court completed an inquest on 30th April 2015. The verdict was of accidental death with a Prevention of Future Deaths Report submitted to London Borough of Hackney.

1.4. The City & Hackney Safeguarding Adults Board (CHSAB) has a statutory duty under s.44 of the Care Act 2014 to arrange a Safeguarding Adults Review (SAR) where an adult with care and support needs has died and the Board knows or suspects that the death resulted from abuse or neglect, and there is reasonable cause for concern about how the Board, its members or others worked together

to safeguard the adult. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work together to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves. The SAR sub-group of the City & Hackney SAB determined at its meeting on 9th July 2015 that the circumstances of Mr BC's death met the criteria for undertaking a SAR.

1.5. The review model chosen was to appoint a SAR panel, with an independent chair, and independent lead reviewer/overview report-writer and core senior level membership from a range of agencies. The Panel's terms of reference were to commission evidence from all relevant agencies involved in the case under review, to assess and analyse that evidence and make judgements about the lessons learnt, paying particular attention to the following questions:

i. What were the key points of assessment and decision making for Mr BC while he was being supported by health and social care services, and what can we learn from how these were carried out?
ii. What was the professional understanding of Mr BC's risk and vulnerability at these key decision-making points and how was this shared by the agencies involved?
iii. What implications does this review have for multi-agency work with service users where there is an identified risk of fire?
iv. Are there any issues of particular importance that the SAR Panel would like the CHSAB to consider in advance of completion of the report?
v. Where can we identify good practice in this case?
vi. How can the City and Hackney Safeguarding Adults Board make sure the learning from this review leads to lasting service improvements?
vii. What can the City and Hackney Safeguarding Adults Board do to hold agencies to account to improve the quality of services to service users where there is an identified risk of fire?

1.6. The Panel commissioned Individual Management Reports from each agency that had involvement with Mr BC before his death, setting out the nature of their involvement, its progress over time, the reasons for actions taken or not taken, and reflection on their learning. The period chosen for scrutiny was between the date of Mr BC's first involvement with Adult Social Care, 20th December 2007, and the date of his death, 7th November 2014. Some IMR writers focused more specifically on the period following his move, in June 2010, to the accommodation in which he was living at the time of his death. The purposes of the IMRs were:

- To enable agencies to reflect on and evaluate their involvement with Mr BC, identifying both good practice and systems, processes or practices that could be improved;
- To contribute the individual agency perspective to the SAR Panel's overview of interagency practice in Mr BC's case;
- To identify recommendations for change, at either individual agency or interagency level.

1.7. From the agencies' chronologies, a consolidated chronology was produced, mapping the actions of each agency by date against the actions of others. From this cross-referencing emerged some significant episodes and key themes in how the agencies, singly and jointly, responded to Mr BC's situation and needs. The narrative reports and interviews with IMR writers allowed further exploration of key episodes and themes.

1.8. Mr BC's family declined the Panel's invitation to take part in this review and did not take up dates offered for sharing its conclusions and recommendations.

2. CHRONOLOGY OF INVOLVEMENT

2.1. The period preceding Mr BC's move to his sheltered accommodation: December 2007 – May 2010: During this period Mr BC, who was living in a 6th floor council flat, became known to Adult Social Care, initially as a result of hospital admission for a stroke, and subsequently through referral by his family, who were providing significant amounts of care and support. A further hospital admission for confusion and urinary tract infection followed. Risks arising from his poor health due to a range of chronic conditions, together with his substantial consumption of alcohol, led to recognition that his independence was at substantial risk. From 2009 he received a care package that gradually increased from 3 to 7 hours per week, and included meals on wheels. There was occasional intervention from the Police when Mr BC became abusive to his adult children during arguments about his drinking, resulting on each occasion in no further action.

2.2. The initial phase of Mr BC's residence in sheltered accommodation: July 2010 – September 2013: During this first phase of his residence in the sheltered housing scheme, Mr BC repeatedly came to the attention of the emergency services for a number of reasons: acute health episodes, fire safety issues and incidents involving abuse of him, sometimes by strangers but more commonly by a neighbour who was a drinking companion (and who was eventually evicted on 1st September 2013). Mr BC himself was also sometimes aggressive to care staff, on occasions declining personal care. While a primary focus was on the risks posed to Mr BC by third parties (strangers and his neighbour), housing scheme staff became increasingly concerned about fire risks from his drinking and smoking, both to Mr BC himself and to others in the building.

2.3. The final phase of Mr BC's residence in sheltered accommodation: September 2013 – November 2014: Mr BC's health was deteriorating and his care and support needs increasing. He continued to smoke and drink, and emergency services were regularly called when he had falls or fires in his flat. The focus of interagency concern became the fire risk. Five months before his eventual death, he suffered smoke inhalation during a moderate fire in his flat, triggering reassessment of his care and support needs. While a move to alternative, more supported accommodation was discussed with him, he consistently refused to consider this. Despite a stated wish to reduce his

smoking, his motivation for this did not seem strong, and his drinking continued. He was judged to have capacity to make decisions about his own welfare. Mr BC died in a fire at his flat on 7th November 2014.

3. LESSONS LEARNT

3.1. The focus here, in line with the remit of a SAR, is upon learning that emerges about multiagency and interagency practice. A number of agencies have indicated in their IMR that changes have been or will be made to their internal systems and approaches. These single-agency actions are not addressed below, but agencies' individual action plans will clearly reflect single agency changes made in response to the review process, as well as actions that respond to the multi-agency conclusions and recommendations specified here.

3.2. Housing: Mr BC was placed in an environment that was, from the start, not entirely suited to his support needs. Research[1] shows that providing support to tenants that goes beyond the level of support commissioned is a common experience for housing providers working with self-neglect. Here, Mr BC's needs were higher than notified to the housing association and involved risks that were not communicated to them. Relevant information about risks from his alcohol consumption and smoking, which were known to Adult Social Care, were not included the information given at application, whereas other factors such as his self-neglect, health issues and isolation were communicated. While it is not possible to identify why this was the case, and there is no evidence that information was deliberately withheld, or that the outcome of his application would have been any different, the fact that risks so quickly became apparent, and posed such challenges in the sheltered housing environment, indicates a need for a greater level of information sharing to facilitate more exact matching of provision to need.

3.3. Interagency risk-management strategy: The lack of overall risk management strategy was clearly evident in the way that agencies responded to Mr BC's needs, and to the risks he posed. While there were some effective lines of communication between different pairings of agencies on a day-to-day basis, a shared whole-system strategy was not in place. No one agency had the whole picture. Each agency focused on what they might be expected to do, given their core function, but often without linking this with what others were doing. This resulted in a number of shortcomings:

- matters that were no-one's job – for example, the smoked detector in the bedroom– did not get attended to;
- no shared perspective on the scale of risk or its management was developed;
- no shared consideration was given to options for intervention.

[1] Braye, Orr and Preston-Shoot, M. (2013)

This is a common picture to emerge from safeguarding adults reviews in cases of self-neglect. When high-risk panels have been implemented, they have been found to be effective in improving interagency liaison on specific cases, and in sharing and managing risk more comprehensively.

3.4. Leadership: The clear leadership that was needed in Mr BC's case was not forthcoming. In its absence, the fact that no agency took the initiative to convene the interagency system further contributed to the fragmented nature of individual agencies' attempts to mediate risks. Again the need for strong leadership in self-neglect cases is a strong theme to emerge from safeguarding adults reviews[2].

3.5. Disconnected systems: Particularly problematic was the disconnect between safeguarding processes and adult social care responsibilities. The ongoing involvement of adult social care was given as a reason for not pursuing safeguarding processes, yet the safeguarding risks identified did not receive appropriate attention in ongoing care management, which focused primarily upon Mr BC's practical care and support needs. Even though risks were acknowledged and risk-reduction strategies attempted, their ongoing failure did not trigger any review of the cumulative picture, and the fundamental approach did not change.

A further disconnect was between health and social care. The GP, who was proactive and engaged with Mr BC's situation, and in routine communication with his family and the housing scheme manager, had much to offer a more strategic level risk management discussion. Yet there is no evidence that such discussion took place, even when the GP raised the question of re-housing with adult social care. This was a key point at which a joint medical/social care approach to assessment, capacity assessment and care planning could have been fruitful.

3.6. Fire safety: Fire safety measures did not receive comprehensive attention. Concerns expressed in fire risk assessments about general safety of residents with low mobility did not prompt timely review by the housing association, and known shortcomings in the functioning of air vents were not attended to. These points are not material in relation to Mr BC's death, but illustrate a need for more proactive follow up.

More pertinently in relation to Mr BC, a smoke detector in the bedroom, given his known habit of drinking and smoking in bed, would clearly have been an appropriate addition to the fire safety measures in the flat. The SAR Panel was concerned at the different accounts given by the Fire Brigade and the housing scheme manager about whether a bedroom smoke detector was recommended after the moderate fire in June 2014.

In addition to that practical measure, it is really not clear why a multiagency discussion of fire risks was not convened – this could have been initiated by any

[2] Braye, Orr and Preston-Shoot (2015a; 2015b); Preston-Shoot (2016)

one of the agencies most centrally involved, and was arguably warranted on grounds of risks to others in the housing scheme, as well as to Mr BC himself.

3.7. Escalation: The overwhelming impression from the accounts of practice with Mr BC given in the IMRs and supporting documentation is of an approach in which a limited number of risk-management strategies was tried repeatedly – increased care, support and oversight from both the care agency and the housing scheme staff, use of a key guard, key chain and door chain, discussion with the family, referral to substance use services, emergency service responses to incidents - despite evidence that they were not working. In these circumstances, escalation within agencies, for example within adult social care, might have been expected, to alert senior managers.

Equally, escalation between agencies would have been appropriate, yet did not happen. Concerns were routinely passed to others: the housing scheme raising safeguarding alerts; the care agency alerted adult social care when they could not deliver care; the GP wrote to adult social care about re-housing and capacity assessment. Not receiving feedback on such communications was part of the pattern of interaction, yet follow up and escalation did not take place. This lack of holding each other to account operationally contributed to Mr BC's case remaining 'under the radar' in terms of whether collectively the system was sufficiently worried about him. Despite repeated preventive home fire safety visits, it took an event (the fire in June 2014) to trigger senior manager involvement, but even then this was not viewed as an operational escalation of his case, the focus remaining on strategic liaison between agencies.

3.8 Relationship-based approaches: The adult social care focus on Mr BC's practical care and support needs gave appropriate attention to his personal care and care of his environment, such that those features of his self-neglect did not become extreme. Care staff and housing scheme staff were sufficiently persistent and persuasive to ensure that the care continued to be delivered, despite his reluctance and occasional refusal, and despite the aggressive challenges made by his neighbour and sometimes by Mr BC himself. However, even though the same social worker remained involved over several years, the opportunity for building a sustained relationship seems not to have been taken. Research [3] demonstrates that it is often only through relationship-based approaches that changes in an individual's pattern of self-neglect, or acceptance of risk-reduction measures, can be achieved. Yet there is little evidence here of exploring the reasons for Mr BC's behaviour, his life history and experiences, or of investing in a relationship of trust through which more assertive intervention could be negotiated.

3.8. Mental capacity: Partly due to the absence of comprehensive risk-management strategy discussion, the agencies involved collectively failed to give systematic consideration to all available options for intervention. It seemed to be assumed, and in some cases was explicitly stated, that because Mr BC had mental capacity then if he chose not to change his behaviour or agree to

[3] Braye, Orr and Preston-Shoot (2014)

moving to a more supervised environment nothing could be done. Yet the lack of documented attention to mental capacity, and indeed the nature of the documentation when it is present, raises concerns: whether the decision-specific nature of capacity was taken into account; whether capacity was reviewed at all appropriate points; whether assessment considered the possibility of impaired executive brain function; whether medical involvement might have been sought. These are all common themes to emerge also from safeguarding adults reviews in high-risk cases of self-neglect.

Even with an enhanced focus on mental capacity in Mr BC's case, he may still have been deemed to have capacity to make key decisions relevant to his wellbeing and safety. In those circumstances, understanding of options for intervention when 'unwise decisions' place the individual or others at risk needs to be stronger than was evidenced in his case. This requires clarity over practice approaches (such as motivational work) that can have positive outcomes and on legal options for imposed intervention.

3.9. Recording practice: Inadequate recording in a number of agencies, as detailed in the thematic analysis, has hampered the work of the IMR writers and of the SAR Panel in this case. More importantly, it seems likely that it will have hampered the ability of practitioners to build a clear and cumulative picture of risk in Mr BC's case, and to have easy access to a chronological overview of his situation.

3.10. Learning: It is vital that learning from this review is maximised. This will require a range of mechanisms for sharing the learning, but also consideration of the organisational contextual factors that facilitate learning transfer (Pike, 2010; Pike & Williamson, 2013). Equally, it is important to learn from examples of successful interagency working as well as from the kind of circumstances that trigger safeguarding adults reviews. Cases in which positive outcomes are achieved can help to identify the features and facilitators of good practice.

4. RECOMMENDATIONS

4.1. There is a need to review how communications between relevant agencies take place in the context of rehousing of people with care and support needs that engage high levels of risk, either to themselves or to others.

4.2. A visible mechanism for interagency case management in high-risk cases is needed. This goes above and beyond what should be routine effective communication between practitioners. It might take the form of a high-risk forum to which such cases can be escalated for discussion that brings all key agencies round the table to share information, discuss available options for intervention, plan and monitor a risk-management strategy.

4.3. Identification and active monitoring of such cases across the borough should be a priority, with a single agency identified for leadership on the mechanisms for implementation.

4.4. High-risk cases that engage the attention of a range of agencies must have a named coordinator whose role it is to convene discussion that results in a shared risk management strategy.

4.5. Safeguarding processes should be reviewed to ensure:

- that where it is proposed not to pursue a safeguarding process (because a case is open to adult social care), feedback is received on the actions taken/in progress to address the risks referred;
- that management oversight of referral closure is always in place;
- that a number of repeat referrals should trigger scrutiny of the cumulative picture rather than decisions in isolation.

4.6. Consideration should be given to how the time needed for relationship-based approaches - which go beyond practical care and support needs and explore the underlying reasons for behaviour, working for change based on trust - can be restored within the context of busy adult social care practice.

4.7. Consideration should be given to how the potential of GP contributions to risk management can be enhanced.

4.8. Housing providers must have robust measures in place to demonstrate that advice given in fire safety assessments is acted upon and be able to provide a strong audit trail on actions taken.

4.9. Assurance should be sought from providers about the quality and thoroughness of fire risk assessments, and how they comply with the duty for them to be suitable and sufficient.

4.10. The Fire Brigade should consider whether the detail of fire safety advice, particularly given in high-risk cases, should be recorded in writing to those with the power to act upon it (in this case the tenant/resident and the managing agent).

4.11. The Prevention of Future Deaths report from the Coroner on fire safety measures to be taken in respect of individuals living in high-risk situations will need to be considered. While this report is addressed to the Chief Executive of the local authority, it has implications for a number of agencies.

4.12. Consideration should be given to what forum is best used for discussions of cases in which measures to contain high fire risk are required. This could be considered alongside the recommendation for an interagency high-risk case management forum.

4.13. Consideration to be given to whether ‘near miss’ fires should be referred to such an interagency panel.

4.14. Staff in all agencies must be aware of mechanisms for raising and escalating concerns if feedback on routine requests and referrals is not received and where high risks remain.

4.15. There is a need for guidance for staff on working with people who do not/will not engage where risks are high.

4.16. A renewed focus on mental capacity is necessary. Measure to support this might include:

- Refresher training across a range of agencies on responsibilities for undertaking and participating in mental capacity assessment;
- Identification of triggers for multidisciplinary capacity assessment, and clarity over the routes for such requests to be shared;
- Review dates for repeat capacity assessments where people in high-risk situations are deemed to have capacity.

4.17. There is a need for guidance for staff on the range of options that need to be considered when people with capacity make decisions that place themselves and/or others at risk. This may need to involve training in particular skills/methods and in legal frameworks.

4.18. It will be important to ensure that legal advice is available to inform both single agency and interagency discussion of options for intervention.

4.19. There should be clear expectations on recording, both within agencies and within the interagency safeguarding process, with routine audit of compliance. Consideration should be given to the introduction of overview chronologies within client recording systems.

4.20. An audit of safeguarding referral form completion should ensure compliance with expectations on dates, signatures, reasoning of decisions, and management oversight.

4.21. There should be a clear communications strategy for the review findings, under the leadership of the CHSAB.

4.22. Consideration should be given to developing a template for use by agencies to self-audit the key features on which action will need to be taken.

4.23. Learning and action plans from all agencies should be monitored.

4.24. The self-neglect protocol should be reviewed to ensure it reflects key features of learning from this review.

4.25. Alongside learning from cases in which a tragic death has occurred, consideration should be given to a practice development strategy that learns from success through a focus on cases where there is evidence that the professionals involved have worked well together.

5. REFERENCES

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