Bracknell Forest and Windsor & Maidenhead Safeguarding Adults Board

# Safeguarding Adults Review of AB

# Overview Report

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**Commissioner: Bracknell Forest and Windsor & Maidenhead Safeguarding Adults Board**

**Date: 29th March 2018**

## 1. Introduction

1.1. This review has been commissioned by the Bracknell Forest and Windsor & Maidenhead Safeguarding Adults Board (SAB) in line with its accountabilities under Section 44 of the Care Act 2014. The author has been selected to ensure independence of the review and in terms of her background experience inclusive of enhanced and substantial experience of operational and strategic multi agency safeguarding practice.

1.2. The timescale for the review spans from the period of April 2016 to May 2017 however will have regard to any relevant previous history in this case.

1.3. To ensure anonymity and for the purposes of this report the individual will be known as AB.

## 2. Safeguarding Adults Review (SAR) Process

2.1. This review process is an individual case and appreciative systemic enquiry into the actions and decisions taken by the relevant agencies and a review of those decisions in the context of the real working conditions which existed at the time.

2.2. Research has shown that methodologies that engage practitioners in reviews are more likely to achieve learning and promote change in practice, therefore the participation of frontline staff is extremely valuable, and such engagement aims to improve the quality of the overall review and the commitment to taking the lessons learnt back into practice.

2.3. A SAR is not an enquiry into how someone died or suffered injury, or to find out who is responsible or apportion blame. Its purpose is to:

- Look at any lessons we can learn from the case about the way all local professionals and agencies worked together;
- Review the effectiveness of safeguarding adults practice, policy and procedures;
- Inform and improve local safeguarding practice for all agencies involved; and
- Deliver an overview report with findings for consideration by the SAB.

2.4. The key outcome of a SAR is to improve the safeguarding of adults in future. For this to happen as widely and thoroughly as possible, professionals need to be able to understand fully what happened and what needs to change to prevent the likelihood of reoccurrence.

2.5. It is the aims of the Bracknell Forest and Windsor & Maidenhead Safeguarding Adults Board to further promote a learning culture by nature of this review and to effect maximum positive change in both single agency and multi-agency working arrangements to ensure the best outcomes for adults at risk and the wider community. It is equally important to highlight areas of good practice and to share that learning.

## 3. Safeguarding Adults Review Governance

3.1. The Chair of the SAR Panel will be responsible for regularly advising the SAB Chair of any emerging findings that require attention as matters arise throughout the review process and before the SAR Overview Report is drafted. In terms of any identified transferable risk to adults with care and support needs, review panel members are responsible for taking any relevant immediate action or escalating within their own agency.

3.2. The draft Overview Report will be sent firstly to the SAR Review panel for comment and subsequently to the SAR Panel and its Chair for sign off, prior to it submission to the SAB and its Independent Chair.

3.3. The Safeguarding Adults Board will be responsible for the co-ordination of any media management in relation to this SAR and its publication, in line with an agreed media strategy, and, in addition to liaison with the Coroner Office awaiting the review report in this case.

## 4. Methodology

4.1. A Multi Agency Learning Process has been adopted for this review using a combination of Independent Management Reports, a series of Review Panel meetings in conjunction with direct conversations with frontline staff involved in the care and treatment of AB and a subsequent shared learning event. Objectives were set for the review as below and terms of reference are attached at Appendix 1.

1. To review the effectiveness of multi agency working in relation to identifying risks associated with fire for people with care needs living in their own homes.
2. To consider the current approach taken to reduce the risk of fire to people with care needs living in their own homes, particularly those who choose to smoke.
3. In particular to examine the current practice of health and social care staff in:
    a. Recognising and identifying fire risks;
    b. Undertaking or instigating appropriate risk assessments, recording and sharing risk assessments including the views of the service user and their family/carers;
    c. Managing and implementing risk assessments with particular reference to fire risks; Sharing risk assessments with particular reference to fire risks.
4. To consider current multi agency working practice around fire prevention and to make recommendations for improvements.
5. To consider current interagency working between health and care agencies and the Royal Berkshire Fire and Rescue Service and how this might be strengthened.
6. To consider whether adult social care should ensure that risk assessments undertaken by care providers are appropriate and mitigations are put in place and, in particular, whether this duty should extend in cases where the service user is in receipt of direct payments.

4.2. For the purpose of this review Independent Management Reports (IMR) were requested and provided by the following agencies:

- Berkshire Health Care Foundation Trust (BHFT)
- Kimara Support Limited
- Royal Berkshire Fire and Rescue Service (RBFRS)
- Housing Solutions
- Frimley Health Foundation Trust (FHFT)
- Windsor and Maidenhead Clinical Commissioning Group (WAMCCG)
- Optalis (RBWM)
- South Central Ambulance Service (SCAS)
- Forest Care

4.3. IMR templates and guidance were provided to the authors who were senior representatives of each agency and had no direct involvement in the case of AB. IMRs included the following:

- a chronology of interaction with AB for the review period.
- detail of the intervention episode/event and the subsequent outcome
- applicable policy and procedure review with identification of whether policy and procedures were followed
- identification of areas of good and poor practice
- analysis of the agencies involvement against the set terms of reference for the review
- conclusions and recommendations from the agency's point of view in terms of lessons learnt and recommendations
- formulation of single agency action plans.

4.4. As part of the review process all agencies have developed a single agency action plan reflective of lessons learnt and identified recommendations. Each action has detail of action required, an allocated lead responsibility and a review date. These are shown at Appendix 2.

## 5. Succinct Summary of the Case

5.1. AB was a 74-year-old female of White British origin. AB resided in her own home and lived alone, having no family of her own. AB was however a godmother to a friend's children from whom she received visits.

5.2. AB was a retired specialist practitioner (District Nurse) and was well known and highly respected by her colleagues throughout the community nursing service and as such was known to the community nurses providing her care.

5.3. AB had a complex medical history of Hypothyroidism, Osteoarthritis, chronic leg ulcers, type 2 Diabetes (insulin dependent) and over the years had become morbidly obese with some consideration that she may have had undiagnosed agoraphobia. In the period prior to her death AB had become immobile having suffered a stroke in April 2017 with indications of minimal effect on her cognitive functioning.

5.4. As a result of her physical health and mobility needs AB and was in receipt of a significant support package of four care calls per day with two carers, AB directly commissioned her care as a self-funder in receipt of direct payments, and was seen over a sustained period for three visits per week by the community district nursing service.

5.5. AB was known to be a heavy smoker and habitually smoked in bed, in 2010 a referral was made to the Royal Berkshire Fire and Rescue Service following referral from the housing association and action was taken to improve the level of fire safety.

5.6. On the 11th May 2017 alarm was raised by a neighbour to the fire brigade in response to a house fire at AB's home address however sadly AB was found deceased.

## 6. Key Events and practice analysis.

6.1. On 1st April 2016 paramedics were called by the carers to provide assistance as AB was stuck in her chair, report to the Local Authority was made by the care provider and a case note referral was subsequently made to the OT, a new chair was ordered.

6.2. During paramedic attendance on this occasion they noted burn marks to AB's nightdress, bedding and a burnt-out cigarette on the floor by her chair. As a result of the identified high fire risk and the reduced mobility of AB the first safeguarding concern was raised to the Local Authority and the Fire Prevention Service.

6.3. This was good practice from the paramedic service in terms of safeguarding practice; however, the Local Authority did not recognise this as a safeguarding matter and therefore did not apply the appropriate multi agency procedures or adequate risk assessment in terms of the level of risk AB presented to herself, nor, in terms of potential risk to the public or staff attending the property. The safeguarding service closed the concern and passed to Duty for follow up.

6.4. SCAS then forwarded the referral to RBFRS Prevention Team highlighting a person at heightened risk of fire, this should have directed action and a multi agency discussion, however, because it was made without consent of AB, the RBFRS action was to send a leaflet to seek consent for a Home Fire Safety Check and to update the mobilising system to inform fire crews of the risk at the premises. The actions were based on the assumption that direct contact could not be made with occupants unless they gave consent.

6.5. A duty telephone contact was made to AB on the 7th April 2016 in response to the safeguarding concern in which AB gave assurances contradictory to the observed and reported evidence. A lack of professional curiosity resulted in a failure to engage multi agency communication, no home assessment or face to face contact was conducted and as such, the level of risk posed was not adequately identified or mitigated. This was a missed opportunity.

6.6. During the period of 9th April 2016 to 29th April 2016 AB was admitted to hospital with a history of not being able to get out of her chair for two weeks. On admission, OT and Physio services were provided to facilitate safe discharge however fire risk was not identified, an onward referral was made to the community physio and the smoking cessation clinic.

6.7. Despite AB's complexity of presenting needs, notifications of admission and hospital discharge were not made to the local authority due to AB's self-funding status. This would have provided an opportunity to reassess AB's apparent changing needs in the community and engage a multi-disciplinary approach.

6.8. On 27th May 2016 the local authority undertook a review of AB's financial situation and AB was subsequently awarded Direct Payments in order to enable AB to remain with her long term care provider¸ this was done in the context of personalisation and continuity of care however there is no record of AB having been assessed in terms of her ability to manage the direct payments and coordinate her own care effectively and ensuring the service she was commissioning understood and could meet her needs. Likewise, no process was implemented to review the quality of care or to support the provider in terms of risk management and multi-agency communications.

6.9. On the 13th June 2016 an urgent referral was made by the care provider for an OT assessment to review Moving & Handling for AB, the assessment was undertaken within two days and identified equipment to support mobility and maintain independence. This was good practice in terms of the referral and response to AB's increasing mobility needs. The assessment however did not identify the increased fire risk associated with AB's reduced mobility and was focused on equipment and mobility review. AB was admitted to hospital during this assessment as was unwell.

6.10. A further OT assessment was undertaken on 16th June 2016 following AB's hospital discharge due to her mobility issues and equipment was appropriately provided to maintain and maximise her independence.

6.11. On the 28th June 2016 the Local Authority received a third safeguarding concern again raised by the ambulance service who had attend as AB could not get out of her chair for a 9 hour period¸ AB was reported to not be taking her medication and to be a high fire risk in addition to concerns that paramedics have attended on numerous occasions over the past six months indicating increasing needs. The increasing risk to AB is not identified and the safeguarding concern is not progressed. This was a further missed opportunity to employ a safeguarding framework or multiagency response.

6.12. An OT home visit was then initiated on the 29th June 2016 which identified AB had very reduced mobility and increased anxiety, the District Nurse was in attendance however an opportunity to fully review AB's needs was not utilised and no risk assessment was undertaken, the outcome was for the OT to seek senior supervision due to the complexity of the situation. There is however no record of further supervision or senior consultation in the case of AB.

6.13. During a District Nurses visit on 4th July 2016 it was identified that as a result of AB's anxiety to mobilise when alone in the house she has become incontinent during the night, previously AB had actively requested support via forest care to provide personal care. This could have provided opportunity to review AB's changing needs and promote her dignity.

6.14. On 12th July 2016 a further safeguarding concern is made to the Local Authority as AB had been in bed from 10pm to 3pm the following day and is at high risk of pressure damage. A call is made to the provider who informed that they did not miss the care calls, but that AB had sent the carer away as she had asked for a particular carer. The Safeguarding concern was closed by the safeguarding service and referred to Duty who contacted the provider to express the importance of care calls, a discussion was not had with AB regards her decision to refuse care and the potential impact this could have on health.

6.15. There was a full assessment of needs undertaken by RBWM Short Term Support & Rehabilitation (STS&R) Social Care Practitioner on 29th July 2016. This was a good quality assessment with outcomes identified in line with the Care Act 2014. To meet the outcomes domiciliary care services were provided. No concerns about AB's capacity were identified. STS&R completed a support Plan on 30th July 2016. There was clear documentation on all of AB's heath concerns (Leg ulcers and legs swollen and painful). There was a risk assessment undertaken as part of the support plan and it was acknowledged that Personal care and support would assist in prevention and management of some risks but not eliminate them, there was a contingency plan identified to provide commissioned care to AB prior to her allocation of a direct payment which was a response to AB's level of care and treatment needs at that time.

6.16. AB called 111 on 13th November 2016 as she is unable to mobilise, paramedics attend, and AB is admitted to hospital with a respiratory infection. During this admission it is recognised by the hospital physio that AB has increasing needs and they discussed an increase of care package with AB. AB is reluctant to accept this, in addition AB is not engaging with her rehabilitation programme. An assumption of capacity is made by the physio despite AB's significant change in need and an opportunity to formally assess AB's capacity in relation to her care and support needs is missed.

6.17. The Local Authority Hospital Team is notified of pending discharge and the need for an increased care package on the 15th November 2016. There is no record of the Hospital Discharge Team having assessed AB and therefore risk that AB's care was not meeting her increased assessed needs.

6.18. AB called 999 requesting an ambulance as she could not get out of the chair on the 30th November 2016 in response the ambulance crew again raise a safeguarding concern to the Local Authority stating they have received four 999 in the past month. The safeguarding concern is not progressed, and the safeguarding team refer AB's case to PDOPT for allocation. In response on the 2nd December 2016 a telephone call is made to AB who advises the OT her needs are being met, the OT schedules a home visit for the 5th December 2016.

6.19. A Home visit was undertaken by the OT to review equipment and AB was assessed as being able to transfer safely. There was no evidence of professional curiosity exploring why and ambulance had therefore been required.

6.20. On 11th January 2017 AB suffers a fall at home and contacts the ambulance service AB was subsequently admitted to hospital, AB had suffered a stroke, poor motivation and increased anxiety is assessed by the hospital physio.

6.21. A complex discharge notification was made to the Local Authority Hospital Team on the 2nd February 2017 and on 6th March 2017 an Adult Social Care assessment was undertaken. This assessment did not identify AB as smoker and therefore fire risk was not identified, assessed or mitigated. AB's care package was increased to four double-handed calls per day to meet her identified needs.

6.22. The District Nursing service undertook a review on the 9th March 2017 and AB's case is closed which was appropriate. However, this was not communicated to other agencies who continued to assume that AB was in receipt of three visits per week from the Community Nursing Service.

6.23. On 17th March 2017 the care provider contacted the Local Authority requesting an urgent OT assessment stating they were at crisis point; on the same day AB's case is closed to the Hospital Team and transferred back to PDOPT.

6.24. During a home visit on the 9th April 2017 the STS&R therapist observed numerous burn marks and large holes on AB's blanket; AB informed that this was as a result of her smoking in bed. The therapist identified the risk of Cetraban cream being used in view of its highly flammable nature and took appropriate action to refer to the Districting Nursing hub for review in line with national guidance which was good practice. However, no action was taken to review the fire risk to AB or others as a result of her being immobile and smoking in bed. This was a missed opportunity to implement safeguarding measures and to fully assess the risks AB posed to herself and others to take risk mitigation action.

6.25. AB's case was then referred back to the Physical Disability Older Persons Team on 12th April 2017.

6.26. On the 7th May STS&R attempted to undertake a home visit, they were informed by a neighbour that AB had been admitted to hospital they then leave a note for AB to contact them on her return. No communication with the hospital is made and it is not known if this is accurate information or not.

6.27. Police contact was received to the Local Authority on 12th May 2017 advising AB had become deceased in a house fire and a request is made to raise a safeguarding concern.

## 7. Summary of findings

### *7.1 How effective were/are agencies working arrangements in identifying and responding to fire risks for immobile/high risk adults in their own home?*

7.1.1 In the case of AB most agencies held information relating to AB's smoking, although it is evident that some practitioners had direct conversation with AB regards this concern they did not translate this into any follow up action or recognise the potential fire risk identified by the ambulance service. RBFRS recognised the risk and tried to deal with it but their processes at that time in regard to consent and capacity stopped the service from making further direct contact with AB and therefore did not adequately deal with the risk.

7.1.2 These observations and concerns however, except for the ambulance service, were consistently seen by professionals in the context of AB's individual lifestyle choices and not in the context of the potential high level of risk she presented not only to herself but to others. As such, the Duty to fully assess this and apply safeguarding procedures in this context was not recognised; the review evidenced multiple missed opportunities when an appropriate safeguarding framework could have been applied which may have potentially reduced risk and promoted a multi-agency approach in line with best practice and Berkshire Safeguarding Policy and Procedures at that time.

7.1.3 An assumption of capacity was made by all professional involved in the care of AB and this acted as a barrier in terms of staff formally assessing AB's capacity despite indicators this may be an issue, in view of high risk and unwise decision making potentially impacting on her health and wellbeing. Although professionals applied the primary principle of the MCA in assuming that the patient had capacity, this could have been explored more fully in view of her risky behaviours and the impact on AB's health and welfare on herself and potentially others.

7.1.4 Assessment tools used within agencies do not include the identification of whether the individual smokes or specific assessment of fire risk. As such these individual and environmental risks are not fully assessed or considered as matter of course for vulnerable adults.

7.1.5 In terms of responding to fire risk, frontline staff (with the exception of the ambulance service) were not familiar with the referral pathway to the Fire Prevention Service, despite the strategic work undertaken across the partnership to promote awareness following the Regulation 28 order issued by the Berkshire Coroner in 2015 and further briefing guidance issued by ADASS in eNewsletter (Issue 520 - 31 October 2017). As such, referrals were not considered or made appropriately or within a timely manner. On the occasion when a referral was made by the ambulance service there was a misconception by the fire service that consent was required to make direct contact which would enable preventative action and for further information gathering and communication to be undertaken.

### *7.2 How effective were agencies in sharing relevant information pertaining to fire risk in this case?*

7.2.1 Despite the complex needs of AB and significant multiple agencies involved in her care, there was minimal evidence of effective information sharing across the agencies. To provide an evidenced based assessment, intervention and holistic support package of personalised care, professionals need to ensure barriers do not exist that preclude the sharing of relevant information in a multi-agency context essentially when the safety and welfare of an individual or others may be at risk.

7.2.2 In the case of AB issues of capacity and consent appeared to be a highly influential barrier to appropriate information sharing despite evidence of escalating need and risk. This point has more general significance within our systems and practice, as if staff do not understand their relevance in terms of not only general practice, but Duty to safeguard adults with care and support needs in high risk situations, there is a potential for further inaction in the case of other similar cases. Whilst acknowledging that professionals need to discuss and obtain consent from patients to share their confidential information wherever possible as good standard practice , in cases where risk has been identified and consent has not been discussed , professionals need to consider the need to share information within the framework of multi-agency safeguarding procedures

7.2.3 The failure to share information across agencies in the case of AB led to an uncoordinated approach to her care. Assumptions and reliance's were made that agencies were continuing to be involved in AB's care when they had in fact closed contact. It is likely that sharing of such information may have led to review of AB's situation.

### *7.3 Are current arrangements in terms of safeguarding practice, identification of risk and review understood and implemented by agencies for vulnerable individuals in receipt of direct payments?*

7.3.1 During the review it was identified that for individuals who commission their own care as self-funders or by use of direct payments, there can be a hesitance and a misconception by the provider of how and when risk information should be shared and who it should be reported to. In the case of AB she was seen by the care provider as their customer and therefore able to direct changes in her care package despite her assessed needs and the impact of these not being met.

7.3.2 The Duty of care to adults with care and support needs who are in receipt of funded support/direct payments to assess and mitigate risk needs to be further explored and promoted. In terms of AB no notification of increasing need and hospital admission or discharge was made to the Local Authority on her admissions to hospital as there is no

formal requirement to do so currently for self-funding individuals and AB was perceived as self-funding, however in terms of adults with care and support needs and with increasing needs, such information may have helped agencies to gain a better understanding of deteriorating condition and subsequent increasing risk factors.

7.3.3 As an individual using Direct Payments AB did not have an allocated care manager or single point of contact within the Local Authority subsequently AB's case was managed across multiple teams, PDOPT, A&I Duty, Safeguarding Team and the Hospital Discharge Team. With multiple team's involvement in individual cases it is evident that the "whole picture" was not seen, unless information is coordinated to a single point or there are processes in place to ensure full review of available information, there is a risk that the trajectory of deterioration and escalation of risk for an individual will be missed due to each contact being seen in isolation in terms of crisis response rather than as a continuum to inform appropriate intervention.

## 8. Other influencing factors and comments from the review team

8.1. The review team consider the impact on decision making and actions taken given that AB was known as a senior professional colleague to the District Nursing service. It was agreed by the review panel that in such circumstance it is important to ensure that this is noted and reflected on within the supervision of such cases. In circumstances where patients or service users are known in terms of being retired professional colleagues, it is important to acknowledge this within the service and act to prevent this fact creating bias or misconception about that individual's level of knowledge, cognition and ability to make decisions regarding risk.

8.2. The engagement of the review team members and their frontline staff in terms not only of the review process, but the quality of IMR's provided and the consistent ethos of openness and transparency throughout this review are noted.

## 9. Consultation and involvement from Family members and other relevant persons

9.1. As part of the review, consultation was undertaken with AB's godsons who had intermittent contact, they have been invited to make comment on the report and its findings which will be incorporated into the report prior to publication.

## 10. Actions taken during the Review period

- ✓ Advice and guidance was reissued by review panel members on the fire risks associated with prescribing Skin products containing paraffin-based products, for example, White Soft Paraffin, White Soft Paraffin plus 50% Liquid Paraffin or Emulsifying ointment, in line with the NHS National Patient Safety Agency guidance.
- ✓ The RBFRS Fire Safety Adults at Risk Programme Guidance was recirculated to all agencies to ensure referral criteria and referral pathways were accessible to all frontline staff.
- ✓ RBFRS undertook a full peer review of the procedure for protecting those at heightened risk of fire using Oxfordshire Fire and Rescue Service. This resulted in recommendations which have now been translated into an action plan to review and improve the service.
- ✓ The SAR panel chair advised all agencies panel members that they were responsible to begin implementation of their single agency action plans with immediate effect.

## 11. Lessons Learnt

i. There is a need to ensure that all agencies and organisations are aware of the requirement to identify and respond to potential fire risk.

ii. When multiple agencies are involved in an adult at risks care, regardless of their funding status, there should be mechanisms to ensure appropriate information sharing and instigation of a multi-agency approach to coordinated care.

iii. When referrals are made to an agency, review of referral information and previous information available needs to be undertaken to ensure adequate assessment and intervention, there needs to be a standard practice of feeding back to the referring agency on actions taken.

iv. Tools and training need to ensure identification of fire risks not only for the individual but in terms of public protection and ensure that the appropriate action plans are put in place which includes referral pathways to fire prevention services and this is embedded in core practice.

v. The role of the GP can be crucial in terms of care coordination for individuals with complex needs in the absence of any other allocated worker

vi. There needs to be processes in place to identify more vulnerable adults with complex or high risk needs who are in receipt of direct payments to ensure effective communication across agencies, appropriate review and that their assessed needs are being met.

vii. In cases where adults with care and support needs make unwise decisions which place them at risk, the assumption of capacity should not preclude formal capacity assessments from being undertaken and recorded to inform further interventions.

viii. Practitioners and agencies need to remain mindful that personalisation is an approach it does not and should not override a Duty of Care.

ix. Issues of capacity and refusal or lack of consent need to be fully assessed and explored and should not act as a barrier to share information in a multi-agency context where the law and circumstances permit it.

x. There are robust policies and procedures in place in terms of safeguarding, agencies and frontline staff (particularly decision makers as to whether a safeguarding framework is required when concerns are raised) need to ensure they a familiar with safeguarding procedures and thresholds, not only in terms of statutory requirements to undertake a section 42 enquiry but in terms of Care Act 2014 requirements to undertake other safeguarding enquires.

xi. The absence of safeguarding framework should not prohibit professionals from convening a multi-agency meeting in cases of complex case management or high risk cases for any agency. There should be a clear and accessible pathway within agencies to convene a multi-agency meeting in such cases.

xii. In such cases when serious incidents occur and as a general rule, the use of paper records within the community can create significant risk, in this case the paper records were burnt in the fire, not only does this create opportunity for professionals to follow poor recording standards and potentially promote false assurances, but in the terms of any form of review it can restrict legally defensible arguments in addition to the holistic learning in individual cases.

## 12. Recommendations

1. **The SAB considers a request of assurance from partners on the training and support available to frontline workers (inclusive of domiciliary care providers) relating to the identification and response to fire risks in the community.**

2. **Individual and multi-agency information sharing protocols be reviewed to ensure they include direction for actions to be taken in terms of adults with care and support needs who may be deemed to have capacity or where consent is not gained.**
3. **The SAB considers use of a briefing note and guidance for agencies and frontline staff on adults who are assessed as having capacity and refuse consent to share information or for appropriate referrals to be made.**
4. **Agencies need to ensure there is an appropriate mechanism to feedback to referring agencies, particularly in terms of safeguarding concerns being raised.**
5. **Consideration should be given to introduce prompts in assessment and review tools to promote consideration of smoking and fire risks and support awareness across agencies.**
6. **The SAB seek assurance on how services proactively identify individuals who require increased provider services as their health is deteriorating, and that there is forum available to promote multi-agency discussion in such cases.**
    a. **The Local Authority should review the process by which Direct Payments are allocated for people with complex and deteriorating needs; this should not prohibit the use of direct payments but ensure that in such case appropriate support and review mechanisms are in place. The SAB ensures there are policies and procedures in place (and that practitioners are aware of how to access such a pathway) for a multi-agency forum to review high risk or complex needs cases.**
7. **A review of training is undertaken across agencies in terms of the Mental Capacity Act to ensure practitioners are clear that the assumption of capacity principle does not prohibit formal capacity assessments being undertaken, when other criteria is met, to ensure a high-risk decision being made is in fact an unwise decision, that this is formally documented, and that consideration of other safeguarding frameworks are made for individuals assessed as having capacity but remaining at risk.**
8. **The SAB review how agencies are implementing the Making Safeguarding Personal agenda against meeting a Duty of Care. The Board may wish to review how thresholds and decision making for safeguarding interventions in terms of the statutory duties of the local authority and how they are being applied in the context of fire risks under the Care Act 2014.**
9. **The SAB seek assurance on how safeguarding practice within agencies is monitored and reported on to inform single agency and multi-agency learning and development strategy.**
10. **That agencies review the use of paper records held within individuals own homes.**
11. **The SAB seeks assurance that commissioners of care have mechanisms in place to ensure provider risk assessments are reflective of individual needs, inclusive of fire risk to individuals and the wider public and are clear of reporting mechanisms when risk factors change and need to be increased.**

**APPENDIX 1**

**Terms of Reference for Safeguarding Adults Review (SAR) of the 'AB' case**

**Aims of Review**

To identify opportunities for learning and improved multiagency communication and working with regard to safeguarding vulnerable adults living in their own homes from the risk of fire.

To review the particular circumstances that arose in the case of 'AB' and whether steps could have been taken to reduce the risk that she faced which subsequently led to her death, in particular, how direct payments influenced the outcomes of this case and identify any learning that arises.

**Background to the case being reviewed:**

'AB' was a retired community nurse who lived alone. She was in receipt of direct payments to fund domiciliary care services from a local provider. She was immobile without assistance and received four calls a day, carried out by two carers. She was an insulin dependent diabetic and deemed to have mental capacity. 'AB' was a heavy smoker and habitually smoked in bed. Prior to this incident it had been noted on a number of occasions by carers that 'AB' had burn marks on her clothing. She died in a house fire whilst in bed.

**Objectives of the SAR**

7. To review the effectiveness of multi agency working in relation to identifying risks associated with fire for people with care needs living in their own homes.
8. To consider the current approach taken to reduce the risk of fire to people with care needs living in their own homes, particularly those who choose to smoke.
9. In particular to examine the current practice of health and social care staff in:
    a. Recognising and identifying fire risks;
    b. Undertaking or instigating appropriate risk assessments, recording and sharing risk assessments including the views of the service user and their family/carers;
    c. Managing and implementing risk assessments with particular reference to fire risks; Sharing risk assessments with particular reference to fire risks.
10. To consider current multi agency working practice around fire prevention and to make recommendations for improvements.
11. To consider current interagency working between health and care agencies and the Royal Berkshire Fire and Rescue Service and how this might be strengthened.
12. To consider whether adult social care should ensure that risk assessments undertaken by care providers are appropriate and mitigations are put in place and, in particular, whether this duty should extend in cases where the service user is in receipt of direct payments.

**Period of Review**

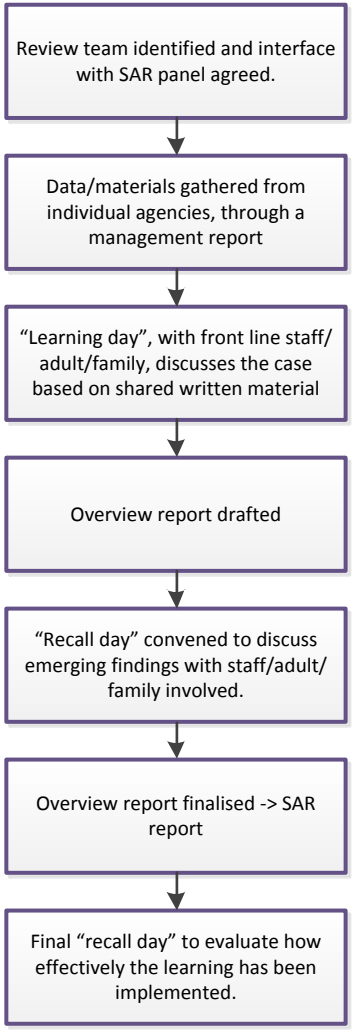
April 2016 – May 2017

The review should have regard to the history of the case of 'AB' from April 2016 until her death in May 2017. However, it anticipated that the review will primarily focus on exploring current policies and practice and identifying learning points.

**Suggested Methodology**

Suggested methodology for this review is the Significant Incident Learning Process (Option C in the Windsor & Maidenhead Safeguarding Adults Board "Safeguarding Adults Review Framework") – see Appendix A.

## Option C: Significant Incident Learning Process




**Key Features:**

- ✓ Review team and learning day led
- ✓ Staff/family involved via learning days
- ✓ Single agency management reports
- ✓ No chronology
- ✓ Multiple learning days over time
- ✓ Explores the professionals' view at the time of events, and analyses what happened and why

| Advantages | Disadvantages |
|---|---|
| • Flexible process of reflection – may offer more scope for taking a light touch approach<br>• Transparently facilitates staff and family participation in a structured way: easier to manage large numbers of participants,<br>• Has similarities to traditional SCR approach so more familiar to most SAB members.<br>• Agency management reports may better support single agency ownership of learning/actions<br>• Trained SILP reviewers available and opportunity to train in-house reviewers to build capacity. | • Burden on individual agencies to produce management reports<br>• Cost – either to train in-house reviewers, or commission SILP reviewers for each SAR.<br>• Opportunity costs of professionals spending large amounts of time in learning days<br>• Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses.<br>• Not been widely tried or tested, nor gone through academic research/review. |

**Available models:**

Tudor, Significant Incident Learning Process

**APPENDIX 2**

## Single Agency Action Plans

| Ref No | Organisation | Action (What) | Lead (Who) | Detail (How) | Date (By When) | Reviewed by | Date completed |
|---|---|---|---|---|---|---|---|
| 1 | Berkshire Healthcare Foundation Trust (BHFT) | Staff allocated to visits read and understand the reason for referral prior to their visit | Community Nursing Team leaders | Online processes<br>Diaries | Action immediate<br>October 2017. | | |
| 2 | BHFT | Trust clinical prescribers develop clear guidance on topical treatments for staff that take account of the potential to contribute to the risk of harm due to fire | Prescribers group within the Trust | Group development and discussion in clinical risk forums | Chair of group to advise | | |
| 3 & 5 | BHFT | Clinical development groups work to develop more comprehensive environmental risk assessment forms that include evaluation of fire risk needing referral to the fire and rescue services. | Clinical development group and Fire Safety Officer | Tabled for discussion<br>November 2017 | Chair to advise | | |
| 4 | BHFT | Service managers to ensure that staff are supported in their understanding of the significance of record keeping and legal and professional responsibilities<br>Mandatory subject for clinical supervision | Service Managers<br>Training and development – clinical | All team leaders<br>Immediately<br>Emailed to managers and receipt of email confirmed<br>November 2017 | | | |
| 6 | BHFT | A practical approach to integrating learning from SARs into practice | Service managers<br>Training and development<br>Safeguarding leads | For team leaders and managers to arrange through local update forums and team meetings<br>Safeguarding team and fire safety officer to support | Ongoing in adult safeguarding training , fire training and trust induction programmes | | |
| 7 | BHFT | Trust to include community nurses in the listening in action programme | Trust managers. | For managers to arrange | | | |
| 8 | Clinical Commissioning Group (CCG) | Emollient safety information to be recirculated to all GP's. | Head of Medicines | Emollient safety information to be added to Meds Optimisation | November 2017 | Named Professional | November 2017 |

| Ref No | Organisation | Action (What) | Lead (Who) | Detail (How) | Date (By When) | Reviewed by | Date completed |
|---|---|---|---|---|---|---|---|
| | | | Optimisation (CK) | page/newsletter and to the online formulary | | Safeguarding Team. | |
| 9 | CCG | Fire Risk Referral Forms available to GP's via DXS system. | Named Professional Safeguarding Team | To discuss safeguarding checklists and referral forms. via DXS. | November 2017 | Named Professional Safeguarding Team | In progress C:\Users\JG015\Desktop\scanned both sides.pdf |
| 10 | CCG | Learning to be shared with GP's. | Safeguarding Team | GP locality Safeguarding Training | Jan-March 2018 | Safeguarding Team | |
| 11 | Frimley Health Foundation Trust (FHFT) | Multi-agency review to be considered for patients who have capacity but are refusing increased care despite a clearly deteriorating condition | Adult Safeguarding Lead | All complex cases to be reviewed by the safeguarding lead in conjunction with the relevant discipline to ensure due consideration is given to increased care needs in those patients at risk from fire at home<br>Email memo to be sent to all HoNs and heads of Physio and OT to raise awareness of the need to consider triggering a multi-agency review<br>Promotion of framework for adults who won't engage with services via all safeguarding training for staff | End January 2018 | | |
| 12 | FHFT | Incorporate a fire safety check for all elderly patients as part of discharge planning process | Adult Safeguarding Lead<br>Lead Discharge Co-ordinator | Meeting with Lead discharge co-ordinator and lead for documentation to ensure amendments are made to discharge documentation<br>To be included in all safeguarding training for staff | End January 2018 | | |

| Ref No | Organisation | Action (What) | Lead (Who) | Detail (How) | Date (By When) | Reviewed by | Date completed |
|---|---|---|---|---|---|---|---|
| 13 | FHFT | Ensure referral is made to fire service for all at risk patients | Deputy Head of Patient safety | Email memo to be disseminated Trust wide to raise awareness of outline the key fire risk factors<br>Email memo to be disseminated Trust wide with contact details for referral to fire safety team | 14th December 2017 | | 13th December 2017 |
| 14 | Housing Solutions | Speak to the HS Telecare Coordinator responsible for completing the installation documentation | Community Services Housing Manager | In 1:1 meeting | End December 2017 | N/A | N/A |
| 15 | Housing Solutions | Liaise with Community Services & IT departments to understand viability of moving the forms online | Head of Business Improvement | Discussions with Louise Lucio-Palk and potentially a change request to be logged with HS IT department. | End January 2018 | N/A | N/A |
| 16 | Housing Solutions | Review documentation to ensure that customers are asked RE their smoking habits and a section to confirm that safeguarding considerations have been taken (and referred if adjudged to be necessary). | Community Services Housing Manager | Reviewing forms and any updates deemed necessary made. | End November 2017 | Head of Business Improvement | 2nd November 2017. |
| 17 | Kimara | Environmental Assessment (persons own home | Deputy Manager | Review and update environmental risk assessment | June 2017 | Registered Manager & Company Secretary | 30 June 2017 |
| 18 | Kimara | Awareness of Fire & Rescue Service | Registered Manager Deputy Manager | Ensure that Fire & Rescue Service is integrated into the risk assessment process and the use material provided by the service | September 2017 | Registered Manager | 30 September 2017 |
| 19 | Kimara | Review Risk assessment process | Registered Manager | Ensure that risk assessment is robust and includes all relevant information | June 2017 | Registered Manager | 2 July 2017 |

| Ref No | Organisation | Action (What) | Lead (Who) | Detail (How) | Date (By When) | Reviewed by | Date completed |
|---|---|---|---|---|---|---|---|
| 20 | Kimara | Staff Training and Update in relation to Fire Safety | Registered Manager | Ensure all staff have up to date awareness of fire risk and the identification of fire risk and the need to report to senior staff | September 2017 | Registered Manager | September 2017 |
| 21 | Kimara | Information Sharing | All staff and managers and directors | Ensure the appropriate sharing of information to all agencies in relation to risk in terms of fire and generally. | Ongoing | Registered Manager | Ongoing |
| 22 | Optalis | All service users referred for Fire Safety Checks from the Fire and Rescue Service, where there are any concerns. | Head of Service | Meeting with the Royal Berkshire Fire and Rescue Service and notification to staff in team meetings and by email of the need to refer | completed | Head of Service Assistant Director | 28/9/2017 |
| 23 | Optalis | All staff to attend mandatory training provided by the Fire Service | Head of Service | To ensure all staff attend fire safety training to raise awareness of fire risks to vulnerable people and when to make a referral to the Fire Service | completed | Head of Service Assistant Director | 15/9/2017 |
| 24 | Optalis | Exploration of feasibility of notification of hospital discharge of people who have a direct payment/self funding to relevant team if there is involvement and they live alone. | Head of Service Assistant Director | Discussion required between Hospital and ASC in relation to feasibility. | February 2018 | Head of Service Assistant Director | |
| 25 | Optalis | Create forum for discussion of people when needs significantly change for reflection to ensure all risks are fully considered. | Head of Service | Quality Circle has been established and case discussions will be included within this forum | completed | Head of Service Assistant Director | |
| 26 | Optalis | Training for staff on the MCA and documenting and mitigating risks where an individual has mental capacity and could be seen as making unsafe choices and is in receipt of funded support. | Head of Service Assistant Director Training Team | Adopt risk framework policy currently being piloted by Bracknell Forest-Council, once approved by the SAB. Staff training | April 2018 | Head of Service Assistant Director | |

| Ref No | Organisation | Action (What) | Lead (Who) | Detail (How) | Date (By When) | Reviewed by | Date completed |
|---|---|---|---|---|---|---|---|
| 27 | Optalis | Explore how smoking and fire risks are routinely identified within the assessment process | Head of Service Assistant Director | Examination of current assessment process and training of staff and possible changes to form | March 2018 | Head of Service Assistant Director | |
| 28 | Royal Berkshire Fire & Rescue Service (RBFRS) | Implement a new course of action where consent has not been given with a referral | Group Manager (LC) | A HFSC operative now makes contact<br>As well as writing to occupant | This changed in September 2017 following feedback from the Peer review team | Group Manager (LC) | Completed September 2017 |
| 29 | RBFRS | Implement new policy and processes for all referrals for persons at risk of fire | Group Manager (LC) | Complete transition to safe and well visits and issue new policy and clear guidance to staff with process maps for all referrals (including high risk and 'no consent') | 31 December 2017 | ACFO (SJ) | |
| 30 | RBFRS | As an interim measure pending new policy and process.<br>Conduct a joint prevention and safeguarding review on all outstanding referrals including those from SCAS and to create an action plan allowing both prioritisation and successful completion within acceptable timeframes. | Safeguarding Coordinator | Assessment of prioritisation of those where RBFRS has been unable to make contact with the individual at risk.<br>RBFRS has provided a list of the outstanding cases to the relevant local authority so that a joint approach can be taken to improve the safety of the occupants. | 15 December 2017 | Group Manager (LC) | |
| 31 | RBFRS | Implement new structure to bring together safeguarding and prevention policy resources | Group Manager (LC) | Agreement with Senior Leadership Team in RBFRS Additional post created. Safeguarding and prevention policy manager in Directorate responsible for Prevention Policy | 30 November 2017 | ACFO (SJ) | Completed 1 December 2017 |

| Ref No | Organisation | Action (What) | Lead (Who) | Detail (How) | Date (By When) | Reviewed by | Date completed |
|---|---|---|---|---|---|---|---|
| 32 | RBFRS | Implement new structure to ensure no single points of failure in referral process | Group Manager (LC) | Agreement with Senior Leadership Team in RBFRS<br>A single data team created with responsibility for processing referrals across two data entry and analysis posts | 1 September 2017 | ACFO (SJ) | Completed September 2017 |
| 33 | RBFRS | Add additional capacity by recruiting more HFSC operatives (Safe and Well technicians) | Group Manager (LC) | The team increased from 3 to 6 | 30 October 2017 | ACFO (SJ) | Completed 30 October 2017 |
| 34 | RBFRS | Add additional managerial capacity by sharing collaborative post with Oxfordshire Fire and Rescue Service | Area Manager (MG) | Shared post to share best practice, create more efficient and effective working and drive innovation | 15 December 2017 | ACFO (SJ) | |
| 35 | RBFRS | Ensure managerial oversight and encouraging the development of a culture of continuous improvement | Group Manager (LC) | Implement structured meetings for teams and one-to-ones reviewing service plans and ensuring action/decisions logs are completed | 20 November 2017 | ACFO (SJ) | Completed 20 November 2017 |
| 36 | RBFRS | RBFRS to seek formal adoption of the Adults at Risk Programme across the 6 unitary authorities in Berkshire | ACFO (SJ) | Through writing to each of the 6 Unitary Authorities in Berkshire | 30 December 2018 | CFO (TF) | |
| 37 | RBFRS | RBFRS to ensure mechanism is put in place to provide Adults at Risk referral statistics to each of the 3 Berkshire SAB's. | Safeguarding Coordinator | A quarterly update is to be provided by the RBFRS Data Team | 30 December 2017 | Group Manager (LC) | |
| 38 | RBFRS | RBFRS to revise the Information Sharing Agreement between RBFRS and SCAS. | Area Manager (MG) | Liaison with SCAS and RBFRS Managers | 30 December 2017 | ACFO (SJ) | |
| 39 | RBFRS | Deliver Safe and Well Training to all front line staff including MECC Level 1 signposting and processes for referrals | Safety Education Manager (NC) and Station Manager (PF) | Safety Education Coordinators and Community Safety Advisors to deliver training to all RBFRS operational crews | Whole time duty staff completed by 22 December 2017<br>Wash up sessions and Retained duty | Area Manager (MG) | |

| Ref No | Organisation | Action (What) | Lead (Who) | Detail (How) | Date (By When) | Reviewed by | Date completed |
|---|---|---|---|---|---|---|---|
| | | | | | staff training will be completed by the end of January 2018 | | |
| 40 | RBFRS | Implement programme of training and mentoring focusing on customer focused outcomes and behaviours and working towards making every contact count | Group Manager (LC) | Develop course with Learning and Development Dept and source and procure a suitable external provider. | 20 February 2017 | Area Manager (MG) | |
| 41 | RBFRS | Carry out audit of effectiveness of new Service delivery hubs | Head of Finance | Engage with Service auditors to carry out an audit of the effectiveness of the new Service Delivery model. Provide a gap analysis and make recommendations for improvement | 1 September 2018 | ACFO (SJ) | |
| 42 | RBFRS | Implement review of corporate targets for Safe and Well Visits and match need to resources | Group Manager (LC) | Utilise | 30 November 2018 | Area Manager (MG) | Completed and implemented1 April 2018 |
| 43 | RBFRS | Continue to work with partners to secure the best data and intelligence to improve the targeting of those most at risk | Group Manager (LC) | Ensure attendance at all relevant meeting.<br>Develop networks and relationships | Ongoing | Area Manager (MG) | Ongoing |
| 44 | South Central Ambulance Service NHS Foundation Trust (SCAS) | Safeguarding briefing document to be sent to all Staff | Head of Safeguarding & prevent lead | | 31/01/18 | | |