SU

SAFEGUARDING ADULTS REVIEW

OVERVIEW REPORT

JULY 2018

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1. INTRODUCTION

1.1 The Care Act 2014, Section 44, requires that Safeguarding Adults Boards must arrange a Safeguarding Adults Review when certain criteria are met. These are:

- When an adult dies as a result of abuse or neglect, or has not died but experienced serious abuse or neglect, whether known or suspected, and
- There is a concern that partner agencies could have worked more effectively to protect the adult.

1.2 Safeguarding Adults Reviews are required to reflect the six safeguarding adult's principles as defined in the Care Act. These are empowerment; prevention; proportionality; protection; partnership; and accountability.

1.3 There are two clear aims of the Safeguarding Adults Review. Firstly, the review should lead to tangible improvements in the safety and wellbeing of adults at risk. Secondly, the review should provide a legacy to SU (initials of adult at risk) and a comfort to SU'S PARTNER (initials of partner).

1.4 There are clear review objectives which have been met, in order to meet these aims. Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the facts (what happened), an analysis and findings (what went wrong and also what went right), the recommendations to improve services and to reduce the risk of repeat circumstances, and an agreed action plan to implement these recommendations. It is not the purpose of the review to re-investigate the suspected abuse or neglect, or to apportion blame to any party.

1.5 The review process to meet these aims and objectives has followed a clear path. The Independent Reviewer has conducted research by analysing relevant records held by involved agencies (and chronologies where available) and by interviewing representatives of agencies.

1.6 Whilst there is some contextual information from 1997, the review has concentrated on the most relevant period, from 2010 to 2016.

1.7 SU'S PARTNER has participated fully in the review; providing a pen picture of SU and contributing to discussion on how services can change to reduce the risk of similar circumstances affecting others, as a legacy to SU. She feels that SU 'would like something positive to come out of something so terrible.'

1.8 Representatives of agencies contributing to the review are listed below (titles are those which applied during the reporting period):

- Partner of SU

- Interim Team Leader – Adult Social Care, North Locality Team
- Social Worker – Adult Social Care, Community Review Team
- Team Leader – Adult Social Care, Short Term team
- Senior Commissioning Lead – Adult Social Care, Commissioning Section
- Team Manager – North Kingston Recovery Support Team, South West London and St George's Mental Health Trust
- Community Psychiatric Nurse (CPN) - North Kingston Recovery Support Team, South West London and St George's Mental Health Trust
- Registered Care Manager – Caremark (Kingston) Care Agency
- General Practitioner (GP) – Churchill Medical Centre
- Station Manager, Commander – Kingston Fire Station
- Lead Nurse, Safeguarding Adults - Kingston CCG
- Detective Constable – Metropolitan Police Service

2. CIRCUMSTANCES LEADING TO THE REVIEW

2.1 SU (DOB 14/05/55) died, aged 61, at his home address in New Malden, within the London Borough of Kingston upon Thames, on 12 October 2016. He was bedbound and immobile following previous strokes and had a history of epileptic seizures, controlled by medication, as a result of a previous traumatic head injury. SU was known to smoke hand-rolled cigarettes and cannabis in bed. He suffered a seizure and, either as a consequence of or separate to this, dropped a lighted cigarette onto his bedclothes; leading to a fire in the bed area and his death, as he was unable to move and escape from the fire.

2.2 The Kingston upon Thames Safeguarding Adults Board was satisfied that the conditions for a Safeguarding Adults Review were met in regard to SU.

2.3 There are relevant enquiries which have preceded and overlapped with this independent review. As there were grounds to suspect the abuse or neglect of SU, a Section 42 Safeguarding Adults Enquiry was undertaken, following a referral by the London Fire Brigade on 13/10/16. The enquiry has concluded in June 2018, finding that there was an inadequate response by involved agencies to SU's needs. The enquiry pointed to the lack of a reassessment and updated care planning and the lack of fire safety advice and support to SU. Actions to improve services and reduce the risk of a re-occurrence were agreed and this review recognises and incorporates an overview of these actions.

2.4 A Metropolitan Police enquiry had also been initiated following the incident, which was completed without recourse to criminal charges against any party.

2.5 The review has also overlapped with a Coroners' Enquiry, West London jurisdiction, which was concluded on 07/06/18. The Conclusion given was that 'the deceased died

in a fire at his home when his lighted cigarette came into contact with his bedclothes, either due to an accident or a seizure.' The medical cause of death was found to be:
1a: Cardiorespiratory arrest
1b: Injuries sustained in a fire
2: Previous Stroke

2.6 On 07/06/18, the Coroner issued a *Regulation 28 Report to Prevent Future Deaths*; raising a concern that the fire safety message in the NHS National Patient Safety Agency report on 26/11/07, entitled *'Fire hazard with paraffin based skin products on dressings and clothing"*, has not been heeded by patients and organisations with a duty of care. The Coroner has required that specific actions are taken to address this concern, which are referenced and incorporated in the recommendations and action plan in this report.

2.7 The review has been coordinated by an Independent Reviewer from May to July 2018. The role of the Independent Reviewer incorporates responsibilities as the Safeguarding Adults Review meeting chair and the author of an overview report and an executive summary report.

2.8 Key themes that have arisen and been explored in the review are listed below and form the structure of the analysis and findings later in the report:

- Responsiveness of agencies
- Adult Social Care allocations, pathway and communication
- Multi-agency information sharing, needs and risk assessments; incorporating health and social care needs, carer and relationship stress and fire risk
- Underpinning consideration of mental capacity, independence and personalisation.

3. PEN PICTURE of SU

3.1 SU spent his childhood in Bury, Lancashire, as one of three children. He had a brother (deceased) and sister and regretted losing contact with his mother and siblings on leaving the area. His sister more recently located him and renewed family contact, which continues to extend to SU'S PARTNER. He worked as a newspaper printer's assistant in Manchester for over ten years and stopped working in 1989. SU moved to Kingston in 1990 and worked as a barman in a pub.

3.2 He experienced an unprovoked and serious assault by a mentally unwell man who hit him on the head and ribs with a machete in 1997. SU'S PARTNER, who he met in 1999, has explained that he was never the same since the assault. The couple separated for two years at one point and, having met again when he was homeless, they lived together thereafter. SU'S PARTNER relates that SU could become frustrated due to his circumstances and they argued at times, which they would then resolve shortly afterwards, and it is clear that they shared a very committed and

loving relationship. SU also, understandably, sometimes presented as rude to others due to his tiredness and frustration at not achieving his wish to be more independent in mobility and daily activities.

3.3 SU is described by his partner as a private, independent, loving, generous, provocative and intelligent person. He developed a love of the country and culture of Russia; of music, particularly Russian marches and the songs of Leonard Cohen; and of the poems of John Cooper Clark. SU also enjoyed drinking at home and in the pub, smoking hand-rolled cigarettes and cannabis, and shopping with his partner. He was interested in reading newspapers and listening to radio programmes on politics, and was also interested in sport. SU'S PARTNER recalls that he would share lots of laughs with his carers. These characteristics endured to the end of his life.

Impact Statement by SU'S PARTNER – JS has reflected very positively on the impact of the Safeguarding Adults Review on her healing process following the loss of SU. She states that the review has helped her to be in a better place and she is glad that she can help others through shared learning. JS further commented that the review "allowed my grief to become less a mourning, more of the joy of remembering him…it was a turning point for me talking to you…you have helped me immensely".

4. FACTS 2010 – 2016

Prior to 2010:

4.1 SU was the victim of an assault in 1997 when he was attacked by a stranger with a machete, resulting in a serious head trauma. As a consequence, he experienced a range of mental and physical health concerns immediately and over subsequent years, including; slight cognitive impairment, depression (he was prescribed anti-depressants), drug and alcohol dependency, severe pain, epileptic seizures, heart disease and strokes in December 2009 and May 2011, and double incontinence (catheter was fitted and he used continence pads). SU was paralysed down his left side, with some mobility on his right side retained, leading to the use of a wheelchair and needing a hoist and two carers for transfers. He required access to 24 hour care, was largely bedbound on an airflow mattress, and needed assistance with all personal care tasks. His partner has also experienced her own mental health concerns.

January 2010 to December 2013

4.2 SU was known to Kingston upon Thames Adult Social Care from 19/02/10, following a hospital referral for assessment and services on discharge.

4.3 Caremark (Kingston) care agency were spot purchased by Adult Social Care to provide support to service users and were the care provider to SU throughout the reporting period. A care plan for SU was implemented by Adult Social Care via

Caremark from 10/08/10. This initially consisted of two calls each day by two carers, at 9.00 am for an hour and at 18.30 pm for 45 minutes, to support SU with personal care and sometimes transfers from bed to a commode or shower. SU'S PARTNER always managed SU's medication, initially independently and subsequently with the support of blister packs and carers reminders, as it was not clear that medication was always administered correctly. These reminders were not in SU's care plan. SU'S PARTNER also prepared meals.

4.4 SU was admitted to hospital on thirteen known occasions between 13/08/10 and 04/06/13, for between two and ten days. On five of these admissions, Caremark advised Adult Social Care. The reasons for admission included a heart attack in November 2010, a stroke in February 2011, a major stroke in May 2011, sickness in July 2011, and a suspected heart attack in August 2011. Adult Social Care considered that the same level of care was required following each hospital discharge.

4.5 There were 11 GP consultations with SU during this period, either home visits or visits to the surgery.

4.6 An Adult Social Care Social Worker was allocated to support SU from 17/08/11 to October 2015. At the time of allocation, an additional daily domiciliary care visit was provided via Caremark, consisting of a 30 minute lunch time call to support personal care; changing a continence pad and emptying a catheter bag. This remained the level of domiciliary care up to the date of the incident in October 2016.

4.7 Review home visits were completed on 18/10/11 and 24/02/12, involving the allocated Social Worker and the Caremark General Manager. On the second of these, SU'S PARTNER advised that SU had become very slow in feeding himself, although remaining independent in this task, and she was more anxious in her caring role. SU'S PARTNER requested and received agreement to the provision of 36 hours relief care per year at the end of March 2012; also receiving agreement to the provision of three single weeks per year live-in respite care (previously receiving one week per year).

4.8 On 03/08/12 and 15/08/12, the London Fire Brigade completed visits to properties in the same street as SU but, as these were unprompted visits to addresses in order to offer fire safety checks, those carried out were recorded and those declined were not (in line with standard operational practice). It has not been established whether SU and SU'S PARTNER were visited and had declined entry on this occasion.

4.9 The final Adult Social Care overview assessment was completed on 19/03/13, in large part reflecting previous information, with further detail. At this time, it was understood that SU had suffered an epileptic seizure on 16/02/13. He refused hospital admission and his General Practitioner visited, prescribing medication to control the seizures. The GP advised Adult Social Care on 22/02/13 that SU was suffering from epilepsy and could not be left on his own. In the overview assessment, it was recognised that the 3 week respite care per year would have to cover 24 hours per day and the 2 hour break does not appear to have been a consideration. SU was described as having no difficulty in communication (he used a mobile phone) and

presenting as generally positive about the future, with occasional low mood and bouts of depression; becoming rude at times to others due to low mood and tiredness. Mild cognitive impairment was recognised and he was assessed as orientated to time, person and place, and able to make decisions about his care independently. SU felt afraid and isolated when left alone and he required reassurance. SU'S PARTNER would hold his hand at night until he fell asleep. He either spent time in bed or, less commonly, sitting in a wheelchair. SU lacked awareness of safety issues whilst transferring and required the assistance of two carers and a standing hoist, with a risk that he might attempt to leave his bed to use the commode and fall. His partner supported personal care between agency carers visits, managed his medication, provided meals and drinks, completed housework and laundry, and handled paperwork. In terms of personal care, SU required assistance with cutting up food, but could feed himself, and he required two carers to assist with washing, dressing and undressing. He was supported by a Brain Specialist in setting goals, such as visiting Richmond Park. A carer's assessment was incorporated in the overview assessment as SU'S PARTNER declined a separate carer's assessment. It was acknowledged that SU'S PARTNER had her own history of mental ill health (she was receiving treatment and support) and, whilst stressed in providing care to SU, she continued to be committed to her caring role.

4.10 From May 2013, the Care Plan made further provision for 3 single weeks live-in respite care per year via Caremark. This comprised 22 hours support each day and night, including on-call assistance at night (from 9 pm to 7 am). The care incorporated assistance at night with transfers to use the toilet, changing bedclothes when wet, changing pads and rubbing his skin with cream, and support with turning at least three times. This support enabled SU'S PARTNER to stay with her parents for breaks to recuperate. A 2 hour gap in care provision occurred between 2.00 and 4.00 in the afternoon, enabling the agency carer to take a break. SU'S PARTNER would book these dates when stressed and could access the care quickly. During these respite periods, SU continued to receive the routine 3 visits per day (one carer to supplement the person already on site). Also, 72 relief care hours per year were provided via Direct Payments.

4.11 A review home visit was completed on 09/07/13, involving the allocated Social Worker and the Caremark General Manager. SU wished to relocate his bedroom space to downstairs and SU'S PARTNER had concerns about the move. He also expressed a wish to travel to Richmond Park and Kingston Town Centre to protest against the Government. SU'S PARTNER said that she would discuss accompanying him and the support that she would need, following a wheelchair assessment which was due the following week. She also provided an update on her own mental health, explaining that she was experiencing further auditory hallucinations.

4.12 The Caremark General Manager met with SU and SU'S PARTNER later in July to check that SU was receiving support from the agency carer with exercises. This was followed by a home visit on 06/08/13, involving the Social Worker and Caremark General Manager, in which agency carers were shown how to support SU with new

exercises. SU'S PARTNER expressed concern that SU was experiencing more and longer epileptic seizures and had a major one earlier in the day, which SU contested.

4.13 In line with the care plan, Caremark provided relief care from 23/06/11 to 04/07/11 in the form of waking nights; also 04/12/11, 18/05 to 26/05/12 and 14/08 to 21/08/12 as on-call at night. Live-in respite care was provided by Caremark from 18/05 to 25/05/13 and 04/10 to 11/10/13.

January 2014 to August 2016:

4.14 Caremark provided live-in respite care from 24/03 to 31/03/14, 29/05 to 06/06/15, 18/08 to 25/08/15, 09/11 to 16/11/15, 02/04 to 09/04/16 and 04/06 to 12/06/16. SU'S PARTNER has commented since the incident that she feels she would have benefited from an increase in respite care. Whilst breaks could be arranged quickly, she felt that these tended to be after she had already worked through a difficult time.

4.15 A review home visit was completed on 01/04/14 by the allocated Social Worker and the Caremark General Manager. SU'S PARTNER wished to continue to manage SU's medication. It was agreed that Caremark would support SU with eating his lunch.

4.16 It is noted in Adult Social Care records on 14/04/14 that SU continued to receive the support of 2 carers, 3x daily for transfers, personal care and support with medication. The records also indicate an issue with the consistency of carers attending. SU'S PARTNER has commented since after the incident that both she and SU had a good relationship with Caremark carers, although she feels that they did not have enough time to complete tasks as they tended to have to rush to the next visit.

4.17 A review home visit was completed on 22/05/14 by the allocated Social Worker and the Caremark General Manager. SU'S PARTNER reported that SU had been sitting in his wheelchair downstairs but it was broken and he had to return upstairs to bed. He was awaiting an assessment the following week for a new wheelchair. SU continued to experience minor leg tremors. He was receiving support with taking showers and carers were encouraging him to have these more often. His medication was now in blister packs.

4.18 On 17/09/14, a Social Work home visit was undertaken to review SU's personal budget (changed from the initial contract to a personal budget on 13/04/14) and his care package. His partner expressed that she was feeling tired as he was waking three to four times per night and needing support.

4.19 On 03/10/14, the Social Worker rang SU'S PARTNER, who expressed that she was feeling unhappy and depressed. Her Community Psychiatric Nurse (CPN) had visited the previous day and was visiting weekly. A Psychiatrist had prescribed new medication.

4.20 On 17/10/14, the London Fire Brigade attended the property as SU'S PARTNER was locked out. This was described as a Special Service Call and the crew enabled SU'S

PARTNER to enter the property. It appears that risk information was not taken on the call and they were not aware that a vulnerable person (aside from SU'S PARTNER) was living at the address. The crew did not enter the premises or offer a fire safety check.

4.21 A review home visit was completed on 02/12/14 by the allocated Social Worker and the Caremark General Manager. SU expressed a wish to be more independent but was unable to access downstairs as his wheelchair was broken. He said that he felt depressed when his partner went out swimming, shopping and for coffee with a friend. It was noted that CPN contact with SU'S PARTNER had reduced from weekly visits to fortnightly phone calls.

4.22 There were 10 GP visits, either at home or the surgery, recorded for SU during this period. On 19/12/14, Dr Epstein (GP) completed a home visit to SU as SU'S PARTNER was concerned about an increase in his epileptic seizures. SU'S PARTNER reported that she was tired due to SU's need for support at night. Dr Epstein relayed this concern to the allocated Social worker on 23/12/14, who agreed to undertake a reassessment.

4.23 SU was admitted to hospital on three occasions during this period; from 21/12 to 22/12/14, 31/01 to 05/02/16 and 14/06 to 24/06/16.

4.24 On 22/12/14 the Social Worker completed a joint home visit with the Caremark General Manager, following a phone call from SU'S PARTNER on the same day to say that SU does not trust her and wishes her to leave. On visiting, SU'S PARTNER said that SU had been confused due to a urine infection and possibly due to a change in medication that he was now calm and they both wished to continue to live together.

4.25 On 15/01 and 19/02/15, the Social Worker rang the Caremark General Manager for an update on the care provision, and there were no concerns relayed about care.

4.26 The Social Worker rang SU'S PARTNER on 26/02/15. SU continued to have severe epileptic seizures and had dislocated a knee during one episode. He had refused to consider hospital admission, despite this being suggested by his GP and agency carer. SU was still awaiting provision of a wheelchair and the Social Worker made calls on subsequent days to the Wheelchair Service on his behalf to request this provision.

4.27 On 19/03/15, SU'S PARTNER rang the Social Worker to report that she was experiencing problems with neighbours who she felt were spying on her. She said that she had been attempting to contact her CPN to discuss her anxiety.

4.28 The Social Worker completed a home visit to SU'S PARTNER on 20/3/15. SU'S PARTNER presented as anxious and was awaiting a CPN visit the following week.

4.29 On 22/04/15, the Social Worker rang SU'S PARTNER, who requested live-in respite care for one week from 29/05/15.

4.30 The Social Worker visited SU'S PARTNER at home on 07/05/15, due to concerns relayed by SU'S PARTNER that she was not managing and that she and SU were arguing. A review was scheduled for 20/05/15.

4.31 A review home visit was completed on 20/05/15 by the allocated Social Worker and the Caremark General Manager. SU said that he wished to move downstairs, but the lift was not working and an adjustment to the kitchen level was required. It was noted that SU would become frustrated and could exhibit angry rages, screaming and swearing at his partner. SU'S PARTNER had no concerns about the agency carers but SU requested that one particular carer, who he did not get along with, should no longer visit him. An agency carer was supporting SU'S PARTNER in organising personal budget payments at the bank. SU'S PARTNER planned to speak to District Nursing about the availability of more absorbent continence pads for SU.

4.32 The Social Worker completed a home visit on 28/7/15, during which SU'S PARTNER expressed concern that SU was lacking motivation and that she had discussed this with the GP surgery. She did not raise concerns about his care needs at this time.

4.33 On 06/10/15, the Social Worker rang SU'S PARTNER to advise that the case had been transferred to the review system for annual review as the situation was considered to be stable and there were no concerns. This decision was taken because SU'S PARTNER was managing the coordination of care via direct payments and had been engaging with the Social Worker, CPN and GP about her own situation. It was therefore considered that the risks were managed and there was not a need for micro- management or constant monitoring. Subsequently, on 13/10/15, SU'S PARTNER rang Adult Social Care to request Social Worker allocation. Since the incident, SU'S PARTNER has commented that they received fewer Social Work home visits following transfer to the review system.

4.34 The previously assigned Social Worker rang SU'S PARTNER on 19/10/15, who expressed no concerns about her caring role or the care received. She was due to meet with the CPN on the same day to raise concerns about the support she was receiving in regard to her own mental health. The Social Worker agreed to discuss social work reallocation due to these concerns. The Mental Health Recovery Support Team nursing and medical notes state that a thorough medical review was completed, with the CPN present, on this date; followed by a letter to the GP. I understand that these records also indicate that, at the time, there were regular appointments with JF to discuss coping strategies regarding ongoing stress and mental health symptoms.

4.35 On 27/10/15, the same Social Worker rang SU'S PARTNER to receive feedback on her meeting with the CPN. SU'S PARTNER expressed that she was unhappy with the level of support provided by the CPN in relation to her mental health. It is understood that SU'S PARTNER's CPN left post on 24/10/15 and that the CPN allocated on 27/10/15 made an introductory phone call to SU'S PARTNER. The Mental Health Recovery Support Team also state that regular visits (6 recorded in year leading up to the incident) and telephone contact (two to three times per week) continued to be in

place to monitor SU'S PARTNER's mental health and wellbeing, including considerable liaison with Housing regarding accommodation. The Social Worker advised SU'S PARTNER that the transfer to the review system would proceed as she had conveyed no concerns about the care package to SU, that there were no increased needs and there was no request for increased support.

4.36 The Social Worker completed a transfer summary on 06/11/15 for the case to enter the review system.

4.37 On 09/11/15, a different Social Worker rang SU'S PARTNER to arrange an annual review home visit. SU'S PARTNER advised that she would be away on a break until 16/11/15 and the Social Worker agreed to ring her on the day after her return.

4.38 On 30/11/15, SU'S PARTNER rang Adult Social Care Administrators to request 24 hour care as SU was in severe pain and calling out through the day and night. She said that she was unable to sleep and relayed concern about the impact on her mental health. The message was passed to the Short Term Team to follow up.

4.39 On 01/12/15, SU'S PARTNER made a further call to Adult Social Care Administrators and presented as very distressed. She asked for someone to ring her, that she was unable to care for SU any longer and needed help. A return call was attempted on the same day but there was no reply; followed by a call to the Caremark Registered Manager who said that SU'S PARTNER 'gets down' if she loses sleep, that the couple receive care at night due to his epileptic seizures and that care is working well. This was followed by a further phone call by Adult Social Care to the CPN, who said that she wished to attend the planned review home visit.

4.40 The previously allocated Social Worker rang SU'S PARTNER on 02/12/15. SU'S PARTNER said that she was experiencing additional stress and anxiety due to SU's increased pain during a temporary change in medication, which was managed again and she had no concerns about his care package. It was confirmed that another Social Worker would conduct the planned review home visit.

4.41 On10/12/15, the Social Worker assigned to complete the review rang SU'S PARTNER, who said that she was stressed as SU was in increasing pain over the previous three to four weeks and would cry out in agony. He was also becoming frustrated with her when she tried to make him comfortable and she would sometimes shout back at him.

4.42 A GP visit was completed on the same day to review SU's condition and the medication prescribed to manage his pain. SU advised the GP that he was feeling down but was not feeling suicidal. He declined the offer of a referral to the Community Mental Health Team.

4.43 A review home visit was completed by the Social Worker and the Caremark General Manager on 11/12/15. SU said that he was happy with the agency carers and had particular praise for one in particular. He commented that he had been in a lot of

pain recently. Referring to the GP visit on the previous day, SU said that the doctor had examined him and prescribed Oramorph (morphine) medication to reduce the pain in his leg; he then wished to be able to have showers and to access downstairs every day. SU'S PARTNER said that she was happy with the quality of domiciliary care and communication, that she could ring the Caremark Registered Manager for live-in respite care when she was feeling anxious and needed a break. She felt that the support was working well and did not need to be increased. SU'S PARTNER said that she did not feel supported by the CPN and that she was unable to contact her when she needed to talk. It was decided to continue with the direct payment arrangement for three weeks live-in respite care and funds for the relief care sitting service, both via Caremark. The situation would be reviewed in six months' time as care provision was stable and SU'S PARTNER and Caremark could notify other agencies of any changes in the meantime.

4.44 On 15/12/15, SU'S PARTNER rang the same Social Worker to say that she and SU were 'alright'; that SU was feeling much better since receiving the prescription for morphine medication.

4.45 On 04/01/16, the Social Worker rang SU'S PARTNER regarding the relief care payment. SU'S PARTNER said that she was feeling very stressed as SU was still in pain despite an increase in the morphine dose. She said that her CPN had missed an appointment on 23/12/15 (contrary to Recovery Team records) and she had made many attempts to ring, without success, due to the CPN being unwell. A triage nurse had advised her to rest and to complete calming activities, such as swimming, when feeling panicky. However, she felt too tired to swim. The Social Worker advised SU'S PARTNER to arrange relief hours with Caremark, which she agreed to do. SU'S PARTNER commented that all was fine with SU, except for the pain he was experiencing.

4.46 On 14/01/16, the Social Worker rang SU'S PARTNER to arrange a home visit for 20/01/16, in order to complete personal budget paperwork. SU'S PARTNER advised that SU was still in a lot of pain, was very agitated at times and had become slightly confused. His morphine dose had been further increased and the GP was due to ring the following week to complete a medication review. SU'S PARTNER was expecting a visit from her CPN and a Psychiatrist on 15/01/16, following previous reported cancellations. This has not been verified, but it is recorded by the Recovery Support Team that the CPN visited SU'S PARTNER at home on 23/12/15, 02/02/16 and 25/02/16.

4.47 On 22/01 and 29/01/16, the Social worker rang SU'S PARTNER in response to her calls regarding SU's personal budget direct debit.

4.48 SU'S PARTNER rang the Social worker on 01/02/16 to advise that SU had been admitted to St George's Hospital on 31/01/16, due to a major epileptic seizure and a possible stroke; that he had developed a weakness on his 'good side.' The Social Worker rang SU'S PARTNER on 05/02/16 for an update. She confirmed that SU had experienced a major seizure and a minor stroke which had caused weakness to his

left side, and that he was due to be discharged home. He was taking antibiotics due to chest and urine infections. SU'S PARTNER rang the Social Worker on 15/02/16 to update that SU had returned home. She was informed that, as the review had been completed, the case would be closed and would be due for review in six months. In the transfer summary completed by the Social Worker on 22/02/16, it was noted that SU'S PARTNER's care plan was assigned to a worker in the Community Mental Health Trust. The Review Team Health and Social Care Plan, stipulating ongoing domiciliary care and direct payment support from 01/02/16, referred to 3 domiciliary care visits (2 carers) per day, 3 weeks live-in respite care per year and an allowance for flexible relief care mini-break hours. The 2 hour gap per day in respite care is not clearly set out in this document.

4.49 SU'S PARTNER rang the same Social Worker on 30/03/16 and conveyed that she was feeling anxious due to neighbours complaining and to her own physical health concerns. She said that SU was fine and was getting better, and that one week live-in care had been arranged from 02/04/16. SU'S PARTNER confirmed that both the GP and CPN were aware of her increased anxiety and were due to visit, and the Social Worker agreed to contact the CPN to discuss her circumstances. SU'S PARTNER further contacted the Social Worker on 01/04/16 to update that the CPN and Psychiatrist had visited her earlier on the same day and that she had been prescribed anti-psychotic medication. There is a Recovery Support Team record of a Psychiatrist telephone contact with SU'S PARTNER on 31/03/16 to assess her situation and to prescribe medication, but not of a home visit on the following day.

4.50 On 07/04/16, SU'S PARTNER rang the Social Worker to say that she was feeling much better, had no concerns and was currently staying with her parents for the one week respite care arrangement.

4.51 The London Fire Brigade attended the property on 11/04/16 at 17.44 (arriving 5 minutes following the request call), as SU'S PARTNER was in the property and could not unlock the door to give access to the agency carer. One fire engine crew attended and remained on the scene for less than 10 minutes, springing open the lock. It was considered to be a routine call and the officer in charge did not have information on vulnerability. SU'S PARTNER is understood to have declined access to the crew and a fire safety check was not offered. In the event of risk circumstances, a Serious Outstanding Risk (SOR) form is completed with follow-up action taken, but risk was not identified on this visit. SU'S PARTNER states that officers did not go upstairs to see SU and did not provide advice on fire safety.

4.52 On 15/04/16, the CPN, Psychiatrist and a second doctor jointly visited SU'S PARTNER at home, completing a full assessment and recommending therapy at the Maudsley Hospital; and also explored her anxiety about the neighbours.

4.53 On 26/05/16, SU'S PARTNER reported to the General Practitioner that SU had experienced a seizure in the previous week, but that this had been 'not as bad as previously'. The surgery did not receive any other reports of seizures in the six

months prior to SU's death and have stated that the anti-epileptic medication had not been altered during this period.

4.54 On 01/06/16, SU'S PARTNER rang Adult Social Care to request the use of relief care hours. The request was relayed by the Contact Centre to the Short Term Team. On 02/06/16, the request was relayed to the North Locality Team via a system message and phone call.

4.55 A GP home visit was completed on 03/06/16, at which SU said that he was not experiencing drowsiness as a side effect of the morphine prescription.

4.56 SU'S PARTNER rang the Social Worker on 28/06/16 to advise that SU had been discharged home from St George's Hospital on 23/06/18, following a further admission. He had been admitted due to sepsis and aspiration pneumonia and still had a fever. She was expecting a call from the GP on the same day regarding a prescription for antibiotics. SU'S PARTNER agreed to ring the Social Worker the next day with an update on the GP response.

4.57 A GP home visit and phone call were attempted on 29/06/16, but there was no reply received.

4.58 On 06/07/16, the previously assigned Social Worker rang SU'S PARTNER. She said that she had no current need for respite care and had available time if a need arose. It was confirmed that a review would be arranged for August 2016.

4.59 A GP visited SU on 11/07/16 and identified that he had a mild urinary tract infection (UTI), prescribing antibiotics. It was confirmed that SU was not experiencing drowsiness as a consequence of the morphine administration. The surgery state that a formal medication review was undertaken on this and all other face to face contacts, with smaller medication reviews undertaken during telephone contacts with SU'S PARTNER.

4.60 On 17/07/16, the GP completed a home visit. This was one of a number of contacts by the GP practice over the summer of 2016.

4.61 On 19/07/16, SU'S PARTNER attempted to ring a Social Worker and, on receiving no answer, rang the Adult Social Care Contact Centre. The Contact Centre sent an internal system message to the Long Term Team duty tray, requesting a non-urgent response. SU'S PARTNER had relayed that SU was still unwell following hospital discharge and she was struggling as he was incoherent and seeming irrational. She had contacted the GP and his morphine dose had been further increased. SU'S PARTNER asked to speak with a Social Worker and was advised that a review was due in August 2016.

4.62 An Adult Social Care Support Officer rang SU'S PARTNER on 25/07/16, who asked to speak with a Social Worker as SU was unwell and she was feeling anxious. She was advised that there was not an allocated Social Worker and SU'S PARTNER said that

she would await the review, as the three daily domiciliary care visits were sufficient to meet his needs.

4.63 A Care Plan Review home visit (the final one) was completed by the Social Worker on 11/08/16. SU was not included in the review as he was asleep during the visit. There was no change identified in SU's care needs and the care plan remained unaltered. The case was returned to the review tray for a review in six months.

4.64 On 31/08/16, SU'S PARTNER rang the GP who further increased the morphine dosage to manage increasing pain.

September to October 2016:

4.65 SU'S PARTNER contacted a Long Term Team Social Worker on 09/09/16, to advise that SU's health had deteriorated significantly, his care needs had changed and he could not be left alone. He was waking at night in pain and the GP had prescribed increased morphine. She was supporting him with eating and drinking and she felt exhausted. SU'S PARTNER felt that SU needed supervision when smoking and was a danger to himself if left alone. It was noted that the case was not allocated and was pending review in February 2017. SU'S PARTNER felt that she needed a break but was saving the remaining one week (of three) respite care until January 2017. It was agreed that SU'S PARTNER would contact Caremark and book relief care, and she decided to wait one week until a preferred carer was available. The Social Worker agreed to seek advice from her manager about the situation and to call SU'S PARTNER back on the same day, but this call did not happen. The case was transferred back to the Short Term Team for action, without a Social Worker handover on the change of circumstances, and was pended until 12/09/16.

4.66 On 09/09/16, SU'S PARTNER rang Caremark to express that she was feeling very tired, was having to support SU with eating and was being kept up by him at night. SU'S PARTNER said that she had spoken to the Social Worker (who had completed the previous review home visit), who had agreed to look into increased relief hours and some waking nights to provide her with a break. This contact was followed on the same day by the Social Worker ringing Caremark to confirm the arrangement, and it was also agreed that agency carers would continue to provide dietary support to SU.

4.67 There was no face-to-face GP contact during this period. On 10/09/16, SU'S PARTNER rang the GP and pain medication was further increased to manage more severe pain. There is no indication that SU'S PARTNER mentioned a need for further support during this contact.

4.68 On 12/09/16, the Community Psychiatric Nurse rang a Short Term Team Support Coordinator to advise that SU'S PARTNER was present and required emergency respite care; that she was exhausted and could no longer cope with the task of caring

for SU. SU'S PARTNER was attending an appointment with the CPN to review all her concerns and she remained compliant with her prescribed medication. The Support Coordinator advised that SU'S PARTNER should access the one remaining respite week and that she would be contacted to arrange a reassessment/ review. There was no reference to the concern that SU'S PARTNER had recently relayed to Adult Social Care about the need for 24 hour cover that it was unsafe for him to be left alone; also supervision with smoking was not addressed in the care plan. SU'S PARTNER said that she was upset about SU's deterioration, that he was in a lot of pain and was taking 35 mg morphine in the morning and at night; that he was generally 'out of it' or in so much pain that she had to restrain him.

4.69 On 12/09/16, the case was transferred by a Senior Social Worker in the Short Term Team to the North Locality Team allocation tray, via a system message, for an urgent review/ reassessment of SU's needs. The Short Term Team had not seen the case note in which SU'S PARTNER advised that SU could not be left alone, so this did not form a part of the message.

4.70 SU'S PARTNER contacted Caremark to book one week respite care, deciding to wait a week for availability of a preferred carer, and on 15/09/16 rang her CPN to inform that she would be starting respite the following weekend. On 21/09/16, Caremark contacted SU'S PARTNER to confirm that the usual live-in carer would arrive on 10/10/16 for the arranged respite break, which was up to 12/10/16.

4.71 On 26/09/16 (the final ASC case note before the incident), SU'S PARTNER rang the Adult Social Care Contact Centre several times to say that she was about to have a 'breakdown' and, even with the respite arrangement on the following Monday, could no longer cope. She requested an urgent phone call response. An electronic system notification was not sent by the Contact Centre to the Short Term Team, but was relayed to two North Team Social Workers (without copying to a Senior) to contact SU'S PARTNER urgently. The message was not picked up by a Social Worker until day of the fire and contact was therefore not made. Also, the ASC pathway did not make provision for a follow-up phone call or email to North Team to ensure receipt of the message. Allocation for reassessment was pended by the North Team Manager until SU'S PARTNER's return from booked respite. It was clearly acknowledged that reassessment was the correct course of action, as this was planned on the return of SU'S PARTNER from her break.

4.72 On 12/10/16, there was a fire at SU's home. Either SU or the agency carer lit his cigarette and at 14.20 the carer left for her break (shortly before the fire started). SU had an epileptic seizure, which may have caused him to drop the cigarette, or the cigarette may have been dropped otherwise. When the fire started, SU was unsupervised and lying on an air-filled mattress. The bedclothes would have had the residue of emollient cream that was applied to his skin as a part of the personal care he received. When the Caremark carer returned to the property after her break, she discovered that there had been a fire in the bedroom and that SU had died. SU'S PARTNER believes that SU may have felt alright to smoke alone on this occasion as he was apparently feeling relatively well on that day. The London Fire Brigade were

called at 14.55 and were on the scene at 15.02, finding the body of SU on the first floor at 15.06.

5. ANALYSIS AND FINDINGS

5.1 Introduction and responsiveness of agencies

There were clear deficits in the care provided to SU and SU'S PARTNER during the reporting period and involved agencies have a duty of care to embrace the learning involved, thereby reducing the risk of similar tragic incidents occurring in the future. These aspects are addressed in some detail within the remaining sections of this report. However, it is also proper to recognise that a fairly comprehensive care needs assessment and care plan were in place for a considerable period and there is evidence that all agencies endeavoured to respond to the presenting needs of SU and SU'S PARTNER throughout the reporting period. It is also notable that the recently completed Safeguarding Adults Enquiry has already led to findings, recommendations and actions, which this report will seek to incorporate and add to.

5.2 Adult Social Care allocations, pathway and communication

Allocations: In SU's experience, there was an allocated Social Worker from August 2011 to October 2015. During this period, it is evident that an attentive Social Work relationship with SU and SU'S PARTNER had developed; alongside close working with Caremark care agency. This placed Adult Social Care and Caremark in a pivotal position to identify and respond to any significant changes in needs and risk levels. In the final year of this period, from September 2014 to October 2015, the allocated Social Worker had thirteen contacts with the couple, and the nature of these is significant. She completed seven home visits, made five phone calls to SU'S PARTNER and received one phone call. However, it should be noted that allocation did not appear to lead to close working with the Community Psychiatric Nurse or to proactive consideration of fire risk, as referred to later in this section.

In the following year, from October 2015 to October 2016, a Social Worker was not allocated to SU. The rationale for this decision was that SU's personal care needs were stable and the care plan was in large measure meeting these needs. However, this decision did not take proper account of the complex, fluctuating and increasing health and social care needs experienced by SU, the increasing risks associated with carer and relationship stress, and the risk of fire. During this period, it is notable that Social Work contacts actually more than doubled to twenty nine. However, these comprised one (or possibly two) home visits, twelve phone calls to SU'S PARTNER and fifteen phone calls from SU'S PARTNER. This demonstrated a marked increase in SU'S PARTNER conveying that she and SU were experiencing difficulty in managing and Social Work responses tended to be reactive to the specific concerns as they arose, with reviews undertaken in response to crisis points. From about July 2016, SU'S PARTNER had increasing difficulty in accessing a Social Worker to discuss her

concerns. Most significantly, there was a missed opportunity during September 2016 to recognise the need for an urgent reassessment and to provide 24 hour care (with the 2 hour carer break covered), as SU'S PARTNER had alerted Adult Social Care that SU was at risk due to deteriorating physical health and smoking in bed, if left alone for any period. Coordination of an urgent reassessment would have been a reasonable expectation of an allocated Social Worker with case ownership and familiarity, receiving and responding to direct communication from SU, SU'S PARTNER and other agencies, if this had been in place.

Pathway: At the time of the incident, cases referred to the Royal Borough of Kingston, Adult Social Care, were addressed along a pathway; consisting of a Contact Centre, Short Term Team, Long Term Teams in the community and Kingston Hospital, and a Review Team. The functions of these teams, alongside changes implemented following this incident, are described in the following paragraphs to provide context to the experience of SU and SU'S PARTNER.

The **Contact Centre** was the first point of contact for new referrals to Adult Social Care and the centre directed referrals to the Short Term Team. New contacts were also directed to already allocated Social Workers, if applicable, in the Long Term Teams.

The **Short Term Team** consisted of approximately 13 to 14 staff, who completed immediate, short term and reablement action on new referrals. If further action was required, referrals were directed to the relevant Long Term Team in the community or hospital. Also, new contacts on urgent cases which were already allocated to long-term Social Workers who were on leave, and on cases in the review system, were addressed initially by the Short Term Team until stable or safe.

The **Long Term Teams** were responsible for active cases which required assessment and care planning, or which were unstable and in need of reassessment. Cases were transferred from active allocation to the unallocated review system when they had been assessed, the care plan had been implemented, there were no more actions and the case was considered to be stable.

The **Review Team** had responsibility to complete standard reviews on cases in the review system when these were due, if they were considered to be stable. The team also completed unscheduled reviews in these circumstances.

When SU and SU'S PARTNER did not have access to an allocated Social Worker, it was unclear in practice which Adult Social Care teams and workers had responsibility to respond to requests for reassessment and increased services. This was most apparent in response to SU'S PARTNER's contact in September 2016. Her initial request to a Long Term Team Social Worker on 09/09/16 was transferred to the Short Term Team for action, without reference to the stated need for 24 hour care; and was pended to 12/09/16, despite the urgency of the request. Further contact by SU'S PARTNER on 12/09/16 to again relay these urgent circumstances, this time involving the Community Psychiatric Nurse in contacting the Short Term Team, was passed to

the Long Term Team allocation tray, without knowledge of the information about the need for 24 hour care. This was not responded to and, when SU'S PARTNER rang the Contact Centre on 26/09/16 to convey that she was close to breakdown due to SU's increased needs and her level of stress in caring, a system message alone was sent to two Long Term Team Social Workers and was not picked up. During this period, SU'S PARTNER was provided with advice to access respite care and she did follow this up, as was the standard practice. However, there was an urgent need for a comprehensive reassessment and for actual 24 hour care to be provided during respite (as well as possible increased support, such as waking nights and counselling) that was not recognised or addressed, as clear responsibility to respond did not appear to sit with one team.

Communication between teams: The pathway concerns were compounded by a lack of effectiveness and consistency in the communication methods employed between teams and workers; particularly in ensuring that the intended recipients had received urgent messages. Communication was principally via electronic case notifications (system messages), which in SU'S PARTNER and SU's experience were not always picked up or prioritised, and there was not a consistent practice of sending back-up emails or making back-up phone calls to the workers concerned.

Changes following the incident: Subsequent to the incident, the allocation process and referral pathway in Adult Social Care has changed on a pilot basis. The Short Term Team has been replaced by an Access Team, consisting of three staff; a Team Leader, Senior Support Coordinator and Support Coordinator (the latter two are not qualified Social Worker posts). The team provides a screening or triage service, transferring referrals, if necessary, to the community or hospital long-term teams. All cases in the Long Term Teams, whether active or review, are assigned to Social Workers to provide continuity. If new contacts on active cases are received via the Contact Centre, these are directed to the allocated Social Worker in the Long Term Team via a phone call; if the worker is unavailable, the contacts are directed to the Access Team via a case notification and also a phone call if it is an emergency.

Summary: It is apparent that there were increasing needs and risk circumstances experienced by SU and SU'S PARTNER, requiring an urgent, coordinated and comprehensive reassessment in at least the month preceding the incident. The decision to de-allocate the case due to a judgement on stable needs and care did not take account of the complexity of presenting needs and risks and limited the potential for a proactive approach by a familiar and accessible Social Worker. There was also a lack of clarity on which team had a responsibility to respond to requests for a reassessment and communication methods between teams were unreliable.

5.3 Multi-agency information sharing, needs and risk assessments (Incorporating health and social care needs, carer and relationship stress, and fire risk)

Increased health and social care needs and risk: It is apparent that agencies were aware of, or had a duty of care to be aware of, information on increased needs and

risks. However, this information was not sufficiently recognised or shared between agencies, particularly in the year leading up to the incident, and this presented a missed opportunity for multi-agency risk assessment and management in a case involving complex needs and risk circumstances.

Pain management: The health and social care needs of SU seemed to increase significantly from about November 2015, and then more markedly from September 2016. He complained of increasing pain and a morphine prescription was provided by the GP surgery in December 2015. This medication is addictive and can cause drowsiness. Based on information in contacts by SU'S PARTNER with Adult Social Care, there were at least 6 occasions in which this prescription was increased following telephone contact by SU'S PARTNER with the GP surgery to convey that SU was experiencing increased pain. There were GP visits in June and July 2016, in which medication was reviewed and SU did not complain of drowsiness as a side effect of the medication. However, in September 2016, SU'S PARTNER reported to the Community Psychiatric Nurse and Adult Social Care that SU was either in so much pain or was 'out of it' due to the effect of the morphine. This presented grounds for a reassessment and potential support, including unbroken 24 hour supervision within the respite provision; alongside a concern that this may potentially have impacted on SU's capacity to make decisions. The circumstances of increased pain had been known to the GP surgery and Adult Social Care, and was either known or should have been known by agency carers who were in attendance for periods every day. However, there is minimal evidence of joint discussion between health and social care agencies about this significant development in terms of SU's care needs, a care needs reassessment was not undertaken by Adult Social Care, and the 2 hour gap in the respite care provision was not picked up as a concern by Adult Social Care or the care agency.

There was a duty of care on agencies to monitor and share information on increasing health and care needs, in particular the increasing pain experienced by SU. There had been regular joint review visits by a Social Worker and Caremark, which significantly reduced in the final year, when the case was no longer allocated to a Social Worker.

Epileptic seizures: The GP surgery informed Adult Social Care in February 2013 that SU had epilepsy and could not be left alone. This was approximately one month before the completion of an overview assessment by Adult Social Care in March 2013, which presented a missed opportunity to recognise and address the issue of unbroken 24 hour supervision during respite care. The care plan in May 2013 refers to the 3 weeks respite arrangement. SU had epileptic seizures in December 2014, February 2015, and in January, February and May 2016. The GP surgery has clarified that there were no further reports of seizures until the incident on 12 October 2016 and the anti-epileptic medication was not increased. The absence of seizures during this period is confirmed by SU'S PARTNER. However, whilst this was not an increasing risk, it is relevant on a similar basis to pain management. it presented a potential risk of a medical emergency whilst smoking in bed and therefore grounds to reassess and provide actual 24 hour supervision during the respite provision.

Caremark and changes following the incident: The Caremark care agency completes in-house needs and risk assessments and care plans on acceptance of spot purchase contracts to deliver home care to service users. The agency has an in-house log sheet. Since the incident, this has been reviewed and incorporates a field supervisor check column to record internal communication of concerns; if a carer raises a significant issue about care.

Adult Social Care Commissioning and changes following the incident: Adult Social Care Commissioning advise that a Provider Requirements form is now used as part of the tendering process, incorporating quality assurance (which includes information sharing and safeguarding adults). A planned home care tendering process will be initiated for 4 area lead providers and 4 area sub-providers, with an expectation that contracted agencies will meet all levels of complexity. The tendering process does not incorporate consideration of a specialist service to cater for complex needs and high risks. It is important that vulnerable adults receive skilled and sensitive care attendance, as it seems that SU did receive. Commissioning now have a contract lead and a quality lead for home care. This has enabled the introduction of care agency audits and monthly contract meetings with the existing 14 home care agencies (to be reduced to 8 agencies), which should enhance performance management.

Community Psychiatric Nursing and changes following the incident: There were reports by SU'S PARTNER that she was experiencing increased stress in caring for SU, alongside her own mental health concerns, which led to arguments and verbal outbursts within their relationship. Stress and relationship concerns were apparent in contacts by SU'S PARTNER with Adult Social Care in December 2014, May 2015, and November 2015 to January 2016; and in March, July and September 2016. Risks to SU'S PARTNER in regard to her mental health were also identified in the Mental Health Recovery Support Team records. Community Psychiatric Nursing support was provided and the team point to regular home visits (6 visits in the year leading up to October 2016) and phone calls (2 to 3 times per week throughout this period and weekend contact with the Mental Health support lines). SU'S PARTNER has said that she did not feel supported and that some visits were cancelled. However, SU'S PARTNER has clarified that CPN support was provided at the level indicated by the Recovery Team and, in fact, increased to monthly visits in the latter months. Her only concern in hindsight was that there was a high turnover of CPNs visiting and contacting her. Whilst the CPN service appears to have been attentive and endeavoured to be supportive, there is minimal evidence of joint discussion between Social Workers and CPNs throughout this period, and CPNs did not attend Social Work review visits. This would have been beneficial in view of the overlapping needs of SU and SU'S PARTNER. As aforementioned, a fairly comprehensive care plan was in place to meet the needs of both SU and SU'S PARTNER.

Since April 2017, there has been a separate Social Work Mental Health Team, which makes referrals to the Kingston Carers Network for carer's assessments. At the time of the incident, these assessments were undertaken by a CPN within the Mental Health Trust.

Smoking in bed and fire risk: There was a significant risk of fire throughout the reporting period that was not on the radar of the involved agencies. It was known by agencies that SU was immobile and smoked hand-rolled cigarettes in bed, although it is understood that he did not smoke when the agency carer was present. Whilst there was a risk of SU smoking unsupervised, this was not considered by involved agencies and there is no apparent incidence of his actually smoking unsupervised before the incident. SU'S PARTNER has confirmed that there were previous occasions when SU had been smoking in bed and had started small fires, but that she was present and able to extinguish these. He had a tendency to stub cigarettes out on himself. She was aware of the fire risk from smoking but did not leave him without supervision at these times. SU had a tub of ready-made roll-ups beside his bed. He could light cigarettes himself and SU'S PARTNER had told him not to do so when alone. However, as aforementioned, the GP surgery had advised Adult Social Care in February 2013 that SU was experiencing seizures and could not be left alone; and SU'S PARTNER had advised Adult Social Care in September 2016 that SU could not be left alone due to his physical health deterioration and smoking in bed. The potential for an epileptic seizure, or of drowsiness due to the morphine prescription, increased the risk of SU dropping his cigarette and causing a fire. The smoke alarm on the premises was not working and a fire extinguisher was not accessible to SU.

Whilst it was SU's choice to smoke in bed, there should have been an awareness of this risk across agencies. Clear information on the risk he was taking should have been relayed to and discussed with him and incorporated in assessment, care and treatment planning. The Adult Social Care and Caremark care plans did not refer to a smoking risk or the need for supervision whilst smoking in bed. The Mental Health Recovery Support Team records do not refer to a fire risk in the household and the GP surgery had not recognised a fire risk.

Paraffin-based emollient creams and fire risk: It was also known that SU was using paraffin-based emollient creams, but none of the involved agencies or SU'S PARTNER were aware at the time of the incident of the risk of emollient creams spreading fire. SU had emollient creams applied to his skin as part of his care and there would have been an accumulation of these deposits on his personal clothing and bedclothes, without the support of a laundry service and the advisable use of biological detergents.

In recent years, there has been an increasing awareness of this risk. A BBC release on 19/03/17, entitled 'Skin creams containing paraffin linked to fire deaths', included London Fire Brigade information that 28 fatal incidents since 2010 were believed to be linked to the use of paraffin-based skin creams. A Pulse article by Eleanor Bird on 12/06/17, entitled '*GPs warned about risks of flammable skin creams*', relayed London Fire Brigade concerns that many creams used for common skin conditions present increased risks for certain people, including smokers and the less mobile. This article points to NHS guidance; NHS PRESCQIPP Bulletin 49, May 2013, v2.0, entitled '*Cost effective emollients with no, or low paraffin content'*, which outlines risk factors and alternative products that are available. It is acknowledged by Kingston Clinical

Commissioning Group (CCG) that there are alternative creams that can be considered.

It was further known that SU slept on an airflow mattress, which also presented a risk of spreading fire, once it had been ignited.

London Fire Brigade and other agencies: As part of the review, the London Fire Brigade confirms that SU was at risk of fire. He was a non-ambulant person who could not self-rescue and there was a need to limit the potential ignition sources (smoking in bed); to reduce the impact of fire spreading (emollient creams); and to isolate the ignition source (flame proof bedding, etc.).

At no point did any agency refer SU to the London Fire Brigade for a home fire safety check and consideration of joint working, advice and support; including increased supervision, support with laundry, and provision of a working smoke alarm, fire retardant bedclothes and possibly sprinklers.

There is a formal non-emergency access route to request Fire Brigade support, involving the completion of a request form on the LFB website, which is directed to the nearest fire station. Additionally, referrers have on occasions accessed the service via informal contact with the Borough or Station Commander.

In emergencies, referrals to the London Fire Brigade are via 999 to an operator at a fire control centre for London. The operator takes the callers details and the system suggests an appropriate response (for the operator to confirm or override) and the nearest available fire station. The referral is sent to the local fire station at the same time as printed details are provided (not including risk information). A further message is sent to the attending crew, with an icon linking to any risk information.

London Fire Brigade missed two opportunities to offer fire safety checks, when crews were called to the address to assist in gaining entry. On both occasions, the attending crews were unaware that there was another vulnerable person in the home, or of the risk factors, and considered the calls to be routine.

Since the incident, London Fire Brigade have offered to provide home fire safety visits all home care users, fire safety information to all home care providers, fire safety advice to vulnerable adults in the borough when called out to addresses for other reasons, fire safety advice to Borough Council staff, and to share the Fire Brigade risk matrix to the Adult Social Care Safeguarding Adults Team and Commissioning. LFB will also consider recording if a home fire safety visit is appropriate, offered and accepted, with an administrative check on whether this was completed. Currently, visits are only recorded if undertaken, not if offered. Also, LFB has delivered a fire safety presentation to the home care provider forum on 29/06/18, and has circulated a video and leaflets to agencies, including GP surgeries.

Adult Social Care Commissioning and response to fire risk: Adult Social Care Commissioning has distributed information to home care agencies on fire safety and

on emollient creams, and has asked that service users who smoke in bed are identified and notified to Commissioning.

Caremark and response to fire risk: Caremark have identified service users who smoke in bed and confirm that agency assessments and care plans are currently being updated to include fire risk. The agency has also made a commitment to include checks of smoke alarms in properties when visiting service users, sharing this information with Adult Social Care Commissioning, and offering home fire safety check referrals to London Fire Brigade to all service users.

North Kingston Recovery Support Team and response to fire risk: The team has received training from the London Fire Brigade on fire safety within the past couple of years and made some referrals in the aftermath. There is a renewed undertaking to access refresher training and to give priority to making referrals to the London Fire Brigade for home fire safety checks.

High risk meetings and panel: As aforementioned, there was a missed opportunity for information sharing and a coordinated, joint approach to needs and risk assessment by agencies, particularly in the year leading up to the incident.

Given the complex and increasingly high risk circumstances, and the range of involved agencies, there would have been merit in an allocated Social Worker arranging a 'team around the adult' risk management meeting or meetings. This would have enabled SU, SU'S PARTNER and agencies to share key information about needs and risks, towards a coordinated and comprehensive risk assessment and risk management plan. At present, there is no formal arrangement for such meetings.

These could possibly be factored into planned and initiated meetings in GP localities, as one option. These would have to be considered alongside and not overlap with Safeguarding Adults planning meetings, where these are relevant, to ensure that there are clearly defined processes. It is understood that multi-disciplinary team meetings have been initiated by Kingston Integrated Care, involving monthly meetings which are attended by GPs, Social Workers, Mental Health Trust staff and other professionals, to discuss frequent attenders to GP surgeries. Any attendees can bring cases with concerns about needs and risks, to develop action plans. There may be the potential to broaden this with the addition of a risk matrix tool for non-safeguarding, high risk cases, to trigger referrals. There is also a Mental Health Trust Borough Care Pathway monthly meeting for high risk cases, with invitations to other agencies.

In some local authorities, there has also been evidence of improved risk management by the development of over-arching high risk panels, for senior managers to address and monitor risk circumstances that have not been mitigated. The two processes can be combined to form a two-tier approach, engaging line managers and practitioners in accountable and effective risk management.

5.4 Underpinning mental capacity awareness, independence and personalisation

Mental capacity awareness: SU was living with a slight cognitive impairment and he experienced bouts of low mood and depression, due to the trauma of the assault and his frustration about increased dependency. However, he was considered in the Adult Social Care overview assessment on 19/03/13 to be orientated and to be able to make decisions about his care needs. This may potentially have been altered when he presented to SU'S PARTNER in the latter stages as at times 'out of it' due to the administration of morphine.

In these circumstances, it was reasonable to have assumed mental capacity in regard to care needs, without recourse to a formal Mental Capacity Assessment and this was in keeping with the requirements of the Mental Capacity Act 2005. It is also unlikely that a formal assessment would have been applicable in the latter stages, as it seems that the effect of morphine on his mental state was not constant and he apparently presented as alert on the day of the incident.

Caremark support the judgement that SU had capacity relating to his care needs, giving the example that he knew when to accept support with leg exercises and when not to, due to the level of pain. This is also the view of the Mental Health Recovery Support Team, based on records, as he presented as aware of his care needs and when his carers were visiting.

It is therefore apparent that reasonable consideration was afforded by agencies to SU's mental capacity and that, as there were no apparent concerns in this regard, it was correct to assume decision specific mental capacity.

Wheelchair access and independence: Given his level of capacity, it is a concern that SU did not appear to be more fully involved in decision making about his level of independence, or enabled to fulfil his full potential, despite reference to assisting him in achieving this goal. In July 2013, he stated a wish to move downstairs and also to travel to Richmond Park and Kingston Town Centre. It was noted at the time that a wheelchair assessment was imminent. In May 2014, the wheelchair was broken and he was awaiting an assessment for a replacement. There is a further record that the wheelchair was broken in December 2014 and he was awaiting a replacement wheelchair in February 2015. In May 2015, SU repeated his wish to move downstairs, but his lift was not working and the kitchen required adaptations. SU said in December 2015 that he wished to be able to access downstairs every day.

Caremark report that there were delays in obtaining a wheelchair, which was then not comfortable for SU; that he then became unwilling to leave bed and a specially adapted wheelchair was therefore not built for him. Whilst there is evidence of liaison with the wheelchair service, the consistent unavailability of a working wheelchair was a gap in provision. As a consequence, SU was limited in his potential to be more independent and to be more stimulated, and this would have undoubtedly had an impact on his emotional wellbeing and level of frustration.

Personalisation: The increasing risks in the situation were primarily concerned with the stress levels and SU'S PARTNER's difficulty in managing both SU's physical and emotional needs and her own mental health concerns. It is notable that there was considerable input by agencies in responding directly to SU'S PARTNER's concerns about SU and herself, often through telephone contact, which meant that the direct views of SU on his care needs and his independence goals were less to the fore, particularly in his final months.

5.5 Summary of analysis and findings

There was evidence of good practice in the provision of a fairly comprehensive overview assessment and sustained care plan that, in large measure for most of the reporting period, responded to the needs and risks experienced by both SU and SU'S PARTNER. Moreover, all agencies demonstrated a commitment to respond to presenting needs as they arose and showed respect and sensitivity in communication.

However, there were clear deficits in the support provided by involved agencies. The Adult Social Care response became more reactive and less accessible when Social Work allocation ceased, compounded by a lack of clear team responsibility and poor communication. There was decreasing information sharing and limited joint working between key agencies, which undoubtedly contributed to a reduced ability in the year leading up to the incident (and in the final month in particular) to fully recognise and effectively respond to increasing care needs and carer stress in a proactive, joined- up way.

Perhaps most significantly, all agencies were unaware of the risk of fire and this did not feature in assessment, treatment and care planning.

Finally, there was insufficient priority afforded to the views of SU and his potential for increased independence, which meant that services with a duty of care towards SU were less personalised than they should have been.

5.6 Could SU's death have been predicted or prevented

The Coroner's enquiry concluded that both the medical emergency and dropping the cigarette to cause the fire were contributory factors in SU's death. As the medical emergency could not have been predicted or prevented, it is not possible to conclude that his death was predictable or preventable. However, the causation of the fire was predictable and preventable and there are clear lessons to be learned by involved agencies to improve systems and practice in risk management. There is clear evidence that agencies have already highlighted and made strides towards addressing the learning from this incident.

6. RECOMMENDATIONS TO IMPROVE SERVICES AND REDUCE RISK

6.1 The following recommendations, arising from the Safeguarding Adults Review, also incorporate an overview of the recommendations of the Coroner and the Safeguarding Adults Section 42 Enquiries, to promote a comprehensive multi-agency response to concerns. These are taken forward in the review action plan, which is an appendix to this report.

6.2 **Recommendation 1 –** Adult Social Care service managers to review the effectiveness of allocating all active and review cases; of measures to improve the transfer of cases between teams; and of measures to improve communication between teams; involving case notifications, email and telephone contact. There should be sufficient capacity for review cases which become active to be addressed as priorities. In the event of limited capacity, it may be appropriate to consider whether there are aspects of Social Work practice that might be addressed by other sections, possibly including financial assessment.

6.3 **Recommendation 2 –** Safeguarding Adults Board to review and redistribute the Board Information Sharing Protocol, to ensure that there are clear expectations placed on partner agencies; Adult Social Care Commissioning to issue a reminder to care agencies to obtain feedback from carers and to share information appropriately with partner agencies.

6.4 **Recommendation 3 –** Safeguarding Adults Board to consider the merits of a dual approach to risk assessment and management, involving 'team around the adult' meetings and, for circumstances in which risk is not mitigated, a multi-agency senior management high risk panel.

6.5 **Recommendation 4 –** Safeguarding Adults Board to produce and promote a multi-agency fire risk strategy. This should incorporate training to agencies (including pharmacies) on awareness of fire risk factors; the provision of awareness raising material to service users and carers; incorporation of fire risk and checking smoke alarms in assessment and care planning tools; referring service users for home fire safety checks, with prioritisation and tracking of people who are non-ambulant and smoke in bed; and consideration of a range of support options, including advice, supervision, alternatives to emollient creams, laundry provision, and equipment (including smoke alarms, fire extinguishers, fire retardant aprons and bedding, and sprinklers).

6.6 **Recommendation 5 –** Safeguarding Adults Board to monitor the provision of training and guidance to staff across agencies on mental capacity awareness and personalisation.