Response to the safeguarding adult review for 'Harry'

Introduction

Harry, a 68 year old white British man died in a house fire at his home on 25 January 2021. His cause of death was due to inhalation of smoke and combustion products and burns sustained during an accidental fire, the cause of which was ignition of a towel which had fallen on a fan heater.

The Board notes that the subsequent safeguarding adults review has sought to understand why things happened in the way that they did, and what Harry's experiences tell us about how systems work. This systems approach focuses on multi-agency professional practice and is not about blame. It is about learning and improving practice for the future. The Board acknowledges comments from the coroner whose view was that both health and local authority services had provided Harry with a "very high standard of care".

Finding 1 - Safeguarding response + finding 5 - Impact of prescribed drugs and excessive alcohol consumption

A multi-agency safeguarding response that seeks to prevent self-neglect and stop it quickly when it happens was not always enacted as per policy process and guidance. (F1)

Practitioners need greater awareness of the impact of prescribed drugs and excessive alcohol consumption and when there may be a need for formal support around this (F5)

The board acknowledges that whilst significant work around self-neglect took place between 2018 and 2020, including the launch of the Waltham Forest Self-Neglect guidance, further action is now required to promote and re-embed greater awareness of self-neglect into practice. The Board also recognises the importance of understanding the intersectional nature of service users with other support needs such as use of alcohol and drugs and fluctuating mental capacity.

Finding 2 - Assessment and support planning + finding 4 - Unsuitable housing + finding 6 - Risk assessment

Assessment and support planning should have greater consistency across specialisms. Assessments and outcomes should be shared. Assessment should be of an appropriate depth and include the consideration and identification of risk. (F2)

Housing may not have been suitable and presented health and safety risks (F4)

Risk assessment by health and social care was inadequate and there were not attempts to complete risk assessment in a joined up and a collaborative manner. (F6)

The board understands the importance and value of joined up assessments and support planning and that this extends to risk assessment. It seems the suitability of his housing could have been explored more, had the assessments and support planning been more considered and in depth. The board notes that this finding relates to professionals' needing to be more curious, asking the 'second' question, as well as seeking out information from other practitioners working with the service user to ensure assessments are joined up.

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Finding 3 Awareness of fire risk

Practitioners need a greater awareness of the risk of injury or death from fire. This needs to be supported by multi-agency policy and process for intervention when fire risk is identified.

From the outset of residents' journeys within care and support services, fire safety should be invested in more, across agencies, particularly for those who have mobility needs. The board acknowledges the selection of fire safety awareness sessions (usually delivered in the context of self-neglect and excessive saving) that have been delivered to practitioners however we accept that specific policy and process for intervention will provide robust foundations for embedding this into practice. We note from discussions within the partnership the need for new fire risk processes to be aligned with existing processes.

Finding 7 Harry's engagement

Harry's engagement with services was ad hoc and sporadic. He engaged well with some services and not so well with others. His non-engagement could have been approached differently.

Engagement with people like Harry could be improved with enhanced dedicated care pathways for self-neglect / fire risk case management, with input from multi-disciplinary teams. The board notes that some services were able to engage well with Harry and this links to finding 2. Had assessments and support planning been more joined up then the successful engagements may have been able to be harnessed and used to better safeguard Harry. We know the challenges that exist for practitioners who may be struggling to engage service users like Harry. In response to these challenges, we are currently trialling a monthly multi-agency / multi-disciplinary panel called the 'Team around the person network' which provides a peer support space that enables professionals to explore alternative interventions for service users that may have multiple needs and / or they are finding difficult to engage.

Action by the Safeguarding Adults Board

The board accepts the reviewers' recommendations and has recognised additional actions that need to take place in addition to these. We commit to the recommendations and the actions which include the following:

- Developing a new joined-up programme of training and awareness around fire safety / risk.
- Continuing to roll out the Team around the person network and use the evaluation to understand and reflect on what difference this is making to practice for those whom practitioners are finding difficult to engage.
- Setting up a working group to develop new pathways / processes for fire safety / risk
- Re-circulating and promoting asking the second question (professional curiosity)

The action plan below will be used to take forward the recommendations from this SAR and will be reviewed accordingly to gather what difference is being made as a result of this review.

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Action plan for SAR Harry				
Recommendation	*Finding (F) this recommendation relates to*	*Objective*	*How might this be achieved?*	*How might we know it's made a difference?*
i. Build greater awareness and understanding of: • Self-neglect • Excessive saving • How to balance challenging conversations with an empathetic and caring approach	F1 - Safeguarding response F3 - Awareness of fire risk F6 - Risk assessment F7 - Harry's engagement	Improved multi-disciplinary response to self-neglect and excessive saving, promoting effective engagement with vulnerable people	Develop a new joined-up (between health, social care & LFB) programme of training and awareness that includes challenging conversations, self-neglect, and excessive saving to encourage and embed good practice, promoting and embedding relevant policies into practice across the partnership. Consider covering how to present to service users in a non-threatening / caring way as well as use of language / jargon? Training should also include all resources available to support practitioners, such as the Self-Neglect Multi-Agency Guidance published by the SAB in 2019.	Numbers of professionals reporting increased awareness and understanding straight after the session and then approx. 12 weeks later
ii. Build greater awareness and understanding of fire safety / risks	F3 – awareness of fire risk	Profile of the fire brigade is raised and improved knowledge and understanding by front line	Develop a new joined-up (between health, social care & LFB) programme of training and awareness around fire safety / risk. Consider making this mandatory for all front-line health and social care practitioners, which would	Numbers of professionals reporting increased awareness and understanding straight after the session and then approx. 12 weeks later

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Action plan for SAR Harry				
Recommendation	*Finding (F) this recommendation relates to*	*Objective*	*How might this be achieved?*	*How might we know it's made a difference?*
		practitioners of fire risk	include details of any new process developed (see below). Ensure appropriate resources from LFB are shared including clutter scales, a short film for carers and residents' home fire safety checker for self-assessing own risk.	Increase in numbers of views of film and hits on online home fire safety checker
iii. Improve pathways for responding to individuals at high risk and / or difficult to engage, including those for whom there are fire risks / concerns, e.g. those who are confined through either ill health or disability to their homes or bed	F1 - Safeguarding response F2 - Assessment and support planning F3 - Awareness of fire risk F4 - Unsuitable housing F5 - Impact of prescribed drugs and excessive alcohol consumption F6 - Risk assessment F7 – Harry's engagement	To help ensure an effective multidisciplinary response for people who are at high risk and difficult to engage	Multi-disciplinary 'high risk' / 'complex needs' panels are developed for people in adult social care and health who support services are finding difficult to engage. This would be linked to a clearly dedicated pathway for LFB referrals/self- neglect cases and standards around risk assessment/MDT (see below) Consider whether regular, separate multi-disciplinary, review meetings of high-risk fire cases are required	Numbers of positive outcomes for individuals who are discussed at panel
	F3 - Awareness of fire risk	An improved multiagency	A multi-agency working group (which includes LFB, health and adult social care) is set up to develop new	Clear process and protocol detailing appropriate pathways are in place

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Recommendation	*Finding (F) this recommendation relates to*	*Objective*	*How might this be achieved?*	*How might we know it's made a difference?*
		response to fire risk	pathways, agreed interventions and refreshed ways of working in relation to fire risk. This should consider appropriate thresholds for triggering a multi-agency response and building generic fire risk assessment into social care and health assessments as well as associated systems such as Mosaic or Rio. Also develop a multi-agency risk assessment process. Explore how fire risk and interventions can be monitored e.g. through regular monitoring meetings by health, social care, housing and LFB from a data collection point	Audits across the partnership show that practitioners are using the pathways and considering risks relating to fire Increase in enquiries made to London Fire Brigade in relation to home fire safety