Learning Bulletin

Safeguarding Adults Review

RJ

This bulletin is designed to share the learning from a Safeguarding Adult Review published in August 2020, following the sad circumstances of the death of 'RJ' who died in 2018.

You can read the full SAR report and executive report here

What was the review about?

RJ was a man in his 60's when he died in tragic circumstances when he accidentally pulled over a portable liquid petroleum gas heater, starting a fire. RJ had tried to leave the room but he had poor mobility and was further compromised by his significant consumption of alcohol and anti-depressant medication. He was overcome by smoke and fumes.

RJ lived alone in his own house, a semi-detached cottage in an isolated rural area in Lincolnshire. His house had no central heating and he managed with an electric heater and a portable gas heater.

It was reported that RJ had been dependant on alcohol for over 35 years. His long history of problematic alcohol use affected both his physical and mental health and he was known to a number of different agencies.

RJ's father and sister tried hard to support him, but he was difficult to reach out to. His sister raised concerns with his GP regarding RJ's drinking and hostile behaviour but RJ denied drinking.

At the time of his death, RJ had regular contact with his GP, Community Health Services, General Hospital and specialist care due to complications from a non-healing fractured tibia.

What was the learning?

RJ was living with multiple factors that put him at high risk of fire. He had complex physical and psychological health care needs and agencies were endeavouring to provide care and treatment.

There were some good examples of professionals working with RJ to engage him in support. However, there were also examples of poor communication and missed opportunities to assess RJ's needs, his home environment and to develop a holistic care plan, including minimising fire risk. On the one occasion when an agency did identify fire risks, a breakdown in communication prevented a risk reduction plan being acted upon and communication has been addressed in the review recommendations.

Fire and safety checks are a vital aspect of care and treatment for individuals such as RJ who have high vulnerability to fire and need to be at the forefront of practitioners' minds and integrated into care planning.

Recommendations

1: Identification and Referral Pathways for Fire and Safety Checks

has been rolled out by Lincolnshire Fire & Rescue and all agencies to have in place mechanisms to identify fire safety concerns, including referral routes to LFR for fire and safety checks.

2: Partnership Working Between Fire and Rescue Service and Occupational Therapists.

Lincolnshire Fire & Rescue, Adult Care & Community Wellbeing and Lincolnshire Community Health Services to develop joint initiatives combining skills and expertise making most effective use of resources in relation to safe and well checks.