LSAB
Making safeguarding personal

Lincolnshire

Safeguarding Adults Board

Safeguarding Adults Review

‘RJ’

Overview Report

Independent Author:
Sylvia Manson
Developed from work
of Gill Poole
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Executive Summary

1. Introduction

1.1. This review considers the sad circumstances of the death of 'RJ' who died in 2018. RJ had 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.

1.2. The Coroner's Inquest recorded the Cause of Death as accidental with a primary cause being inhalation of products of combustion under the influence of alcohol and sertraline, an anti-depressant medication.

1.3. RJ had many health and social care needs and was known to a number of different agencies. This review examines learning for agencies. It considers how agencies worked together and whether there were potential opportunities to avert the tragic circumstance of RJ's death.

2 Summary of the Learning Points from the Review

Summary of Key Learning Points	
i	The combination of RJ's physical and psychological health needs alongside his living environment, put him at high risk of fire. Professionals were working to help RJ address his multiple health problems. However, there was a need to look beyond the immediate presenting task and use 'Making Every Contact Count,'[1] to try and address health and wellbeing. This included considering the context of RJ's environment and living conditions – fire safety being a key element of this.
ii	RJ had complex health needs and there were many good practice examples of professionals being responsive to him and trying to address his needs. However, the lack of Occupational Therapy home based assessment was a vital missing element in his care. Occupational Therapy may have used strategies, techniques and equipment to help RJ adapt to his home environment and improve his safety and wellbeing. Crucially, an OTs skill in home-hazard assessment may also have identified and mitigated fire risk.
iii	Fire and Rescue Service are able to provide services to help reduce risks of fire. However, they are reliant on a partnership approach to identify and refer those people who are in the most vulnerable circumstances. There is a need for all professions to be knowledgeable and vigilant to fire safety concerns, integrate this into care planning for people in higher risk groups and understand referral routes for fire safety checks.

[1] Making every contact count is an approach to behaviour change that utilises day to day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations. https://www.makingeverycontactcount.co.uk/ Accessed February 2020

Main Body of the Report

3. Context of Safeguarding Adults Reviews

3.1 The Care Act 2014, requires Safeguarding Adults Boards (SABs) to arrange a Safeguarding Adults Review (SAR) if an adult (for whom safeguarding duties apply) dies or experiences serious harm as a result of abuse or neglect and there is cause for concern about how agencies worked together. The Care Act section 44(4), also permits reviews to be carried out where these criteria are not met but where there may be valuable learning for the partnership. This review is being carried out under section 44(4).

3.2 Lincolnshire Safeguarding Adults Board (LSAB) commissioned an independent author, to carry out this review. This SAR was initiated by an Independent Author Gill Poole who unfortunately was unable to complete the review. A second Independent Author was commissioned to complete the report and has built on the work of Gill Poole. Both authors are independent of LSAB and its partner agencies.

3.3 The purpose of SARs is '[to] *promote as to effective learning and improvement action to prevent future deaths or serious harm occurring again'*.[2]

3.4 A SAR enables all of the information known to agencies to be seen in one place. This is beneficial to learning but the SAR also recognises that this benefit of hindsight was not available to individual practitioners at the time.

3.5 The Department of Health's six principles for adult safeguarding should be applied across all safeguarding activity[3]. The principles apply to the review as follows:

Empowerment:	Understanding how the service users were involved in their care; involving those close to the person in the review.
Prevention:	The learning will be used to consider prevention of future harm to others.
Proportionality:	Understanding whether least restrictive practice was used; being proportionate in carrying out our review.
Protection:	The learning will be used to protect others from harm.
Partnership:	Partners will seek to understand how well they worked together and use learning to improve partnership working.
Accountability:	Accountability and transparency within the learning process

[2] Department of Health, (2016) *Care and Support Statutory Guidance Issued under the Care Act 2014*
[3] Ibid

4 Terms of Reference and Methodology

4.1. Terms of Reference

4.1.1. The review is focusing on the period beginning August 2017 when RJ sustained his leg injury in a fall at his home until the date of his death in November 2018. The review focuses on the circumstances surrounding RJ's death including contributory factors relating to fire hazard. The specific areas of enquiry are as follows:

Terms of Reference
1. Is information shared well across agencies - is there anything that stops agencies sharing?
2. Did practitioners and agencies have sufficient information about the risks and vulnerabilities of RJ to care for him well? Were there barriers or things that stop this happening?
3. Do practitioners know how, and is it easy to refer into other agencies? Are there any barriers, or things that stop them being able to share information?
4. Were there opportunities to manage the complexity of RJ's situation differently or that would have led to a different outcome?
5. Is there anything which practitioners and agencies experience which particularly helps or blocks /stops them from being able to provide the best possible support for someone like RJ?
6. Do practitioners receive appropriate supervision / guidance, training or awareness within their teams, including about what other agencies may offer?
7. Are there any other helpful or unhelpful things they think affected the support RJ received?

4.2. Methodology

4.2.1 The methodology applied for this SAR combined a chronology from each agency with a reflective learning event to draw out further detail with the agencies involved.

4.2.2. Understanding the experiences of those receiving support from agencies is central to learning. The independent author is grateful to RJ's father and sister for their contribution to this SAR.

4.2.3. The privacy of those involved has been protected through use of a pseudonym, chosen by his father. Some information and dates within the report have also been deliberately generalised to protect the confidentiality of those involved.

Participating Agencies and Context of Involvement	
East Midlands Ambulance Service (EMAS)	Conveyed RJ to hospital and referred care concerns including fire safety to ACCW
Libertas Care Services (LPS)	Provider of re-enablement services to aid step down from hospital. This provider took over from a different provider no longer in operation who provided a package of care to RJ in Sept 2017
Lincolnshire County Council- Adult Care and Community Wellbeing (LCC -ACCW)	Local Authority providing Adult Social Care services in Lincolnshire, as required by the Care Act 2014. Services included assessments for care and support and occupational therapy assessment.
Lincolnshire Community Health NHS Services (LCHS)	Provide a range of community nursing and therapies and community hospital care and transitional care from hospital discharge. Had extensive involvement with RJ providing community-based nursing as well as hospital care.
Lincolnshire Partnership NHS Foundation Trust (LPFT)	Providers of mental health and learning disability services including inpatient care, community mental health teams, talking therapies through Steps2Change and crisis support. Provided a response to RJ through a Community Psychiatric Nurse and their Crisis Resolution Home Treatment team
Lincolnshire Police	Had no involvement in care or responses to RJ other than following his death.
Lincolnshire Fire and Rescue (LFR)	Lincolnshire Fire and Rescue is the statutory fire and rescue service serving the area of Lincolnshire in which RJ lived. As well as emergency response, they provide Home Fire Safety.
South West Lincolnshire CCG	Commissioners of local health care. Provided information relating to the GP's care and treatment of RJ.
United Lincolnshire Hospitals NHS Trust (ULHT)	Trust providing General Hospital care through range of inpatient and outpatient services. ULHT provided emergency and general nursing care to RJ as well as plastic surgery; orthopaedics and vascular treatments.

5. RJ and the Background for this Review

5.1. RJ was a man in his sixties when he died in tragic circumstances through smoke inhalation having pulled over a portable heater in his home.

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

5.3. In the past, RJ had worked as a paint sprayer but then was unable to work due to his multiple

health needs.

5.4. RJ had cerebellar ataxia[4] due to a long history of problematic alcohol use. This affects gait and muscle coordination and gave him tremors in his hands and feet. RJ also had coronary heart disease and impaired vision. These factors restricted his mobility and RJ used a wheelchair and gutter frame walker to assist him. RJ's conditions put him at high risk of falls.

5.5. Understandably RJ's health conditions also had a significant impact on his mental health and wellbeing. RJ had periods of depression with feelings of hopelessness and at times saying he wanted to end his life. He continued to use alcohol which greatly exacerbated his risk of falls.

5.6. RJ had reported he had been dependent on alcohol for over 35 years. Records indicate RJ had had consultations with his GP from early 2013 regarding problematic use of alcohol. He successfully abstained for a period of nearly two years but relapsed in December 2014 following the death of his mother. During 2016, RJ's sister raised concerns with his GP regarding RJ's drinking and hostile behaviour but RJ denied drinking.

5.7. In the last years of RJ's life, his father reported that RJ's alcohol intake was considerable. He would visit the local shop on a daily basis, regularly consuming eight tins of cider and a bottle of whiskey during a day.

5.8. RJ's sister and father tried hard to support him. RJ could be difficult to reach out to. His father described him as his own man, very independent and would not listen to anyone. Despite this RJ enjoyed a good relationship with his father - he could be very funny and they went out for Sunday lunch every week and regularly went on holiday together.

5.9. RJ was well known to health services. Prior to the scope period, he had had support through his GP in relation to his drinking. RJ had been prescribed anti-depressant Sertraline since 2013 and received counselling, had been referred onto mental health services along with practical support with benefits. RJ was also referred to neurology in relation to his cerebellar ataxia and for occupational and physio-therapy.

5.10. From 2017, he had very regular contact with his GP, with Community Health Services, General Hospital and specialist care due to complications from a non-healing fractured tibia. Sadly, despite treatment, the wound did not heal. At the time of his death, RJ was waiting for amputation of his leg.

5.11. The following section outlines key events leading up to RJ's death. An analysis of involvement by different agencies follows in section 7.

6. Summary of Key Events

[4] Acute cerebellar ataxia (ACA) is a disorder that occurs when the cerebellum becomes inflamed or damaged. The cerebellum is the area of the brain responsible for controlling gait and muscle coordination. https://www.healthline.com/health/acute-cerebellar-ataxia

6.1. In **August 2017**, RJ sustained a fall resulting in a fractured tibia. At point of discharge, the hospital referred him to the LCHS Community Therapy Team requesting a falls, OT and equipment assessment within the home. The community team liaised with hospital and established RJ was to be followed up by ULHT outpatient physiotherapy. No home assessment was carried out. RJ was provided with a wheeled commode through the Joint Equipment Discharge Scheme and received a package of care four times a day.

6.2. From this point, the Integrated Community Team visited two-to-three times a week providing care for the fracture wound and endeavouring to prevent pressure wounds caused by his limited mobility. Tissue Viability Nurses (TVN) had provided a wound care plan. However, by **Dec 2017**, the fracture wound was still not healing and had become infected. The Community Nurse worked with the GP to treat this. In **January 2018,** the Tissue Viability Nurse (TVN) reassessed RJ's wound. The LCHS community nurses asked RJ for the updated care plans – there was no record of direct communication between community nurses and TVN. RJ also continued to attend ULHT outpatient departments with involvement from plastic surgery, vascular surgery and orthopaedics.

6.3. In **January 2018** RJ's mobility remained very restricted although he began gradual weight bearing exercises. His house was very cold as he had no heating on. He told the community nurse that he couldn't afford gas and was advised to speak to the council about this.

6.4. RJ's infected wound was still not healing. It was hoped that a planned operation by the vascular team would improve his circulation. He had a further appointment with his orthopaedic surgeon in **March 2018.** He continued to have treatment for the wound and pain care by his GP and LCHS. Understandably, RJ had episodes of being low in mood – he reported being frustrated and feeling nothing was being done for his leg and the pain he was in.

6.5. In **April 2018**, RJ had a further fall. He told the community nurse of the fall the next day but declined to be checked over by the nurse or GP.

6.6. RJ had a further fall in **May 2018**. He attended the Emergency Department (ED) on advice of Community Nursing but left before he was seen as the wait time was 6-7 hours.

6.7. The following day RJ contacted Lincolnshire Adult Care and Community Wellbeing (ACCW) to request an Occupational Therapy (OT) assessment. He wanted to talk to an OT about adaptations he could do in his home and what grants may be available to him. The referral was passed through to the OT service. The service attempted to contact in May and left a voice mail advising of referral.

6.8. RJ had been due to have a by-pass operation for his leg in **May 2018**. He attended but was sent home again as no beds were available. When the community nurse arrived to redress his leg, RJ was at a low ebb. He said he couldn't stand the pain anymore and could not see any way out. He repeatedly asked the nurse for a shotgun so he could "*finish himself off.*" The nurse sought advice from RJ's GP who increased his pain relief, visited RJ at home and arranged for him to be admitted to hospital due to cellulitis. The nurse spoke with RJ's father who came to accompany him in. When the ambulance crew arrived, RJ was in a wet bed, feeling unable to get up. There

was no heating in the property – RJ told the ambulance crew *'he hated his life and doesn't want to be at home as can't cope'***.** He was conveyed to hospital. During May, RJ was also referred to an out of area specialist bone disease unit.

6.9. In **June 2018** RJ was notified by ACCW that he was on the waiting list for an OT assessment. He had a full assessment by the Community Nursing team. This assessment referenced that RJ was supported by his father and had a cleaner. He was able to prepare and cook his own meals. He used a wheel chair indoors and electric scooter outdoors. There had been no recent falls recorded.

6.10. RJ had his rescheduled bypass vascular surgery operation in **June 2018** and community nurses received an updated care plan referral from the TVN at ULHT. However, by **July 2018**, RJ's wound was deteriorating further with possible sepsis. Following consultation between him, community nursing and his GP, he was admitted to hospital. RJ had ward based care for an ilio-femoral bypass. He stayed in hospital as it was hoped this would aid healing, something RJ was keen to try. He was discharged five days later following treatment and continued his care through the Community Nursing team.

6.11. In **August 2018**, RJ phoned 999, asking for an ambulance. He was intoxicated and feeling suicidal. The mental health crisis team were in attendance as the ambulance crew arrived. RJ told the crisis team nurse he wanted to end his life. He refused to be conveyed to hospital and following assessment, remained at home, continuing to have treatment by community nursing for his leg.

6.12. Two weeks later the community nurse found RJ semi-conscious on the floor as a result of a further fall. RJ did not want an ambulance to be called so the nurse called a colleague to help. RJ complained of having hit his head so an ambulance was then called. RJ refused to be conveyed to Emergency Department and this was recorded as a capacitous decision. Following discussion with RJ, the community nurses arranged a bed at the Community Hospital.

6.13. The ambulance crew submitted a 'Care Concern' referral into ACCW, requesting a social care assessment. This noted the fire risks – RJ was not a hoarder but was a smoker, had no fire alarms, no key-safe, no lifeline, and unsteady, 2 falls in 3 days. EMAS also shared the referral with RJ's GP. It was not shared with Lincolnshire Fire and Rescue (LFR).

6.14. On receipt of the referral, the social care Customer Service (CSC) (access point for ACCW) sent the information through to their OT Team as RJ was still awaiting allocation for an OT assessment. CSC also established that RJ was inpatient at LCHS Community Hospital but his discharge was imminent. They shared the information and concerns with LCHS staff on community hospital ward.

6.15. RJ had already been seen by a physio-therapist who had liaised with Community Nursing regarding the home circumstances and whether he needed a discharge visit. RJ declined a discharge visit by the physio-therapist, saying he had everything he needed. The physio-therapist had asked RJ about getting a Lifeline.[5] RJ agreed to arrange this and the physio-therapist provided him with information leaflets. The physio-therapist also asked RJ about a package of care

5 A lifeline alarm is a pendant or bracelet that is worn in the home and garden, which allows the wearer to get immediate assistance at the push of a button should they need it.

to support him. He declined this but did agree not to use his electric wheel chair indoors in the future and to attend a follow up outpatient appointment. RJ was conveyed to hospital.

6.16. RJ was attending an Out of Area hospital for specialist treatment when CSC reported the additional concerns about fire risks to LCHS. LCHS's plan on RJ's return from the specialist centre was to ask his permission to refer him to the Wellbeing service to fix a temporary key-safe and to refer him to the LFR. However, while at the specialist unit, RJ had received some bad news regarding his referral for treatment. When he returned to the Community Hospital, he informed staff he was intending to discharge himself rather than await the planned discharge the following day. Staff tried to dissuade him, pointing out his father, who was a key support, was also away on holiday.

6.17. RJ could not be dissuaded and this was seen as a capacitous decision. RJ declined a taxi transfer as he planned to wheel himself to the local supermarket. The hospital contacted Community nurses to arrange for him to be visited the next day. There was no evidence that the concerns raised through CSC regarding fire safety were handed over by LCHS to their Community Nursing team. There was also no evidence that the plans relating to falls assessment or fire safety were communicated i.e. discussions on Lifeline; not use his electric wheel chair and to seek RJ's consent for a referral to LFR.

6.18. CSC had liaised with the Community Hospital about a discharge support plan. RJ had declined a care package but CSC did process a request from ULHT for RJ to be provided with a key safe.

6.19. When the Community Nursing team visited RJ the next day, he appeared in good spirits. He talked of seeing a consultant at London Hospital and having decided to have further surgery there to remove the steel bolt from his leg and have skin grafts.

6.20. However, two weeks later in **September 2018**, the Community Nurse found RJ intoxicated and saying he wanted to end his life by jumping into the river, as he couldn't see anything getting better for his leg. The nurse liaised with his GP, LCHS, the ambulance service and the LPFT mental health crisis team. The nurse also contacted RJ's father to be with him while they tried to find a place of safety for him. The crisis team phoned RJ and agreed he would go to his GP for a medication review the next day and be referred to Steps2Change for psychological therapies. As RJ was intoxicated, the crisis team followed up the next day to reiterate this plan and communicated with his GP. However, RJ reported that his mood was better and declined any further support with his mental health.

6.21. During **September 2018**, the hospital had a letter outlining plans to have reconstructive surgery at the out of area specialist unit for early October. However, understandably, RJ was struggling to make decisions about his treatment. During this same period, RJ consulted with his GP and made a decision to have his leg amputated.

RJ attended hospital again in **October 2018** due to bleeding from his leg that could not be controlled. He was discharged the same day. Later that month RJ phoned ACCW, requesting a full Care Assessment. He was advised that his request would be actioned however this request was not forwarded by the Duty Worker to the area lead for allocation.

6.22. The out of area specialist hospital made a referral to Therapy Services at LCHS requesting full physiotherapy and occupational therapy assessments to be completed in RJ's home environment pre operatively to his planned reconstructive surgery to his leg. This was never carried out.

6.23. During **October 2018**, a Community Psychiatric Nurse also became involved with RJ following his GP making a referral to LPFT. RJ was low in mood. The CPN reviewed his medication and agreed to explore options of further support for him. The CPN contacted the ACCW Wellbeing advisor giving RJ's background, that he had a planned amputation and was struggling to maintain his personal care. The CPN requested a full Care Assessment, flagging that RJ may need a grant for adaption to his home. The CPN referenced that RJ did not have heating in the property other than 'old fashioned' electric heaters that cost a lot of electric so had limited money for food. ACCW passed the referral to the area team for consideration within expected timeframe.

6.24. RJ continued to receive Community Nursing care for his leg. In **November 2018** the nurse was very concerned about the protrusion of plate and screws in his leg. They spoke with his GP to ask if RJ's hospital appointment could be brought forward from the planned date in January 2019. RJ's GP advised that the delay with hospital appointment was because RJ was still deciding between plastic surgery or an amputation and until he made the decision, this limited what could be done to manage his wound. The nurse discussed this with RJ and his GP made an urgent referral to orthopaedics consultant.

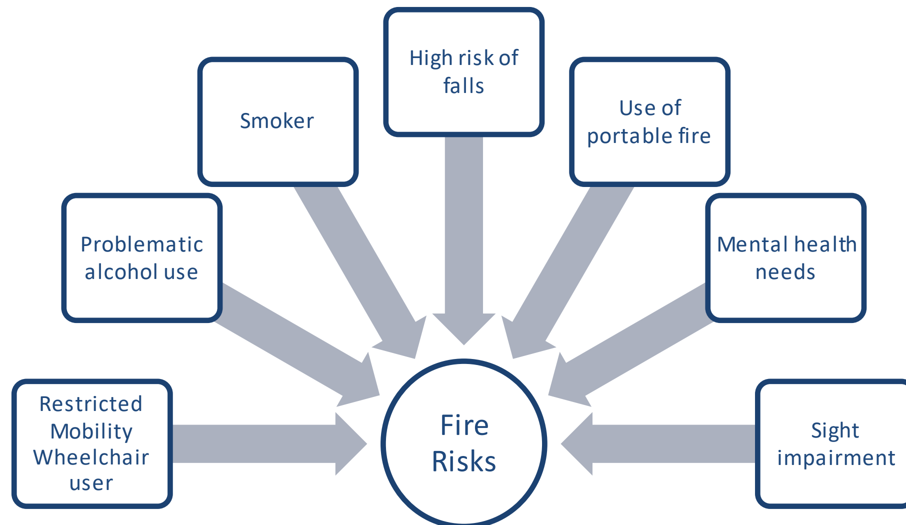
6.25. Very sadly, nine days later, the community nurse found RJ deceased, lying on the floor with his mobility scooter next to him. His liquid petroleum gas portable heater had fallen over on the floor, causing smoke to engulf the room.

7 Analysis and Learning

The coroner's inquest into RJ's death reported:

> *'The deceased had consumed a large quantity of alcohol and the anti-depressant sertraline. He mobilised with an electric mobility scooter. In attempting to adjust a portable LPG heater in his living room which was mounted on castors, it appears to have toppled over and started a fire which caused damage to the carpet and wooden floor boards. [RJ] appears to have made efforts to leave the room but was overcome by smoke and fumes. This was an accidental death, although the deceased's poor mobility and significant consumption of alcohol and sertraline were contributory factors.'*
>
> ***Coroner's Findings***

The Fire and Rescue Service report identified the following risks associated with fire :



The analysis will consider how agencies:

1. Responded to RJ's care needs that contributed to the fire risk and
2. Recognised and responded to fire risk

7.1. Responses to RJ's care needs that contributed to the fire risk

7.1.1. The summary of events highlights the complex nature of RJ's physical and mental health needs. Very sadly, this resulted in a long period of pain and severely impaired mobility as a consequence of his fracture failing to heal and the wound becoming infected.

7.1.2. Non-union of a fracture may have many contributory factors and unfortunately cannot always be prevented.[6] There were multiple health services involved in trying to treat RJ's leg and he had a high level of involvement. There were good examples of shared care between Primary, Community and Acute Health care services and referrals onto specialist services to try and resolve the non-union of RJ's fracture and his infected wound.

7.1.3. RJ was understandably frustrated and despondent as no progress was made. His GP recalls RJ's frustrations at surgery being cancelled for his proposed vascular procedure due to bed shortages – a sad example of the pressure on resources within the NHS and the impact this has on patients. His father recalled that he took RJ to outpatients twenty-eight times and felt that the hospital should have referred his son sooner to a specialist consultant once it was apparent that the wound was not healing. ULHT confirmed that whilst the referral could potentially have been made a few weeks earlier, RJ had been referred to a specialist within 3 months of his surgery. ULHT referenced that the 28 appointments (pre and post the referral), were to check progress, review findings and continue to plan care. The nature of RJ's diagnosis made his care challenging. Ultimately RJ decided to opt for an amputation, due to the complications of 'free flap operation'[7] and the time required to spend in hospital.

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[6] V Perumal; Factors contributing to non-union of fractures Current Orthopaedics (2007) 21, 258–261; http://www.wessexdeanery.nhs.uk/pdf/Fracture%20non-union.pdf [Accessed January 2020]
[7] A free flap is a piece of tissue that is disconnected from its' original blood supply, and is moved a significant distance to be reconnected to a new blood supply using microvascular surgery

7.1.4. RJ could be resistant to the prescribed treatment and also declined to accept short term and longer-term packages of care at home that may have helped him. His father recalls RJ having carers for three weeks following his discharge from hospital but then terminating this as they were visiting at inconvenient times.

7.1.5. There was good evidence of agencies trying to support RJ's decision making, helping him to weigh up options and risks and considering his capacity. This was evident in the GP helping him to consider treatment options including the impact of amputation. It was also evident in ULHT and with the LCHS community hospital when RJ made a decision to self-discharge.

7.1.6. There were many examples of LCHS Community Nurse team working to engage RJ. RJ's father commented very positively on the role of the Community Nurses and the good relationship they had built up with his son.

7.1.7. The Community Nurse team used their relationship with RJ to negotiate his physical health care, finding alternative solutions to minimise risks where he was resistive. Their response to RJ's fall in August 2018 was a good example of this. When RJ had a further fall and declined to attend Emergency Department, they were clear with RJ about risks of that choice. Having confirmed he had capacity to make this decision, they arranged alternative care to minimise risks, sourcing a bed at the LCHS Community Hospital.

7.1.8. There was also learning for LCHS Community Nurse team in relation to falls management. There were occasions when falls risk assessments should have been carried out including discussion with RJ about a Lifeline. It was not until RJ's admission to the LCHS Community Hospital in August 2018 that there was a record of discussion with him about obtaining a Lifeline. This was by the physio-therapist. The physio-therapist also recommended to RJ not to use his electric wheelchair indoors to try and reduce risk of falls. Unfortunately, the discharge plan was not communicated through from the Community Hospital to the Community Nurse team so that they could reinforce it.

7.1.9. At the review learning event practitioners considered information sharing within and between agencies. Participants reflected that generally information is shared well when required, but there can be a lack of coordination of care. It can also take time for up to date information at the point of discharge to be uploaded on the system. There have been some advances nationally in IT solutions to share records between agencies such as MOSAIC software and use of a care portal but not all agencies are connected to this, for example community nurses. Challenges remain with GP Practices and Community nurses, not being on the same record systems and experiencing particular difficulties within rural areas.

7.1.10. However, in this incident, the communication and discharge plan were within the same organisation, LCHS. The fact that RJ had made a decision to discharge himself without notice was a complicating factor. Nonetheless, this information should have been relayed to their Community Nursing team and was an oversight by LCHS. Crucially, the rushed discharge also prevented the inpatient staff from talking to RJ about fire safety and communicating this to the Community Nursing team – this is considered further in section 7.2. below.

7.1.11. The lack of progress in treating RJ's leg had a major impact on his mental health and on his con-

tinued use of alcohol – both factors that also increased fire risk.

7.1.12. RJ's problematic alcohol use had been diagnosed for many years. RJ may have viewed alcohol as helping him to cope although sadly it is likely to have had a detrimental effect on the healing process,[8] increased his depression and risk of suicide as well as significantly increasing risk of falls.

7.1.13. The review learned that although RJ had a diagnosed alcohol problem for many years and been supported by his GP in alcohol reduction, the community nurses were not aware of his alcohol dependency until September 2018. Once known, there is no evidence that RJ's alcohol use was incorporated into an integrated care plan. ULHT were also not aware of RJ's alcohol use or mental health needs and so this was not integrated in his care plan. This is a learning point in relation to communication between Primary, Community and Acute health services. This was also a missed opportunity for community nursing, with whom RJ had a good relationship, to take opportunities to improve health and wellbeing in line with 'Making Every Contact Count'[9]

7.1.14. RJ had been experiencing depressive symptoms for some time. His GP had prescribed anti-depressant medication sertraline since 2013. NICE guidance highlights the value of psychological interventions for treatment of depression[10] and the benefit that nonpharmacological treatment can have for pain management.[11] RJ had historically been supported by counselling but referral for psychology to assist in pain management and depression earlier in 2018 may have been beneficial.

7.1.15. When RJ was experiencing suicidal thoughts, his GP did involve the LPFT crisis response team in September 2018. The crisis response team provided timely response and followed up the next day. They encouraged RJ to see his GP and he was then referred to Steps2Change for psychological therapy but unfortunately RJ did not follow this up.

7.1.16. Working with resistance to care is challenging for practitioners and takes time to build relationships and make use of moments of motivation. There was evidence of good joint working between the GP and Community Nurses in relation to his leg injury. As RJ had positive relationship with Community Nurses this could also have been as an effective means to encourage his engagement with mental health services.

7.1.17. RJ was allocated a Community Psychiatric Nurse (CPN). This was the month before RJ died. The CPN's referred RJ to ACCW for a full Care Assessment, flagging the need for adaptations to his home and referencing the poor state of his heating system. This response indicates good practice by the CPN taking a holistic approach to RJ's needs. Recognition and referral of fire risks is considered in section 7.2.

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8 Advanced Tissue: 2014 Factors That Inhibit Wound Healing https://advancedtissue.com/2014/08/factors-inhibit-wound-healing/ [Accessed January 2020]

9 NICE Making Every Contact Count (MECC) is an evidence-based approach to improving people's health and wellbeing by helping them change their behaviour. The MECC approach enables health and care workers to engage people in conversations about improving their health by addressing risk factors such as alcohol, diet, physical activity, smoking and mental wellbeing.

10 National Institute for Health and Care Excellence 2009 Depression in adults with a chronic physical health problem: recognition and management https://www.nice.org.uk/guidance/cg91/chapter/Key-priorities-for-implementation [Accessed January 2020]

11 Sturgeon 2014 Psychological therapies for the management of chronic pain https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3986332/

7.1.18. This referral by his CPN to ACCW followed a self-referral by RJ to ACCW twelve days earlier when he also requested a full Care Assessment. RJ was advised that the request would be acted upon. However, the request was not forwarded by the Duty Worker to the area lead for allocation. ACCW have identified that this was an error in practice.

7.1.19. Given RJ's complex care needs, it is notable that there had not been earlier referrals by other services for assessments for adaptations and assessments of the home environment.

7.1.20. The summary of events highlights the lack of Occupational Therapy (OT) available to RJ. This was a vital missing element. Occupational Therapists are skilled in working with co-morbidities and complex presentations such as RJ's where his combined physical and mental health needs and sight impairment were so debilitating for him. Occupational therapy may have improved his confidence and used strategies, techniques and equipment to help him adapt at home. Crucially, OTs are also skilled in home-hazard assessment – section 7.2. considers this further in relation to fire safety.

7.1.21. The summary of events highlighted missed opportunities to carry out home assessments. This related to LCHS and ACCW.

7.1.22. In August 2017, when RJ first sustained his fractured tibia, ULHT referred to LCHS Community Therapy team for an OT assessment. Following liaison between the services, the plan was for physiotherapy assessment at outpatient so no home assessment was carried out. In the period that followed, RJ was living downstairs, mobilising with a frame and wheelchair and records reference him being in a cold house as he couldn't afford heating. As his leg deteriorated, his alcohol use continued and with further incidents of falls (April, May and August 2018), this should reasonably have led to a referral for OT assessment.

7.1.23. It is noted that in October 2018 the specialist hospital that was due to carry out reconstructive surgery, requested LCHS physiotherapy and occupational therapy to carry out assessments of RJ's home environment. This was not acted on in the four weeks before RJ died.

7.1.24. In relation to ACCW, there was a similar lack of home-based assessment. In May 2018, RJ made a self -referral to ACCW requesting assessment for aids and adaptations – he was put on their OT team waiting list. ACCW reported that when the information from EMAS in August 2018, regarding fire risk was received, this should have prompted a review of the priority status given to the OT referral but did not. At the point of RJ's death he remained on the OT team waiting list. This was five months after RJ's self-referral and three months after EMAS raised concerns about his fire risk.

7.1.25. The fact that RJ had made self-referrals to ACCW for OT in May 2018 and for Care Assessment in October 2018 but received no outcome is concerning. This is particularly the case given the risks that were specified by EMAS in August 2018. It is a sad irony that RJ was known by some services to be difficult to engage but on two occasions he actively sought help, it was not provided.

7.1.26. ACCW referenced that there were long waiting lists for OT at this time and a need for appropriate prioritisation. ACCW has identified learning for their service. Their duty and triage processes

have been reviewed, to improve communication and cross referencing of information between teams and prioritisation of resources.

7.2. Recognition and response to fire risk

7.2.1. The LFR referenced that they have a referral process to allow partner agencies to highlight and pass on information relating to vulnerable individuals.[12] Their belief was that had they been made aware of RJ's circumstances, they may have been able to carry out interventions to support the identification of fires, and apply control measures to mitigate and limit the effect of fires within his home.

7.2.2. On receiving a referral LFR stratify and categorise the risk, allocate resources and carry out a home visit. The responses available include:

- Person Centred Risk Assessment to identify specific risks; further assessment and support by partner agencies if required.
- Smoke and CO Detection
- Flame retardant items, e.g. bedding packs/aprons
- Close links with Well-being Lincs enabling a collaborative approach to support mechanisms, e.g. telecare/lifeline
- Partnership referrals and information sharing
- Identify issues with heating and replace old heaters with safer versions.
- The potential to install a misting unit

7.2.3. Making best use of this service required

1. Agencies to identify the fire risks and
2. Knowledge of referral routes

7.2.4. It is apparent from the summary of events that RJ was receiving intensive support and had many practitioners involved. Many saw his home environment. It is acknowledged that RJ may not have been using the portable gas heater on every occasion practitioners visited. However, RJ's father reports he had been using the gas heater for at least two years. On balance, it is highly likely that he would have been using it on many occasions that practitioners visited. This, linked with his high risk of falls; ataxia; restricted mobility, smoking and alcohol use should have raised alarm bells but in the majority of interactions did not.

7.2.5. There were some instances such as in October 2018, when the LPFT CPN recognised RJ's difficult living circumstances and referred on for a full Care Assessment. Whilst this was good practice, there also needed to be recognition of the fire hazard and a direct referral made to LFR service.

7.2.6 The review questioned what training and guidance practitioners receive in relation to fire safety for the users of their services. LCHS reported that staff had been trained in making fire and safety risk assessment referrals but the nurses caring for RJ had not considered him to be high risk. ACCW also referenced that though their assessment documentation contains a section to

[12] Subject to the adult's consent unless the adult lacks relevant capacity or where there are public or vital interests such as safeguarding concerns.

identify and respond to serious risks, the issue was that the professionals visiting RJ did not recognise his increased risk.

7.2.7. In 2019 LFR launched a campaign using the acronym of SHERMAN to flag vulnerability factors:

- **S**moking
- **H**oarding
- **E**lderly people or those who live alone
- **R**educed mobility, hearing or visual impairments
- **M**ental health issues
- **A**lcohol misuse, drugs/medication dependence
- **N**eeding care or support

7.2.8. Environmental hazards, including fire safety and SHERMAN, should be integrated within care planning and interventions for individuals with high vulnerability, for example, prompting within discharge care plans; care and support assessments and in key areas such as falls assessments.

7.2.9. Some agencies such as LCHS, reported that SHERMAN is now incorporated into their mandatory training and that their teams now consider fire and safety risk assessments, using SHERMAN criteria, in admissions, review assessments and discharge planning. This is good practice.

7.2.10 There is a need for the LSAB to seek assurance from partner agencies regarding how SHERMAN has been rolled out within agencies and that agencies have training and processes in place to assist practitioners to identify and escalate fire risks. An analysis by LFR of the source of their referral statistics would assist in this assurance work.

[Recommendation 1]

7.2.10. For some professions such as OT, environmental safety including fire safety, should be key aspects of their role – interaction between environment, occupation and impact of disability. Section 7.1. outlined the missed opportunities for home based environmental assessments. Had these been carried out, it is likely that fire risks would have been identified and referral made through to the LFR for fire preventative work.

7.2.11. Within all the interactions, there was one exception where practitioners identified the fire risks. This was the EMAS crew that attended in August 2018. Identifying the fire risks was good practice by the EMAS crew as was referring this through as a care concern to ACCW and notifying the GP. EMAS identified learning that the risks were not notified to LFR as this was expected practice where there are two or more fire risks.

7.2.12. As outlined in 7.1, the plan by LCHS Community Hospital to address the fire risks was appropriate i.e. reduce risk of falls; Lifeline, keybox and referral to LFR for fire prevention work. There was learning for that service in this plan not being communicated when RJ took his discharge.

7.2.13. It is not possible to say whether RJ would have accepted the LFR fire prevention visit. However, the learning from this review highlighted the need to strengthen how well agencies identify fire safety risks and ensure agencies are aware of referral routes through to the LFR and that any agency can refer.

[Recommendation 1]

7.2.14. In some parts of the country, Fire and Rescue services are partnering with OTs in a joint initiative for fire prevention with referral pathways between services and joint work on complex cases such as hoarding.[13] Fire Risk is incorporated into OT assessments and OTs can provide training and advice to fire and rescue service staff in interventions, such as preventing falls and how to adapt approaches and communication when working with people who have a range of conditions such as dementia and psychosis. LFR has met with the OT Lead for Lincs County Council with a view to exploring opportunities for the two agencies can work together. A recently developed hoarding protocol[14] should also strengthen multi-agency working and have a positive impact on reducing fire risks.

[Recommendation 2]

8. Conclusion

8.1. 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.

8.2. 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 his needs within his home environment and to develop a holistic care plan that included identifying and 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.

8.3. Had a home assessment and fire and safety checks been carried out, it is likely that this would have reduced the fire risk factors and *may* have averted the sad circumstances of his death.

8.4. 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.

9. Recommendations

9.1 The review has identified a number of learning points for individual Health and Social Care agencies. This learning needs to be disseminated within agencies to inform their quality assurance and improvement processes.

9.2 Recommendations have focused on multi-agency responses specific to fire safety:

[13] Royal College of Occupational Therapists: Fire and Rescue Services; The value of working in partnership with occupational therapists file:///C:/Users/User/Downloads/Fire%20and%20Rescue%20Services%20the%20value%20of%20working%20in%20partnerships%20with%20occupational%20therapists.pdf [Accessed January 2020]

[14] [Draft note: Add in reference to hoarding protocol]

Recommendations
Recommendation 1: Identification and Referral Pathways for Fire and Safety Checks The LSAB to seek assurance from partner agencies regarding: i) how SHERMAN has been rolled out within their agency ii) the mechanisms each agency has in place to promote identification and risk reduction of fire safety concerns, including referral routes to LFR for fire and safety checks The assurance should include analysis of referrals to LFR to evaluate the outcomes achieved through these processes.
Recommendation 2: Partnership Working Between Fire and Rescue Service and Occupational Therapists LFR, ACCW and LCHS should review opportunities to develop joint initiatives between Fire and Rescue Services and Occupational Therapists. This is with a view to combining skills and expertise making most effective use of resources in relation to safe and well checks. The review may wish to consider national initiatives including those cited within this review.

Sylvia Manson

Sylman Consulting

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Glossary

CPN Community Psychiatric Nurse

ED Emergency Department

EMAS East Midlands Ambulance Service

LFR Lincolnshire Fire and Rescue service

LCC -ACCW Lincolnshire County Council- Adult Care and Community Wellbeing

LCHS Lincolnshire Community Health NHS Services

LPFT Lincolnshire Partnership NHS Foundation Trust

LSAB Lincolnshire Safeguarding Adult Board

OT Occupational Therapist

SAR Safeguarding Adult Review

ULHT United Lincolnshire Hospital Trust

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About the Reviewers

The review was initiated by Gill Poole who has a background in Nursing Health Visiting and Safeguarding. Gill has worked as a Senior Nurse in Safeguarding Children for East Yorkshire, has been Chair for Safeguarding Adults for Hull and East Riding and a Senior Manager for the NHS. Gill has authored six Safeguarding Adult Reviews, Domestic Homicide and Fire Death Reviews and has been co-author for another SAR commissioned by LSAB. Gill contributed to setting the methodology and terms of reference for the review and leading the learning event.

The review report was written by Sylvia Manson, of Sylman Consulting, building on the work of Gill Poole. Sylvia is a mental health social worker by background and has many years' experience in Health and Social Care senior management and commissioning. Sylvia has held regional and national roles in implementing legislation and developing safeguarding policy, including as Department of Health, lead for NHS, developing the Safeguarding Adult Principles, now incorporated into the Care Act statutory guidance.

Sylvia now works for the Mental Health Tribunal along with independent consultancy focused on partnership development, service improvement and statutory learning reviews.

Sylvia Manson

sylmanconsulting@outlook.com
www.sylmanconsulting.com