Derbyshire Safeguarding Adults Board (DSAB)
Multi-Agency Learning Review MALR16A Case Summary

Derbyshire Safeguarding Adults Board commissioned a multi-agency learning review in February 2016 in relation to the death of an Adult who had died in an accidental fire at home. A multi-agency learning review can be undertaken for any case where the criteria set in the Care Act for a Safeguarding Adults Review (SAR) to be undertaken is not met, but where it is felt that there may be valuable learning for a number of DSAB organisations about the way in which they work together to safeguard adults with care and support needs.

The Subject of this review had been involved in a Vulnerable Adult Risk Management (VARM) process previously due to concerns about unsafe home conditions and self-neglect contributing to poor health. The Adult has been known to a number of organisations for several years including Derbyshire County Council Adult Care, Derbyshire Fire and Rescue Service, Derbyshire Constabulary, Chesterfield Royal Hospital NHS Foundation Trust, Derbyshire Community Health Services NHS Foundation Trust, District Council and Environmental Health Service and Derbyshire Clinical Commissioning Group. The above organisations were part of the learning review panel and contributed to the review by submitting reports and timelines and attending several meetings. The Coroner and family members were also informed and their views were incorporated into the final report which was authored by Jill Ryalls, Head of Safeguarding for Derbyshire County Council Adult Care. The report and recommendations were signed off by DSAB members in June 2017. Below is a summary of the key points identified in the Review and the recommendations made in the final report. The DSAB SAR Sub Group is responsible for overseeing the implementation of recommendations and providing assurance to the Board that this has been achieved.

Good Practice

- All agencies were positively engaged in promoting the welfare of the Adult and supporting their wish to live independently at home.
- Significant time and investment by agencies working together bought about improvements to the living conditions and care arrangements of the Adult enabling them to return home following discharge from hospital.
- The Adult was always involved in decisions about their care and aftercare. Agencies were explicit with the Adult about their concerns.

Identified Learning

- Derbyshire Fire and Rescue (DFRS) did not attend the VARM meeting but had been significant contributors in the earlier months in relation to fire safety in the Adult's home. DFRS may have been able to make further recommendations for fire safety measures.

- DFRS were not aware that the Adult had a hearing impairment, and if they were aware could have installed a visible smoke alarm. With reduced mobility it is not a safe assumption that the Adult could have exited to safety unaided.

- DFRS did not know the Adult had been issued with a pendant alarm. If known, DFRS would have suggested that a smoke alarm linked to third party monitoring would have alerted someone to contact the fire service much earlier.

- Derbyshire Constabulary were not aware to attend the VARM. There had been a number of isolated incidents where police officers had attended the Adult's home and involvement in the VARM may have enabled information sharing amongst police officers and provided opportunities to check on the Adult with increased awareness of the Adult's vulnerability.

- The Environmental Health Service attended a previous hospital discharge planning meeting but were not invited to any subsequent discharge meetings. Previously they ensured that the necessary housing repair works had been completed to a basic safe standard and that the property was clean and the required pest control treatments had been carried out. As part of any subsequent discharge arrangements, the Environmental Health Officer could have arranged to accompany the Social Worker on a discharge review visit to identify any current risks which may have been present in the property.

- Heating within the property had been identified as an issue from the Derbyshire Community Health Service (DCHS) Falls Partnership Team but had not been raised as an area to explore on the environmental scan to consider potential alternatives for heating sources which may have been available through the District Council or by discussion with the Adult. When considering heating sources the risk of fire should be factored into decision making.

- There was significant background work taking place within the hospital in relation to the Adult but this was not recorded within the patient record and there is a need to review the single patient record within the hospital.

- The Adult was in receipt of services from both directly provided services and then subsequently purchased services. Within the case record there is no clear system for incorporating the day to day knowledge of carers into the electronic record. There needs to be more pro-active recording and discussion between the case manager and the providers of care. DFRS can provide fire safety training to care providers on request. Care providers could produce evidence of staff training in home fire safety which in turn could be passed on to self-funding clients to aid decision making when selecting care providers.

- A safeguarding referral received by Adult Care was dealt with by the Community Social Worker undertaking S42 enquiries. Given that the Adult was still the subject of a VARM at this point it would have been good practice for a Next Steps meeting to have been convened to address the cause of the concern within the Safeguarding referral but also to have undertaken a full review of all the concerns that had previously occurred.

- There are records of formal capacity assessments being undertaken and whilst it is not suggested that the decisions taken were incorrect, a more consistent understanding of a specific element of the Mental Capacity Act is required. Staff were mindful of the Mental Capacity Act and the requirement to assess an individual's ability to make decisions but there was a lack of evidence to suggest the Adult had a diagnosis under Part 1 of the 2 part test and therefore part 2 of the test would not have applied.

- There is a need to address the issue of multiple MCA assessments and consider how these maybe shared as a basis from which to start future assessments.

Recommendations

Recommendation 1: That the DSAB instigates a review of the VARM policy, procedures and guidance applicable to all DSAB agencies.

The VARM process is designed to provide a strong multi-agency framework for professionals working with people with capacity who are at risk of serious harm or death. The current policy is deficient in providing robust unequivocal instruction to agencies involved in VARM in particular regards to

- Training and experience requirements for VARM chairs
- Timescales of meetings, action plans, distribution of records
- Ownership of coordination and monitoring of VARM case (including transfer of ownership as risks change)
- Record keeping and information sharing protocols
- Arbitration or disputes resolution
- Ensuring the Adult/their advocate is fully included throughout the VARM process.
- DSAB should ensure the VARM process is clear in identifying a single point of contact for family and friends and those involved in the process to ensure continuity and accountability.

Recommendation 2: That the DSAB explores a pathway for communication and raising awareness between organisations/agencies of people that are subject of VARM or that have been subject to VARM within the previous 12 months.

Had the individual been subject to a VARM and the receiving hospital known then records could have been accessed and relevant agencies alerted. Without access to important historical and contextual information there is an on-going risk of a lack of consistent multi agency working.

Recommendation 3: That DSAB assures itself that relevant agencies are robustly recording and tracking progress of any individuals subject to VARM and that there is agreed governance of all open VARM cases within Derbyshire.

Recommendation 4: DSAB to seek assurance that MCA responsibilities are understood by all DSAB partners.

Recommendation 5: DSAB promotes the use of hard wired smoke detection and telecare systems that is linked to third party monitoring in all cases of single occupancy where there is inherent risk of fire and the occupier is subject to safeguarding or VARM.

Recommendation 6: Given there are lessons to be learnt from this case for all agencies involved in the Adult's life DSAB should accept this report; disseminate its findings to all SAB partner agencies and assure itself that appropriate indication plans are being implemented.