SAFEGUARDING ADULTS REVIEW: Mr CS

A briefing for practitioners

Lewisham Safeguarding Adults Board has published a Safeguarding Adults Review relating to the death of Mr CS, aged 69.

What is a Safeguarding Adult Review?	How was this review undertaken?
Under the Care Act 2014, the Safeguarding Adults Board has a legal duty to review any case in which: • an adult with care and support needs has died (or sustained serious injury) • as a result of abuse or neglect (including self-neglect) • where there is cause for concern about how agencies worked together to safeguard the adult The terms of reference of the SAR required a wider consideration of circumstances and context of Mr CS's death in respect of policy, procedure and practice. It was intended to support, scrutinise and challenge the subsequent actions of those involved as well as to aid future prevention and learning.	The Safeguarding Adults Board set up a review panel that included: • Senior representatives of the Board's statutory partners • An independent lead reviewer The preparation of the SAR overview report involved consideration of the papers and findings of the Coroner's Inquest, reports submitted by the agencies involved plus the deliberations and thoughts of the SAB panel. The review findings and recommendations were shared with a representative of Mr CS's family.

Case Summary

1. Mr CS died of extensive burns after a smouldering cigarette which had dropped in his clothing became ignited by a breeze. He was alone smoking in the outside shelter at Manley Court[1] and had been unsupervised by the care staff for around 45 minutes. Had he been supervised, had he had a means of calling for assistance or been wearing a protective apron he would have survived.
2. Critically had Mr CS been the subject of a thorough risk assessment both the likelihood of such an accident happening and its impact would have been significantly reduced. If he had decided not to consent to the protective measures of a risk assessment, as he was capable of doing, he would have been making an unwise decision against professional advice.

[1] The home is variously called a care home, nursing home and nursing centre. This report refers to the home as Manley Court.

3. Born on the 10th March 1947 in Jamaica Mr CS came to live in the UK as a teenager. He married and had two sons and two daughters, three grandchildren and one great grandchild. Subsequently he divorced. His son, David, described him as a likeable and popular man who was 'into his music' and poetry. He said his Dad liked to talk about his time in Jamaica[2].

4. Mr CS was admitted to Manley Court on the 21st December 2006 aged 59 after a stroke resulted in him experiencing left sided paralysis which impacted on his ability to look after himself independently. He was deemed a young person with a disability. His medical records showed him to have had a history of schizophrenia, hypertension and diabetes.

5. Mr CS was re-assessed in May 2011 and at the time the recorded health issues were:

    - Cerebrovascular Accident with left hemiparesis
    - Hypertension
    - Schizophrenia
    - Type 2 diabetes
    - Poor mobility due to pain in the knee and back pain
    - Poor speech

    All of which had continued to impact on his general well-being and independence. Mr CS appeared to suffer from regular left sided pain – hand and foot including swelling. He was referred to a specialist for this and additionally for possible gastric/digestion problems. His ailments and pain were put down to lack of mobility and exercise and treated at various times with medications.

6. His medication regime had been reviewed on 25th February 2016 and tests resulted in a normal/no action outcome. The GP acknowledged that some of Mr CS's medication could cause sedation or confusion. He said Mr CS had been on them for *many years* and *shown no signs of sedation or confusion during the time he had been on them.*

7. The continuing diagnosis of schizophrenia had been confirmed in December 2012 with the GP saying the illness was in remission and controlled by medication. The GP said, of Mr CS, that he *did not encounter him displaying any symptoms of mental disorder.* He judged that over the time he knew Mr CS there to be *no concern about his capacity to consent to the medical treatments prescribed.*

8. Although Mr CS expressed a wish to return to the community, he was assessed as continuing to require assistance with all activities of daily living 24 hours a day. He was doubly incontinent and required assistance of two staff members for washing and dressing and to maintain his personal care. Mr CS was deemed not safe to self-medicate because he was sometimes forgetful. Likewise, he required assistance to meet his nutritional and dietary needs. By and large he could eat and drink unaided and was aware of the need for a balanced diet as a diabetic.

[2] Witness statement of David Skyers

9. Mr CS needed the support of two staff for all transfers using a standing hoist, and staff used a manual wheelchair for mobility around the home and outside. Additionally, he needed support with repositioning. The care plan included safe-handling in respect of mobility and required that Mr CS be secured by a posture-belt in his wheelchair. Additionally, Mr CS was at risk of falling out of bed and, with his consent, had bed rails in place to protect him.

10. Notwithstanding his physical dependency and enduring left-sided pain Mr CS came across as being strongly independent of will and spirit. He declined some personal support services, chose to eat takeaway food, dreamed of Jamaica and disliked what he felt was being 'treated as a baby'. A typical day saw Mr CS assisted with his personal care and in taking his *due and prescribed*[3] medications, he usually slept, ate and drank well and was supported to wash and toilet. He commonly spent much of his day in the garden smoking and interacting with other service users. He watched some TV (football and cricket), listened to the radio, enjoyed a good book and joined in activities and outings – music, poetry, bingo, dominoes, arts, crafts and pottery, shopping and trips to the seaside. He had the occasional visitor – his son David and a woman friend - and attended Catholic Church.

11. A general risk assessment was completed on the 3rd January 2016 after the absence of risk assessments in the care plan was raised at a review on 22nd December 2015. The reviewing officer made this an action point in respect of Mr CS's *smoking habits.* The consequent risk assessment identified the hazards of burns, smoke inhalation and death. Harm could be caused to residents, staff, relatives, visitors and contractors. The current mitigation was the provision of the smoking shelter in the garden. Additional measures were for the admin/activity coordinators to buy Mr CS's cigarettes and they be *given to the nurse on duty to give to him whenever he asks for cigarettes* and staff to take him to the garden. Unfortunately, there was no consideration that Mr CS might harm himself from smoking and thus no self-protective measures included in the plan.

12. Mr CS died on the 13th March 2016 in the resuscitation room of King's College Hospital, London. He was transported there by ambulance after having been discovered *engulfed in flames* in the smoking shelter located in the garden of Manley Court Nursing Home where he lived. Earlier he had been taken to the shelter in his wheelchair so that he could smoke. The cause of death was recorded as *extensive burning (50%).*

13. *The most probable cause for this fire was a cigarette coming into contact with Mr CS's clothing, initiating a smouldering fire. The transition to a flaming fire would have been aided by the natural ventilation from the breeze in the garden*[4]

[3] A turn of phrase used routinely in the day logs of care staff

[4] Fire Investigation Team Watch Managers report August 2016

14. The regulation 28 report[5] from the Coroner documented the circumstances of Mr CS death as:

> **CIRCUMSTANCES OF THE DEATH**
> Mr Skyers was a hemiplegic resident of Manley Court Nursing Home, who could not stand or reposition himself on his own, nor propel his wheelchair. He was wheeled into the garden to smoke, a regular routine, on the morning of 13th March 2016. He was assessed as safe to smoke on his own, but the staff were unaware that some of his laundered clothes had burn marks. He was known not to like supervision. He was unusually left alone in the garden and it was not evident how he could summon help. At about midday, he was seen to be on fire and immediate attempts were made to extinguish the fire by smothering and water, which was effective. It lasted less than five minutes.
> It had been caused by the breeze fanning his smouldering clothes, burnt by his lit cigarette. Emergency services attended promptly and despite full resuscitation he died at 13.05 in hospital of extensive burning.
>
> Had he been supervised or had means of alarm call, he would likely have survived.
>
> Although not recorded, as evidence from the nursing home on the wearing of smoke aprons was not heard, Fire expert advice was accepted that had he been wearing a smoking apron, he would also have survived.

The review findings

- The review did not uncover any causative factors beyond those identified by the fire investigator and Coroner. However, Mr CS setting himself on fire through smoking was both predictable, even if at the lower end of the likelihood scale, and preventable with his consent to readily available harm reduction measures.
- Smoking of itself is a harmful activity and it should not have been so readily accepted (or even encouraged) that Mr CS should be enabled to smoke. The reports showed no efforts to support him cease his habit.
- The SAR raises questions and offers responses in six areas:
  - The use of paraffin-based emollient creams
  - The matter of burn-holes found in Mr CS's clothing in his wardrobe
  - Medications that can cause sedation
  - Wheelchair use, posture belts and immobile residents who smoke (a concern raised by the Coroner)
  - Whether Mr CS could have been 'saved'
  - The question of supervision – and associated issues of risk assessment and preventative measures.

[5] A report issued by the Coroner to prevent future deaths – the verdict is in the narrative. In the case of Mr CS, the report was sent to the Chief Executives of BUPA and CQC as well as the chair of the Lewisham Safeguarding Adults Board.

- Mr CS was regarded as safe to smoke unsupervised and that this was his preference. He was deemed to have the mental capacity to make this decision and physically capable of undertaking all the actions of smoking safely. This information was established after the event – witness statements and BUPA's own investigations - but was not documented in pro-active care planning, review and risk assessment.
- A smoking risk assessment must consider the possibility of the smoker harming themselves from smoking. If they refuse consent to protective measures this should be recorded as an *unwise decision*.
- Supervision ought to be considered for all immobile people wherever and whenever they smoke.
- Residents clothing and appearance are indicators of care and having burn-holes in clothing suggested that Mr CS dignity and respect were being compromised in the way his care was provided.
- Manley Court had been failing to improve over several years and inspections, with the absence of any continued approach to enforcement of required standards. Action plans and warnings had failed to stimulate lasting improvements.
- Contract monitoring and safeguarding staff not being able to stem a litany[6] of safeguarding alerts as breaches of contracts.
- The approach to reviews of Mr CS's case worked without history or any understanding of the purpose of the placement.

The recommendations

i. The Safeguarding Adults Board consider establishing a steering group approach to oversee and communicate about investigations where there are fluid issues of primacy of investigator, complexity of legal and regulatory requirements and changing timetables.

ii. The Care Quality Commission are invited to share their views about how they use their regulatory and enforcement powers in circumstances such as those appertaining at Manley Court and advise on how concerns about providers are effectively managed by the SAB.

iii. The Police are asked to consider the evidence put before the Coroner to see if Mr CS has been the victim of wilful neglect under the Criminal Justice and Courts Act 2015.

iv. BUPA and other care home providers should actively support residents in smoking cessation programmes.

[6] Between 2012 and 2016 there were at least 16 Safeguarding Case Conferences regarding a multitude of types of allegation – many of which were substantiated. The overall catalogue of concerns documented by the Lewisham Safeguarding Quality and Risk team over those years leads one to query the statement of the BUPA Regional Director stating she had no more concern about Manley Court than her other homes.

v. BUPA should clarify the roles and tasks of the 'allocated care assistant'.

vi. Notwithstanding the various recommendations and actions put in place by BUPA, it is suggested Manley Court engage in a wider approach to care practice improvement such as those offered by SCIE[7], the Social Care Commitment[8], registered managers networks[9] and/or *My Home Life.*[10]

vii. BUPA and other care home providers should introduce values-based recruitment and training with testing of the judgement of the workforce and management at the point of recruitment and through annual appraisal.

viii. BUPA and other care home providers should establish an approach to medication reviews which has the GP, pharmacist and registered manager working together as recommended in the materials available from the National Care Forum.[11]

ix. The local authority should initiate joint work with LFB, BUPA, and other care providers in the borough on risk assessment – specifically to include fire, smoking, immobility, wheelchair use and first aid – to establish mutually clear and consistent standards and expectations.

x. The BUPA Responsible Individual and the Director of Adult Social Services should ensure their organisations have fulfilled their respective duties of candour.

The Safeguarding Adults Board's action plan

Since receiving the review report, the Safeguarding Adults Board has routinely monitored the implementation of action plans by the agencies involved.

Further information

If you would like to read the review report, you will find it at https://www.safeguardinglewisham.org.uk/lsab/lsab/what-is-safeguarding/safeguarding-adult-review-mr-cs-october-2018

If you have any questions about the review, or the Safeguarding Adults Board's actions since, please contact the Board Business Manager.

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[7] Lewisham SAB has the SCIE Improving Personalisation in Care Homes – Action Planning Tool on its website at http://www.safeguardinglewisham.org.uk/lsab/lsab/professionals/improving-personalisation-in-care-homes-action-planning-tool (accessed 14th July 2017). Links to all the good practice resources identified in this recommendation could usefully be added.

[8] See https://www.thesocialcarecommitment.org.uk/ (Accessed 12th July 2017)

[9] See http://www.skillsforcare.org.uk/Leadership-management/Registered-managers/Your-local-registered-managers-network.aspx (Accessed 12th July 2017)

[10] See http://myhomelife.org.uk/ My Home Life is a UK-wide initiative that promotes quality of life and delivers positive change in care homes for older people. (Accessed 12th July 2017)

[11] Free resources for supporting the safe use of medications in care facilities see: http://www.nationalcareforum.org.uk/medsafetyresources.asp (Accessed 11th July 2017)