Bexley Safeguarding Adults Board

7-minute Learning Summary

SAR - Victoria

1. Rationale for Safeguarding Adult Review (SAR):

The BSAB regularly carries out SARs. They are extensive pieces of work, that look in details at cases when an adult at risk of abuse dies or has experienced serious neglect or abuse, and there is concern that partner agencies could have worked more effectively to protect them. This SAR was carried out so that the agencies involved in providing services to Paul could learn lessons and improve practice.

Agencies looked at how they worked as individual agencies and how they worked together. The aim of this work is to provide information, understanding and insight.

The overall aim of a SAR is to improve services because of that learning. **What do you do?** Make sure you embed the learning and can evidence to the BSAB especially if you work for an agency that was involved in this SAR.

The full report can be found here –

https://www.safeguardingadultsinbexley.com/wp-content/uploads/SAR-VICTORIA.pdf

2. What happened in the case of Victoria?

The subject of this review is a woman in her late seventies who suffered from a range of medical conditions. At the time of her death she was housebound and in receipt of a comprehensive package of domiciliary support. She also benefitted from regular visits from her family. She died as a result of smoke inhalation emanating from a fire that had started in her bedroom. The circumstances of her death will have caused distress to her family, but also to the professionals who knew her. I want to extend sincere condolences to Victoria's family. Victoria was known to a number of different health and care agencies, and to the Fire and Rescue Service. This review has led to recommendations on improving communication and the sharing of information between agencies, where there is an identified issue of concern. In this instance the concerns related to the risks where oxygen is being used by an individual who smokes.

1 2 3 4 5 6

3. Involvement of Family Members:

Victoria's two sons were contacted and sent a copy of the draft report. Reviewer spoke with of the sons prior to sending the explained to him the purpose of 7 under-taking the SAR, and offered and his brother the opportunity for a further conversation once they had r received the report. There was no subsequent contact from him, and therefore assume that they are content with the report, and do not wish to add anything from the family's perspective.

4. Background / Summary:

Victoria was a woman who lived on her own in a flat. She had two sons, one of whom was her main support. Her sons and grandchildren visited regularly. Victoria suffered from a range of medical conditions including chronic obstructive pulmonary disease, and hypertension. Victoria was known to Bexley Social Services and had a care package in place provided by Rapid Improvement Care Agency which began in December 2017. Following a hospital admission in April 2018, her lounge was set up to also be her bedroom and became 'a micro environment for her' to live in with equipment she needed. She was no longer physically able to manage her personal needs and was partially dependent on family members and home carer to support her. At the time of her death in October 2019, her package of care consisted of 4 visits per day, each visit lasting thirty minutes by one carer. Victoria required support with various activities of daily living. Victoria was well supported by her family alongside the domiciliary care. In addition, she had a cleaner visiting once a day. She is described by those who knew her as sociable and welcoming of her frequent visits. Victoria was clear about the support she needed and able to discuss any concerns she had. Within her home she was able to move around using a walking aid and was advised to do so with the support of one person.

5. Findings: London Fire Brigade -

1. Ensure all staff on home fire safety visits are reminded to refer people for fire retardant bedding. 2. Review completed home fire safety visits data for the local area and consider any further action to reach local community 3. Provide Bexley DN's with fire risk/person centre risk training 4. Liaise with LA to ensure all care contractors include fire safety information in their care plans. **Care agencies** - 1. Office staff attend a briefing with the fire service. 2. Paper work for fire risk assessment for all clients has been introduced. 3. Care workers have been reminded to be robust in their reporting and recording especially where there is family involvement. 4. Care Workers to be supported to have the confidence to challenge family when needed. **Adult Social Care-** ASC had limited involvement. There was an opportunity to identify and discuss the risks about smoking/oxygen when Victoria was assessed on discharge from hospital and then Reviewed but it does not appear that this happened. Whilst these had been addressed to some extent by the respiratory nurse And LFB following hospital discharge, it is not evident that the ASC workers were aware of this as it is not noted in the social care assessments as Well as not following up on Tele-Care reports by the LFB. Victoria died later that day. NICE guidance was not followed Re: Oxygen / Smokers.

6. Recommendations:

1. Staff in all agencies should be reminded of the risks associated with smoking and use of oxygen, and advised to report concerns to their manager. 2. Any agency working with an adult where they have concerns about ongoing risk should contact adult social care to ask for a multi-disciplinary meeting to review the risks and the care plan.