Statutory Safeguarding Adults Review (SAR) Report and Findings in respect of an individual to be known as Victoria

This report has been prepared under the statutory requirements of the Care Act 2014 by Internal Reviewer, Eleanor Brazil, independent chair of the Bexley Safeguarding Adult Board.

1. Introduction

This Safeguarding Adult Review (SAR) was carried out so that the agencies involved in providing services to Victoria could learn lessons and improve practice. The report is anonymised to ensure no individuals can be identified. Agencies have 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 and importantly, to improve services as a result of that learning.

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.

2. Criteria for undertaking a SAR

A Local Safeguarding Adults Board must undertake reviews of serious cases in specified circumstances under Section 44 of the Care Act 2014 which sets out the criteria for a Safeguarding Adults Review (SAR). This includes circumstances involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if there is reasonable cause for concern about how the Safeguarding Adults Board, members of it or other persons with relevant functions worked together to safeguard the adult, and the adult has died.

The purpose of the review is primarily to:

(a) identify any lessons to be learnt from the adult's case,
and
(b) apply those lessons to future cases.

3. Decision to hold a Safeguarding Adults Review (SAR), Terms of reference and methodology

The circumstances relating to this case were considered by the SAR Sub Group in October 2019 and a recommendation was made by partners to the Independent Chair, that this case met the requirements for a SAR. It was agreed that due to the relatively limited range of issues, the review should be led by the Independent Chair, who agreed and then wrote to statutory partners and agencies known at the time of death, that she would be the independent reviewer on this case in order to capture the learning. The agreed terms of reference are:

> a) establish lessons to be learned from the case of Victoria, in terms of how professionals and organisations worked, both individually and together, to safeguard the adult at risk and prevent harm
>
> b) identify required improvements and the timescales in which they will deployed, identifying how and what is expected to change as a result, and agreeing required monitoring systems

It was agreed that this SAR would be conducted as learning process, with involved agencies being asked to complete their own review, and those reviews being brought together and considered at a number of joint meetings. The first meeting was held at the end of February 2020. There has been a short delay in further meetings and finalizing the report due to the need for agencies' to prioritise response to the Covid-19 crisis.

Summaries of involvement were received from:

1 Darenth Valley Hospital
2 London Fire Brigade (LFB)
3. Rapid Improvement – Care Agency
4 Local Authority / CCG Integrated Services Integrated Rehabilitation
5. Oxleas NHS Foundation Trust – Community respiratory service
6. GP Practice – any update

4. Involvement of Family Members

Victoria's two sons were contacted and sent a copy of the draft report. I was able to speak to one of the sons prior to sending the report, explained to him the purpose of undertaking the SAR, and offered him and his brother the opportunity for a further conversation once they had received the report. I have not subsequently heard from him, and therefore assume that they are content with the report, and do not wish to add anything from the family's perspective.

5. 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.

6. Health and care involvement

For the purpose of this review I have only considered the sixteen-month period prior to Victoria's death. In April 2018, following a hospital admission the Bexley social care integrated rehabilitation service was briefly involved at the time of discharge in assessing Victoria's care needs and then reviewing the care package in July that year. Victoria received support from Community Respiratory nurses in addition to the domiciliary support. Her GP undertook some home visits and but also relied on the nurses and Victoria's son to make contact and raise any new concerns about her health.

As part of the discharge plan, Victoria was assessed as requiring oxygen to support her. It was known that she had been a smoker and efforts were made to discourage her.

7. What was known about the smoking risk and use of oxygen

During Victoria's hospital admission in 2018, she was reviewed by the respiratory team and agreed that she would need long term oxygen therapy due to hypoxia. Victoria was referred to the Respiratory nurse specialist from Oxleas NHS Foundation Trust. It was identified that she was required to have oxygen therapy on discharge but she was a smoker. The risk of smoking around oxygen was highlighted to Victoria. In the referral made to Oxleas, it states that Victoria is a smoker but notes that she said that she will not smoke around the oxygen and that she has been referred to the smoking cessation service. It was requested that a review of Victoria take place sooner than the usual time for assessment to ensure that the risk had not increased and that she was coping with the oxygen. Victoria was discharged with two litres of oxygen. No referral was made at that time to the London Fire and Rescue service. However, the Fire and Rescue Service did carry out a home fire safety visit on the 19/05/18 as part of a group risk visit at the block where Victoria lived.

On discharge from hospital Victoria also had support from the Hospital at Home Team and was noted to have a care package in place. Referrals were also made to the district nursing team for wound care, to the continence service and to the community rehabilitation team.

In June 2018 the GP surgery was made aware by the Community Respiratory nurses of the risk that existed as Victoria continued to smoke with oxygen in the property. As a result, the large emergency cylinder was removed leaving the oxygen concentrator. Her smoking was discussed with her by the Respiratory nurse at each of their visits the last being in June 2019.

The Respiratory team have reviewed practice regarding the prescribing of oxygen to patients who are known to smoke. The Home Oxygen Checklist, that is completed prior to discharge, asks whether the Fire and Rescue Service is informed that a patient is being discharged with oxygen. On this occasion it appears that the patient was not referred. It was not until August 2019 that they were informed following a police call out, and they then visited to conduct home fire safety visits.

On 13/8/2019, social services were informed by the police that Victoria had called the London Ambulance Service and then the line had then gone dead. The police broke in and found Victoria breathless but conscious. The Police report risk assessment set out the following: Danger - nothing to note, Environment - nothing to note, flat was adequately clean. Social care decided that no further action was required at that time as Victoria was not admitted to hospital and her care package continued as normal.

On 13/8/2019 the London Fire and Rescue service received a referral from the London Ambulance Service following their attendance at the address. The Ambulance Service advised that the resident lived alone, had O2 cylinders, smoked in bed and that there were scorch marks on the bedding.

The Fire and Rescue Service attended later that day and assessed Victoria to require fire retardant bedding due to signs of careless disposal and near misses from smoking. This was provided during this visit. As Victoria was not present at the time of the visit the bedding and care instructions were provided to her son. A return visit was made the following day to confirm that the bedding was in use and to check the smoke alarms were in good working condition, plus a check of the rest of the property to identify any outstanding risks. The officer who visited spoke to Victoria, and highlighted the risks of smoking in bed and the risks associated with oxygen therapy. Victoria is said to have stated that she understood the risks and was going to try and cut down on her smoking.

The Carers did not see Victoria smoking but said family and friends brought alcohol and cigarettes when they visited her. They were aware that smoking with oxygen cylinder in the house was dangerous but it seems that they failed to report this to their manager because of family involvement.

8. What happened on 30/8/2019

In the evening of 30/08/2019 the London Fire Brigade Operations Centre (LFB LOC) received the first and only call, from a neighbour, reporting fire at Victoria's address. The alarm was raised by a neighbour who smelt burning, looked outside and saw

smoke coming from the flat directly above. The neighbours had the code to a key safe for Victoria's flat, and opened the front door to find her standing, with the aid of a frame, behind the door. They assisted Victoria to move outside the flat. The smoke detection was heard. On arrival fire crews discovered a fire in the living room, which was being used as a bedroom by Victoria. The fire was extinguished and two oxygen cylinders were found. Approximately 60% of the living room was damaged by fire.

Victoria was treated by the ambulance service and taken to Darenth Valley Hospital where sadly she died.

On 31/8/19 a phone call from the fire service was received by the out of hours team and passed onto Rapid Response in adult social care requesting information about the telecare equipment as it appeared to not be working. The Social Worker emailed the telecare company and informed them of concerns about the equipment, asking them to contact the fire brigade. This was not followed up when telecare did not reply back to the social worker. She assumed they had contacted the fire brigade directly.

9. NHS Guidelines

Greenwich Oxygen current prescription policy issued in 17/1/2020 covers Oxleas and therefore Bexley community respiratory nurses. Similar guidelines were in place in 2018. The policy states:

"NICE (2015) only recommends oxygen for COPD patients who do not smoke. Since smoking will negate the positive benefits of oxygen therapy, the risks of doing so will outweigh the benefits. This will almost certainly be the case for any respiratory prescription. Be aware that e-cigarettes/vapes are also heat sources and can ignite oxygen. Use of these is therefore also a contra-indication to home oxygen.

For patients who are current smokers where oxygen remains in situ from an historic prescription, we will not prescribe cylinders including the back- up cylinder. Any increase in oxygen therapy will not be considered unless the patient stops smoking.

It is worth noting that some time in 2020 the London commissioners for oxygen will no longer be commissioning oxygen for COPD patients who smoke. This will apply to both current and future prescriptions."

10. Findings and actions following independent reviews by the key agencies involved included the following:

<u>Fire and Rescue Service</u>

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 District Nurses with fire risk / person centre risk training
4. Liaise with Bexley Council to ensure all care contractors include fire safety information in their care plans.

<u>Care agency</u>

1. Office staff have attended 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 members when needed.

Adult Social care

Adult social care had limited involvement. There was an opportunity to identify and discuss the risks about smoking and oxygen when Victoria was assessed on discharge from hospital in April 2018 and then reviewed in August 2018 but it does not appear that this happened. Whilst these had been addressed to some extent by the respiratory nurse and the fire brigade following hospital discharge in April 2018, it is not evident that the social care workers were aware of this as it is not noted in the social care assessments. The social care IMR mentions a further opportunity in August 2019 when after the fire the telecare was reported by the fire service as not working but beyond reporting this, there was no follow up. In any event Victoria died later that day.

Darenth Valley Hospital and the respiratory team

During the process of the independent management review there was discussions with the Respiratory team regarding the prescribing of oxygen to patients who are known to smoke. The Home Oxygen Checklist, that is completed prior to discharge, asks whether the Fire and Rescue Service is informed that a patient is being discharged with oxygen. On this occasion it appears that the patient was not referred. The Respiratory Team confirmed that it was usual practice to refer a patient to the fire and rescue service.

Not all patients who smoke who require home oxygen therapy are discharged home with oxygen, it is reviewed on an individual basis and is dependent on the opinion of individual consultants.

11. Summary

Victoria was a woman with significant medical needs who lived alone in a flat. Her living room had become her bedroom with all her needs met there. She was housebound, but could walk using an aid and was well supported by both professional carers, including respiratory nurses, and family. The fact that she continued to be a smoker was known by some of the professionals but not all. This creates a significant fire risk especially for someone like Victoria who required and was given oxygen.

The respiratory nurses, GP and the fire and rescue service did talk to Victoria about the risks of continuing to smoke but it does not seem to have resulted in her ceasing to do so. The home carers knew at least that visiting family smoked and brought cigarettes into the house but did not alert their manager to this.

There were opportunities after Victoria was discharged from hospital in April 2018 when at any time any of the professionals visiting the flat could have suggested a

multi-disciplinary review to discuss the risks and to consider what needed to be done to mitigate them. The NICE guidelines are clear that oxygen should only be recommended for COPD patients who do not smoke.

12. 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.

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