Safeguarding Adults Review re: Mr. K
Executive Summary

Case Summary

Mr K, a man in his sixties, died in late 2014 after suffering serious burns in a fire in his home. He had lived alone in sheltered accommodation since 2008, having previously been homeless, and misusing alcohol, for some years. Whilst it appears that during the early years of his tenancy Mr. K managed reasonably well, from the summer of 2012 there was increasing evidence of him experiencing difficulties in managing his domestic affairs, and of his health deteriorating rapidly since January 2013. A range of health and social care services were in touch with him but he was a very strong character with no family, who often refused attempts to help and support him.

Learning From Experience and Recommendations

- Improve understanding of fire safety awareness amongst frontline staff
- A need for a clear understanding of the formal designation of sheltered accommodation, and the consequences of that for fire safety precautions.
- A need to ensure an understanding of the safeguarding implications of self-neglect and how to assess the associated risks.
- Establish robust arrangements for assessing mental capacity especially in situations where capacity may fluctuate and implications of risk are not fully understood.
- Ensure a clear understanding of when and how to refer people to alcohol services.
- Create robust arrangements in statutory and non-statutory agencies for escalating concerns about cases to partner organisations.
- Develop systems to co-ordinate input across all relevant agencies.
- Need to conduct thorough assessments and ensure robust support, supervision and management by the SAM.
- Review arrangements within the district nursing service to ensure adequate contact and monitoring and improve practice.
- Need to initiate SARs in a more timely fashion and secure improved contributions from all relevant agencies.
- The Board should use this case review to promote a better understanding of self neglect, and how best to respond to it, across all partner agencies.
- London Borough of Tower Hamlets to demonstrate that, where a vulnerable adult may be at risk through self-neglect, this is recognised, investigations and assessments are conducted without delay and all procedural and good practice requirements are met.

- Barts Health to demonstrate that the Community Nursing service is meeting all the requirements of good professional practice when working with vulnerable adults who may be neglecting themselves

- Key partner agencies to consider setting up Community Multi-Agency Risk Assessment Conference (MARAC) arrangements. These would provide a forum for discussing and developing risk management plans for people who are hard to help, including people who would not normally meet the threshold for care management services

- All partner agencies to promote staff understanding of mental capacity, including;
  - the need for statements or decisions about capacity to be evidenced.
  - how capacity can fluctuate.
  - the requirement to ensure that individuals are made aware of the implications of potentially unwise decisions.

- Promote arrangements where in complex situations, agencies consider appointing a key worker to co-ordinate the services' response.

- All services provided or commissioned by Board partners should empower their staff to escalate concerns to more senior managers where those staff are concerned about decisions made by partner agencies.

- The Board should work with the relevant agencies to develop an appropriate range of service responses to those whose use of alcohol is causing serious harm. Alcohol services should also recognise their expert role in signposting to more appropriate agencies if they receive a referral which does not meet the criteria for their service.

- The Board should work with the London Fire Brigade to develop and promote clear and well-publicised arrangements for individual fire safety assessments in respect of vulnerable adults.

- The Board should work with the London Fire Brigade and other relevant agencies to ensure that there is clarity and consensus about the nature and designation of residential services and sheltered housing provision, and any consequent duties or requirements.

- The Board should require the London Borough of Tower Hamlets to demonstrate that they have made arrangements which will ensure that, in the event of any subsequent Serious Adult Review, they are able to provide a professionally sound and timely contribution to that review.

- The Board should ensure that the Care Quality Commission is offered the opportunity to participate in any subsequent SAR.