East Ayrshire Adult Protection Committee

Learning Review: Adult O

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Independent Lead Reviewer

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Report Contents

Learning Review Report – Adult O

Core Data	
Adult's identifier	Adult O
Age of adult	81
Disability	Sensory deficits
Health needs (including mental health and/or learning difficulties)	Cognitive impairment
Living circumstances prior to incident	Lived alone in an East Ayrshire Council tenancy.
Position in family/number of siblings	Widowed
Nature of injury/cause of death	Adult O lived alone and died from injuries caused by a house fire in the early hours of the morning on 22 February 2022 following a visit to the Emergency Department the day before.
Legal status of adult	Subject to Adult Support & Protection (ASP) processes
Agencies/Services involved	Health, Social Work, Scottish Fire & Rescue Service, East Ayrshire Council Housing, Sensory Impairment Team.

Environmental Factors	
House conditions	Poor house conditions noted by professionals accessing the home.
Support from extended family/community	Family providing increasing support over the months leading up to Adult O's death.

Introduction

Adult O was known to services at time of their death, being an open case to the Adult Concern Initial Response Team (ACIRT); the Elderly Community Mental Health Team (ECMHT) and the Scottish Fire and Rescue Service (SFRS). Other services involved prior to and at the time of death included: General Practice; Front Door Services; Sensory Impairment Team; Financial Inclusion Team; Housing Team and included a visit to an NHS Emergency Department (ED) the day before their death. Adult O was an Adult who was subject to Adult Support and Protection processes and the occurrences (surrounding their death) gave rise for reasonable cause for concern about how professionals and services worked together to protect Adult O from harm. In this instance Adult O was identified as an adult at risk as there were increasing concerns in terms of the impact of their sensory deficits and presenting cognitive state on their ability to self-care, as well as increased risks as a result of their long

term heavy smoking. Adult O lived alone and died in a house fire in the early hours of the morning on 22 February 2022.

Of note, in the two weeks following Adult O's death a family member lodged a formal complaint with Ayrshire & Arran NHS board, due to their collective concerns in respect of the care in the months leading up to their death. This complaint included a detailed chronology from the family's perspective, including environmental photos taken from within the timeframe of the various agencies involvement which they felt highlighted Adult O's increasing levels of self-neglect. A single agency response, in the form of an NHS Local Management Team Review (LMTR) was carried out. This concluded in June 2022 (Appendix 2). The LMTR acknowledged the lack of pro-active service provision, resulting in the family having to pursue follow up themselves.

Though a single agency LMTR had been completed, consideration of the circumstances for Adult O, from a multi-agency perspective, was deemed necessary. Therefore, in parallel to the formal complaint response being undertaken through the NHS, an Initial Case Review (ICR) through the Adult Support & Protection legislation/guidelines was commenced through the Health & Social Care Partnership (HSCP) in the March of 2022. The grounds for this being the fact that Adult O was an open case to the ACIRT at the time of their death, having multi-agency involvement in relation to concerns about their health, welfare and increasing fire risk. It was felt likely that the case would meet the criteria to proceed with what would, at the time, have been described as a Significant Case Review as per the National Framework for Conducting SCRs. In the summer of 2022 the Scottish Government introduced new National Guidance for conducting Learning Reviews which would replace the previous document. This subsequently led to the development of an Ayrshire Guidance and East Ayrshire Operational Procedures within which this Review sits. This review was deemed to meet the criteria as outlined in the National Guidance which states that:

'the adult is or was subject to adult support and protections processes and the incident or accumulation of incidents gives rise for reasonable cause for concern about how professionals and services worked together to protect the adult from harm and the adult at risk of harm dies and harm or neglect is known or suspected to be a factor in the adults death and the death is by suicide or accidental death'

Relevant services/professionals were asked by the Learning Review Panel to submit reports outlining the nature and extent of their involvement. From the information collated, a multi-agency chronology began to form. Panel meetings were convened and it was agreed that the criteria for proceeding with a Learning Review were indeed met.

In May 2023 the Adult Protection Committee (APC) endorsed the recommendation of the Learning Review Panel Meeting to proceed with a Learning Review and to seek authority of the Chief Officers Group (COG) to appoint an external Lead Reviewer who would direct the work of the Review/Review Team. This was endorsed by COG in June 2023. It was agreed that the findings and recommendations of the LMTR would also be considered as part of the Learning Review. The Terms of Reference (ToR) were discussed and initially agreed, with the proviso that these could be reviewed if necessary (Appendix 1).

A multi-agency Learning Review Panel has overseen the Learning Review and was the main contact point for the Review Team. Due to the level of complexity and multi-agency involvement in this case, an external Lead Reviewer was commissioned.

The family of Adult O had been fully involved in the LMTR process and the subsequent Learning Review considerations, with opportunities to meet with representatives of the APC. On being informed of the decision to progress to Learning Review, they were keen to remain involved.

The Review Process

As defined in the national guidance, a Learning Review is a means for Public Bodies and Office Holders with responsibilities relating to the protection of adults at risk of harm to learn lessons from considering the circumstances where an adult at risk has died or been significantly harmed. Learning Reviews are not investigations, they are an opportunity for in-depth analysis and critical reflection in order to understand complex situations enabling organisations to develop strategies to support and improve practice. The overall purpose of a Learning Review is to bring together agencies, individuals and families in a collective endeavour to learn from what has happened in order to improve and develop systems and practice in the future and thus better protect adults.

The Review Team (Appendix 3) met collectively for the first time in October 2023 with the Independent Chair of the Adult Protection Committee (APC) and the Adult Protection Lead Officer. The review team had representation from the HSCP; Health; Housing and SFRS, as well as the Independent Lead Reviewer. Administrative support was available throughout which enabled a central point for information to flow through and was key in terms of the organisation of the various aspects of the Learning Review process. The team were given an overview of the case, with a detailed report on the processes which had been undertaken to date. This included the full multi-agency chronology; the completed ICR documentation as well as the Panel meeting minutes. It was acknowledged that the chronology/timeline within the LMTR was limited in terms of the fact it began in September 2021 and focused solely on one service, the ECMHT. All agreed that information held within this was very relevant to the multi-agency Learning Review and would be referenced within this report. The Review Team meetings gave the team an opportunity to develop early working relationships and ask relevant questions in terms of their roles & responsibilities. Using the National Guidance for Adult Protection Committees undertaking Learning Reviews as previously referenced, this Learning Review would examine the multi-agency response to the circumstances for Adult O with a focus on the effectiveness of multi-agency information sharing, risk assessment and risk management.

Adult O had been known to services since early 2021 and as such the Review period would be from 18 January 2021 until their date of death on 22 February 2022. The ToR, already agreed, were discussed in more detail.

It was important for the Review Team to be familiar with the key core principles and values which would underpin the Learning Review and ensure these taken into account throughout. These being:

- *To promote a culture that supports learning; placing an emphasis on learning and organisational accountability and not on culpability;*
- *To recognise that a positive shared learning culture is an essential requirement for achieving effective multi-agency practice; ensuring the review is objective and transparent;*
- *Ensure the review is sensitive to the needs and circumstances of the adult and their family; Ensure that staff are engaged and involved in the process and supported*

throughout the period of the review; recognising the complexities and difficulties in the work to protect adults and to support families;

- *Produce learning which can be disseminated, both at local and national level, so it directly impacts on and positively influences professional practice and organisational systems;*

Initially, fortnightly MS Teams meetings were arranged. Given the volume of information to be absorbed, it was agreed to communicate through email in terms of requests for additional information. During the course of the review process, relevant case notes were requested and received from both health and social work.

As well as early contact with the family (which is detailed in the next section), it was essential to arrange the Practitioner and Line Manager focus group to inform the review & subsequent report. It was identified that staff involved in the process should have the support of their Line Managers as well as the respective Review Group Member/s relevant to their service. This included opportunities to directly contact the relevant staff to more fully explain the process and outline how the learning workshops would be managed.

To allow front line personnel the opportunity to attend the focus group, a planning period of 6 weeks was built in. This session had 17 participants, representing all the services who had involvement with Adult O (Appendix 4). SFRS hosted the event in the local Fire Station. The session was held around the collated chronology, which was displayed around the room, giving a good visual representation of involvement of services within the timeframe agreed. Team members took on the role of facilitators & scribes. In recognition of the potential impact of personnel involved, the session began with a presentation from the East Ayrshire Council (EAC) Health & Safety Support Officer. During this presentation, resources were shared in terms of well-being, which personnel could take away for future reference. Two groups had the opportunity to clarify their roles during this time period and consider their decision making at that time. This moved into a phase of considering alternative ways of working and potential actions/recommendations moving forward. Personnel were engaged and interactive throughout the day. A summary of the key points from the day was produced, which would inform next steps. The Review Team met the following week to format the information received to inform the strategic leader's focus group. A template was populated which would form the basis of the next session.

The strategic leader's focus group was held on the 17 April 2024. Importantly, this session also had representation across all the services involved with Adult O. The visual chronology was again utilised to open the session, allowing the personnel the opportunity to re-familiarise themselves with the case, and add their own comments ahead of a more focussed discussion around learning & future ways of working to continue to improve care. Again, this group were engaged and pro-active in terms of where change requires to be considered. Key leads took away actions for themselves ahead of the outputs of the review, predominantly in terms of earlier intervention and increased joint working opportunities. Again the Review Team had the opportunity to analyse the outputs of the strategic leader's session, to seek to clarify the key points raised and inform the review in terms of improving practice & systems.

As General Practice had been unable to attend the focus group the Clinical Director supported separate meetings with both the GP Practice and Pharmacotherapy personnel. The Lead Reviewer and health representative were in attendance, feeding back to the wider Review Team.

The Lead Reviewer also had the opportunity to speak with the Area Commander of the SFRS to obtain more detail from this service.

This report includes the outputs of the information collated from these various sources.

The Facts

Involving family

The Lead Reviewer established early contact with one of the members of Adult O's family and agreed that contact could either be through email or via telephone in between key points in the Review. In addition to this, the Review Team recognised the importance of meeting with the family as a collective to determine their views and perspectives, to ensure these are captured within the review.

The Lead Reviewer, accompanied by one of the team, met with family members and their local Councillor in November 2023. Understandably this was a difficult meeting for the family given the circumstances of Adult O's death. They spoke openly of their family member prior to the involvement of services, as well as their journey through the timescales which the review was to capture. The aftermath, and their own support needs, also discussed in terms of ways in which services consider ongoing involvement. From the family's perspective the timescales to the commencement of the Learning Review were difficult to accept, though they had been kept updated by members of the APC. The family were keen to meet with members of the Review Team despite the personal difficulties reliving their experiences and that of their loved one. They described ongoing distress and frustration looking back at the events leading up to their loved one's death and continued to describe upsetting triggers. At this initial meeting, as part of the Learning Review, a recap of the process, as well as a general overview of Adult Protection was shared.

Summary of family meeting

The family described their loved one with warmth and affection. They described an individual who was involved in their local church, as well as an avid follower of their local football team. They described an independent, intelligent and proud individual. The individual was a long term heavy smoker, and over time the risks associated with this grew. Prior to the Covid pandemic Adult O had been independent, and socially active. As the restrictions starting lifting, difficulties became apparent. In December 2020 a gradual decline described, this increasing as the months progressed. The family having no real knowledge of services, though did, in August 2021, make a self-referral to the HSCP Front Door Service for some support. By this point family and friends were starting to notice a deterioration and red flags. Examples included Adult O's dishevelled appearance, as well as being more confused. Latterly Adult O was spending virtually all their time in bed smoking, increasing the fire risks. The family were also aware they weren't taking their prescribed medication, pharmacy confirming they had not picked up their prescription for over a year. Adult O was seen by the GP, and a referral was made to the ECMHT. The family could see the risks growing, actively speaking to their loved one in terms of the wider risks to others around them, as well as continuing to contact services for help. They were aware that long term care would not have been a chosen option for their loved one, but the family felt they would soon have benefitted from this type of environment.

The family were frustrated, they did not feel 'heard' by the various services involved. They spoke about the missed and/or cancelled appointments, as well the process itself and the gaps in follow up in terms of potential referrals, aids/equipment. The family did not have emergency/out-of-hours numbers to call. The lack of action from their perspective in terms of

Adult O's non-compliance with medication and the deterioration in their sight & cognition, which may well have, with hindsight, differentiated or explained some of their changing behaviours.

Although open to the ECMHT no diagnosis was established for Adult O at the time of their death. The family described the difficulties they experienced emotionally in terms of having to give an honest perspective of the situation to professionals given the lack of insight of their loved one, and the subsequent awkwardness this then caused in their relationship. The family gave examples of their own positive actions when asked, and they felt they did everything that was asked of them. With hindsight the family questioned whether their level of informal support hindered service provision. Despite the escalating risks, they did not feel these were identified as such. The family believe their attendance at the ED on the day before Adult O's death may have resulted in a hospital admission. They are disappointed that this was not the outcome and Adult O was assessed as 'fit for discharge'. The family also described the lack of support for them as a family in the immediate aftermath of their loved one's death.

In summary, the family felt that Adult O hovered below the "thresholds" for concern and risk, never enough to instigate protective measures, never quite "ticking the box". They believed if professionals had looked at the situation more holistically it would have been obvious that Adult O was at increasing risk. Their view was that "nothing was joined up". They were keen to see what has/can change which will improve the experience for people in similar situations moving forward.

Summary of service involvement

Front Door Service
Adult O lived alone, supported by their family who were becoming increasingly concerned about a deterioration of their physical/mental health and in their ability to care for themselves. Having no knowledge of services which might be in a position to support Adult O, a self-referral (family made this on Adult O's behalf) was made to the Front Door Services in August 2021. During the assessment visit Adult O declined offers of formal support, though did agree to an onward referral to the Sensory Impairment Team acknowledging their sight/hearing issues. They were also in agreement to make an appointment with their GP in respect of their general health. Discharged from social work at this time.

Sensory Impairment Team
During their contact, the Sensory Impairment Team focused on ways in which to promote independence and quality of life in terms of their sight and hearing deficits. Providing necessary aids and recommending review where indicated. Thereafter discharged from their service. During their initial contact, the Sensory Impairment Team recorded that a referral was made to SFRS however there is no evidence of this having been received. This was fully investigated following Adult O's death, with mitigating factors now firmly in place. This does raise the question of the necessity to ensure onward referrals to the SFRS have been received ahead of any potential discharge.

GP Practice
In September 2021 Adult O was accompanied to the Practice Nurse by a family member. An epilepsy monitoring review was undertaken, including a full blood screen. This was followed by a return visit to the practice for a GP consultation. The GP considered the information already obtained at previous visit and concluded the physical and mental health review, taking into account the views of the family in attendance. The outcome was an agreed referral to the ECMHT.

Elderly Community Mental Health Team
Adult O was to see the ECMHT for an initial assessment. This had been planned for October 2021 however due to a range of issues this did not take place until 10 December 2021. This visit focussed on Adult O's deteriorating physical/cognitive wellbeing and their level of fire risk, utilising the Ayrshire Risk Assessment Framework. Whilst this concluded a reasonable level of cognition there were serious concerns about low body weight, dishevelled appearance, poor home environment, low mood and immediate risks relating to smoking. A number of actions were identified to be followed up which included: liaising with GP in respect of medication management, onward referrals for community alarm and 'just checking' services to support Adult O to keep safe, handrails for the hall stair way to support Adult O given their poor mobility and frailty and a referral to the Financial Inclusion Team to ensure benefit maximisation. These actions were not taken forward at that time. The family were advised to purchase metal buckets so that they could extinguish cigarettes more safely, this undertaken. No referral to SFRS at this time. Ahead of next planned visit, family contacted the ECMHT on two separate occasions to raise further concerns. They felt their family member was deteriorating physically and mentally, and increasing time in bed causing further concern in terms of fire risk. The ECMHT visited Adult O along with a family member mid-January 2022 and at this point completed SFRS referral for a fire safety visit. Smoke detectors were checked to be working. Due to concerns in respect of their vision the ECMHT asked family to arrange appointment with Optician, which they did, this confirmed Adult O was blind in their right eye with possible macular degeneration.

In relation to the input from ECMHT, the LMTR carried out by the service was considered as part of this Learning Review Process. This LMTR concluded the service could have been more proactive particularly around the delay after the initial missed appointment by Adult O and during periods of planned and unplanned leave of staff that contributed to the delay in first and subsequent appointments. Additional processes were identified and implemented for staff who are on leave to ensure any imminent risks are identified and actioned by the wider team. Learning was also identified in relation to the discussion of all new assessments within ECMHT multi-disciplinary team meetings to ensure the benefit of the range of professional views, particularly when there is a significant change in risk status or other concerns. Furthermore changes were made to supervision arrangements to ensure that caseload demand and size is included as part of the agenda within all line management supervision sessions across the ECMHT workforce.

Scottish Fire and Rescue Service
SFRS completed a Home Fire Safety Check and raised a concern referral to the ACIRT Team on 02/02/2022 due to concerns highlighted in respect of significant cigarette burns within bedroom area and consequential level of risk. Fire retardant bedding was provided on 10 February 2022 however fire retardant mats, which had been identified as being necessary, were not provided at that time, but were planned for delivery by 23 Feb (day after death of Adult O's). This raises the question in terms of availability of equipment and the process in terms of delivery/providing this in high risk individuals.

Adult Concern Initial Response Team
The ACIRT team opened an adult support and protection episode and an Initial Inquiry report on the day referral received via SFRS, however this was not progressed and not identified as such until after Adult O's death. The referral was received & screened but not yet actioned. The allocation process has since been reviewed to mitigate future risks.

Emergency Department
The day before their death, Adult O attempted to attend church, however had a fall resulting in a visit to ED. Whilst there, they were reviewed by medical staff given the reported concerns from the family which included a brief cognitive assessment. They were considered fit for discharge; with the knowledge/understanding that the ECMHT had a planned visit the following day. There was no immediate mechanism for alerting the ECMHT of the ED attendance as this service does not operate over the weekend. Unfortunately this planned visit did not happen due to sickness/absence, though the staff member had still contacted the family directly and suggested an alternative named contact to call, which they tried without success. This was addressed through the LMTR.

Overview & Analysis from the Practitioner/Line Manager Focus Group

The focus group were receptive to look at what could have been done differently, particularly as the journey evolved for Adult O. There was a balance and challenge identified when working with Adult O with whom services were unable to fully engage with. This also raised the question of the family involvement in this situation in terms of how services engaged and supported them in their caring role, when it was seen that they, too, were unable to meet their needs due to Adult O's lack of insight and self-determination. There was no shared understanding of expectations.

Shared risk
There was a real focus on the necessity to shift the perceived burden of risk by involving the wider team, be they single or multi-agency. In this case the wider perspective was not sought in a multi-agency way, services worked individually, which negated the opportunity for a joint approach/shared responsibility. There was discussion around the potential role of a Lead Professional. It was identified, in this case, this could have sat within the ECMHT. If this role had been recognised from a multi-agency perspective there could have been additional opportunities to share risk and knowledge, as opposed to the singular responsibility which was evident.

Role of housing
The housing team attempted to engage directly with Adult O, following accrual of a small rent arrears balance. During visits the Neighbourhood Coach would knock on Adult O's door. When not receiving a response they would leave a calling card which was, in turn, responded to by Adult O's family. The rent arrears were immediately resolved with their input. As a result housing had no further role. During discussion it was acknowledged that had housing had the opportunity to get into Adult O's home this could have alerted them to take additional actions to support the tenancy. It was also noted that the lack of communication back to housing from the involved services in terms of self-neglect & fire risk were key areas in which there could have been more joint working opportunities with housing. Acknowledged that if risks are identified services need to be more aware to get in touch with housing as soon as practicable. If agencies do not already have contact details, nor a mechanism for same, this will require to be rectified.

Maintaining involvement
There were conversations in terms of how to positively remain engaged with individuals. It was agreed opportunities, however slim, can be optimised. Timescales, from discussing referrals to these being acted upon, can result in 'missed opportunities for engagement'. In this case, at the point of social work closing the case as Adult O didn't want to consider further supports, the accepted referral to the Sensory Impairment Team & the Financial Inclusion

Team, with the additional advice of contacting their GP may have allowed the case to remain open to facilitate joint working opportunities.

Optimising practitioners' generic skills base
It is acknowledged that too many services and professionals can be off-putting for individuals, particularly when there is a lack of insight. The group agreed these should be kept to a minimum wherever possible. Though accepting the specialist input each service offers, there are core skills which flow through professional groups which should help overcome this challenge.

Community Alarm
The complexity around the community alarm service in terms of how this can be interlinked to support those with a fire risk who may be reluctant to accept this given the financial implication versus the right to protection and safety of self/others was widely debated. The group agreed this would be a key question for the Strategic Leaders to clarify. Acknowledged the necessity to remove this barrier if services assess a significant risk. Discussed this service being free of charge as discretionary when a significant fire risk is identified.

Carers
The Carers (Scotland) Act 2016 defines a carer as 'an individual who provides or intends to provide care for another individual'. Once established, there is a duty on authorities to offer them an adult carer support plan in their own right. Despite this legislation, and the guidance that has been subsequently implemented across the HSCP, had this family been formally identified as carers, what might they have expected in this role? A broader approach, particularly when the individual themselves are not fully accepting of support, is required. In this case the family were the main point of contact for all the agencies. Adult O wasn't always in agreement with them in terms of the support they required, causing increased levels of stress and frustration.

Advocacy
The role of advocacy was explored. This sits firmly within the ASP legislation. It was acknowledged within the group that had ASP processes progressed this service would have been offered to Adult O. Given the discrepancy between Adult O and their family in terms of the levels of support they required, could advocacy have had an earlier role. If so, are all services aware of how to refer in and the specific role they might have in situations such as this.

Capacity
The law in Scotland generally presumes that adults are capable of making personal decisions for themselves and of managing their own affairs. Presumption of capacity being the starting point. Discussion led to the possibility that, in the latter stages as risks increased, Adult O may have required to have their capacity formally assessed. This didn't feature in conversations/documentation, neither being questioned nor investigated, including that of their executive functioning. Would their potential incapacity in some areas of decision making have changed any of the decisions made by Practitioners' at that time'? Exploring Adult O's capacity may have resulted in other avenues being considered, and may well have featured as part of the mental health diagnostic pathway. There also continues to be some misunderstanding when considering capacity when it comes to ASP. There is a necessity for ongoing awareness and training required in this respect.

Communication
Communication was discussed both in terms of good individual communication, as well as that across the multi-agency teams. During the workshop it was apparent that services have

single agency meetings every week. Pre-Covid these might have been multi agency in some instances. Members of the review team met with representation from General Practice separately as they were unavailable to attend the focus group. The extended focus group would have welcomed the opportunity to have their input into the session as questions raised in respect of their role within the wider multi-agency team. Good practice, pre-covid, was described in terms of meetings held within the GP practice which promoted informal discussions in respect of individuals with whom the team had concerns. It was anticipated, in some areas, that these might get re-established, as highlighted through one of the Practitioners from the Social Work team. It was acknowledged that the membership of these meetings should be considered and regularly reviewed to optimise care.

The limits on time within the working day to attend additional meetings was acknowledged, however the benefits in terms of sharing relevant information were seen to be a worthwhile investment. In addition to this, there had been a cultural shift, both during and following the Covid pandemic. The practice of working from home impacting on the informal conversations which took place within office environments, be they single or multi-agency was discussed by the focus group. These conversations were viewed positively in terms of peer support. It was acknowledged that supportive conversations help to prevent that sense of isolation which can be felt when working out in community services. As staff have returned to their shared spaces, face to face team communications have been re-established.

Workforce
Staffing and recruitment was also covered by the focus group. Acknowledged that services require to have robust contingency planning built into their policies to support safe practice at times of pressure on the service.

SFRS referrals
It was acknowledged that referring agencies should continue to improve the completion of the online document being sent into the SFRS which would, in turn, aid with prioritisation. Currently if the information is not clear or missing, the SFRS are unable to accurately allocate in terms of priority which may result in those at higher risk being missed for an early visit. Following Adult O's death in February 2022 the SFRS, along with their colleagues in the Community Action Team, targeted over 200 homes in the local area to offer home fire safety advice. Important to promote the fact that anyone can self-refer for a home fire safety visit.

Meeting with GP & Practice Manager
During the meeting with the GP and the Practice Manager they reported that there was no specific mechanism in place for Adult O when they did not order their prescribed medication. Adult O would have been offered an annual 'opt in' review, if declined/or not responded to, no further action would be taken routinely. With regards smoking cessation, this is done opportunistically when questions relating to lifestyle are asked. They spoke of monthly integrated care meetings which had been held prior to Covid, no immediate plans to re-establish these, though did speak of their benefit.

Meeting with Community Pharmacist
The community pharmacist spoke of serial prescribing, which would not have been in place during 2021. This proactive service benefits those on long term medication who are deemed to be stable. There is a robust recall built into this system, with direct contact to individuals when compliance is a concern. Good communication with the GP is also reported. They described having an increase in community pharmacists which, in turn, enhances the services they can now offer.

Collective key learning points

- Lack of joint working/shared responsibilities in terms of risk management within multi-disciplinary team
- No identified Lead Professional role
- Negative impact of service delivery during periods of absence planned/unplanned with identified delays between visits
- Acknowledged there were earlier opportunities to identify/manage risks – including wider discussion within the multi-disciplinary team and/or referral onto multi-agency partners
- Lack of multi-agency chronologies
- Assumptions made in terms of family involvement v professional responsibility and accountability
- No mention of carer needs/assessment
- Challenges experienced by family in terms of contacting services
- The impact of COVID in terms of inability to return to previous levels of social interaction for Adult O
- Given the limits of engagement with services and the evident self-neglect, there were questions in terms of how professionals work pro-actively with this group of individuals & support family/carers to do the same
- A lack of professional curiosity across the services acknowledged, leading to discussion around the training opportunities available and the caseload supervision held
- Discussion around the rights to self-determination versus the right to protection, which brought in the topic of General Data Protection Regulations (GDPR)
- The Adult Support & Protection thresholds across services led the group to identify where there may have been earlier opportunities to raise concerns through this legislation
- No advocacy role identified
- At no point was Adult O's capacity raised
- Seeking clarity in terms of the role of General Practice in terms of general health review and smoking cessation opportunities
- No specific mechanism for non-compliance of medication for individuals with long term health conditions at that time. Serial prescribing now an option which can be considered;
- Adult O had not responded to long term condition health review
- Smoking cessation discussions opportunistic
- The availability of a community alarm when cost may be a barrier in higher risk situations
- Longer term clarity required around responsibilities in terms of fire retardant equipment
- The role of housing - questions raised in respect of the knowledge base of the wider services in terms of what they can offer from a multi-agency perspective
- Fire safety referrals discussed in terms of the information which is required by the SFRS, identifying ongoing training opportunities across services
- Questions were raised in terms of the different information systems which are in place across the various services, which are believed to have a negative impact on the sharing of information
- Integrated care team meetings, discontinued during the Covid pandemic, have not been reinstated.

Key learning points from the Strategic Leaders Focus Group

There was an acknowledgement from this group at the outset that change needs to happen as there are recurrent themes coming up across learning reviews. These are summarised below.

Joint working opportunities
There was a real focus around MDT/multi-agency working and the necessity to work across the silos, recognising this is "patchy" at the present time. The collective group were keen to explore ways in which they could extend and formalise their ways of working. The topic of co-location was raised, recognising this as one of the ways to potentially promote and enhance joint working opportunities.

Multi-agency meetings
Conversations held in terms of how to best enable the wider team to call an MDT/multi-agency meeting. Though it was acknowledged that, in theory, any agency should be able to call a multi-agency meeting, it was recognised that this task generally falls to social work. Agreed that a wider understanding is required across all agencies that multi-agency colleagues can instigate this, particularly when they have a Lead role in the person's care. This fits in with the necessity to consider how the Lead Professional role is currently being implemented. Identified that an exploration of what might be the trigger for these may also be beneficial in a wider context.

Case closure processes
When Adult O was referred in July 2021 to the Front Door Service, the group gave consideration as to what could have been done from an early intervention perspective. It was determined that the closure process within the Front Door Service should be given further consideration. The Front Door Hub meeting supports an MDT discussion, though acknowledged membership could be extended. Personnel require the autonomy/permission and support to keep cases open when there is a potential for the situation to change given factors highlighted during assessment/review contacts, keeping cases open for monitoring purposes. Within this case, despite a deterioration from previous levels of functioning and self-care identified, the case was closed pending onward referrals. An early MDT discussion as an alternative could have been adopted. In tandem, there requires to be further consideration to risk assessment in case closures at this point.

Early intervention
Given the self-referral into the Front Door Service, and the concerns raised and documented, it was highlighted that enhancing the MDTs at an early stage would provide a forum for information to be shared. The additional benefits of an early intervention way of working would, in turn, contribute to promoting the commencement of a multi-agency chronology where required, acknowledging the importance of chronology as a starting place at a much earlier point. Thresholds could be further considered when individuals sit below that which might otherwise be considered for an MDT or multi agency meeting, for example in the case of legislative responsibility. The Clinical Lead gave an example of this in terms of the frailty work sitting around the GP Practice, an MDT which could be replicated into other areas of practice. Proactive case finding of people in the community who are mild, moderate or severely frail using an electronic frailty index and complexity case finder. Early testing work has taken place and involves a multidisciplinary discussion about Individuals who may require support from community services. There is a Frailty and Falls Assessment pocket guide planned to roll out across the HSCP to support multidisciplinary discussions and interventions. In the case of Adult O they would be someone that would be likely to 'flag' on the electronic frailty index or

complexity case finder and would, subsequently, be part of the multidisciplinary discussions and have a multidisciplinary frailty and falls assessment.

Professional responsibility
Given the gaps/omissions identified in between referrals, the question was raised in terms of the ongoing responsibility of the referrer, particularly when the service is then discharging the individual. The necessity to consider whether they have the assurance that the onward referral is 'in hand' and that there is no further action required on their part.

Sharing of information
The necessity to work within realistic timescales across all aspects of service delivery was highlighted. In turn, giving clear information to individuals and their families/carers in respect of this, with details of who to contact if required.

Barriers
The question was asked "what are the barriers to referring into services and how can we address these collectively". Removing barriers, for example the charges for community alarm and the waiting times for services whilst awaiting other inputs. Agreed that all agencies should be delivering care in a holistic, person centred way to address the potential for unnecessary delays in the care pathway. With regards to the community alarm, one of the Strategic Leaders representatives sent a clear message that if there are high risk concerns the fee should be waived where necessary and sought assurance that this was embedded into practice.

Adult protection referral
It was noted that consideration to vulnerability and statutory intervention in the context of adult protection was not made prior to the referral made by SFRS in February 2022, only weeks before Adult O's death. The group agreed that the silo working was a contributory factor in the lack of thought to statutory interventions. On reflection, given the risks identified through the assessments carried out this may have been an appropriate consideration. As the workforce is constantly changing we need to be assured that new and existing personnel have a robust understanding of thresholds of risk and how this impacts across the services/agencies, continuing to shift the balance of practice from subjective to objective.

Family roles and responsibilities
The role of the family and the lack of a shared understanding made by the professionals involved warranted further discussion. This highlighted the fact that well-defined contact with family/carers, to obtain clear, concise information as to the care arrangements in place, their specific role within this, as well as their own expectations, particularly when working with multiple individuals who may have varying views (including that of the service user themselves) is essential. Agreed there is a need to formalise carers' assessment in line with legislation expectations.

Supervision
The role of staff supervision, as a means to discuss risk assessment/management was discussed. Good supervision is a cornerstone across all professional groups and must continue to be under review in terms of the efficacy of this protected time for those working with vulnerable groups.

Housing
Housing Services are currently piloting an annual Connecting Housing and Tenants (CHAT) visit which will enable them to meet with tenants in their home, creating opportunities to support tenants where required at a much earlier stage to avoid the need for crisis intervention.

In instances of being unable to gain access to the home, Housing Services will work on a multi-agency basis to identify concerns and mitigate risk.

Cognitive testing
Though a comprehensive assessment had not yet been completed within the ECMHT, Adult O had elements of cognitive testing carried out. It was felt by the group that there was an over reliance on this limited memory test in terms of their presentation. Moving towards a formal diagnosis might have supported longer term planning. Though initial cognitive assessment was planned in this case, delays to this were identified through the chronology.

Fire retardant equipment
It was acknowledged that with the changing demographic in terms of older adults that there will be a greater demand on services. Of note, for the purposes of this report, that on the current availability of fire retardant equipment. Further discussion across the Partnership is required to ensure those at highest risk are prioritised in terms of available stock. The group identified that fire retardant supplies must be prioritised for the highest risk cases, this raises the question of how are people at 'highest risk' identified? In the current financial climate, additional sources for the supply of this equipment must be considered across the agencies, are individuals and their families being sign-posted to what they themselves could purchase, what is the potential within the self-directed support budget. Following on from this, each service then has to know how to access when required.

The focus group session ended with the acknowledgement that there would require to be a prioritisation in terms of the recommendations for the report.

Summary of learning

- Services need to consider ways in which they can optimise joint working opportunities
- The knowledge in terms of responsibilities as to when and who can arrange a multi-agency meeting, particularly when a specific individual or service has a lead role, require to be embedded into practice
- The closure processes within the Front Door service requires further consideration, with a focus on how staff are enabled to keep cases open where necessary.
- Earlier intervention was noted to be a key area in which services were keen to focus. The frailty work seen as a model which could be replicated.
- At the point of potential discharge, professionals have a responsibility to ensure onward referrals are in process
- It is essential that realistic timescales are shared with individuals and their family/carers
- Barriers to service delivery should be highlighted and ways in which to address these explored
- The importance of when to make an adult protection referral requires to be consistently reinforced
- More understanding is required in terms of the carer's legislation and the responsibilities on statutory services.
- Staff supervision has a key role in terms of risk assessment/management.
- Housing can have a key role in terms of identifying concerns early.
- Person centred, holistic care will continue to be a focus for services.
- The supply of fire retardant equipment to the most vulnerable and 'high risk' requires all services to know the routes in which these can be accessed.

As indicated earlier within the report a LMTR had already taken place, with actions and recommendations completed, attached within Appendix 2.

Practice and organisational learning

A focus on earlier intervention from an MDT/multi-agency perspective is required. This will involve the pending review of multi-agency guidelines, as well as relevant service specific policies, procedures and guidelines. These need to make reference to the ways in which services should engage with individuals who may not always be accepting of the support they require. Front Door Services hub meetings should be functioning as the early intervention discussion, to determine if a case requires multi-disciplinary input. It is important that any review of this is not over complicating the current process, to promote effective engagement of personnel involved. Case closure processes within Front Door Services will consider this from a person centred perspective when a situation is anticipated to deteriorate, managers supporting personnel, giving them the permission and autonomy to keep cases open where indicated.

More consideration in terms of when services are unable to fully engage with individuals, and require a more holistic approach. Training opportunities for the multi-agency teams.

With regards community alarm a wider discussion is required across the HCSP to determine if/when barriers are presenting in higher risk cases. Important to get this message to front line practitioners, as there has to be a balance in terms of optimising safety/statutory duties, with ASP being priority, in the current climate of financial constraints. There requires to be a joint understanding of risk in terms of cost and the short & longer term impact.

Consider how to further promote early thinking when working with vulnerable adults in terms of an ASP referral. Following discussions through the focus groups it is anticipated a further review of the ASP self-evaluation audit tool is also indicated in order to obtain more relevant information for the services.

The Clinical Lead spoke of the necessity to consider our vocabulary in terms of single/multi-disciplinary & multi-agency teams which then clarifies who sits in each of the staff groups identified.

The NHS ASP Lead shared the fact that there have been some common themes identified through recent health specific learning reviews. Of note being the application of the 3 point criteria; repeat referrals in terms of potential cumulative risk; the support of staff to embed a trauma informed approach and the ASP escalation process requiring manager's oversight. It is anticipated this review will provide a comprehensive understanding of learning around these themes and the areas for improvement. Early considerations are to broaden the guidance for supporting people who decline or resist interventions; to link with the APC multi agency audit of ASP Process; review the supervision policy to include recognition of increasing risks e.g. repeat referrals and the review of the multi-agency escalation process.

As there was an assumption of capacity throughout the journey for Adult O, there was questions raised in terms of the general understanding of front line personnel in terms of capacity/incapacity? Practitioners require the knowledge and understanding of when a capacity assessment should to be considered necessary. At the present time single agency Council Officer training has capacity incorporated into the programme. The wider group would like to consider how to develop the multi-agency opportunities in this area.

It was acknowledged that agencies operate within varying electronic systems. This necessitates team members having to effectively communicate relevant information in other ways. Each single agency has to continue to develop pathways to share information with multi-agency partners as necessary (including out of hours), particularly when there are risk factors to take into account. A positive example to the sharing of information in respect of vulnerability and/or high risk is the flagging system which has now been adopted in health which identifies those individuals sitting under ASP, to promote communication within these cases.

The ECMHT to consider the wider workforce challenges, building on the actions captured in the LMTR in terms of 'best value' within all the competing demands. There will be a necessity to keep standard operating procedures under review. As with the Front Door hub, they will consider how to manage a longer term review to keep individuals on caseloads.

There is a necessity to manage expectations for individuals and their family/carers, sharing clear & concise information in terms of service contact and keeping them informed if timelines shift.

Consider how this Learning Review informs the work of Getting It Right For Everyone (GIRFE) going forward.

The SFRS, along with the wider services, were keen to attain knowledge and skills in new recruits/personnel in terms of multi-disciplinary/multi-agency joint working opportunities and good communication. For example, the SFRS recognises the need to build in capacity to attend forums where their service will add value, this would be relevant for all services.

Consider and review where necessary the generic skills base/documentation required during first contact visits, irrespective of the discipline involved, to capture risk factors, ensuring skills are maintained and built into the induction of new personnel.

Review of the fire safety training which is delivered to health personnel carrying out home visits, requires to have a focus on the community environments routinely visited within the working day.

Ongoing review of the annual Housing Services CHAT visit and instances of no access, linking with key stakeholders in terms of multi-agency information sharing and risk mitigation, including HSCP Frailty Index and ASP vulnerable persons.

Wider partners to consider role of Housing Service and ensure linkage as part of broader approach to support.

Carer's assessment requires more discussion in a multi-agency context.

Serial prescribing, in the management of stable long term conditions, to continue to expand across the localities.

Effective practice

There was recognition that there were a wide range of services involved with Adult O with evidence of onward referral.

Equipment was supplied from SIT to support sensory difficulties.

A detailed referral was sent onto SFRS via health.

Local area Home Fire Safety Advice was carried out through SFRS following Adult O's death.

Suggested strategies for improving practice and systems

1. All services should be making early referrals onto SFRS for a Home Safety Visit when fire risks are evident.

2. When onward referrals are sent to the SFRS by professionals they should, in turn, ensure these have been received ahead of any potential discharge from their own service to ensure these are in process.

3. All services need to consider the timely follow up which may be necessary for any referrals which have been sent onto SFRS.

4. Referring agencies need to continue to improve the completion of the online document being sent into the SFRS.

5. Longer term clarity is required around the availability and responsibility for supply in terms of fire retardant equipment for individuals identified to be at a high level of fire risk.

6. Ensure there is a service wide understanding that the community alarm fee can be waived when a significant fire risk is identified.

7. The Front Door Service in the HSCP receives and screens all new referrals to determine any further supports required. Part of this screening process is a weekly MDT hub meeting to consider how to achieve the right support at the right time for people requesting assistance. An invitation could be extended to include wider services and include, as standard, decisions to progress risk assessments and case closures creating an environment in which practitioners are supported to continue to work with individuals where necessary or transfer to Locality Teams for ongoing care management.

8. The multi-agency guidance to support Multi-Agency Planning Meetings should be further promoted to provide opportunities for the completion of multi-agency chronologies at a much earlier point in planning processes for vulnerable adults.

9. An improved understanding of the thresholds of risk, capacity and executive capacity, particularly when services are unable to engage with a vulnerable adult, requires further multi-agency consideration in terms of training opportunities. Any review of opportunities should be assured of its focus on supporting professionals to assess and escalate risk.

10. Utilise ASP frameworks to re-establish and/or enhance MDT/multi-agency opportunities for case discussion and risk management.

11. Enhance professional curiosity across the services through multi-agency training opportunities and robust caseload supervision.

12. The wider implementation of the Lead Professional role should be considered.

13. Ongoing awareness and training required in respect of capacity and the wider implications of executive functioning. Consider wider multi-agency opportunities to extend the training provided to Council Officers.

14. Consider how to enhance the shared understanding of family's roles, responsibilities and expectations in the context of the MDT/multi-agency ways of working.

15. Increase the shared understanding of the responsibilities of statutory services for Carers, as per legislation and the findings of the Mental Welfare Commission Investigation into the death of Mrs F.

16. Increase the knowledge base around the role of advocacy - how to refer in and the specific role they might have.

17. Consideration to be given to the availability of ECMHT advice and support during the out of hours period.

18. Consider how, from a multi-agency perspective, we support families in the aftermath of tragedies such as this.

19. Consider how existing case closure processes can influence MDT discussions and promote greater professional curiosity.

Appendix 1

East Ayrshire Adult Protection Committee

Adult Support and Protection Learning Review Panel Terms of Reference

Learning Review for Adult O April 2023

1. Aim

Using the National Guidance for Adult Protection Committees undertaking Learning Reviews (May 2022) this Learning Review will examine the multi-agency response to the circumstances for Adult O with a focus on the effectiveness of multi-agency information sharing, risk assessment and risk management.

Background

The East Ayrshire Health and Social Care Partnership (H&SCP) submitted an Initial Case Review (ICR) Notification on 15 March 2022. An Initial Case Review Planning meeting was held on 26th April 2022 in respect of Adult O to consider if the case was likely to meet the criteria for conducting a Significant Case Review (SCR) as outlined in the National Framework for Conducting a SCR. This meeting concluded that the case was likely to meet the criteria in that the Adult was an Adult at Risk who died and the incident or accumulation of incidents gives rise to significant serious concerns about professional service involvement. As such all of the relevant services/professionals were asked to submit reports outlining the nature and extent of their involvement.

It should be noted that the Planning Meeting were advised that a H&SCP Local Management Team Review (LMTR) was being conducted, which is a single agency process followed by NHS Ayrshire and Arran and overseen by the Adverse Events Review Group.

An Initial Case Review Panel meeting was subsequently held on 30th January 2023 to consider the circumstances leading up to and surrounding the death of Adult O including a review of all of the reports submitted by services/professional including the LMTR report completed on 10 June 2022.

The Panel meeting held on 30th January 2023 concluded that the criteria for proceeding with a Learning Review was met, (as outlined in the National Guidance) in that;

The adult is, or was, subject to adult support and protection processes and the incident or accumulation of incidents

Gives rise for reasonable cause for concern about how professionals and services worked together to protect the adult from harm, **and the adult at risk of harm dies and harm or neglect is known or suspected to be a factor in the adults death and the death is by suicide or accidental death.**

2. Methodology

The Learning Review (LR) should adopt a systemic approach to understand not only individual and professional practice but also wider systemic factors within and across organisations and the wider context. The Review Team will determine the methodology used to ensure this is consistent with the National Guidance for Adult Protection Committees Undertaking Learning Reviews.

Review Team

A Review Team will be established to oversee and manage the LR process. An Independent Lead Reviewer, externally commissioned, will be appointed to conduct the review and write the report with the support of the Review Team. The Lead Reviewer will have the appropriate level of skill, knowledge and experience to conduct the LR. The Review Team has been drawn from relevant agencies/partners and will be supported by the LR Panel. Administration support will be available.

Principles and values

Using the methodologies agreed by the Review Group, the Learning Review will be underpinned by the following core principles and values:

- To promote a culture that supports learning
- To place an emphasis on learning and organisational accountability and not on culpability
- To recognise that a positive shared learning culture is an essential requirement for achieving effective multi-agency practice
- To ensure Reviews are objective and transparent
- To ensure Reviews are sensitive to the needs and circumstances of adults, children, young people, and families
- To ensure that staff are engaged and involved in the process and supported throughout the period of the review
- To recognise the complexities and difficulties in the work to protect adults, children and young people and to support families
- To produce learning which can be disseminated, both at local and national level, so it directly impacts on and positively influences professional practice and organisational systems.

Purpose

A Learning Review is a means for Public Bodies and Office Holders with responsibilities relating to the protection of adults at risk of harm to learn lessons from considering the circumstances where an adult at risk has died or been significantly harmed.

A Learning Review is not an investigation, it is an opportunity for in-depth analysis and critical reflection in order to understand complex situations enabling us to develop strategies to support and improve practice.

The overall purpose of a Learning Review is to bring together agencies, individuals and families in a collective endeavour to learn from what has happened in order to improve and develop systems and practice in the future and thus better protect adults. The National Guidance supports these objectives helping those considering undertaking a review to: undertake them at a level which is necessary, reasonable and proportionate; adopt a consistent, transparent and structured approach; identify the skills, experience and knowledge that are needed for the review process and address the needs of the many different people and agencies who may have a legitimate interest in the process and outcome and take account of the evidence base.

Objectives

In order to understand the full circumstances leading up to and surrounding the death of Adult O, who at the time of their death was designated as an Adult at Risk of harm and consider the following areas:

1. Examine single and multi-agency case files in respect of Adult O as appropriate / proportionate.
2. An initial multi- agency chronology has been collated and the Learning Review should examine this and all relevant associated events including referral process / meetings / discussions / assessments including risk assessment / decision making and contact with Adult O.
3. The Learning Review should take account of the NHS single agency Local Management Review Report including the findings and recommendations therein.
4. Establish the circumstances culminating in multiple indicators of concern presenting for Adult O.
5. Examine the extent of the contact between agencies known to Adult O prior to the decision to undertake a Learning Review and establish whether there were any opportunities for agencies to have intervened earlier.
6. Examine communication and information sharing in and between agencies and establish strengths and identified areas for improvement.
7. Adopt an analytical and evidence-based approach that looks beyond what went wrong to include an analysis of effective practice.
8. Explore the interrelated and interdependent parts of different services and agencies and the impact this had on the lived experience of Adult O and their family. This should have a focus on the extent to which decisions and actions were person centred.
9. Analyse whether decisions and actions taken were in line with available single and / or multi-agency policies, procedures, and guidance.
10. Did all agencies exercise their full legal powers to ensure the safety and wellbeing of Adult O

11. To what extent was self-neglect understood across the multi-agency adult protection partners
12. Report Review findings to the Chair for consideration by the Learning Review Panel and the East Ayrshire Adult Protection Committee (EAAPC).

3. Commissioning and Reporting Arrangements

An independent external Lead Reviewer will be commissioned. This is preferred in the main due to the level of complexity and multi-agency involvement in this case. A single agency Local Management Team Review has been completed and it is clear that we require to consider the circumstances of this case from a multi-agency perspective. The family of Adult O have been fully involved in the LMTR process and consider there is further learning to be gained from a multi-agency process. In the interests of transparency and impartiality the LR Panel consider it necessary to appoint an external reviewer.

The Learning Review will be undertaken by the Learning Review Group and overseen by the Learning Review Panel on behalf of EAAPC (see Appendix 1). The report will be submitted to the Chair of the Panel for consideration ahead of endorsement of the findings by EAAPC and the East Ayrshire Chief Officers Group (COG). The final report will be owned by EAAPC.

4. Review Period and Reporting Timescales

Adult O had been known to services since early 2021 and as such the Review period will be from 18 January 2021 until their date of death due to a house fire on 22 February 2022, unless additional information of further significant events comes to light during the review process which suggests the review period should be extended. In this case the Review Group will seek to vary the Review period with reference to the Learning Review Panel.

The Review will be concluded within 6 months from the date of the notification to the Care Inspectorate and the Terms of Reference being agreed by the Learning Review Panel.

5. Dissemination of Learning

The dissemination and implementation of learning from a Learning Review has several components which are:

- The implementation of suggested strategies, specified in the report, for improving practice and systems
- Dissemination of learning at a local level
- Dissemination of learning at a national level

Following the completion of the Learning Review, a plan to share findings and learning will be created by the Review Group and Review Panel with a timeline for dissemination.

6. Confidentiality

All information and data collected by or produced through the Learning Review will be managed in accordance with the principles of the General Data Protection Regulation (GDPR 2018).

There will be **no disclosure** of information in respect of the Review (information collated, analysis or findings) without reference to the Chair of the Learning Review Panel.

In respect of Freedom Of Information (FOI) enquiries, the full Report is data sensitive and will remain in the ownership of the EAAPC.

7. Care Inspectorate

The Care Inspectorate is the central repository for all Learning Reviews conducted and as such will be notified of the commencement of the Learning Review within 42 days of agreement to go ahead via the online form. The Link Inspector for East Ayrshire will be advised when the Review concludes, and a full anonymised Learning Review report will then be submitted via the online process.

8. Contact with Family

The family of Adult O has engaged with the LMTR process and has been communicated with by the Chair of the Panel to advice of our consideration of proceeding with a LR. The Chair will meet with the family once the TOR has been agreed and signed off by the EAAPC and EACOG to discuss the process and ascertain how the family would wish to be involved in the LR.

9. Support for Staff

Staff involved in the process will be supported by line managers and their respective Review Group Member/s throughout the process. The respective Review Officers will meet with relevant staff prior to the Review commencing and explain the review process and outline how the learning workshops will be managed. Following the workshop/s, supports will be in place for all staff who were involved in the sessions. Out with line management support, a variety of individual support services are available to staff and details of support will be shared with staff at the start of the learning workshops.

10. Managing Media Interest

Consideration of potential public or media interest will be discussed by both the EAAPC and the EACOG when required**.**

NB: If the Review is likely to attract high public and media interest, a strategy will be prepared allowing for a range of scenarios. Media statements will make it clear that

the purpose of the Review is learning and not culpability. Consideration must be given to the impact on the staff involved in the review, advising and supporting them as much as possible.

In the event of publication or media interest, reference will be made to the East Ayrshire Council Corporate Communications Procedure for Handling Media Relations. The Corporate Communications Team handles all corporate media activities for East Ayrshire Council. All media activities are centrally co-ordinated through an online media management system (PRGloo), which ensures that all enquiries, statements and proactive press releases are logged, managed and monitored effectively and in a consistent, efficient manner. All media statements will be approved by the Head of Service for Locality Health and Care Services for final approval prior to dissemination. East Ayrshire Council Communications team will consider the request and determine if it is appropriate for EAAPC to respond or if the enquiry should be directed elsewhere.

Susan Maguire
Learning Review Panel Chair
11 April 2023

Appendix 2

Local Management Team Review Action Plan

(NB all completed at time of Learning Review)

Notes audit to be completed within line management supervision every month to ensure proactive provision of assessment and intervention.	Record keeping audit standard operating procedure - completed
All staff must record date and time of next patient appointment (unless documented to why this has not occurred) and have clear plan of intervention with clear timescales	Monitored with audit process - completed
All new referrals to Older People's Community Mental Health Team must be discussed at multidisciplinary team meeting following first assessment, all staff to be clear of this expectation and process in place to check and audit to ensure compliance	Local system implemented to ensure first assessment are discussed at MDT meeting.
Allied Health Professional (AHP) workforce tools and risk assessment to be applied to Older People's Community Mental Health Occupational Therapy Team to identify service demand and staffing requirements for safe practice.	Workforce tool completed and implemented.
OT service to develop a standard operating procedure for DNA appointments, which will include timescales for re-scheduling.	Completed.
Guidance developed and shared with all staff regards cancelling of patients when on unplanned leave	Completed.
All staff reminded to prioritise clinical supervision, as per supervision guidance.	Completed.

Appendix 3

Learning Review Panel and Learning Review Group Membership

Learning Review Panel

Name	Designation
Susan Maguire (Chair)	Independent EAAPC Chair & Review Panel Chair
Dale Meller	Senior Manager Protection & Learning
Marion MacAulay	Head of service (CSWO)
Lianne McInnally	AHP Senior Manager , LMTR Lead Reviewer
Dr Alexia Pellowe	Clinical Director - East Ayrshire HSCP TEC Clinical Lead – NHS Ayrshire & Arran Associate Adviser for CPD / Quality Improvement / Patient Safety NHS Education for Scotland
Gary Craig	Strategic Manager , EAC Housing & Communities
Andrea Templeton	DCI Public Protection
Donna Sinforiani	Adult Protection Lead Officer
Ian McMeekin	Scottish Fire and Rescue

Review Team

Jackie Daly	Independent External Lead Reviewer & LR Group Chair
Anita Heyes	Service Manager ,Locality Health and Care Services ,EAHSCP
Lisa Punton	Housing Services Manager ,Housing & Communities
Sharon Hackney	NHS Senior Manager North HSCP
David Murray	Community Safety Engagement Officer, Scottish Fire and Rescue Service

Appendix 4

LEARNING REVIEW STAFF FOCUS GROUP PROGRAMME

ADULT O

WEDNESDAY 28TH FEBRUARY 2024, 10AM – 3.30PM

KILMARNOCK FIRE STATION,

33 CAMPBELL STREET, KILMARNOCK, KA1 4HL

9.45 – 10.15am	Tea Coffee on arrival
10.15am	Introduction – Jackie Daly, Independent Lead Reviewer Housekeeping – David Murray, Scottish Fire & Rescue
10.30am	Staff Care/Wellbeing Jane McKie, Health & Safety Support Officer, East Ayrshire Council
10.45am	Chronology of events – Anita Heyes, Sharon Hackney, Jackie Daly
11.00am	Staff group workshop 1
12.30 – 1.00pm	Lunch
1.00pm	Staff regroup – Afternoon session commences
1.30 – 3.00pm	Staff group workshop 2
3.00pm	Summary – what next
3.30pm	End of session

References

Item 1 National Framework for Conducting SCR Interim National Framework for Adult Protection Committees for Conducting a Significant Case Review (www.gov.scot)

Item 2 National Guidance for conducting learning reviews National Guidance for Adult Protection Committees Undertaking Learning Reviews (www.gov.scot)

Item 3 Ayrshire Guidance and East Ayrshire Operational Procedures east-ayrshire-public-protection-learning-review-guidance-june-2023-final.pdf

Item 4 Carers (Scotland) Act 2016 Carers (Scotland) Act 2016

Item 5 Front Door Service Booklet (supporting document available)

Item 6 Ayrshire Mental Health Risk Assessment Framework (supporting document available)

Item 7 Role of the lead professional Getting it right for every child Practice Guidance 3 Role of the lead professional 2022 (www.gov.scot)

Item 8 Frailty & Falls Assessment and Intervention Tool frailty-and-falls-assessment-and-intervention-tool.pdf (ihub.scot)

Item 9 Home fire safety visits | Scottish Fire and Rescue Service (firescotland.gov.uk)

Home Fire Safety Visit Rating Form (supporting document available)