East Ayrshire Adult Protection Committee

Executive Summary

Learning Review

Adult O

October 2024

Contents

1. Context

This Learning Review Summary has been published by East Ayrshire Adult Protection Committee (EAAPC) following the completion of a Learning Review into the circumstances of Adult O whose 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 Learning Review was carried out in compliance with the East Ayrshire Adult and Child Protection Committees Ayrshire Learning Review Guidance (2023) which is consistent with the National Guidance for Adult Protection Committees Undertaking Learning Reviews (Scottish Government 2022).

Learning Reviews are a vital part of improving adult support and protection systems and are an opportunity for in-depth analysis and critical reflection, to gain a greater understanding of inevitably complex situations and to develop strategies to support practice and improve systems across all services and agencies. Learning Reviews are not investigations. The key features and underlying principles and values of Learning Reviews can be found in the National Learning Review Guidance.

This Executive Summary provides a high level summary of the

- Circumstances leading up to the death of Adult O
- Review process and methodology
- Key findings and learning points

2. Why This Case Was Chosen for a Learning Review

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

Adult O was known to services at time of their death, being an open case to the Adult Concern Initial Response Team, the Elderly Community Mental Health Team and the Scottish Fire and Rescue Service. Other services involved prior to and at the time of death included: NHS General Practice, Social Work Front Door Services, Sensory Impairment Team, Financial Inclusion Team, Housing Team and included a visit by the adult 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 because there were increasing concerns in terms of the impact of their sensory deficits and presenting cognitive state on their ability to care for themselves, as well as increased risks as a result of their long term heavy smoking.

Of note, in the two weeks following Adult O's death, a family member lodged a formal complaint with NHS Ayrshire & Arran NHS, 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. 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 March 2022. The grounds for this being the fact that Adult O had active involvement with the Adult Concern Initial Response Team at the time of their death, having multi-agency involvement in relation to concerns about their health, welfare and increasing fire risk. It was thought likely that the circumstances 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 replaced the previous framework for reviews. This subsequently led to the development of the Ayrshire Guidance and East Ayrshire Operational Procedures within which this Learning 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'

A Learning Review Panel provided governance and oversight of the process and was chaired by the Independent Chair of the EAAPC and included senior leaders and professional advisers from the key services involved in the care of Adult O.

Relevant services and 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 was created. A Learning Review Panel meeting was convened and it was agreed that the criteria for proceeding with a Learning Review were indeed met.

A Review Team was then established, drawn from all of the relevant services, and led by an independently commissioned Lead Reviewer to conduct the learning review.

3. The Learning Review Process

Methodology

The overall purpose of the Learning Review was 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, children and young people" (East Ayrshire Guidance 2023). The Review Team therefore met and developed a full multi-agency chronology. As well as early contact with the family, interactive learning workshops for both Practitioners and Line Managers were delivered to inform the review and subsequent report. This was also utilised to develop a visual chronology for a Strategic Leaders learning workshop with a focus around future ways of working to continue to improve care and to identify where change required to be considered. Key leaders took away actions for themselves ahead of the outputs of the Learning 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 Learning Review in terms of improving practice & systems.

As General Practice staff had been unable to attend the learning workshops, the local Clinical Director supported separate meetings with both the GP Practice and Pharmacotherapy services. The Lead Reviewer and NHS representative from the Review Team 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 Scottish Fire & Rescue Service to obtain more information from this service.

The full Learning Review report includes the outputs of the information collated and analysed from these various sources.

Review Team

The Review Team membership was drawn from agencies involved with Adult O but who had no decision making responsibility in relation to the family. The Review Team supported the analysis of all of the information & data and the writing of the full Learning Review report.

Membership of the Review Group:

Independent Lead Reviewer	Review Group Chair
Social Work	Service Manager, Locality Health & Care Services
Scottish Fire & Rescue Service	Community Safety Engagement Officer
Housing and Communities	Housing Services Manager
NHS	Allied Health Professional Senior Manager, North Ayrshire HSCP

Date Period of the Learning Review

The Learning Review timeline focused on the period from 18 January 2021 until Adult O's death on 22 February 2022.

Aim of the Learning Review as Defined by EAAPC

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, by considering the following:

- Examine single and multi-agency case files in respect of Adult O as appropriate / proportionate.
- Examine the multi-agency chronology and all relevant associated events including referral process / meetings / discussions / assessments including risk assessment / decision making and contact with Adult O.
- The Learning Review should take account of the NHS single agency Local Management Review Report including the findings and recommendations therein.
- Establish the circumstances culminating in multiple indicators of concern presenting for Adult O.
- 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.
- Examine communication and information sharing in and between agencies and establish strengths and identify areas for improvement.
- Adopt an analytical and evidence-based approach that looks beyond what went wrong to include an analysis of effective practice.
- 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.
- Analyse whether decisions and actions taken were in line with available single and / or multi-agency policies, procedures, and guidance.
- Explore whether all agencies exercised their full legal powers to ensure the safety and wellbeing of Adult O.
- Explore to what extent self-neglect was understood across the multi-agency adult protection partners.
- Report the Learning Review findings to the Chair for consideration by the Learning Review Panel and the East Ayrshire Adult Protection Committee (EAAPC).

Ongoing Legal Process & Engagement with family members

At the commencement of the Learning Review there were no other ongoing legal or review processes taking place. The family of Adult O had been fully involved in the Local Management Team Review process and the subsequent Learning Review considerations, with opportunities to meet with representatives of the Adult Protection Committee.

On being informed of the decision to progress to Learning Review, Adult O's family were keen to remain involved. Therefore the Lead Reviewer established early contact with one of the members of Adult O's family and agreed communication arrangements at key points in the Review recognising the importance of meeting with the family as a collective to determine their views and perspectives, to ensure these were captured within the review. The family members thereafter remained fully involved throughout the Learning Review process.

4. Data Protection and Publication

All information and data collected by or produced through the Learning Review was managed in accordance with the principles of the General Data Protection Regulation (GDPR 2018). There was **no disclosure** of information in respect of the Learning Review (information collated, analysis or findings) without reference to the Chair of the Learning Review Panel. In respect of Freedom Of Information enquiries, the full Report is data sensitive and remains under the ownership of the EAAPC.

5. Context & Brief Overview of Events

5.1 Adult O was 81 years of age and lived alone. Adult O was living with sensory and cognitive impairment. There were several agencies involved with Adult O including NHS, Social Work, Scottish Fire and Rescue, East Ayrshire Council Housing Services and the Sensory Impairment Team. Adult O had also been involved with General Practice, Financial Inclusion and the Emergency Department. At the time of death, Adult O was subject to Adult Support and Protection processes related to concerns with respect to the ability to self-care given sensory, cognitive issues and elevated risks arising from being a heavy smoker. Adult O died on the morning of 22 February 2022 as a result of a house fire.

5.2 Adult O's family raised a complaint into the NHS care, specifically increasing self-neglect. This complaint was handled under the NHS Local Management Team Review (LMTR) process and concluded in June 2022. This review found a lack of proactive care had resulted in the family having to follow-up themselves. The review proposed changes to improve multi-disciplinary discussion and decision making where increasing risk is concerned.

5.3 Given the agencies involved with Adult O, it was agreed that a Learning Review should commence in compliance with the East Ayrshire Adult and Child Protection Committees Ayrshire Learning Review Guidance (2023). A Learning Review Team was established and an independent Lead Reviewer commissioned. Adult O's family continued to be involved at key stages.

5.4 Adult O's family highlighted the independence, community involvement and pride Adult O enjoyed and that they had noticed a deterioration in this following the easing of pandemic restrictions. Most notably family saw this in relation to Adult O's appearance, level of confusion, not taking prescribed medicines and heightened fire risk.

5.5 These concerns resulted in a number of contacts with services:

Time	Service	Outcome
August 2021	Front Door Service	Assessment visit with support declined and onward referral to Sensory Impairment Team
August 2021	Sensory Impairment Team	Visual and hearing assessment, equipment provision and closure
September 2021	General Practice	Consultation, monitoring, testing, follow-up consultation and referral to ECMHT
October 2021	Elderly Community Mental Health Team (ECMHT)	Initial assessment planned October 2021, took place 10/12/21, risk assessment form, planned actions GP liaison, community alarm, adaptations, financial inclusion. Further visit in January 2022 recommending Optician appointment and making SFRS referral.
February 2022	Scottish Fire and Rescue Service (SFRS)	Home Fire Safety Check 02/02/22, fire retardant bedding 10/02/2022, fire retardant mats planned for 23/02/2022, referral to ACIRT
February 2022	Adult Concern Initial Response Team (ACIRT)	Adult Protection episode opened 02/02/22 following SFRS referral. Referral screened but not yet actioned.
February 2022	Emergency Department (ED)	Attended ED 21/02/22 following fall, reviewed by medical staff, considered fit for discharge in expectation of ECMHT planned visit.

5.6 The family of Adult O felt that they were not 'heard' by the services involved and felt frustrated by escalating risks that were not identified as such. The family reported that Adult O hovered below the thresholds of concern and risk, never quite 'ticking the box'. From the family's perspective 'nothing was joined up' and they were keen to improve the experience of others in similar circumstances.

5.7 In identifying areas for learning, practitioners, line managers and strategic leaders focused on the following:

- Optimising opportunities for embedding joint working in earlier intervention, shared responsibilities, lead roles and decision-making in relation to risk management and chronologies;
- Family roles and responsibilities – need to ensure good connection is achieved with families, clear sharing of information, offer of carer assessment and clarity of expectation;
- Greater professional curiosity and strategy where there is self-neglect and non-engagement;
- Recognition of the role of Housing Services as an early contact around concerns such as neglect and self-neglect;
- Clearer referral arrangements for SFRS Home Safety Check Visits and access to fire retardant equipment for the most vulnerable;
- Ensuring that there is consistent awareness of the role of advocacy across teams;
- Seeking to remove physical barriers to support, e.g., appropriate awareness of fee waiving policy for most vulnerable and at risk individuals;
- Supervision – critical to ensuring staff are appropriately supported around identification of risk and risk management planning, and;
- Review of case closure processes to enable risk assessment and monitoring where appropriate.

6. Effective Practice

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

6.2 Equipment was supplied from the Sensory Impairment Team to support sensory difficulties.

6.3 A detailed referral was sent onto Scottish Fire and Rescue Service via NHS.

6.4 Local area Home Fire Safety Advice was carried out through Scottish Fire and Rescue Service following Adult O's death.

7. Suggested Strategies for Improving Practice

The Learning Review identified a number of strategies for improving practice, detailed below:

7.1 All services should be making early referrals onto the Scottish Fire & Rescue Service (SFRS) for a Home Safety Visit when fire risks are evident.

7.2 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.

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

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

7.5 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.

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

7.7 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 Multi-Disciplinary Team 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.

7.8 The multi-agency adult support & protection 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.

7.9 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.

7.10 Utilise adult support & protection frameworks to re-establish and/or enhance Multi-Disciplinary Team / multi-agency opportunities for case discussion and risk management.

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

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

7.13 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.

7.14 Consider how to enhance the shared understanding of a family's roles, responsibilities and expectations in the context of the Multi-Disciplinary Team / multi-agency ways of working.

7.15 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.

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

7.17 Consideration to be given to the availability of Elderly Community Mental Health Team advice and support during the out of hours period.

7.18 Consider how, from a multi-agency perspective, support is provided to families in the aftermath of tragedies such as this.

7.19 Consider how existing case closure processes can influence Multi-Disciplinary Team discussions and promote greater professional curiosity.

8. Conclusion

8.1 It is important to acknowledge the terrible circumstances in which Adult O died and the devastating impact this has had on their family members. The Adult Protection Committee would want to offer sincere condolences to them and thank them for their involvement, which has been a crucial part of the Learning Review process.

8.2 Individual staff and services have also been affected by what has happened and it is important to acknowledge their openness and willingness to learn from this most difficult situation.

8.3 The Learning Review Report and this Executive Summary lay out clearly what happened and why from a multi-agency organisational point of view; identifying clear learning and improvement actions to be taken forward.

8.4 An Improvement Plan has now been developed to take forward all of the actions identified within the review process and this will be reported to the East Ayrshire Adult Protection Committee in due course to ensure there is ongoing governance and oversight of this work.

8.5 A Short Life Working Group has also been set up to take forward the publication of the Learning Review Report and oversee the dissemination of the learning across all key organisations and partnerships.

8.6 The Chair of the East Ayrshire Adult Protection Committee will continue to liaise with the family of Adult O so that they are assured on an ongoing basis that the appropriate learning and improvements are being acted upon.

8.7 Finally the Adult Protection Committee would like to acknowledge the work of the Independent Reviewer who led this review and the significant contribution of the Review Team members.