Sutton Safeguarding Adults Board

Safeguarding Adults Review – EE (5th February 1957 – 1st March 2018)

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June 2019

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1. **Introduction**

1.1. EE lived with three other residents in a supported living house staffed by the provider. On 1st March 2018 it appears that EE set fire to himself. Staff were unable to persuade him to leave but succeeded in evacuating the other residents. Police, Fire and Ambulance Services all attended. EE was found inside a ground floor bathroom. He was pronounced dead at the scene. Preliminary findings on cause of death indicate burns to the body rather than smoke inhalation.

1.2. EE was White British. He had a significant fire and mental health history. Another resident was apparently known to be a fire risk. A further resident is recorded as being a significant offender. All the residents had histories of significant mental distress.

1.3. EE was not known to Adult Social Care (ASC) in the London Borough of Sutton. He was the responsibility of the London Borough of Merton and Merton and Wandsworth CCG. None of the other residents were known to the London Borough of Sutton or Sutton Clinical Commissioning Group (CCG). They had been placed by Merton and Wandsworth CCG. Neither Sutton ASC nor Sutton Community Mental Health Services appear to have known of this multiple occupancy serviced house.

2. **Safeguarding Adult Reviews**

2.1. Sutton Safeguarding Adults Board (SAB) has a statutory duty[1] to arrange a Safeguarding Adult Review (SAR) where:

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and
- There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

2.2. The SAB also has discretion to commission reviews in circumstances where there is learning to be derived from how agencies worked together but where it is inconclusive as to whether an individual's death was the result of abuse or neglect. Abuse and neglect includes self-neglect.

2.3. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future[2]. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

2.4. At the SAB's SAR review meeting on 26th April 2018, three cases were considered. All three cases concerned men living in different locations within the London Borough of Sutton. It was agreed that the case of EE met the statutory criteria for a mandatory SAR. The two other cases

[1] Sections 44(1)-(3), Care Act 2014
[2] Section 44(5), Care Act 2014

(GG and HH) also involved fire, smoking-related risks, self-neglect concerns and mental health. GG died as a result of the fire; HH survived. Although these cases were judged not to meet the criteria for a mandatory SAR, the review meeting agreed that there was potentially significant learning to be derived from considering these cases at the same time. The SAB Independent Chair therefore exercised her discretion to commission an analysis of these two cases also. I was confirmed as the independent reviewer at the same meeting for all three cases.

2.5. Once the chronology concerning EE had been analysed, it became apparent that there might be learning associated with another individual who was living in the same setting as EE. The panel and independent reviewer agreed to include learning from FF's case at appropriate points. He survived the fire but was injured as initially he could not exit the premises, a door being locked.

2.6. The membership of the SAR Panel comprised the following members:

- Independent overview report writer:
  - Michael Preston-Shoot
- Sutton SAB Business Manager
- Sutton Adult Social Care (ASC)
- Metropolitan Police Service (MPS)
- Sutton Clinical Commissioning Group (CCG)
- South West London and St George's Mental Health NHS Trust
- London Fire Brigade (LFB)
- Royal Marsden NHS Foundation Trust
- Epsom and St Helier NHS Trust

The SAR Panel received administrative support from the Sutton Safeguarding Adults Board Business Support Officer.

2.7. MPS investigated the fire. As no criminal conduct was found, the investigation was closed and primacy for investigation transferred to LFB.

2.8. Information collated as a result of investigation into the fire and the accommodation context in which it took place has been shared by LFB with the SAR panel and independent reviewer. This report draws on the LFB findings.

2.9. On 14th August 2018 an inquest was opened and adjourned pending the outcome of this SAR.

2.10. A root cause analysis was completed by South West London and St George's Mental Health NHS Trust. This analysis has been made available for the SAR and the contents of this report draw upon its conclusions.

2.11. A section 42 Care Act 2014 adult safeguarding enquiry was commenced by Sutton ASC but paused pending completion of this SAR. Some relevant information obtained as part of the section 42 enquiry has been included as part of the thematic analysis in this report.

3. **Review Process**

3.1. Focus

3.1.1. From June 2014 when EE had returned to the UK until his death in March 2018 the panel wished to focus on learning from good practice and from shortcomings regarding how agencies worked together and shared information by analysing EE's case as follows:

3.1.2. the quality of assessments undertaken, decision-making and planning with respect to the suitability of the provider of the final placement;

3.1.3. the quality of assessments undertaken, decision-making and planning regarding how the final placement was arranged, risk assessments were completed and then monitored, the outcome of the placement reviewed, and oversight of the implementation of care and support plans;

3.1.4. the quality of assessments undertaken, decision-making and planning to address EE's physical and mental health needs, and care and support needs;

3.1.5. communication and discussions, for example regarding EE's final placement, which took place between mental health services, local authorities, CCGs, LFB, MPS and regulatory agencies;

3.1.6. co-operation between different agencies involved, including the effectiveness of information-sharing;

3.1.7. the opportunity for agencies to identify and assess safeguarding adult risks, including fire risks;

3.1.8. agency responses to any identification of safeguarding adults issues, including fire risks;

3.1.9. the balance struck between autonomy/self-determination and the duty of care;

3.1.10. use of available single agency and multi-agency policies and procedures;

3.1.11. how organisational factors, such as capacity, culture, knowledge of legal requirements and understanding of agency roles and responsibilities impacted on practice;

3.1.12. effectiveness of agency actions measured against expectations in multi-agency policies and procedures for adult safeguarding, mental health after-care, and meeting needs for care and support, and against health and safety legislation and commissioning guidance;

3.1.13. and concluding with recommendations to implement learning on policies and practice from the extracted lessons, which will improve inter-agency working and more effectively safeguard adults at risk.

3.1.14. The panel wished to undertake a proportional review that analysed the case through the lens of evidence-based learning from research on self-neglect[3], the findings of other published SARs on adults who self-neglect[4] and the conclusions of two thematic reviews of SARs[5].

3.2. Methodology

3.2.1. Agencies were requested to provide a chronology of their involvement with EE within the agreed timeframe. They were advised to also include anything that they judged significant that fell outside the agreed timeframe for the review.

3.2.2. The individual chronologies were combined. Panel members and the independent reviewer then identified specific issues and questions that the agencies involved were asked to address in follow-on management reports.

3.2.3. A learning event with practitioners involved in EE's case was planned in order to explore key episodes and events within the timeframe being reviewed based on issues and concerns emerging from the combined chronology and agency responses to the panel's observations and questions. However, the learning event was postponed because staff from the accommodation and care provider would have been present alongside members from LFB. As LFB had not completed its investigation as a prelude to deciding whether or not to prosecute the provider, this would have acted as a barrier at a learning event which is designed to learn lessons. Staff might have been hesitant to contribute on grounds of not wishing to incriminate themselves.

3.2.4. The panel meetings sought to analyse learning from this case through the lens of evidence from the aforementioned research and other SARs that has enabled a framework for policy and practice to be constructed for effective work with adults who self-neglect and/or present with mental health issues and/or fire risks. The focus was therefore on identifying the facilitators and barriers with respect to implementing what has been codified as good practice. Thus, a hybrid methodology has been used, designed to provide for a proportional, fully inclusive and focused review.

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[3] Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence. Braye, S., Orr, D. and Preston-Shoot, M. (2013) *A Scoping Study of Workforce Development for Self-Neglect*. Leeds: Skills for Care.

[4] Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews.' *Journal of Adult Protection* 17 (1), 3-18. Preston-Shoot, M. (2016) 'Towards explanations for the findings of serious case reviews: understanding what happens in self-neglect work.' *Journal of Adult Protection* 18 (3), 131-148. Preston-Shoot, M, (2017) 'On self-neglect and safeguarding adult reviews: diminishing returns or adding value?' *Journal of Adult Protection* 19 (2), 53-66. Preston-Shoot, M. (2018) 'Learning from Safeguarding Adult Reviews on self-neglect: addressing the challenge of change.' *Journal of Adult Protection* 20 (2), 78-92.

[5] Braye, S. and Preston-Shoot, M. (2017) *Learning from Safeguarding Adult Reviews: A Report for the London Safeguarding Adults Board* (London: London Safeguarding Adults Board); Preston-Shoot, M. (2017) *What Difference Does Legislation Make? Adult safeguarding through the Lens of Serious Case Reviews and Safeguarding Adult Reviews. A Report for South West Region Safeguarding Adults Boards* (Bristol: South West ADASS).

3.2.5. Where relevant, information regarding other residents living alongside EE, especially FF, will be included in the chronology and subsequent thematic analysis. Having analysed the learning from EE's case, the report will also include learning that has been derived from case file analysis regarding GG and HH.

3.3. Family involvement

3.3.1. EE's cousin was interviewed as part of the South West London and St George's Mental Health Trust root cause analysis procedures and her observations are reported in section 7 of this SAR.

3.3.2. The independent reviewer was able to have a telephone conversation with EE's cousin. Her observations are reported in section 7 of this SAR. Other members of EE's family live around the world and the cousin did not think it appropriate or necessary for them to be involved. She had acted as EE's guardian and advocate when he was residing in the UK.

3.3.3. Various documents seen by the independent reviewer, including social circumstances reports prepared by Cygnet Hospital/Lodge, refer to contact with EE's cousin and other relatives.

4. **EE: Pen Picture**[6]

4.1. EE was born in the UK but moved to Zambia when aged 11. He had a wife and two adult children in Zambia. Since 2010 he had experienced approximately ten admissions to hospital. In October 2012, whilst unwell, he set five fires. He was detained in hospital but escaped and returned to the family home on 9th December 2012 with the intention of burning his family to death. In 2013 he was detained in prison and repatriated to the UK on his release.

4.2. Various reports seen by the independent reviewer, especially the discharge summary prepared by Cygnet Hospital/Lodge in September 2017, contain detail of EE's childhood, including references to adverse childhood experiences; his employment, mental health and marital history, and contact with and support from different family members.

4.3. On his arrival at Heathrow Airport on 31st May 2014 he was assessed and detained under section 2, Mental Health Act (MHA) 1983, and was admitted to Hillingdon Hospital.

4.4. Medical records give the following diagnoses: bipolar affective disorder, malignant neuroleptic syndrome[7], type 2 diabetes and hyperthyroidism[8].

4.5. EE did not have any convictions or adult cautions recorded by UK Police.

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[6] Information in this section has been obtained from a root cause analysis completed by South West London and St George's Mental Health NHS Trust, from assessments prepared by Cygnet Hospital/Lodge and from MPS.

[7] A rare but life-threatening reaction to neuroleptic medications

[8] Overactive thyroid

5. **Chronology**

5.1. For ease of reference, the chronology has been divided into seven episodes. The events outlined below are derived from the combined chronology compiled from submissions by the agencies involved with EE.

5.2. Italics are used in this section to denote evidence-based components of the approach for working effectively with adults who self-neglect.

5.3. June – December 2014

5.3.1. On arrival in the UK, EE was compulsorily admitted to Hillingdon Hospital. He is recorded as experiencing paranoid delusions and was prescribed anti-psychotic medicine. The records contain references to needing to subdue his aggression. During June and July he alleged on several occasions staff assaults in telephone calls to the Police but on investigation no evidence is found to substantiate these claims. In August he reported a theft by another patient but the missing item was retrieved. He also alleged threatening behaviour by another patient. These allegations are investigated and represent the beginnings of what became a *repeating pattern* in this case.

5.3.2. There are also early signs of what became another *repeating pattern* in this case, namely *reluctance to engage*.

5.4. January – July 2015

5.4.1. EE was transferred to Springfield Hospital under section 3, MHA 1983, coming under the care of South West London and St George's Mental Health NHS Trust on 21st January 2015.

5.4.2. In February he was transferred to the NHS Trust's rehabilitation facility. He remained under section 3, MHA 1983.

5.4.3. At the end of May, section 3 was rescinded and EE became a voluntary patient.

5.4.4. In July he was discharged from the rehabilitation facility to live in a privately rented flat with his cousin. He became the responsibility of Morden Recovery and Support Team. He was allocated a Care Coordinator, who provided *continuity* in this case by working with EE up until his death. The Care Coordinator began to visit weekly. *Hospital discharges* will form part of the later analysis since they are key transition points where *risk assessment* and *multi-agency coordination* are components of good practice.

5.5. August – December 2015

5.5.1. The next entry in the chronology records that EE attended a care plan review meeting.

5.5.2. On 30 November unnamed *family members are recorded as raising concerns* about a decline in EE's mental health. Apparently he was abusing alcohol and drugs, not eating, not talking to his cousin with whom he was living, and expressing a wish to die.

5.5.3. At this time the chronology also records that the Care Coordinator was having *difficulty making contact* with EE.

5.5.4. On 30th December, following assessment, involving Police attendance, EE was detained under section 2, MHA 1983. He is recorded as having used the floor as a toilet, to be refusing to eat or wash, and to be drinking a bottle of vodka daily, all *features of some self-neglect* cases. He is reported as saying that he wanted to drink himself to death but that he had no other plans to end his life. This is the second record of *suicidal ideation*.

5.6. January – December 2016

5.6.1. On 22nd January the section 2 order lapsed with EE agreeing to be a voluntary patient.

5.6.2. On 5th February EE is recorded as becoming manic, expansive in mood, with inflated ideas and unrealistic plans. He is recorded as lacking insight and to be reluctant to take medication. He was detained under section 3, MHA 1983.

5.6.3. In June he is recorded as assaulting another patient, with the result that he was transferred to another hospital ward. Graduated leave arrangements began. This is another *transition* point.

5.6.4. During July he did not comply with his leave conditions, continuing the *repeating pattern* of *reluctance to engage*. He is reported also as having not engaged with the Merton Home Treatment Team whilst on graduated home leave. The *pattern* and *history* of threats of suicide, aggression, violence and self-neglect are noted.

5.6.5. Once again he contacted Police during this hospital admission with allegations of assaults and thefts against staff and/or patients.

5.6.6. Once again he was transferred to other wards as a result of financially exploiting other patients or being sexually disinhibited.

5.6.7. Diagnoses refer both to schizophrenia and bipolar disorder.

5.6.8. His sister also reported her concerns to Police, namely being bombarded by text messages.

5.6.9. As a result of Police involvement following his sister's concerns, reports of inappropriate contact with a young woman, and with EE's allegations, four MERLINS were sent to Adult Safeguarding in Merton, demonstrating *awareness and use of adult safeguarding provisions in the Care Act 2014*. The last of these was sent on 20th October. The chronology then falls silent until April 2017.

5.7. January – October 2017

5.7.1. On 26th April EE was assessed on the hospital ward for a locked ward rehabilitation placement at Cygnet Hospital/Lodge, Woking. The following day the placement provider confirmed that he was suitable for admission. On 3rd May EE transferred to this placement, regarded by the Care Coordinator as the best available placement for him. This *hospital discharge* represents a key *transition* point.

5.7.2. FF enters the chronology during this specific time episode. On 6th April as a result of violent behaviour he was assessed by a mental health team and taken to Springfield Hospital. On 11th April he assaulted another patient. In June 2017 he assaulted a road sweeper and was taken to hospital for a mental health assessment.

5.7.3. On 14th September EE was admitted to acute hospital having had a reaction to his psychotic medication resulting in a decline in his physical health. His medication was stopped. Cygnet Hospital/Lodge Woking were unwilling to accept him back, believing that the placement could not manage him safely.

5.7.4. He returned to a Springfield Hospital ward where on 15th September he was assessed and diagnosed with bipolar affective disorder. He is noted to be treatment resistant. Also noted are neuroleptic malignant syndrome, which had resulted in this latest episode, and his diabetes. He is also recorded as having chest sepsis, hypercholesterolemia[9] and possible latent TB. *Risks* are recorded as physical violence when unwell, *history* of arson and *history* of self-neglect in the form of *alcohol misuse.*

5.7.5. EE is recorded as spending time isolated in his bed space and as reporting that he felt low and depressed.

5.8. October – December 2017

5.8.1. On 1st November funding was agreed by Merton and Wandsworth CCG for supported accommodation. On 8th November EE viewed the proposed accommodation run by the provider in the London Borough of Sutton. He expressed anxiety about leaving the hospital ward and dislike of the accommodation. However, he appeared open to a trial placement. The plan for hospital leave was agreed. This is another *hospital discharge* and key *transition* point.

5.8.2. FF moved into the placement on 13th November.

5.8.3. Leave of one week began and EE settled. He is specifically noted in the minutes of a section 117 meeting held on 20th November 2017, as washing himself, which he had not done whilst on the hospital ward. The home manager, EE and a doctor were present at the meeting, with

[9] Very high level of cholesterol in the blood

the Care Coordinator joining later. He is reported as coping well, going to the shops by himself and getting on well with other residents. He was sleeping and eating well. EE is reported as describing the accommodation as "okay" but he said he was not eating much and had been depressed for a long time, although he did feel safe. He was not yet registered with a GP. The Care Coordinator is recorded as saying that EE could end up drinking if given the chance and that he could be non-compliant with medication, becoming manic very quickly. On 20th November the section 3, MHA 1983 order was rescinded and he was formally discharged from hospital. The Care Coordinator was to do a seven day follow-up and provide ongoing support in the community.

5.8.4. EE was discussed at a Morden Recovery Team *multi-disciplinary meeting* on 22nd November and he was *reviewed* on 27th November by the Care Coordinator and a Recovery Support Worker. EE stated that he was feeling well and satisfied with the placement but still adjusting to the local environment. The Care Coordinator arranged a medical review and a meeting with the Placement Manager to review his support plan. The Care Coordinator made *contact with EE's family* to provide his current address, and reminded everyone that if EE felt unwell, he should see a Doctor as soon as possible.

5.8.5. On 11th December EE is recorded as having stated that he was missing his family in Africa and living with his nephew. His cousin had visited. He also stated that he preferred the placement at Cygnet Hospital/Lodge Woking because there was more to do there. However, whilst at Cygnet Hospital/Lodge Woking he had not engaged in activities provided and he could not articulate to the Care Coordinator what activities he wished to follow. Staff are recorded as reporting that he was compliant with medication and settled.

5.8.6. On 28th December EE was reviewed by a Doctor with his Care Coordinator. He described his mood as more low than elated and as worse when thinking about his family in Zambia. He denied drinking or using illicit drugs. He was advised to register with a local GP for diabetic care and yearly diabetic reviews. Fortnightly visits by the Care Coordinator visits were planned. He is reported as managing his money, cooking independently and settled. The risk assessment and care plan were updated.

5.9. January – March 2018

5.9.1. By January 2018 FF was resident alongside EE and two other individuals. On 9th January Police were called to the residence by staff as FF was experiencing a mental health crisis, including head banging. He was taken to hospital by an ambulance. A MERLIN was submitted by Police to Sutton ASC.

5.9.2. On 13th February Police visited an address in Mitcham where FF was found. Apparently this was his home before his placement in supported living. The place was described by Police as cold, dirty and untidy. FF appeared to have been smoking cannabis. He agreed to return to his placement. A MERLIN was submitted by Police to Sutton ASC. The following day he was reported missing by staff but later returned.

5.9.3. On 19th February EE reported theft of his bank card and also alleged assaults to Police. He reported a theft again on 21st February. A MERLIN was submitted by Police to Sutton ASC. On 23rd February when the Police visited the placement because EE's whereabouts were unknown, he returned and was intoxicated. A MERLIN was submitted by Police to Sutton ASC. He made further contact with the Police on 26th February because he had broken house rules by taking alcohol into the premises and drinking. The following day he complained that staff had confiscated his alcohol – several bottles of wine and vodka. Staff also reported that he was smoking when intoxicated, thereby placing himself and other residents at risk.

5.9.4. These events represent known *risks* and a *repeating pattern* in his case.

5.9.5. MPS sent three MERLINS regarding EE to Adult Safeguarding in Sutton between 19th and 28th February 2018 and *information was shared* once at the Multi-Agency Safeguarding Hub (MASH).

5.9.6. On 28th February the provider requested a review by the Care Coordinator, concerned that EE was drinking heavily. The Care Coordinator arranged to visit the following week. That night the staff member on duty made a telephone call for support from the Sutton Home Treatment Team. The Support Worker also called LAS, concerned that EE had been saying that he was in pain. Staff had also been instructed to call an ambulance if EE was drinking heavily. He was taken to A&E but absconded. Police were called and returned EE to his accommodation in the early hours of 1st March. He is recorded as being angry and hostile whilst with the Police, adamant that he would continue to drink and smoke. A MERLIN was submitted by Police to Sutton ASC.

5.9.7. He is then reported as having become calmer after the Police left, such that the staff member on duty felt able to leave the immediate scene to begin to write up her report of what had taken place. It was whilst the staff member was elsewhere that a fire began, initially hitting EE's bedroom. EE was seen by the staff member on duty in a locked downstairs toilet and he refused to leave the property. FF sustained smoke inhalation, burns and superficial grazes as he left the property.

5.9.8. On the morning of 1st March, the Care Coordinator discussed EE's case at the *team's multi-disciplinary meeting*, being unaware at the time that EE had died.

6. **Evidenced-Based Model of Good Practice**

6.1. Reference was made earlier to research and findings from SARs that enable a model of good practice to be constructed. The model comprises four domains, which are summarised here.

6.2. It is recommended that direct practice with the adult is characterised by the following:

6.2.1. A person-centred approach that comprises proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes;

6.2.2. A combination of concerned and authoritative curiosity appears helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills;

6.2.3. When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage; loss and trauma often lie behind refusals to engage;

6.2.4. It is helpful to build up a picture of the person's history;

6.2.5. Recognition and work to address issues of loss and trauma in a person's life experience;

6.2.6. Contact should be maintained rather than the case closed so that trust can be built up;

6.2.7. Comprehensive risk assessments are advised, especially in situations of service refusal, alcohol misuse, non-compliance with treatment and fire setting history;

6.2.8. Where possible involvement of family and friends in assessments and care planning, with carer assessments offered;

6.2.9. Thorough mental capacity assessments, which include consideration of executive capacity;

6.2.10. Careful preparation at the point of transition, for example hospital discharge and placement commissioning, to ensure multi-agency involvement in risk assessment and risk mitigation planning.

6.2.11. Thorough care plans and regular reviews.

6.3. It is recommended that the work of the team around the adult should comprise:

6.3.1. Inter-agency communication and collaboration, coordinated by a lead agency and key worker, which may be termed working together;

6.3.2. A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture;

6.3.3. Multi-agency meetings that pool information and assessments of risk and mental capacity, agree a risk management plan, and consider legal options;

6.3.4. Use of policies and procedures for working with adults who self-neglect, express suicidal ideation and/or who have multiple and complex health, housing and social care needs;

6.3.5. Use of the duty to enquire (section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy;

6.3.6. Evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy;

6.3.7. Clear and thorough recording of assessments, reviews and decision-making.

6.4. It is recommended that the organisations around the team provide:

6.4.1. Supervision that promotes reflection and critical analysis of the approach being taken to the case;

6.4.2. Support for staff working with people who are hard to engage, resistant and sometimes hostile;

6.4.3. Specialist legal and safeguarding advice;

6.4.4. Case oversight, including comprehensive commissioning and contract monitoring of service providers;

6.4.5. Attention to workforce and workplace issues, such as staffing levels, organisational cultures and thresholds.

6.5. SABs are recommended to consider:

6.5.1. The development, dissemination and auditing of the impact of policies and procedures regarding self-neglect;

6.5.2. Workshops on practice and the management of practice with adults who self-neglect and/or who have complex health, housing and social care needs.

6.6. This model enables scrutiny of the chronology in this case and exploration of what facilitated good practice and what acted as barriers to good practice.

7. **Thematic Analysis**

7.1. This analysis draws on contributions from the agencies involved in EE's case. The themes are derived from this evidential base and matched against the model of best practice outlined in the preceding section of this report.

7.2. Direct practice with EE

7.2.1. On *family and carer involvement*, EE's cousin told the root cause analysis review[10] that the family were not involved in decision-making regarding EE's final placement. The same review observes that no family member was offered a carer's assessment. As the duty to offer such assessments resides with the local authority under the Care Act 2014, this represents a missed opportunity for the NHS Trust and placing CCG to *work together* with the ASC in the London Borough responsible for him.

7.2.2. EE's cousin also told the independent reviewer that the family had felt excluded from decision-making.

7.2.3. This is in marked contrast to social circumstances reports prepared by Cygnet Hospital/Lodge in August and September 2017, partly in preparation for a Mental Health Tribunal hearing, EE's application for which was subsequently withdrawn, and partly for his discharge. These reports detail the family's support for that particular placement.

7.2.4. On *relationship-building and continuity*, EE's cousin is reported as having commented positively on the relationship that EE had with his Care Coordinator. Indeed, the Care Coordinator had had a continuous relationship with EE since July 2015. The aforementioned root cause analysis has noted with concern, therefore, that the Care Coordinator did not visit EE after the December 2017 review when he would have been well-placed to monitor and review EE's progress and mental health. Indeed, the summary of a review held on 28th

[10] South West London and St George's Mental Health NHS Trust

December 2017 clearly states that the Care Coordinator would visit two weeks later but this did not happen. It is unclear why this visit did not happen.

7.2.5. EE's cousin also told the independent reviewer that the Care Coordinator had been helpful. However, in her view, the Care Coordinator had been excluded and side-lined by hospital ward staff in the run-up to EE's final placement.

7.2.6. One key line of enquiry has been how EE's final placement was found, given that the actual house was a new setting, and how its suitability was assessed and by whom with respect to EE, FF and the other residents placed there, to ensure that the property was suitable and the staff appropriately qualified to manage people with complex needs. On this final *transition of hospital discharge*, EE's cousin expressed to those preparing the root cause analysis her concern about the speed of the discharge in November 2017 following a lengthy period in a highly supportive inpatient care environment. She also believed that EE remained physically unwell when discharged.

7.2.6.1. The root cause analysis concludes that the discharge proceeded with "pace" and was quick even though EE was fit for discharge. It concludes that a slower transition would have been preferable, even though his mental health was stable and discharge was the normal approach once a placement had been found. Although Cygnet Hospital/Lodge Woking refused to take EE again when approached, because of their concern that they would be unable to manage his physical and mental health needs, an opportunity was missed to approach other rehabilitation units.

7.2.6.2. The root cause analysis attributes the speed of the discharge in part to the lack of a regular Consultant in the preceding month, which connects with another component of effective practice in self-neglect and other cases, namely attention to *workforce and workplace issues*, specifically staffing.

7.2.6.3. However, staff at the Recovery and Support Team had used the provider before and this placement was judged to be appropriate because they could offer 24-hour staff cover and were able to administer medication.

7.2.6.4. Nonetheless, Merton and Wandsworth CCG in their contribution to the review state that normally a clinical team will identify a person's needs and the Care Coordinator or Discharge Care Coordinator then identifies a suitable placement. The application for commissioning the provider was not made by the Care Coordinator in EE's case. Normally, the Care Coordinator or Discharge Care Coordinator complete the funding and placement application form and make a presentation to the CCG panel. It is unclear why this normal procedure was not followed in EE's case.

7.2.6.5. The root cause analysis also notes that EE was not registered with a GP immediately on discharge, which would have been advisable for someone like EE with complex medical comorbidities and as the hospital only supplied two-weeks of medication on discharge.

Provider staff registered EE with a local GP promptly and he was prescribed the medication he required.

7.2.6.6. Guidance on *transition* between inpatient mental health settings and community settings[11] recommends a collaborative, person-centred and suitably paced discharge based on a thorough *assessment* of the individual's social, safety and practical needs, including risk of suicide, a care and crisis *plan* that includes relapse indicators and recommended responses, the involvement of *family* members where appropriate, and frequent and comprehensive *reviews*. Mental health practitioners should respond quickly to requests for assessment from hostel/housing support workers. The panel and independent reviewer have concluded that the thematic analysis demonstrates that this guidance was not fully implemented in EE's case.

7.2.7. Observations regarding *transition* interlink with the process of placement *commissioning*. EE's cousin expressed concern about how the placement had been assessed as suitable. She questioned the provider's fire alarm and fire extinguisher systems and evacuation procedures. She noted the absence of a sprinkler system, mindful presumably of EE's history of fire-raising. She is recorded as suggesting that the support provided was inadequate, with EE requiring more structured accommodation than this provider organisation set up to provide. She noted that EE had difficulty identifying and engaging with meaningful occupation, in orientating himself in his community, and in managing activities of daily living. She believed that EE had been left unsupported regarding meaningful occupation, nutritional support and management of money. One question raised here is the process by which the placement provider was assessed as being suitable. Another question is what the after-care plan (section 117, Mental Health Act 1983) was for EE.

7.2.7.1. The root cause analysis observes that the provider had been used for other NHS Trust patients but this particular accommodation had not been used before by the Care Coordinator's team and the Care Coordinator had no prior knowledge of the provider. It did, however, meet criteria in terms of having 24-hour staff and being able to supervise medication. An application for funding had been considered by the usual CCG/NHS Trust panel on 4th October 2017. As was not unusual, there was no specific discussion of the organisation that would provide the accommodation but the panel agreed that EE's needs could be met in supported living accommodation.

7.2.7.2. However, the provider was chosen by ward staff, particularly the Bed Manager at Springfield Hospital who is not a clinically trained professional, and agreed by the CCG. The Care Coordinator, probably best placed to advise on procuring a placement based on his knowledge of EE over several years, was not consulted and there was no specific policy requirement for such consultation. This is an omission. The Care Coordinator knew how complex EE's needs were and how he could become very difficult to manage when drunk. Apparently "it is unusual for inpatient wards to identify community placements."[12] It remains unclear why this

[11] NICE (2016) Transition between Inpatient Mental Health Settings and Community or Care Home Settings.

[12] South West London and St George's Mental Health NHS Trust

approach was adopted in this instance and why Merton and Wandsworth CCG agreed to spot purchase this placement in this way.

7.2.7.3. The absence of any evidence available for the section 42 enquiry from the NHS Trust casts doubt on whether there was actually any matching exercise before the placement or at any time subsequently. EE's cousin is reported as believing also that EE was not matched with other residents there. The four residents moved in at different times (between 11th August 2017 and 14th December 2017) and were under the care of different Trust teams.[13]

7.2.7.4. This view is supported by the contribution from Merton and Wandsworth CCG. The four residents were placed separately with no reference to each other. This is not good practice. The accommodation was designed to house four residents with shared kitchen and bathroom facilities.

7.2.7.5. In her conversation with the independent reviewer, EE's cousin forcibly expressed concern about this final placement. She stated that six weeks earlier she had been told that EE would require lifelong mental health supervision. She was firmly of the view that he was discharged because the hospital needed the bed.

7.2.7.6. Panel members and the independent reviewer have also expressed concern about the rationale for this transfer. There does not appear to have been an assessment of the appropriateness of placing EE with the other residents already there. Moreover, his previous placement outside Springfield Hospital had been at Cygnet Hospital/Lodge Woking, a high secure rehabilitation facility. He was now being placed in supported living yet his profile of needs and risks had not changed significantly. The provider has described the placement as supported living to support residents to transition to independent living with low level support. It was aimed at people who required minimal support to be fully integrated back into the community. The philosophy was one of promoting independence but with support provided to enable residents to make safe choices, with action taken where necessary to minimise or reduce risk. Two questions immediate arise. Firstly, what detailed risk assessments had been undertaken to determine EE's and FF's suitability for this placement? Secondly, did the provider have sufficient staff with appropriate knowledge and skills?

7.2.7.7. Indeed, on the first question, a risk formulation prepared by the Care Coordinator observes that EE had been unable to sustain independent living due to heavy drinking, poor compliance with medication, his disagreements with medical opinion about his health, and poor self-management. The Care Coordinator also observed that EE remained vulnerable due to his complex mental health condition, exacerbated by hypersensitivity to prescribed antipsychotic medication. This risk formulation calls into question the placement with the provider. Nor have the panel and independent reviewer seen either an assessment that details what had changed in EE's presentation that indicated the appropriateness of a move to supported living, or a risk mitigation plan designed to manage the risks identified by the Care Coordinator.

[13] South West London and St George's Mental Health NHS Trust

7.2.7.8. *Risk assessment* is a crucial component of effective practice. The aforementioned reports prepared by staff at Cygnet Hospital/Lodge in August/September 2017 identified risks of self-neglect, alcohol misuse, disengagement, physical ill-health and violence towards others. The reports express considerable doubts that EE could be managed effectively in the community and recommend his continued detention for "safe management of his healthcare needs."

7.2.7.9. A health and social care assessment dated October 2017, prepared by the Care Coordinator, notes that EE was unreliable with respect to medication management, erratic in his engagement with treatment and "unlikely to cope effectively in a home environment." This assessment concludes that EE required a period of rehabilitation to get better, to understand his condition and to learn new skills of self-management. Assessment of his social care needs identifies need across all ten areas named in the Care Act 2014. Assessment of his healthcare needs identifies medium to high need across all areas, especially mental health monitoring and medication compliance. The Occupational Therapy assessment recommends a need for support to develop routines, skills, accessing the community and identifying occupations and interests. In concluding that a locked rehabilitation environment remained appropriate, it notes the high risk of relapse, of mismanagement of medication, financial mismanagement and risk to others.

7.2.7.10. It is difficult to understand what had changed by 27th November when Morden Recovery and Support team appear to have concluded that EE did not need to be managed in an acute psychiatric setting. It is unclear how a recommendation had been taken forward from the Team to the Care Coordinator on 22nd November that an out of borough placement be explored. Equally, when detention under section 3 (Mental Health Act 1983) was discharged on 20th November, it is unclear what on-going support was to be provided by the Care Coordinator. Despite requests, the independent reviewer has not seen a section 117 after- care plan or any document that details arrangements to mitigate the risk of relapse.

7.2.7.11. Moreover, it appears that any assessment of EE's suitability for the placement involving this provider organisation was undertaken during his initial week's leave from Hospital there and no documentation has been seen regarding how the CCG, as the placement commissioner, or the NHS Trust responsible for Springfield Hospital, assessed the suitability of the placement as having a reasonable chance of meeting his needs. It does not appear that provider staff met EE before he began his initial week there although a representative of the provider met him in hospital when he was still an in-patient following the referral by the NHS Trust on 17th October.

7.2.7.12. EE's cousin is reported as holding the view that the placement was unsuitable. The panel and independent reviewer understand that there was only one carer on duty for the residents, that there was no structure or routine, and that there were no activities to keep EE and others engaged. Indeed, family members have described how they had to drive EE around the area to orientate EE to the area, to locate shops for him and to identify transport links. In the immediate vicinity there was access to only one corner shop and a public house. Given EE's needs profile, including diabetes, breathing problems and need for active engagement, the panel and independent reviewer question placement suitability.

7.2.7.13. EE's cousin told the independent reviewer that, in her view, the location of the placement was inappropriate. There was nowhere for EE to go. She described it as "a desolate place to live."

7.2.7.14. The provider has stated that key working sessions and resident meetings were offered, together with support for meal preparation, daily living skills and medical appointments. No other support to promote different areas of EE's wellbeing appears to have been provided, either by the provider or by the Care Coordinator. For someone with EE's needs, the question arises as to whether this was sufficient and adequate?

7.2.7.15. The provider has also stated that staff had the skills to support residents, including EE. It is difficult to see, in the time and contact available before the placement was confirmed, how this judgement was reached. Staff may have had training relating to fire risk, smoking, health and safety, de-escalation techniques and recognition of changes of behaviour, as stated by the provider, but it is unclear whether and how this level of training was assessed as enabling staff to manage someone like EE with complex needs.

7.2.7.16. EE's cousin in her conversation with the independent reviewer was firmly of the view that staff had not been appropriately trained for meeting the needs and managing the risks presented by EE. She believed that staff may have been frightened. She attributed the placement to resource shortage.

7.2.8. Another key line of enquiry is what information was shared with the provider organisation when EE was admitted. Effective practice with adults who self-neglect and other adults at risk requires comprehensive *risk assessments*. One known risk in EE's case was suicidal ideation, perhaps associated with *loss* of his family in Zambia. Other risks related to fire and fluctuating mental health. It is unclear how these risks were factored into risk assessments and what the care plan was to address them. It is unclear whether in structured work with EE any attempt was made to work with the losses he had experienced in his life.

7.2.8.1. The root cause analysis states that EE's detailed history was contained in the referral to Merton and Wandsworth CCG responsible for approving the placement and agreeing the funding for it. However, it also records that historical information from a September 2016 risk assessment was not integrated into the risk assessment in November 2017, such that no evidence then is recorded about his history of relapses, often foreshadowed by drinking and aggressive behaviour, and of fire-setting.

7.2.8.2. However, the root cause analysis also notes approvingly that the final risk assessment completed by the Morden Recovery and Support Team Care Coordinator was of high quality, having included relevant information. Indeed, the independent reviewer has seen the health and social care assessment, dated October 2017[14]. It is a thorough assessment of need and

[14] See section 7.2.7.9.

risk. It is difficult to discern, however, how this risk assessment was used in decision-making about EE's final placement and any after-care (section 117 Mental Health Act 1983) planning.

7.2.8.3. The information collated for the section 42 enquiry found that the risk assessment completed by the Care Coordinator dated 28th December 2017 did not mention the risk of arson, although there is reference to the history of fire setting in Zambia, and the risk of self-harm was recorded as low. Whilst the risk of fire setting might have been low in a ward environment, the change of placement does not seem to have prompted a review of this particular risk. The risk assessment does, however, record evidence of harm to others when EE was living in Zambia and also during his hospital stays. It records as low to moderate the risks associated with alcohol abuse and his attitudes towards his own health. It records as medium evidence of physical health risks, involving latent TB, diabetes and neuro-malignant syndrome. The risk assessment notes that EE had been unable to sustain independent living because of heavy drinking, poor medication compliance, his attitude towards his health and poor self-management. He is assessed as a moderate risk.

7.2.8.4. This risk assessment continues a trend that can also be observed in a report prepared by a Nurse for a Mental Health Review Tribunal in September 2017. There is passing reference to arson associated with events in Zambia but more historical detail is given to the historical background of risks associated with suicidal behaviour, absconding, bullying, physical violence and alcohol misuse. In all respects, when this report was prepared, no current risks were identified. EE was engaging with peers and staff, had positive contact with relatives and was complying with escorted section 17 (Mental Health Act 1983) leave. However, this report acknowledges his history of hospital admissions due to non-engagement with community teams and non-compliance with treatment. It records a history of challenging behaviour, including assaults, sexual misconduct and exploitation of vulnerable patients. It recommends that EE remain an inpatient on a locked rehabilitation ward, with use of escorted section 17 leave to gradually promote his independence by moving towards unescorted leave, and with psychoeducation to develop EE's insight into his mental illness and the importance of compliance with treatment.

7.2.8.5. A Care Act assessment for EE dated April 2016 had not been updated, which would have been appropriate especially on hospital discharge, although an addendum was added by the Care Coordinator on 23rd October 2017. The interface between the Mental Health Act 1983, especially section 117 after-care, and the Care Act 2014, especially section 9 assessment of care and support needs, will be further addressed below under *legal literacy*.

7.2.8.6. Risk assessment should be accompanied by a risk mitigation plan. The medical review in December 2017 by Morden Recovery and Support Team concluded that risks were moderate, specifically relating to alcohol misuse and the likelihood that EE would stop taking medication and/or experience relapse. The plan was for provider staff to make immediate contact with the Care Coordinator if EE showed signs of relapse but in the event it appears that this was not followed since EE's behaviour, indicative of relapse, had been deteriorating over a period of time.

7.2.8.7. The supported living provider has commented that the NHS Trust provided a risk assessment referral form and a medical report on the progress EE had made. The provider has stated that this did not identify the risk of fire or suicide as a concern. The risk of his drinking heavily was clearly identified. Smoking and alcohol were therefore included, according to the provider, in a risk assessment and support plan. No smoking or alcohol was allowed inside the building. Staff were required to monitor this. Police, the GP, the Care Coordinator and Emergency Services were to be called if and when EE was not engaging with the care plan and/or there were signs of relapse. However, it appears that there were signs of relapse in the days before 28th February which were not flagged to the GP or Care Coordinator. Thus, one conclusion is that the risk mitigation and management plans were not followed through.

7.2.9. Another feature of effective work with adults who self-neglect and/or who have complex health, housing and social care needs is *thorough care planning and reviews*.

7.2.9.1. EE's final placement was initially reviewed approximately one month after its commencement. The plan was then to review it between every six and twelve months. The root cause analysis questions the appropriateness of this time gap given EE's needs as expressed in the care plan and his patient journey. It was however in line with the NHS Trust's procedure for patients with EE's diagnostic cluster.

7.2.9.2. It is also critical of the absence of a specific timescale for reviewing EE continuing on Sertraline[15] medication following the medical review in December 2017. However, it writes approvingly of the advice given by the reviewing Doctor to EE with regards to visiting his GP for diabetes checks.

7.2.9.3. It has already been observed that EE had complex medical comorbidities. The observation regarding Sertraline, when considered especially against his other known mental and physical health issues, raises the question of how he was treated as a whole person, with equivalence given to his physical and mental health wellbeing, sometimes referred to as parity of esteem.

7.2.9.4. Merton and Wandsworth CCG confirm that, following EE's placement, there were two home visits and two telephone calls between the Care Coordinator for the Mental Health Trust and the provider, alongside one CPA review in December. The Mental Health NHS Trust root cause analysis confirms that the Care Coordinator did not book a follow-up appointment for EE after 28th December 2017, when EE attended a medical review with a Junior Doctor and his Care Coordinator, and has recognised this as "learning".[16] The panel and independent reviewer seriously question whether that level of contact, to ensure that standards were being maintained and the placement meeting EE's needs, was sufficient.

7.2.9.5. The independent reviewer has read an undated care and support plan prepared for EE's final placement. The risk of heavy drinking is clearly detailed, with the plan being for the care

[15] An anti-depressant that in diabetic patients can make it more difficult to keep blood sugar stable. Patients who develop thoughts of harming themselves are advised to consult a GP immediately.

[16] South West London and St George's Mental Health NHS Trust

provider to alert the Care Coordinator if this risk materialised. The aim of maintaining EE's stable mental health and promoting his recovery and safety was to be supported by the care provider feeding back to the Care Coordinator on the outcome of daily monitoring, with the Care Coordinator visiting every four weeks or as agreed to check progress, which as is known did not happen, and liaising with EE's cousin. EE would be registered with a GP for routine health checks and escorted to appointments by care provider staff, who would also ensure that he took his medication and notify the Care Coordinator of any missed doses. There is no reference to fire risk in this care and support plan.

7.2.9.6. A glimpse into EE's feelings is evident through this care and support plan and in the minutes of the meeting held on 20th November 2017 to review the trial placement (section 5.8.3). In the section on abiding by tenancy rules, he is recorded as saying that the home was "very far from public transport." His cousin, as noted earlier, has also questioned the appropriateness of the location of the placement. In the section on medication, EE is recorded as saying it was "a lot to take." EE is also recorded as having said to the Care Coordinator on 11th December that he was happier at Cygnet Hospital/Lodge as "staff did things he enjoyed." It is not clear from the plan what weight, if any, was given to these expressed views or how it was modified to address EE's concerns. It is hard to discern what ongoing support, as recorded in the plan arising from the 20th November meeting, was actually provided by the Care Coordinator and the placement.

7.3. <u>Practice of the team around EE</u>

7.3.1. The Police demonstrated *safeguarding literacy* in June 2014 by sending to ASC a MERLIN[17] following investigation when Hillingdon Hospital reported that EE was missing. MPS in their management report for this review have observed that further MERLINS could have been submitted for at least some of the sixteen occasions when EE contacted them in June and July 2014 alleging that he was being held against his will and was physically unwell.

7.3.1.1. MPS submitted a further MERLIN after they had attended the MHA 1983 assessment on 30th December 2015. The MPS management report refers to five MERLINS having been submitted to Merton ASC between 6th July 2016 and 20th October 2016, when EE had been reported missing or as making contact with a young female minor via social media, or when he had himself alleged assaults or being threatened, or when his cousin had voiced concerns for his welfare. Merton ASC has no records relating to EE. This discrepancy highlights the importance of clear *referral pathways*, accurate *recording*, and *following-up* on referrals that have been sent.

7.3.1.2. The MPS management report refers to three further MERLIN submissions, this time to Sutton ASC. On one occasion this followed a report that he was missing. On the other two occasions EE had alleged theft and threats of assault or items being removed by staff from his room.

[17] A process for notification of concern regarding vulnerability of an adult at risk

7.3.2. On *working together*, none of the MERLINS submitted by MPS regarding EE appear to have triggered an adult safeguarding enquiry or any form of multi-agency response. No liaison has been reported between either Merton or Sutton ASC and the responsible CCG or Mental Health NHS Trust following these notifications of concern, or between Merton and Sutton ASC. It does not appear that Sutton ASC, on receipt of the three final MERLINS from MPS, conducted any kind of enquiry relating to the placement provider and the people placed there, or contacted Merton and Wandsworth CCG and Merton ASC to share information and to agree a response. Sutton ASC records for the first MERLIN, dated 20th February 2018, note that matters were to be resolved at a house meeting. This Police referral followed allegations by EE of fraudulent use of his bank card. A worker spoke to EE who indicated that a house meeting had been arranged. The second MERLIN, sent on 23rd February 2018, was only entered on to MOSAIC on 1st March, to be passed to the Community Mental Health Team. The third MERLIN arrived in Sutton ASC on 5th March. Thus, the final two MERLINS were considered after EE had died. This sequence raises questions about *referral pathways, timeliness of risk assessment, follow-up* and *recording*.

7.3.2.1. Sutton ASC records has three entries regarding FF, two relating to MERLINS (10th January and 14th February 2018) and one a referral from St Helier Hospital (27th December 2017). The referral from the Hospital related to an overdose. It was judged that the accommodation provider took appropriate action, calling an ambulance, replacing the medicine cabinet and updating FF's risk assessment and management plan. It was unclear however whether the medicine cabinet had been left open or had been forced. The first MERLIN was sent to the Mental Health Trust for attention and followed conveyance to hospital by ambulance as FF had a gash to his head following head banging. A contingency plan was advised regarding FF having difficulty sleeping. The second MERLIN followed FF not returning to his placement. He was found and returned by Police. The Sutton ASC record indicates that the MERLIN was to be sent to Merton and Wandsworth CCG but no checks appear to have been made regarding whether this care provider location was known to Sutton ASC.

7.3.2.2. Similarly, on *working together*, the Care Coordinator was not involved in the selection of the provider organisation as the placement provider. As confirmed by Merton and Wandsworth CCG, the decision to place EE with the provider was taken by the Ward Team and Discharge Coordinator and he was sent on one week's trial leave. After the week's trial leave a review meeting was held on the hospital ward but the key worker/manager from the provider organisation had left the meeting before the Care Coordinator arrived. They subsequently discussed handover by telephone. In light of EE's complex needs and the known outcomes from previous placements, the panel and independent reviewer question whether this approach was adequate. A proper handover only took place after EE's formal placement had begun, with staff advised to alert the Care Coordinator immediately if EE began to drink and to call the emergency services if he lost control.

7.3.2.3. When the Police returned EE to his accommodation on the night of 28th February, they provided him with a lighter so that he could smoke outside. They may not have been aware that lighters are a contraband item in the home. They may also not have been aware of his past suicidal ideation and the mental health relapse indicators.

7.3.2.4. The placement provider, reflecting on lessons to be learned from EE's death, acknowledges the need for improved communication with the agencies involved. There does appear to have been a delay in communicating signs of relapse with the Care Coordinator, GP and CCG commissioners.

7.3.3. On *information-sharing*, the root cause analysis report concludes that it is unclear which staff in the placement setting knew of EE's history of fire setting and whether the placement manager was fully aware of his risk history. At the November 2017 hospital discharge meeting, at which the accommodation manager had been present, the specific risks associated with relapse are not recorded.

7.3.4. On *recording*, the root cause analysis found that multi-disciplinary meeting discussions regarding transfer of EE's care to his final placement provider were not recorded in the clinical record. It also observes that historical information from September 2016 regarding *risk assessment* had not been pulled through into a November 2017 risk assessment, which omitted this evidence regarding his relapse and fire-setting *history*. A multi-disciplinary team meeting discussion in early January 2018 has not been documented.

7.3.4.1. As the root cause analysis concludes, staff must ensure that historical risks are kept in a current risk summary. All multi-disciplinary team discussions must be recorded in patient notes. In addition, IT recording systems in use must enable practitioners to track patterns and risks in a case.

7.3.4.2. In November 2017 the discharge summary was sent to his old GP and contained both an old address and information regarding another patient. Clearly his patient record was out-of-date. The breach of data security regarding another patient clearly underlines the importance of *legal literacy* regarding data protection.

7.3.4.3. As identified above, not all MERLINS recorded as submitted by MPS appear to have been received, recorded and/or actioned in a timely way, perhaps because of workload pressures.

7.3.5. Another feature of how the team surrounding the person practises relates to *commissioning* and *contract monitoring*. In fact, by the time of EE's death, the contract had not been signed for this placement as the provider had not provided all the documentation required for due diligence. Contracting discussions had therefore not been concluded.

7.3.5.1. Indeed, Merton and Wandsworth CCG confirm that the contract for the placement was subject to prolonged negotiation. At the time of the fire, the process had not been concluded.

7.3.5.2. No local authority or CCG took responsibility for quality assurance of this placement and provider.

7.3.5.3. One feature of any placement decision and review, alongside whether the placement staff have the capacity and capability of meeting the individual's needs, should be the fit with the

other residents. From the time of EE's final placement there were incidents involving other residents, one of whom sustained hand burns and smoke inhalation in the fire, from which he recovered. The root cause analysis concludes that for any placement the mix of people housed should be considered and this does indeed represent best practice. It did not happen in this instance.

7.3.5.4. The root cause analysis also concludes that the Care Coordinator should be engaged in and responsible for making placement recommendations, which did not happen in this case. This conclusion also represents best practice.

7.3.6. On *use of policies and procedures*, the root cause analysis report comments approvingly that the Morden Recovery and Support Team followed NHS Trust policy in conducting a seven-day follow-up of the final placement, which was done face-to-face even though it was in accommodation out of area. The report also observes that this *review* is very well *recorded*.

7.3.6.1. Similarly, in line with NHS Trust standards, the Care Coordinator responded to a call on 28th February from provider staff for a review by replying on 1st March and planning a visit on 6th March. However, knowing the mental health relapse indicators, was this call a missed opportunity to act more swiftly? It appears that EE had been well up to the week before. Then he had begun to drink heavily and to challenge the rules set for living in the accommodation. Knowledge of his *history* would have indicated that these were indicators of possible relapse and, indeed, the placement provider had apparently been told to contact a Doctor in the event that these indicators re-emerged.

7.3.6.2. The Care Coordinator did not book a visit to monitor EE at the December 2017 review and did not in fact see him between then and his death. This was not in accordance with NHS Trust procedures. The NHS Trust policy of zoning patients according to the level of risk and need might have been a contributing factor here, as EE was zoned as "green". It might be appropriate to reconsider how the different zones are codified.

7.3.6.3. Another component on the use of policies and procedures relates to out of area placements. Local authorities and CCGs have received practice guidance[18] with which they should be conversant on notifying "receiving areas" of out of authority placements. The guidance does not appear to have been followed at any point in the period under review in this case.

7.3.7. On *legal literacy*, the combined chronology notes that section 3, Mental Health Act 1983, was rescinded on 20th November 2017. EE would have been eligible for a section 117 after-care plan but neither the chronology, root cause analysis nor responses from the Mental Health Trust make reference to this. After-care planning is a joint duty on health and social care services to meet any needs arising from mental disorder and to reduce the risk of deterioration. Provision can include employment services, supported accommodation and

[18] NHS England (2012) National Protocol for Notification of NHS Out of Area Placements for Individual Packages of Care (including Continuing Healthcare). ADASS (2016) Out-of-Area Safeguarding Adults Arrangements: Guidance for Inter-Authority Safeguarding Adults Enquiry and Protection Arrangements.

services to meet social need (section 75, Care Act 2014). EE's *transition* from hospital to the community represents an important interface between the Mental Health Act 1983 and the Care Act 2014, where Adult Social Care, CCG and NHS Trusts, alongside housing providers, can work together to provide person-centred care and support.[19] Policy guidance advises integrated assessment and a multi-disciplinary approach under the direction of a Care Coordinator.[20] This does not appear to have happened in this case.

7.3.7.1. The panel and independent reviewer have concluded that opportunities were missed in EE's case to use Care Act 2014 duties to promote wellbeing and through the provision of care and support interventions to encourage his participation in work, education, training and/or recreation, to enhance his physical, mental health and emotional wellbeing, to aid his recovery and prevent the known risks of people being detained more than once in any calendar year because of shortcomings in care and support.[21]

7.4. Organisations around the team

7.4.1. On *support*, Morden Recovery and Support Team practitioners reported that they felt well supported by line managers. The provider's staff had apparently received training that included recognition of changes in people's behaviour. However, there was a delay in reporting changes in EE's behaviour during later February 2018, which raises questions as to the adequacy of on-going supervision of staff.

7.4.2. On *workforce and workplace issues*, the Care Coordinator had a "heavy workload" that may have contributed to the oversight in not making arrangements to visit EE to monitor and review his progress after the review at the end of December 2017[22].

7.4.3. On *commissioning* and *management oversight* of provision, submission to this review by the provider has indicated that, subsequent to a fire risk assessment that identified the absence of a fire alarm system except smoke alarms, fire-fighting equipment was made available in hallways and kitchen areas. It believed that, in aiming to minimise fire risk, it was using adequate fire prevention and risk assessment techniques.

7.4.3.1. The provider has stated that it had applied for a license for the property as a house of multiple occupation and has commented that requirements are not clearly defined. London Fire Brigade, however, has observed that, although the provider had stated that annual visits would be carried out by LFB, the service had had no involvement with the premises or the provider prior to the incident and, as far as LFB was aware, the accommodation was a single private dwelling.

[19] Department of Health (2015) Mental Health Act 1983 Code of Practice

[20] Department of Health and Social Care (2018) Care and Support Statutory Guidance: Issued under the Care Act 2014

[21] CQC (2018) Monitoring the Mental Health Act in 2016/17

[22] South West London and St George's Mental Health NHS Trust root cause analysis.

7.4.3.2. The provider has supplied an undated basic emergency action plan in the event of fire and a more detailed but undated fire safety policy that covers action required in response to fire, a fire risk assessment protocol that itemises daily and weekly checks, and staff training. A dated no smoking policy has also been provided. The provider has acknowledged that in future regular reviews must be undertaken to ensure that all relevant checks, including fire drills and fire safety checks, are carried out. It has stated that audits are now in place to ensure that systems and procedures are used, including reviews and feedback on residents.

7.4.3.3. The root cause analysis has concluded that CCG funding panels, NHS Trusts and Care Coordinators must have sound knowledge of potential providers and as part of the placement process should consider the mix of people housed within the placement. This did not happen in this instance and there were gaps in evaluating the suitability of this service provider.[23]

7.4.3.4. The root cause analysis has also concluded that the CCG approving panel should quality assure decision-making regarding placement recommendations. The panel and independent reviewer would go further by stating, in addition, that funding panels should also review the effectiveness of the care and support that has been purchased.

7.4.3.5. EE's cousin in conversation with the independent reviewer was of the opinion that the placement was unsafe, not least because of inadequate inspection of fire safety arrangements. London Fire Brigade are continuing with their investigation into the adequacy of the arrangements made for fire safety.

7.4.3.6. EE's cousin also stated her belief that there were "huge" and longstanding "issues" at Springfield Hospital and she observed also the impact of reduced funding for mental health services.

8. **Cross-Case Analysis of Other Fire Deaths**

8.1. When the SAR regarding EE was commissioned, Sutton SAB decided that the statutory criteria for commissioning a SAR on another fire death and two incidents where service users had survived a blaze were not met. Nonetheless, the SAB requested that a desk-top file analysis be conducted of these cases.

8.2. At the fire in which EE died, another resident, FF, was injured. FF was placed with this provider at the same time as EE. FF was born in February 1988 and information for this SAR has been obtained from records supplied by South West London and St George's Mental Health NHS Trust. There are references in the records to adverse childhood experiences and child protection concerns. There are references to a history of self-harm, harmful drug misuse, mental health admissions and ambivalence about medication dating from 2005. The psychiatric diagnosis is recorded as schizophrenia and drug-induced psychosis.

[23] South West London and St George's Mental Health NHS Trust

8.2.1. For the purposes of this SAR, the sequence begins with FF's admission to a psychiatric ward under section 2 (Mental Health Act 1983) on 7th April 2017. He applied to the Mental Health Review Tribunal on 20th April. He was discharged on 27th April and referred to the Merton Home Treatment Team. He has his own tenancy at this time. Risks were assessed at the time and noted as liable to change, especially those relating to harm to others and alcohol/drug misuse. The April 2017 risk assessment has been updated since then, in March 2018 and March 2019.

8.2.2. FF was formally detained again under the Mental Health Act 1983 in June 2017. Threatening behaviour was again involved in the circumstances surrounding this admission. The independent reviewer has read a very detailed Occupational Therapy report prepared in September 2017 regarding whether FF could sustain independent living. The independent reviewer has also read an undated health and social care assessment prepared, it seems, as part of the proposals for FF to live in supported accommodation. This assessment records that FF does not have any eligible needs as codified in the Care Act 2014 but that he did have needs surrounding access to specialist services, mental health monitoring and compliance with medication. Risks were recorded concerning violence towards and from others. He was assessed as lacking capacity to resist illicit drug use.

8.2.3. The independent reviewer has not seen any documentation that explains how the decision was reached to place FF with the same care provider as EE. There does not appear to have been any consideration as to the appropriateness of placing the residents together.

8.2.4. The independent reviewer has had access to documentation that indicates that FF had settled well by December 2017 but that his Care Coordinator should work with him on motivation and accessing community and occupational activities.

8.2.5. Records after the fire note its impact on FF's mental and physical health, and his social needs. The records suggest that it cannot be ruled out that FF did not contribute to the fire and there is one reference to his having been expelled from school after setting a fire. Risk assessments since the fire conclude that there are very high risks from others, towards others, illicit substance misuse, accidental risks, mental health relapse and poor physical health due to smoke inhalation and burns. Nonetheless reviews record that he is engaging with mental health practitioners.

8.3. The records held by Sutton Adult Social Care and by Sutton Community Health Services (provided by Royal Marsden NHS Foundation Trust), the latter responsible for meeting his healthcare needs, have been examined relating to the case of GG, who died aged 81 at the beginning of January 2018 following a fire at his home address on 30th December 2017. This was thought to have been caused by either a cigarette or lighter fuel having impregnated his clothes although it has not been possible to determine the precise cause. The Coroner did not issue any Regulation 28 notices with respect to this death.

8.3.1. GG, who is recorded as white within the case file, suffered from Parkinson's disease and moderate level dementia. He had limited mobility. He is described in Adult Social Care records as forgetful and anxious. A care package had been in place since March 2016,

initially for two visits a day but increased to four in June 2016. GG had personal care needs and required assistance with activities of daily living. His care package was reviewed, as required in law, in October 2016 and again in October 2017. Internal adaptations to his social housing property had been made in October 2017 in order to assist with his mobility. There are records relating to Occupational Therapy assessment and support dated December 2017.

8.3.2. Following expression of concern by relatives, a safeguarding enquiry was conducted by Adult Social Care into the care being provided by the care providers. GG's dogs were apparently defecating on the floor, GG himself was reported as not always wearing incontinence pads and as urinating on the floor. He was reported as sometimes refusing care and being non-compliant with arrangements in place to ensure that he took his medication appropriately. On occasion he could be angry and aggressive towards his carers. Poor record keeping by the carers was substantiated and the care provider acknowledged unacceptable service provision and warned staff accordingly.

8.3.3. Adult Social Care records indicate concerns about GG's non-compliance with arrangements to ensure he took his medication appropriately from May 2017. The care provider expressed concern about the state of his property on several occasions in July, September and October 2017. Carers called an ambulance in August and September 2017 because of concerns about his health. The care plan does not appear to have been revisited because of these episodes. This case therefore raises an issue about the safety of the practice of closing cases once a care package has been arranged pending review. This issue has been foregrounded in a number of SARs (Preston-Shoot, 2019[24]). Systems must be in place to recognise and respond to increasing risks surrounding a care package without waiting for the next annual review. There are parallels here with EE's case in respect of the root cause analysis and this review questioning the wisdom of relying on annual reviews in a case involving complex needs, historical repeating patterns and comorbidities.

8.3.4. Focusing on the reviews there is no mention in either the October 2016 or October 2017 reviews to GG's smoking and to fire safety as a risk. In the care provider's own assessment in June 2016 the risk from animals is mentioned and assessed as low. There is no mention of fire risk. A care and support plan, which is not dated but which appears to have been prepared for a reassessment scheduled for June 2017, has assessed GG as able to manage his toilet needs but experiencing difficulty with mobilising, vulnerable to falls, and requiring assistance with activities of daily living. There is no reference to smoking and fire risk, despite his Parkinson's disease and dementia. Adult Social Care records imply that it may also have been the case that he was being treated with emollient creams. The significance of this relating to smoking and fire risk is not highlighted.

8.3.5. A fire safety check was requested at the end of October 2017 but it is unclear from the Adult Social Care records whether this was done before he died.

[24] Preston-Shoot, M. (2019) 'Self-neglect and Safeguarding Adult Reviews: Towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection* (forthcoming).

8.3.6. Following the fire the Police sent a MERLIN to Adult Social Care. A safeguarding enquiry was conducted which found that there had not been any reference to smoking and fire safety risks. Whilst he did not present as a "dangerous smoker", there had been evidence of burn marks on his clothes and his Parkinson's disease should have prompted assessment of the risk of harm as a result of shaking. The enquiry notes that GG's relatives thought that he was at a greater risk of falls and also observed that care provider staff had received health and safety training that included fire safety. Nonetheless, communication between care provider and commissioners could have been more comprehensive.

8.3.7. The housing provider has responded with action plans that cover home fire safety referrals, tenancy audits, liaison with London Fire Brigade and portable mist systems.

8.3.8. There do not appear to have been any multi-agency meetings that focused on information-sharing regarding known risks and aimed to agree a risk mitigation plan. This is an omission where there is a likelihood of risks arising again, which would be significant if they were to occur.

8.3.9. Much of the above is echoed in the records of community health services provision held by Sutton Community Health Services (provided by Royal Marsden NHS Foundation Trust). From January 2017 until his death, GG was visited at different times by District Nurses, Podiatrists, Dieticians and Incontinence Nurses. During some of these visits one of GG's relatives was present, mainly his grandson but also his nephew. Indeed, the NHS Trust records indicate that some refusals of care were because he preferred personal care to be provided by his relatives, who assisted him with taking baths for instance. He is recorded as not liking carers to touch him.

8.3.10. On some visits GG was noted to be incontinent of urine and/or faeces. Variations in alertness and orientation are also recorded but no mental capacity assessment appears to have been done on these occasions.

8.3.11. There are references to GPs requesting urgent District Nurse visits and assessments, and these were responded to in a timely manner. The records do not indicate what feedback was given to the GPs and how this affected the overall response of primary care. These visits were often prompted by tissue viability concerns, with the ordering of equipment, advice to GG and treatment being given before District Nurses closed down their involvement. Given the evidence of self-neglect, especially intermittent compliance with advice and treatment, and a recurring pattern of tissue viability issues and GP referrals, his case might have been kept open[25]. Indeed, at times, GG is noted to have been impatient and verbally aggressive, and to have declined examination. At times he is recorded as having been unkempt, dirty and wearing malodorous clothes.

[25] On at least one occasion his case was closed by the incontinence service even though there was a pattern of

incontinence of urine and/or faeces.

8.3.12. As also noted in Adult Social Care records, home care staff had advised that sometimes GG allowed them to provide him with some care but generally he declined personal care, such as changing his incontinence pads. His grandson is recorded as confirming this, and as agreeing that GG could be "difficult." There is nothing to suggest that his self-neglect, the difficulties of home care staff implementing the care and support plan, and GG's reluctance to act on the advice from healthcare staff about, for instance, sleeping in his bed, triggered any consideration of a multi-agency risk management meeting or a notification of concern to adult safeguarding. Rather, each service did what it could, for instance cutting and cleaning his toenails when these were long, dirty and discoloured, or applying creams to his Category 2 pressure sores. This is an omission. When neither the nephew nor the grandson were present, there is evidence that healthcare staff sought to update GG's relatives and to organise joint visits, which is good practice. There is also evidence of healthcare staff sharing information with the agency commissioned to provide personal and home care, and of healthcare staff responding in a timely way to concerns expressed by carers, which again is good practice.

8.3.13. Throughout 2017, therefore, the pattern of healthcare staff involvement continues. Pressure areas are checked. Sometimes there were open wounds which were treated; sometimes there were no open wounds. Advice was given about using his bed and the need for padding for his feet but this advice was sometimes rejected. Towards the end of December the records note that carpets were squalid and that his relatives were trying to support GG in difficult circumstances. The records then fail to give any indication as to whether referral for a carer's assessment was considered and no notification of concern was sent to adult safeguarding or escalation of concern to Adult Social Care, which had commissioned a care and support plan. GG continued to reject advice about self-care and to decline some personal care.

8.3.14. Sutton Community Health Services (provided by Royal Marsden NHS Foundation Trust) made available to the independent reviewer an internal single agency learning review. It is critical of the omissions to consider self-neglect as a significant risk and to share information about the risks that were apparent. It observes that smoking was not recognised as a risk factor and therefore this did not prompt a fire home safety visit. It observes too that there is no record of fire risks being considered, for instance because of the use of emollient creams. Although the amounts of cream being used on individual visits were small, and not all creams being used were paraffin-based and therefore carried a fire risk, the possible build-up of cream on GG's clothes was not appreciated. Therefore the use of the creams was not recognised as a fire hazard and the review notes that Sutton CCG did not advise patients about the risks of creams when associated with smoking although Merton CCG had provided such guidance. The learning review concludes that there were missed opportunities to promote fire safety. An action plan, comprising training and strengthening of procedures has been put in place.

8.3.15. The panel and independent reviewer would add to this analysis by recommending review of when healthcare staff escalate concerns about self-neglect and/or consider convening or requesting multi-agency risk management meetings, and review of when such cases might prompt mental capacity assessments. It would be good practice in future for records to

indicate when healthcare staff discuss candidly with patients the risks that they perceive to the individual themselves and to others, and how the person's responses inform their assessment of risk and mental capacity.

8.4. The final case relates to HH who survived a fire at his second floor flat in an extra care sheltered accommodation in April 2018. On-site support was available throughout the week and he had moved in with three hours of care support in late December 2017. He was 67 at the time of the fire. The file records his ethnicity as white.

8.4.1. HH is a heavy smoker and staff had observed previous fires in his flat. He had a history of refusing to comply with requests from staff about smoking safety. He did not always engage with staff and could be verbally aggressive towards other residents. The smoking related fire that began in his flat placed his life in danger and caused danger and distress to other residents. It rendered his flat uninhabitable and he was placed as an interim measure in a nursing home where his smoking could be monitored. A referral for an advocate was made in order to assist HH to explore his future options.

8.4.2. Following receipt of a MERLIN, a full safeguarding investigation was conducted. Among the salient facts to emerge, a fire involving HH at a previous property was known to London Fire Brigade but may not have been known more widely. It does not appear to have featured in risk assessment and decision-making regarding his placement in extra care sheltered accommodation and there does not appear to have been reconsideration of this placement, or review of other options, when he was non-compliant with smoking rules. He was known to fall asleep while smoking and he had been diagnosed with personality disorder and memory retention issues. As with the case of EE, it is unclear what detailed assessment took place of HH's suitability for extra care sheltered accommodation and what consideration was given to matching with other residents.

8.4.3. HH had been provided with a fire bucket and there was an integrated smoke/fire alarm and intercom system. There was no sprinkler system. Prior to the incident smoking and fire risk had been discussed by staff with him. London Fire Brigade had completed a fire safety check and had not requested any changes to arrangements. A fire risk assessment was in place and fire retardant equipment had been requested. Adult Social Care had agreed to fund a sprinkler system. Nonetheless, the adult safeguarding enquiry concluded that the flat was not suitable for his needs as HH required close monitoring.

8.4.4. The records contain minutes of four meetings of professionals to determine whether HH could eventually return to his flat. In favour of a return it is noted that his flat had been well maintained prior to the fire and there was no evidence of cigarette butts everywhere. He had cooperated and worked well with carers. However, other residents were anxious about his return and there were expressed concerns about on-going risks. In November 2018 his flat was still uninhabitable and he was served with an eviction notice.

8.4.5. The care and support plan completed after the fire observes, in relation to eligible needs (Care Act 2014) that HH could only manage his nutrition and hygiene with difficulty, and that

he could make use of his home safely only with difficulty. His self-neglect was evident in his often unkempt presentation and poor home conditions. His accommodation had been deep cleaned on three occasions since 2015 but HH had been unable to maintain the cleanliness of his property. The RSPCA had removed pets in 2015. Although angry at the removal of animals, persistence and help with his welfare benefits had enabled trust to be built and he had accepted some help from Adult Social Care staff. Nonetheless, the care and support plan records HH as having limited insight and needing prompting to manage his diabetes and personal needs.

8.4.6. Adult Social Care records contain acknowledgement of lessons learned, namely the need to assess people more rigorously, to consider the appropriateness of referrals for extra care sheltered accommodation, and to respond when there are difficulties of enforcing rules regarding smoking.

8.5. In summary, whilst there are differences in how the fires originated and their outcome, there are some striking similarities between the cases of the people involved. EE had a history relating to mental health, alcohol misuse and fire risk. HH had a profile including mental health, smoking related fire risks and self-neglect. GG's history included smoking risks, use of inflammable emollient creams, and concerns about risks arising from dis-engagement and self-neglect. There was a reliance on reviews to monitor placements and on care providers to alert other agencies in the event of relapse or non-engagement and non-compliance. For individuals with complex needs, risk-taking behaviours and repetitive histories, this reliance is inadvisable. In three of the four cases, there does not appear to have been any matching of residents or detailed consideration of the suitability of placements, perhaps reflecting market strain. Agency staff may have liaised, particularly at times of heightened concern, but the absence of multi-agency risk management meetings is noteworthy across these cases.

9. Triangulation of Evidence from Safeguarding Adult Reviews

9.1. Other SARs illustrate that the findings of this review are not unique. Thus, whilst most of the recommendations arising from the findings will be addressed to Sutton SAB to take forward within its partnership arrangements, the SAB and its statutory and non-statutory partners might, with other regional and national networks, seek to promote a national debate on the enablers and the barriers to meeting the standards within the evidence-base outlined in section 6 and note 24 above.

9.2. Lack of familiarity and/or failure to follow guidance for Local Authorities and CCGs when arranging placements across boundaries[26] has been found in other SARs, for example Adult A (East Sussex SAB). A national review of this guidance would be timely since currently it is advisory rather than having mandatory force.

9.3. The importance of thorough and regularly reviewed risk assessments, including of cases involving fire risk, has been emphasised in SARs. One example is WWF (Wandsworth SAB). Risk

[26] See note 18

assessment tools and guidance on care and support needs assessments and reviews must draw to the attention of assessors and reviewers a requirement to focus on the likelihood and potential significance of fire-related risks, for example from smoking. Multi-agency risk management meetings are advisable to coordinate information and intervention via a risk mitigation plan. Other SARs[27] have also questioned the advisability of closing cases pending review where risks of dis-engagement and non-compliance are likely and potentially significant.

9.4. Other examples include Mr BC (City of London and Hackney SAB), Mr K (Tower Hamlets SAB) and Mr C (Bristol SAB). They highlight the importance of risk assessments and the involvement of Fire and Rescue Services in multi-agency meetings.

9.5. Other SARs have criticised the lack of oversight by commissioners of placements which they have purchased. The SAR on Mendip House (Somerset SAB) is illustrative here. Thematic reviews of SARs across the London and South West regions[28] have also highlighted this concern.

9.6. The importance of matching tenants when placements are being considered is also a theme emerging from SARs. One example is the case of AA and BB (Hillingdon SAB, 2018), which explores the thoroughness of assessment and questions whether the type of accommodation selected was appropriate.

9.7. The case of Adult F (West Sussex SAB) highlights the lack of contact between a Care Coordinator and the patient alongside a critique of the lack of clarity regarding the objectives and timescales within a care plan. There appeared to have been little if any consideration of social inclusion in the plan and the SAR noted the absence of a contingency plan. Another case (Bedford Borough and Central Bedfordshire Council SAB) also highlights concerns about the implementation of the Care Programme Approach.

10. **Concluding Discussion**

10.1. Completing this SAR has been delayed by competing pressures on those working for Sutton SAB when coordinating this review and the difficulty in securing timely responses to requests for information from some agencies.

10.2. It is important for reviews to try to answer “why?” questions, to focus not just on what did or did not happen but on what facilitates good practice and what acts as barriers obstructing good practice.

10.3. The root cause analysis concludes that there was nothing to indicate the risk of EE setting fire to himself or his accommodation. However, the likelihood of risks and the significance of them should they arise should be kept under constant review. The panel and the independent reviewer concur similarly that risks should be constantly reviewed and have concluded that, in

[27] See note 24

[28] See note 5

decision-making regarding EE's final placement and in monitoring of his progress there, insufficient attention was paid to risk mitigation.

10.4. Returning to the terms of reference, the panel and independent reviewer have concluded as follows:

10.4.1. Assessment, decision-making and planning for EE's final placement was rushed and the rationale for it is difficult to fathom knowing his history. The Care Coordinator was insufficiently involved and it is unclear why the NHS Trust and the CCG allowed such a significant departure from their expected procedures.

10.4.2. Assessment and decision-making regarding the specific provider that was commissioned was insufficiently thorough. The panel and independent reviewer have not been provided with any documentation that demonstrates that a matching process was undertaken with respect to proposed residents or that the capability of provider staff was assessed against EE's known needs and risks. Once again, planning appears to have been hurried.

10.4.3. The panel and independent reviewer have not been shown a section 117 (Mental Health Act 1983) after-care plan, to which EE was entitled as a result of having been subject to a section 3 detention. Equally, there does not appear to have been a section 9 (Care Act 2014) assessment of his care and support needs. It is therefore difficult to discern how his final placement was designed to meet his care and support needs and his physical and mental health needs.

10.4.4. Communication and information-sharing with the provider in the immediate run-up to the placement reveals some discrepancies in terms of who was involved and who knew what regarding EE's history and risks. Arrangements for subsequent information-sharing and communication, for example in the event of relapse, were agreed but then were not used by the care provider. The sense of urgency at the end of February was either not conveyed to, or fully appreciated by the Care Coordinator.

10.4.5. Both EE and FF brought risks into the accommodation setting. Reliance appears to have been placed on the training that staff received with insufficient consideration of how to support staff to recognise and respond to the challenges that EE and FF presented. Arrangements to manage fire risks appear to have been incomplete by the time of the fatal fire.

10.4.6. The Mental Health Trust has concluded that not all of its policies were followed, especially in respect of how the placement was arranged and the frequency of visits by the Care Coordinator. It is unclear how familiar staff were with procedures to manage risks within the home and how rigorously procedures were carried through, especially relating to fire safety.

10.4.7. Some organisational factors impacting on practice in EE's case have been noted in section 7.4.

10.5. This case also highlights concerns about supported living properties and houses of multiple occupation run by private rented landlords or companies with particular reference to regulation and monitoring. Fire Services and Local Authorities appear to be unsighted about such houses of multiple occupation and checks before placements are commissioned appear to be inadequate. CQC is limited in relation to its regulatory powers except where the service provides care, support and supervision. Commissioners, if aware of the provider, are therefore responsible for maintaining oversight of how providers are keeping people safe, enhancing quality of life and promoting choice and control. This is also a national issue as highlighted by reviews[29] and research[30].

10.6. All four cases illustrate the importance of multi-agency information-sharing, especially of fire and self-neglect risks, and of multi-agency risk management meetings to agree and follow through on risk mitigation plans.

11. **Recommendations**

11.1. Review of the findings and conclusions at panel meetings resulted in the shared view that EE's case was not unique. Interlocking systemic factors are recognisable that could, if unchecked, reappear in other cases. The recommendations that follow are designed to strengthen how agencies work together in similar cases in the future.

11.2. Arising from the analysis undertaken within this review, the SAR Panel recommends that the Sutton Safeguarding Adults Board:

11.2.1. Audits agency performance on carer assessments and on family involvement in placement decisions;

11.2.2. Request a review from relevant NHS Trusts and CCGs on the operation of the Care Programme Approach, with particular reference to frequency of contact with patients and reviews of their cases;

11.2.3. Ensures that single agency and multi-agency risk assessments include consideration of the likelihood and significance of fire risks;

11.2.4. Undertakes, with CCG and Local Authority statutory partners, a review of standards within supported living and other unregulated providers, to be repeated and updated at least annually;

11.2.5. Request at least annual audits from Local Authority and CCG commissioners and contract monitoring managers, including review of how recommendations and decisions on placements are made. Care Coordinators and key workers must be engaged and responsible for making placement recommendations and CCG and Local Authority approval panels should quality assure decision-making regarding placement recommendations;

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[29] IH Learning Review, Ealing SAB

[30] Raisbeck, T. (2018) "I feel like I'm making decisions blind. I do." Risk, Safety and Wellbeing in Shared 'Exempt' Accommodation in Birmingham, England. Birmingham SAB and University of Birmingham Housing and Communities Research Centre

11.2.6. Audits adult safeguarding cases, with particular emphasis on the quality of risk assessments, the use of multi-agency risk management meetings, and practice with people who self-neglect;

11.2.7. Considers the provision of training on (fire) risk assessment and on working with adults who self-neglect;

11.2.8. Seeks reassurance that placement commissioners and contract managers are familiar with standards for fire safety in placements and consistently check to ensure that these standards are in place before placements are confirmed and are adhered to subsequently;

11.2.9. Commissions an independent review after one year to evaluate the degree to which practice change has been achieved as a result of implementation of this review's recommendations.