Board Statement on the Publication of the Safeguarding Adult Review concerning Mr CS

Lewisham Safeguarding Adults Board has today published a Safeguarding Adult Review that has scrutinised the circumstances surrounding the tragic death of Mr CS.

First and foremost all Board members wish to extend their sincerest condolences to Cedric's family and to express their determination that lessons will be learned from this review. The Board is also very grateful for the way in which Cedric's family has engaged with the review.

Lewisham Safeguarding Adults Board is under a statutory duty to commission a Safeguarding Adult Review where an adult has died as a result of abuse and/or neglect and there is concern about how agencies worked together. The review includes the terms of reference and details the findings concerning the circumstances surrounding Cedric's death as a result of burns sustained whilst smoking unsupervised by care staff.

The review explores the roles and responsibilities of care staff when working with disabled people who require care and support, and assistance with all aspects of daily living. It explores the use of paraffin-based emollient creams and medications that can cause sedation. It covers care home standards and contract monitoring, and best practice with respect to people who have mental capacity and prefer to smoke unsupervised but where this decision exposes them to potential risk. It covers the use of wheelchairs and posture belts for immobile residents who smoke, and evaluates the quality of risk assessments, medication reviews and supervision in this case.

There are recommendations that have emerged from an analysis of the available evidence, covering risk assessment and medication reviews, the roles and tasks of care home staff, and their recruitment and training. There are recommendations with respect to the use of enforcement and regulatory powers regarding care homes, practice standards in care homes, and the approach to safeguarding adult reviews when other investigations are running in parallel. Implementation of the recommendations will be designed to ensure that professionals involved in providing residential and nursing care, and in overseeing the quality of that care, are fully aware of their roles and responsibilities.

Lewisham Safeguarding Adults Board has required each organisation that had some involvement with Cedric at the time to prepare and submit an improvement action plan. These action plans have been scrutinised and approved by the Board, which will monitor implementation at subsequent meetings to ensure that the necessary policy and practice changes are achieved.

The Board will also ensure that a briefing summary is circulated to all staff members within the organisations involved to ensure that the learning from this case is disseminated widely. The review report will also be the focus of forthcoming learning and service development seminars, again to ensure that the learning is circulated widely and that the outcome of implementation of the recommendations gives reassurance about how organisations will provide quality care and support in future.

Professor Michael Preston-Shoot
Independent Chair
Lewisham Safeguarding Adults Board
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