Hampshire Safeguarding Adults Board (HSAB)

George Safeguarding Adult Review (SAR)

This safeguarding adult review has been completed by:

- Independent Reviewer: David Thornicroft
- HSAB co-ordination: Carrie Voyle, Safeguarding Adult Review Coordinator
- HSAB quality assurance: Learning and Review Subgroup (LRS)

1. Introduction

The Learning and Review Subgroup (LRS) made a recommendation on 01/09/2022 for a Discretionary SAR to be completed under Section 44 of the Care Act.

The methodology was considered on 13/10/2022 when LRS recommended using a proportionate approach to understand any learning in the context of the local safeguarding system and recent thematic review of fire fatalities and serious injuries completed by the 4 local safeguarding boards Fire Safety Development Group, as well as identifying any new learning in relation to the identification and response to fire safety risks.

The HSAB chair agreed this recommendation on 25/11/2022.

To maintain confidentiality and in respect of family wishes this report uses a pseudonym name and not the adults real name.

2. Review methodology

The review was commissioned by the HSAB. The Learning and Review subgroup maintained oversight and quality assurance of the process.

The review methodology involved the following key components:

- The main focus is on the findings section.
- A chronology has been developed using the collated multi-agency scoping information provided for use within the review activity.
- The reviewer spoke on the telephone with George's daughter for about 30 minutes.
- Facilitation of one multi-agency practitioner workshop to inform understanding of the reasons behind the systemic weaknesses or strengths identified.
- The draft report was shared with LRS for quality assurance.
- The draft report was shared with involved agencies to check factual accuracy.
- The report was finalised and presented to the HSAB members.

3. Case summary

George was described by his daughter as “one in a million”. He loved his children and grandchildren and was obsessed with his dog. He enjoyed fishing and watching football and rugby. He was very aware of his own abilities, and the areas of his life where he was struggling to cope. He didn’t want to go into a care home. Professionals who knew him described him as a “pleasant chap” who knew his own mind. The best way to get him to accept a new idea was to plant the seed in his mind and then let it grow slowly. He didn’t like being told what to do.

George lived alone but was in regular contact with his wider family. His wife died some 25 years previously. He had some physical health conditions and reduced mobility which significantly impacted his ability to move around his home independently. George had a private care package in place, of 4 care visits per day. Care staff supported him with personal care, continence care, medication administration, meal preparation, domestic tasks and companionship. His daughter visited him regularly but was not “formally” recognised as his carer by professionals.

George was known to the Hampshire and Isle of Wight Fire and Rescue Service with safe and well visits completed following referrals from a family member. George was a smoker and used a prescribed emollient cream. Primary care health agencies were involved with his care as well as the local authority occupational therapy team. Adults Health and Care had received a referral in June 2021 for assessment as George would require financial support for his ongoing care package. At the time of George’s death a financial assessment had been completed, but a care and support assessment (Care Act S9) had not been completed.

On 6th July 2022 emergency services were alerted to a fire at George’s home. Neighbours had raised the alarm and gained access to the property prior to emergency services arriving. George was alight, and he was pulled from the armchair by a neighbour who used a cushion to extinguish the fire. George was taken to hospital and information received from agencies states that he later died of his injuries.

A coroner inquest confirmed the cause of death to be: 1a) Respiratory and Cardiovascular Failure, 1b) Constrictive Eschar of the Chest, 1c) Extensive Thermal Burns, II End Stage Renal Failure.

4. Terms of Reference

This review will:

- Consider the learning that emerges in the light of what is understood already through national research and SAR findings.
- Seek to understand how the local safeguarding system is working together to identify fire risks and whether there are strategies in place to effectively support individuals.
- Seek to understand how effectively the local safeguarding system worked to identify, assess and respond to the adult’s individual circumstances and the impact of these on the individual’s vulnerability to and risk of fire.

In place of recommendations, there will be a ‘questions for the board’ section which will allow key challenges for the system to be identified and presented to the HSAB to consider how they need to respond. The questions will be shaped using a co-production style of working between the

independent reviewer, the safeguarding adult review co-ordinator and the Learning and Review Subgroup.

5. The Findings

1.	
Theme	Fire risk of emollient creams
Summary of safeguarding risks generated	According to the NHS website: **"Emollients are moisturising treatments applied directly to the skin to soothe and hydrate it. They cover the skin with a protective film to trap in moisture.** Emollients are often used to help manage dry, itchy or scaly skin conditions such as eczema, psoriasis and ichthyosis. They help prevent patches of inflammation and flare-ups of these conditions." [https://www.nhs.uk/conditions/emollients/] The risk is that many emollient products are highly flammable when absorbed into fabrics, a fact which is perhaps not widely known. This is not specifically a safeguarding risk, of course, but George's limited mobility undoubtedly made it difficult for him to raise the alarm and to remove his clothes during the incident that caused his death.
Evidence in this case	George used Balneum Plus cream – this was prescribed to treat his dry skin, which in turn was caused by his kidney failure. The medication contains the warning: *"Do not smoke or go near naked flames – risk of severe burns. Fabric (clothing, bedding, dressings etc) that has been in contact with this product burns more easily and is a serious fire hazard. Washing clothing and bedding may reduce product build-up, but not totally remove it"* George was also a smoker. The Review looked into the question of George's mental capacity to make decisions about using the cream safely. The Review found clear evidence that his mental capacity regarding this issue was considered by several agencies, and there was no evidence to doubt his mental capacity on this issue. However, it is not clear from the records how frequently, or how robustly, George was reminded of this risk and offered support/advice to reduce those risks.

Improvement activity	• Hampshire and Isle of Wight Fire & Rescue Service is working with the Hampshire ICB on a public information campaign on the fire risks of emollient creams. • Southern Health NHSFT now has a flyer available on the fire risks of emollient creams, a copy of which they say should now be kept in the folder of each patient who lives at home and who uses emollient creams. The folder should also contain a record of discussions that have taken place with the patient regarding fire risks. This action is a direct result of George's death. • The Care Agency that was providing daily care visits to George now makes a point of raising this issue regularly with clients who use emollient creams and recording that in their notes.
Questions for the board	• Should the Board take responsibility for assessing the impact of the information campaign being led by ICB, HIWFRS and Community Pharmacy? • Should the Board seek an assurance from all member organisations that their staff are now aware of the fire risks of emollient products, and are actively telling service users about these risks? • What efforts have been made by member organisations to get the message across to groups who might struggle to understand its importance? (for example, could there be an easy read version of a flyer, or a simple animation such as this one on a different issue from Norfolk Safeguarding Adults Board: https://www.norfolksafeguardingadultsboard.info/about-us/current-campaigns/tricky-friends-animation/) . If such information exists in different places, might it be useful to collate it all in one place, eg the SAB website? • Should the Board consider sharing more widely this campaign and video clip? https://www.gov.uk/guidance/safe-use-of-emollient-skin-creams-to-treat-dry-skin-conditions

2.	
Theme	Alternative skin treatments for people who smoke?
Context and safeguarding risks	A simple Google search reveals numerous examples of serious burns caused to people who use emollient creams. For example

generated	https://www.edp24.co.uk/news/23790195.kings-lynn-care-home-resident-dies-cigarette-fire/ https://southwarknews.co.uk/area/around-south-east-london/care-home-gets-record-million-pound-fine-after-wheelchair-bound-resident-burns-to-death/ https://www.bbc.co.uk/news/health-46605897 People using smoking materials, who have mobility issues, or cognitive issues, are likely to be at even greater risk of experiencing burns, and/or being unable to deal with burns in an emergency.
Evidence in this case	As above, George was prescribed Balneum Plus cream, was known to be a smoker and was known to have mobility issues. This SAR from Sutton, south London, looked at the fire-related deaths of 5 different people, one of whom (Annie) used emollient creams: https://www.suttonsab.org.uk/static/practitioners_files/Learning%20Briefs%20for%20Fire%20Risk%20Awareness.pdf Like George, Annie was a heavy smoker and it is not clear how much advice she was given regarding the fire risks relating to emollient creams.
Improvement Activity	HIOW ICB instigated an action plan in March 2023 with the aim of identifying and ultimately reducing the risks of emollient-related fire incidents. As of January 2024, according to the ICB, this work is ongoing. The 4LSABs published a multi-agency fire safety framework in 2021. https://www.hantsfire.gov.uk/wp-content/uploads/2021/05/Multi-Agency-Fire-Safety-Framework-May-2021-1.pdf The framework is due for review by the Fire Safety Development Group, which published a learning briefing in 2024. The 4LSAB Fire Safety Development Group publish an annual learning briefing collating all the learning from fire related deaths and injuries during a 12-month period. The latest learning briefing published in 2023 highlighted the risks posed by emollient products. The briefing also emphasised that Safe and Well visits are available for all service users, even those with “low level vulnerabilities”.
Questions for the board	• Should the Board encourage ICB/HIWFRS to work with GPs/Hospitals to identify fire risk and vulnerabilities, and to consider prescribing alternative creams where risk is high? In due course, say by the end of 2024, should the Board ask the ICB/HIWFRS what progress has been made in this respect?

	• Should the Board check the extent to which the 4LSAB Multi Agency Fire Safety Framework is embedded into the practice of partner agencies?

3.	
Theme	Recognition of George's adult children as Carers as defined in the Care Act 2014.
Context and safeguarding risks generated	Section 6.16 of the Care Act Statutory Guidance states: *"Where an individual provides or intends to provide care for another adult and it appears that the carer may have any level of needs for support, local authorities must carry out a carer's assessment."* This is not directly a safeguarding concern in itself, but it is good practice to identify and support carers. This identification can, in turn, lead to the identification and management of risk for some adults.
Evidence in this case	• It would appear that any of George's children who were regularly involved in his life would meet the definition of "carer" above. • It would also appear that none of his children were formally recognised as carers, and therefore no referrals were made to adults health and care for a carers assessment to be offered.
Improvements already achieved	The Gillian SAR in Hampshire: https://www.hampshiresab.org.uk/safeguarding-adult-reviews/gillian-september-2023/ Emphasises the importance of identifying carers, and their needs, which in turn can benefit the cared for person. Gillian's carers (her son and daughter) themselves had levels of care and support needs that were not identified until after their mother's death.
Questions for the board	• The Gillian SAR found that the LA are clear about the eligibility for carers assessments – the issue is currently the initial identification by all agencies to then make the referral. Is the board assured the improvement actions identified from Gillian SAR are sufficient?

Appendix 1

1. **Glossary of terms -**

HSAB	Hampshire Safeguarding Adult Board
SAR	Safeguarding Adult Review
LRS	Learning and Review Subgroup
ICB	Hampshire and IoW Integrated Care Board
FSDG	Fire Safety Development Group
4LSAB	4 Local Safeguarding Adult Boards (Hampshire, Southampton, Portsmouth, Isle of Wight)
HIOWFRS	Hampshire and Isle of Wight Fire and Rescue Service
HCC AHC	Hampshire County Council Adults Health and Care
HCC AHC OT	Hampshire County Council Adults Health and Care Occupational Therapy
PHU	Portsmouth Hospital University Trust
CA	Care Agency
SHFT CN	Southern Health NHS Foundation Trust Community Nursing

References

4LSAB Fire Safety Development Group 2023 learning briefing:

FSDG-Learning-Briefing-2023.pdf (hampshiresab.org.uk)

4LSAB Multi Agency Fire Safety Framework:

Multi-Agency-Fire-Safety-Framework-May-2021.pdf (hampshiresab.org.uk)

HSAB Gillian SAR:

Gillian (September 2023) | Hampshire Safeguarding Adults Board (hampshiresab.org.uk)