

**Safeguarding Adult Review Report – Adult A**

**Written by: Ian Boldy, Designated Nurse Safeguarding Adults, Doncaster Clinical Commissioning Group**

**Date: November 2018**

1. **Introduction**

This SAR looks at a fatality of a male in a house fire, in this report he will be referred to as Adult A. The fire took place on 17th October 2015 at 21.33 hours. Adult A was 64 years old when he died. The request for the SAR came from the Safeguarding Officer from South Yorkshire Fire and Rescue Service. Although this incident has been reviewed under the SAR methodology, it was not actually subject to a safeguarding process at the time of the incident. As a result some of the process undertaken has taken the form of an ‘Investigation’ as opposed to a review.

1. **Case Summary**

The SAR looks at the death of a gentleman in a house fire, Adult A. The fire took place on 17th October 2015 at 21.33 hours. Adult A was 64 years old when he died.

The key focus of the review will look at the identification, assessment and process for securing a piece of medical equipment, against a ‘back drop’ of an associated ‘Medical Device Alert’. The review will look at what channels of communication were utilised and how the alert was processed and implemented.

1. **Adult A**

Adult A was married and had been employed in the past as an Engineer Surveyor. Adult A was known to enjoy drinking Alcohol and also enjoyed smoking.

Adult A had a medical history of Hypertension (High Blood Pressure), Mild Respiratory Disease and Alcoholic Liver Disease.

The wife of Adult A was a Community Nurse of many years and so provided the Nursing Care to Adult A whilst at home as he become more infirm due to longstanding illness.

1. **Terms of Reference**

A meeting was undertaken involving representatives from the agencies involved in this review, a timescale for the review was agreed at 3 years prior to death.

The review will cover the following;

* The care provided by all agencies
* Review communication between agencies to identify any lessons learned
* Review of information provided by all health agencies to;
	+ Ensure planned actions were appropriate and carried out
	+ Identify any omissions in these plans

As part of the SAR process the author made contact with the partner of Adult A and provided her with an opportunity to comment on a draft version of this report. The comment made was that they felt the report was fair and made appropriate recommendations. They were thanked for their contribution and contact details were shared should there be any further comment in the future.

1. **Agencies Involved**

In order to fully understand the circumstances around the case, the two local health providers, Doncaster Bassetlaw Hospitals Foundation Trust (DBHFT) and Rotherham Doncaster and South Humber NHS Trust (RDaSH) provided information. Contact was also made with Doncaster Metropolitan Borough Council (DMBC), Occupational Therapy Services.

Following the initial organisational reviews, increased focussed reviews/investigation was undertaken by the author, leading to contact being made with the Community Nursing Team from RDaSH and with the Occupational Therapist Team at the Montagu Hospital. Contact was also made with the Medical Engineering/Estates Department at Doncaster Royal Infirmary.

One of the key areas of focus has been the communication of Medical Device Alerts from an organisation called Medical and Healthcare Products Regulatory Agency (MHRA). The agency’s contacted regarding this patent are DBHFT, RDaSH, Mediquip and NRS.

In summary involvement in the review has come from;

* DBHFT - Safeguarding Team, Nursing Team, Estates Team and Occupational Therapist Team
* RDaSH - Community Nursing Team
* DMBC - Occupational Heath Team
* Community Equipment Providers - Mediquip
* NRS
* Others; General Practice
1. **Chronology**

Adult A had a period of hospitalisation during the Autumn of 2014. During this period Adult A was bed bound and required hoisting from his bed due to his poor mobility. As a result of these care needs when Adult A was discharged home he required a ‘Pressure Relieving Air Mattress’, this judgement was made following a ‘Home Assessment’ completed by the Occupational Therapist and Physiotherapist from the Montagu Hospital, which is part of the Doncaster and Bassetlaw NHS Foundation Trust.

The mattress was provided by the then Doncaster Community Equipment Provider-NRS who were a month or so in taking over the Community Equipment Contract in Doncaster. The process of ordering mattresses at that time was the responsibility of the ‘Ward Nurse’ as it was a mattress was deemed to be ‘Nursing’ equipment, but for ease of purpose a decision had been made internally to pass this authority onto the Occupational Therapists.

A year or so before, in October 2013, the Medicines and Healthcare Regulatory Authority (MHRA) issued an alert numbered 2013/073. The alert related to all Pressure Relieving Mattresses and Overlay Mattresses and identified the high risk problem being risk of fatality from house fire from lit cigarettes being dropped onto non fire retardant bedding covering air mattresses and overlays.

There is no evidence that neither the Occupational Therapist nor the Physiotherapist made reference to the alert during the ordering process. The ordering of the mattress was processed without challenge from the equipment supplier.

Adult A remained at home for the following year before the critical incident.

This review has identified that following the hospital discharge in October 2013, Adult A received care only once at home, immediately following his discharge, when he had bloods undertaken by a member of the Community Nursing Service, on the 30th of October. Following this episode all care was provided by his GP, it is thought within the practice.

On the 14th October 2015, Adult A was visited by his GP. Within the clinical notes there is mention of a ‘special bed’ and that Adult A smokes a few cigarettes, but no recognition that these two factors together created a high level of risk to Adult A. At this consultation the GP identified Adult A was probably coming towards ‘end of Life’ and so completed a ‘Do Not Resuscitate Cardio Pulmonary Resuscitation’ (DNACPR) order and also requested that the local Community Nursing Team attend to provide Pressure Area Care. The Community Nurses processed the referral appropriately and attended on the 18th, unfortunately Adult A had passed away the evening before.

1. **Findings**

Adult A was a capacitated adult, who had a clinical history of Alcoholic Liver Disease and was a Heavy Smoker, as a result of this Adult A had several periods of hospitalisation for a variety of clinical interventions and care.

During one of these periods of hospitalisation action was undertaken to organise a Pressure Relieving Mattress as a result of the high level of assessed risk of developing a pressure ulcer.

The key focus of this SAR has been the processing and reaction to the MHRA Alert, as clearly this was instrumental in this case.

The alert was distributed to a range of organisations including the CQC, CCG’s, NHS England and NHS Trusts. Despite the alert indicating it was sent to CCG’s and Local Authorities, the entry route of this remains unknown in terms of the Doncaster organisations.

**6.1 DBHFT**

Regarding entry into DBHFT, this is received through the Medical Equipment Team and a process of communication is undertaken. The alert was processed and ‘risk assessed’, resulting in it receiving the following comment, ‘refers to systems used at home, it is sent for awareness and information only’. The alert along with this comment was then sent out to a range of staff, all of which would have routinely received MHRA Alerts. The action beyond this point is determined by the receiving ‘lead’. Some could discard it as it would not have relevance, others could take any other appropriate action. Clearly, the system adopted anticipates that a more local ‘risk assessment’ would be undertaken by the ‘local’ lead.

In this case the lead was a Nursing Matron, who indicated the alert would have been communicated to all appropriate staff at a ‘Governance Meeting’. It is not clear whether the ‘risk assessment’ of the alert (‘refers to systems used at home, it is sent for awareness and information only’) influenced the importance of this communication. Unfortunately there are no minutes available to reflect the specifics of what was shared.

The alert was issued by the MHRA almost a year before the incident in question, there is also no clear evidence of a process of how staff are repeatedly reminded of ‘crucial’ alerts. This alert did not trigger any change in process or pathway within DBHFT.

**6.2 The Equipment Provider**

At the time of the alert, October 2013, the equipment provider to Doncaster was a company called Mediquip, the author has had great difficulty understanding their actions following receipt of the alert.

The provider changed in September 2014 and so the mattress was provided by the current provider Nottingham Rehab Services (NRS), who upon enquiry around the alert indicated their view was that there was no action to be taken for the provider, that this was an action deemed to be relevant to organisations ‘ordering’ the equipment. The view was that the risk assessment was the responsibility of those ordering and not those supplying.

On the 14th October 2015, Adult A was visited by his GP. Within the clinical notes there is mention of a ‘special bed’ and that Adult A smokes a few cigarettes, but no recognition that these two factors together created a high level of risk to Adult A. This probably reflects the failure of process in the MHRA alerts getting into the GP Practice.

In the final days of Adult A’s life a request was made to the Community Nursing Service to provide ‘End of Life’ support. A referral was made however in light of the priority that was given to the referral the Community Nurses attended Adult A’s property the day after the fatal fire.

**7.0 Recent Developments**

The current equipment provider has now placed an alert on the electronic request system. This means that there early on in the referral process the question ‘does the patient smoke’ flash up onto the system. This means that the referral cannot proceed without answering this question.

**8.0 Conclusions**

This review has identified that the requisition of the Air Mattress and the associated MHRA Alert was central to this incident. The author has identified that the receipt of the MHRA in each organisation has been far from robust. Within DBHFT, the management of the alert was somewhat fragile due to the initial risk assessment and how a ‘community alert’ relevance was seen to an Acute Hospital Trust. It is not clear whether the low risk assessment was reviewed when it reached the ‘local area’ through the Matron as unfortunately there are no records to neither substantiate or refute what was communicated.

The second challenge faced by DBHFT is how they ensured that the alerts remain relevant. In this review, there is no evidence of any change in clinical practice or process as a result of the alert. This therefore resulted in individual staff having to remember the directive of the alert when ordering equipment, which would appear to been a significant gap in this situation.

This situation was compounded by the approach taken by the equipment provider who took the view the actions were the responsibility of those requesting the equipment. It is not known whether there was any communication around this position with providers.

**9.0 Recommendations**

The author has identified three key areas that require evaluation, these are

1. How MHRA alerts are received into organisations
2. How MHRA alerts are evaluated and managed
3. How organisations ensure that historic MHRA alerts remain current within clinical areas
4. Seek assurance that equipment providers receive alerts and in conjunction with care providers ensure that responsibility is picked up

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Appendix 1 - Shared Learning Brief

A more robust mechanism is adopted for receiving MHRA (Medical and Healthcare Products Regulatory Agency) to a range of organisations including the CQC, CCG’s, NHS England and NHS Trusts.

Change in clinical practice or process as a result of MHRA alert that would result in evaluating the alert when ordering equipment.

How MHRA alerts are evaluated and managed. A better evaluation of how this is communicated to relevant services. It is not clear whether the ‘risk assessment’ in this case influenced the importance of this communication.

A clear process of how staff are repeatedly reminded of ‘crucial’ alerts. This alert did not trigger any change in process or pathway within DBHFT.

The current equipment provider has now placed an alert on the electronic request system. This means that early on in the referral process the question ‘does the patient smoke’ flash up onto the system. This means that the referral cannot proceed without answering this question.

A review of how MHRA alerts are communicated to GPs Within the clinical notes there is mention of a ‘special bed’ and that Adult A smokes a few cigarettes, but no recognition that these two factors together created a high level of risk to Adult A.

How organisations ensure that historic MHRA alerts remain current within clinical areas.

Seek assurance that equipment providers receive alerts and in conjunction with care providers ensure that responsibility is picked up