7minute briefing – December 2022: Safeguarding Adults Review (SAR) for Harry For all those working with adults, children and families

About Harry

Harry was a single 68 year-old white British man, who died in a house fire at his home on 25 January 2021. He rented a room from his friend David, effectively a 'live in' landlord, who helped with shopping and cooking. Harry died from smoke inhalation and burns after a towel had fallen on a fan heater. Contributory factors were related to poor health, poor mobility and intoxication.

WHAT YOU CAN DO NOW

- Read this <u>self-neglect</u> guidance
- Discuss the professional curiosity resources pack with your team
- Learn about <u>mental capacity</u> and how to support an individual making unwise decisions
- Discuss <u>thresholds</u> and how to apply to safeguarding concerns
- Use the London Fire Brigade's
 Home Fire Safety Checker

SAR findings

There were a number of findings that came out of Harry's experiences that related to:

planning

i.the safeguarding response

v.impact of prescribed drugs and

excessive alcohol consumption

ii.assessment and support

iii.awareness of fire risk

vii.Harry's engagement

iv.unsuitable housing

vi.risk assessment

• Harry's engagement

Harry's engagement with services was ad-hoc and sporadic although he engaged well with some services. This reminds us of the value of those positive relationships that can be harnessed to deliver positive outcomes for the adults and children we work with. This also links back to risk assessment and the importance of recording and taking a joined up approach A SAR takes place when an adult with care and support needs is seriously harmed or has died due to abuse and/or neglect and there are concerns about how agencies have worked together. Its purpose is to look at what happened / why / what action will be taken to improve practice as a result of the review's findings.



Safeguarding response + impact of prescribed drugs and excessive alcohol consumption

There has been a lot of work done to raise awareness of self-neglect in recent years but there is a need to do more as the safeguarding response to Harry wasn't robust enough. A coordinated response is vital as well as recognising the intersecting nature of a service user's different needs.

Awareness of fire risk

There are lots of different risks that need to be considered when working with service users / families and the risk of fire should not be underestimated. Work is underway within the partnership to improve policy and process and to make sure this is aligned with existing processes to make it meaningful and impactful. Assessment and support planning + risk assessment + unsuitable housing

The findings around assessment, support planning and risk assessment are all connected. Had these been sufficient then Harry's housing (and also his use of prescribed drugs and alcohol) may have been picked up and addressed earlier. This also raised the need for professionals to 'walk alongside' and ask the second question, i.e. be a bit more curious. This also reminds us about making sure there is good join up with other agencies involved.

to self-neglect wasn't sufficient. It also recognised that deaths of vulnerable people by fire is not out of the ordinary and that the issues in this review resonate with other SARs relating to self-neglect.

The review concluded that our response

The Waltham Forest Local Safeguarding Partners have accepted the review's findings and recommendations and have committed to working together to improve practice.

Visit www.walthamforest.gov.uk/strategicpartnerships for other useful resources