Lewisham Safeguarding Adults Board
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Lewisham
Safeguarding Adults Board
A working partnership to prevent abuse

Andrew Harris
Senior Coroner
London Inner South
Coroner for Inner South District Greater London
Southwark Coroner's Court
1 Tennis Street
Southwark
SE1 1YD

Thursday 22nd June 2017

Dear Mr Harris

Re Cedric Skyers (00725/2016)
Regulation 28 report to prevent future deaths

I refer to your letter dated 26th April 2017 in which you enclosed the report of your investigation and findings relating to the death of Cedric Skyers.

I can confirm that a decision was taken by Lewisham Safeguarding Adults Board to commission a Safeguarding Adult Review in April 2016. Upon the appointment of a new Independent Chair for the Lewisham Safeguarding Adults Board in December 2016, the terms of reference for the Safeguarding Adult Review were reviewed and revised, progress on the collection and analysis of information was reviewed also and a new overview report writer was appointed.

The terms of reference for the Safeguarding Adult Review are as follows:
Safeguarding Adult Review into the death of Mr CS

Terms of Reference (revised 3rd May 2017)

Introduction

1. The Lewisham Safeguarding Adults Board (LSAB) has determined that the death of Mr CS satisfies the Care Act 2014 (Section 44) statutory requirement for a Safeguarding Adult Review (SAR). The LSAB has decided that an overview model, which documents events and analyses their causes, is appropriate in the circumstances; thereby satisfying the statutory guidance that the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

Scope of the SAR

2. It has therefore been determined that an independent overview author be appointed to:
   a. Document and examine the events leading up to the fire on Sunday 13th March 2016
   b. Review the original reasons for and suitability of Mr CS's placement and the outcomes of subsequent placement reviews

c. Review Manley Court care plans and risk assessments relating to Mr CS; examining whether Mr CS was subject to any Mental Capacity Assessments, and the outcome of these; and any Physical Ability Assessments that were carried out
d. Examine the standards of practice within Manley Court Nursing Centre managed by The British United Provident Association Limited (BUPA)
e. Consider whether these comply with BUPA-wide and/or local policies, procedures and guidance with particular attention given to care planning and risk assessment as well as smoking – residents, staff, visitors and contractors
f. Evaluate whether these meet statutory and/or regulatory requirements and guidance (e.g. Health & Safety, Fire Safety, the Mental Capacity Act, and National Patient Safety Alerts etc.).

Methodology

3. The independent overview author will work with a panel of the SAB to:
a. Prepare a composite headline chronology
b. Consider the review and learning of individual agencies since the incident and focus on good practice, identify aspects for further improvement and areas where multi-agency action is required
c. Undertake an analysis of causes and remedial actions recommended at professional, individual agency and across the multi-agency safeguarding system
d. The SAR investigation will seek to avoid duplicating the work of investigations by other authorities (the Coroner, the London Fire Brigade, the Metropolitan Police Service and Care Quality Commission) but rather draw on these for information and advice as well as providing an opportunity to pull together the findings of them all and explore any gaps
4. In terms of specific methodology the independent over view report has been asked to:
a. Utilise where beneficial the NHS Root Cause Analysis (RCA) Tool[1] as the model is tried and tested in healthcare. (https://www.england.nhs.uk/patientsafety/root-cause/#). It has features which assist identify multiple causes and/or contributory factors focusing on those with the greatest potential to cause (and therefore prevent) future incidents.
5. It is expected that the SAR will:
a. Identify and summarise relevant data (e.g. documents, interviews, records, logs etc.)
b. Invite individual agencies to undertake their own analysis and then be a position to consider these in the round
c. Describe the chronology of events
d. Carry out an overview analysis to identify contributory factors (here it may be possible to utilise the National Patient Safety Agency Contributory Factor Classification Framework, see Appendix 1)
e. Order contributory factors by importance/impact
f. Identify policy, procedure and practices that may require improvement and recommend how and who needs to act and with what urgency.
6. The approach and methodology are intended to identify themes, solutions and achievable recommendations which could prevent similar occurrences and facilitate learning both specific to the incident and more broadly from the latter life and subsequent death of Mr CS.

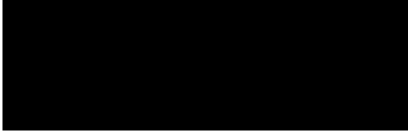
The purpose of the Safeguarding Adult Review is to learn lessons and, through their implementation, to seek to eliminate or reduce the risk of future deaths created by the circumstances that led to Cedric Skyers' loss of life. It is planned that a draft report will be considered by the case review group of the Lewisham Safeguarding Adults Board at its June meeting and a timeframe for expected conclusion of the review process has been set for the end of July 2017.

As required by the Care Act 2014 statutory guidance, the Board's annual report for 2017/2018 will contain full details of the lessons learned and of the action plan that the Board will put in place.

Learning and service development seminars will also be held, and a briefing note produced and circulated, to ensure that the lessons learned through the review lead to service, policy and practice transformation where appropriate.

If you wish to receive a copy of the final report of this Safeguarding Adult Review, please write to me to that effect.

Yours sincerely,



Independent Chair
Lewisham Safeguarding Adults Board