



Emergency Planning College
Occasional Papers
New Series

Number
July 2014

11

Planning for the Needs of Vulnerable Adults in Emergencies

David Mellor
EPC Associate Lecturer
Emergency Planning College



Please Note:

This Occasional Paper is a discussion article, written and published in order to stimulate debate and reflection on key themes of interest to the resilience community. It is part of a series of papers published by the Emergency Planning College on the Knowledge Centre of its website and available freely to practitioners and researchers. The opinions and views it expresses are those of the author. This paper does not constitute formal guidance or doctrine of any sort, statutory or otherwise, and its contents are not to be regarded as the expression of government policy or intent.

For further information, including a submissions guide for those who wish to submit a paper for publication, please contact:

Mark Leigh

Emergency Planning College

T: 01347 825036

E: mark.leigh@emergencyplanningcollege.com

About the author:

David Mellor is an associate lecturer with the EPC who specialises in understanding and meeting the needs of vulnerable people in UK emergencies. Drawing upon his experience as an Independent Chair of two safeguarding children boards, he worked with the EPC and Save the Children UK to deliver the “Neither Seen Nor Heard” seminar in 2013 which focused on addressing the specific needs of children and young people in UK emergencies. He made use of his experience as an Independent Chair of a safeguarding adults board to host a recent EPC webinar on identifying the needs of vulnerable adults in emergencies. The webinar generated considerable interest, and comments of the record number of colleagues who participated in the event have been incorporated into this paper.

Planning For The Needs Of Vulnerable Adults In Emergencies

Introduction:

This paper focuses on the challenges involved in identifying adults who are less able to help themselves in the event of an emergency in the UK. Despite the fact that it was published as recently as 2008, national guidance is out of date. Whilst the principles set out in the guidance retain validity, the ways in which care is provided to our growing elderly population and other adults with complex needs has changed substantially and continues to do so.

The paper reaches the following conclusions:

1. Ensuring the safety of our growing elderly population is a substantial challenge.
2. UK guidance no longer reflects the facts on the ground. As a result emergency planners are experiencing difficulties in identifying vulnerable adults quickly and efficiently in the event of an emergency.
3. The new Local Health Resilience Partnerships could play an extremely valuable role in navigating a path through the changing landscape of care for vulnerable adults.
4. There is a strong case for creating a dedicated role of advocating for, and monitoring the experiences of vulnerable adults in an emergency.
5. The needs and voices of vulnerable people should be heard at all stages of an emergency, particularly the planning and preparation stages.

UK Guidance:

The 2008 Cabinet Office publication “Identifying People who are Vulnerable in a Crisis: Guidance for Emergency Planners and Responders” (hereafter referred to as “the 2008 guidance”) is intended to guide the development of local action plans for identifying groups of people who may be vulnerable in an emergency.

The guidance advocates the following four step approach:

1. Building Networks – working with those best placed to have up-to-date records of individuals and who will be aware of their needs.
2. Creating List of Lists – given the impossibility of maintaining a central up-to-date list of vulnerable people, make lists of organisations and establishments who can be contacted for relevant information in the event of an emergency
3. Putting in place Data Sharing Protocols and Activation Triggers to enable lawful and timely information sharing
4. Determining the Scale and Requirements – it is anticipated that working through steps 1 – 3 above will enable the potential scale of requirements to be estimated and planned for.

The 2008 Guidance preceded the development of Community Resilience. However the focus of the former guidance on those “that are less able to help themselves in the circumstances of an emergency” is compatible with the latter’s aim of building resilient communities so that responders are able to concentrate their limited resources on those who are less able to take action to keep themselves safe.

However the six years which have elapsed since publication of the guidance has seen a transformation in the way that care is delivered to the elderly and people with complex needs.

- Local Authorities have increasingly contracted out the delivery of services to the elderly to the private, voluntary and independent sector
- Local Authorities have introduced personalised budgets which allow individuals to use funding from the local authority to purchase the care they need from independent providers
- The impact of austerity and the growing elderly population is creating a “perfect storm” of financial pressures on Local Authorities and Health Services leading to greater integration of services and a financial imperative to care for more and more people with complex needs in their own homes rather than in expensive care homes and hospital beds
- The Coalition Government completed a substantial restructuring of the NHS on 1st April 2013. It would be difficult to argue that the new structures are simpler and more streamlined than those they replaced
- Scandals such as the abuse of patients at Winterbourne View Hospital have resulted in major reviews which have led to major changes. As a result of Winterbourne View, adults with learning disability who were cared for in hospitals often located some distance from their homes are now to be cared for in community settings as near as possible to their homes. This is a major change of approach which is proving challenging to implement.

The 2008 Guidance focuses to a large extent on specific establishments or places such as hospitals, retirement homes and sheltered housing estates. This remains a highly relevant focus but greater attention is required on the substantial numbers of people with complex needs who are being supported in their own homes. The 2008 Guidance stresses the importance of building relationships with bodies responsible for vulnerable people but increasingly important groups such as private sector providers and Carers Groups are overlooked or given insufficient prominence.

There is a risk that national guidance lags behind profound changes on the ground. When this happens there is a risk that responders will be ill-prepared for emergencies, as was the case with the response to the Foot and Mouth outbreak in 2001 when government plans were predicated in part on the previous outbreak in 1967 when the agricultural market was

much more localised and the speed and range of spread of the disease much slower as a result.

Case Studies:

To illustrate some of the key challenges in identifying and supporting vulnerable adults in the event of an emergency, a number of anonymised case studies will be examined.

The first case is not an emergency as defined by the Civil Contingencies Act but it was similar to a “rising tide” emergency in that the authorities were made aware of the potential crisis in advance, it involved a disruption in care to very vulnerable people and plans had to be quickly implemented to provide alternative care. Tragically one of the vulnerable adults died as a result of alternative arrangements for her care not being put in place. In January 2013 Council B was informed of the likely closure of a commercial provider of care to elderly people in their own homes. The commercial provider employed a number of illegal immigrants. When raided by the Border Agency they were unable to continue trading. Council B had been advised of the raid in advance and had identified a number of service users who relied upon services from the provider which the Council funded. They were then provided with a list of 8 people who resided in Council B’s area, who funded their own care from the provider. On this list was Adult A, who was an 81 year old former Company Secretary who lived alone. She had vascular dementia and relied on four visits a day from the provider to help her with personal care including getting out of bed, dressing and washing. Council B was responsible for organising alternative arrangements for people on both lists but neglected to do so for Adult A, who was discovered by a District Nurse in a very poor state of health 9 days after the provider ceased to trade. She died several days later in hospital and the local Safeguarding Adults Board commissioned a serious case review.

The serious case review conclude that serious mistakes were made by a social worker who failed to make contact with Adult A and made an assumption that as a “self-funder” she would make her own alternative arrangements despite her file stating that she suffered with dementia.

Adult A is one of 40,000 such “self-funders” in Council B. Council B has now put in place a “Provider Failure Protocol” to be followed in such cases but the serious case review commented that the protocol needed to be trained and exercised against and that the protocol needed to be accompanied by professional judgement exercised by staff.

This case raises a number of issues for emergency planners. In the event of a Civil Contingencies Act emergency, how easy would it be to obtain details of people like Adult B and other vulnerable adults who “self-funded” their care? Her care was provided by a commercial provider. How well integrated into local resilience arrangements are commercial providers of care to vulnerable adults? And how widely has the “Provider

Failure Protocol” developed by Council B been shared with the emergency planning community in the UK? The case also demonstrates that reliance on lists and lists of lists as advocated by national guidance is only part of the solution. Adult A was on a list and it did not save her. We all know that humans make mistakes particularly when under pressure. Here a professionally qualified member of staff made erroneous decisions which went unchallenged by management.

Adult C and Adult D were elderly women who died in a UK emergency which met the Civil Contingencies Act definition. Adults C and D were 79 and 86 respectively and next door neighbours in a city in England and died when a local river burst its banks and flooded the city in 2005. The flooding was particularly severe in the area in which Adult C and D lived and both drowned in their homes. Unlike the other residents of the road on which they lived, Adult C and Adult D were not evacuated. It is unclear why these two vulnerable adults were not evacuated and everyone else was. Media reports reveal that an inquest was held and that a verdict of accidental death was recorded in respect of both women. The Coroner was shown a video of the floods in the road on which they lived which were over a metre deep.

The obvious issue emerging from this case for emergency planners is that if it is not possible to speedily access information about vulnerable adults then the consequences can be fatal. The second point is that in comparison to the detailed analysis publicly available in respect of the death of Adult A, there is very little information in the public domain to explain why Adults C and D died and identify any lessons for responders. So should there be some kind of serious case review process for deaths arising from emergencies to learn lessons and act upon those lessons?

The case of 21 year old Adult E reminds us that vulnerable adults are not necessarily elderly or disabled. In November 2012 Adult E died when a spruce tree fell on her tent near an English city during heavy storms. She was a rough sleeper who had spent many years in foster care, moved onto “sofa surfing” before living on the streets. She had no substance abuse or alcohol problems. She had been unable to successfully make the transition from a challenging childhood to a secure adult life. Adult E’s needs may have been insufficient to justify any services from Adult Social Care services although Children’s Social Care services are now more likely to offer support to former care leavers up to the age of 25.

The recent case of a man living with paranoid schizophrenia illustrates how severe weather emergencies can seriously disrupt care and potentially result in avoidable inpatient admissions putting pressure on acute services at a time when they are likely to be stretched as a result of the emergency. This man received significant support from the Community Mental Health Team, social services and other support services to enable him to live in the community. The daily visits he was accustomed to receiving stopped when the village in which he lived became impassable following heavy snow. This situation continued for 8 days and physical mobility problems prevented him from accessing food from village shops. His

support worker was able to make innovative use of private sector options for delivery of food but for those 8 days he received no other visits and his physical and mental health was not monitored during that time.

The final case study concerns the deaths of numerous severely ill patients at the Memorial Medical Centre in New Orleans in the aftermath of Hurricane Katrina. In an extreme situation in which circumstances deteriorated rapidly as patients, staff and local residents waited for several days to be evacuated, the 52 most seriously ill patients, many of whom were bed bound and required electric ventilators to breathe, were chosen to be evacuated last of all. Many died and subsequently several health professionals faced criminal allegations that they had deliberately injected patients with drugs to hasten their death. This case raises many profound ethical issues, but for the purposes of this paper I ask whether the “reverse triage” approach to evacuation of the most seriously ill patients, is consistent with what appears to have become a guiding principle of emergency management in recent years – that limited resources should be focused on those least able to help themselves?

Research:

This is a brief section as there does not appear to be a great deal of research into the needs of vulnerable adults in emergencies and much of what exists emanates from the USA. The National Council for Disability (NCD) in the USA has produced a number of helpful reports in recent years. They state that “people with disabilities are disproportionately affected by emergencies because their needs are overlooked or disregarded.” Amongst many examples they cite to support this conclusion, is the use of transport for the evacuation of disabled people which lacked a wheelchair lift. They also conclude that people with disabilities “are often grouped into one homogeneous population and are provided with instructions which are not appropriately communicated or are impossible for them to follow.” Here the National Council for Disability observe that visual and hearing impaired people were often unable to obtain relevant information about what action to take in the event of an emergency in a form they could access.

The UN Convention on Disability, Natural Disasters and Emergency Situations takes the view that people with disabilities should be seen not as objects of charity, medical treatment and social protection, but as citizens with rights which they are capable of claiming and citizens able to make decisions about their lives based on free and informed consent.

Experiences in the Field:

In April 2014 I hosted an EPC webinar on this issue which attracted a great deal of interest which appeared to reflect the importance of the issue and a degree of anxiety in the emergency planning community about their ability to identify vulnerable adults in the event of an emergency. Many colleagues provided examples of difficulties in accessing

information with many gaps revealed by recent severe weather emergencies. Specific reference was made to people cared for in their own homes and “self-funders.” Lists from some sources required cross referencing with other lists. For example GP surgeries provided a very long list of people eligible for flu jabs which would contain many people who were unlikely to be vulnerable. There was a general view that it was unwise to rely completely on lists and that a holistic approach was required including classic but labour intensive options such as door-knocking. There was general agreement that current national guidance was in need of review to take account of the reality on the ground. And there was widespread anxiety about the various impacts of continued austerity. One colleague said that it was impossible to keep plans up to date because of the speed and depth of cuts to services.

Conclusions:

It is clear that providing services for the growing elderly population is proving a massive challenge for local authorities and their health service partners. Ensuring the safety of this growing elderly population in an emergency is a challenge of similar size but it seems that the task of determining the potential scale of requirements of vulnerable people – stage 4 in the 2008 Guidance – is proving to be an increasingly complex challenge.

UK guidance no longer reflects the facts on the ground. Care is being provided in distinctly different ways to adults with complex needs in 2014 than it was when the guidance was written in 2008. And the way in which care is provided will continue to change as the elderly population continues to grow and the effects of austerity continue to be felt for many years to come. Different models for delivering care will emerge which will require the emergency planning community to work ever more closely with their colleagues in Adult Social Care and the Health Economy in order to understand the implications of these changes for planning to meet the needs of vulnerable adults in emergencies.

Local Health Resilience Partnerships are a relatively new part of the Local Resilience Forum architecture which could play an extremely valuable role in navigating a path through the changing landscape. The Partnerships are intended to be local strategic forums to enable all parts of the reformed Health economy to collaborate with Local Authorities to plan for emergencies.

Taken together, the case studies and the research begin to make a strong case for someone to be given the dedicated role of advocating for, and monitoring the experiences of vulnerable adults in an emergency. This individual would be expected to have a sound professional knowledge of Adult Social Care and Health systems and would additionally be able to provide invaluable advice to those managing the emergency response, given the concerns expressed by emergency planners earlier in this paper. This requirement for advocacy and monitoring applies equally to the needs of children and young people in emergencies.

Finally, the UN Convention referred to above recommends that the needs and voices of disabled people should be heard at all stages of an emergency, particularly the planning and preparation stages. I suggest that this recommendation is extended to all adults who are less able to help themselves in the event of an emergency and those agencies, groups and individuals which provide them with care.