
Executive Summary
of the
Serious Case Review
in respect of
Mrs P
27/07/1925 – 12/02/2008

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1. Preface

- 1.1 It was the view of the Panel that when Mrs P died in a house fire at her home on 12th February 2008 her death was both predictable and preventable. There was sufficient evidence available over an extended period of time to indicate that Mrs P was at high risk of death by fire, given her habits, physical condition and circumstances.
- 1.2 The Panel believed that no single agency or individual was directly responsible for what happened to Mrs P, but rather she was the victim of a catastrophic failure on the part of each agency with which she had contact to recognise the full extent of the risks to which she was exposed and to take protective action.
- 1.3 The Panel was informed by the Fire and Rescue Service representative that had a referral been received on Mrs P before her accident that it would have been a relatively simple matter to install the necessary equipment into her home to prevent her death from the tragic accident which killed her.
- 1.4 The Panel has considered in some depth the circumstances surrounding Mrs P's death and has critically reflected on the practices of all the agencies with which she had contact. Important lessons have been identified and a number of recommendations have been made which, if implemented alongside those contained in the individual agency Management Reviews (IMR's), would significantly impact on the care and protection offered to older people in Leeds.

2. Introduction

Circumstances leading to the decision to undertake a Serious Case Review

- 2.1 Mrs P died on 12th February 2008 following a house fire which it was believed was caused by accident through her careless disposal of a match she had used to light a cigarette. Mrs P was an habitual heavy smoker.
- 2.2 Mrs P was 83 years old at the time of her death; she was housebound, had limited mobility and suffered a number of medical conditions that were controlled with medication. Mrs P was a widow. She did not receive any help from her family, but was supported by her longstanding friend, Mrs C, and her next-door neighbour, Ms F. She was an intelligent and strong willed woman who was fiercely independent and determined to remain in her own home until she died.
- 2.3 Mrs P had been known to Leeds Adult Care Services (ASC) since 2002 following a referral from her neighbour Ms F. She was the subject of a Community Care Assessment and an Occupational Therapy Assessment. She was provided with equipment to aid her mobility and a daily support package to help with meal preparation, cleaning and laundry.
- 2.4 Mrs P was the subject of two reviews from the Adult Reviewing Team (ART) (in April 2006 and June 2007), both of which noted her continued difficulties with personal care and agreed ongoing support arrangements which amounted to 7.5 hours per week daily assistance provided initially by one private provider and later by another.
- 2.5 In January 2008 Mrs P's condition deteriorated after she contracted a chest infection and a referral was made on 23rd January 2008 by her friend, Mrs C, for an urgent reassessment as Mrs P's additional needs were placing an unmanageable burden on her informal carers.
- 2.6 Mrs P was seen on 31st January 2008 by a Social Worker who undertook the reassessment and concluded that an uplift in Mrs P's care package from 7.5 hours to 16.25 hours was indicated. This proposal was placed before the Gatekeeping Panel on 6th February 2008. The decision of the Panel was to defer approval of the proposed care plan and request instead an assessment from the Intermediate Care Team (ICT). This assessment was completed on 8th February 2008 and concluded that Mrs P did not meet the criteria for ongoing support from that service, but did require additional help to reduce 'carer strain'.

- 2.7 Upon receipt of this information the original proposal that had been made to the Gatekeeping Panel was approved and agreement was given to uplift Mrs P's care package to 16.25 hours weekly. However, due to the short notice of the need for increased provision, her private provider was not able to provide what Mrs P needed immediately and instead she received support from the Community Support Service (CSS) over the weekend of 8th-10th February 2008.
- 2.8 On 11th February 2008 the Manager of the CSS contacted ASC to report the concern that her staff had raised about Mrs P following their contact with her over the previous weekend. They were concerned about her physical condition, the circumstances in which Mrs P was living and the risk of fire. The CSS Manager requested an urgent visit.
- 2.9 On 12th February 2008, at about 1:00pm, Mrs P's home was attended by the West Yorkshire Fire and Rescue Service following the report of a fire. Mrs P was pronounced dead at the scene by Ambulance Paramedics.
- 2.10 On 30th June 2008 an alert was raised by the Assistant Chief Fire Officer for West Yorkshire Fire and Rescue Service with the Safeguarding Adults Board indicating that the circumstances of Mrs P's death met the criteria for a Serious Case Review. This recommendation was agreed by the Chair of the Safeguarding Adult Board on 25th July 2008.
- 2.11 On 25th September 2008, at the Coroner's Inquest, it was concluded that Mrs P had suffered an accidental death.

3. Terms of Reference

- 3.1 The Safeguarding Adults Co-ordinator produced a draft document outlining the terms of reference on 8th December 2008 which outlined the purpose and scope of the Review and a suggested timescale for its completion.
- 3.2 The following issues were identified as the purpose of the Review:
- (1) To establish the facts about events leading up and following Mrs P's death on 12th February 2008.
 - (2) To examine the roles of the agencies involved in her care and well-being, the extent to which she was dependent on those agencies, and the appropriateness of single agency and inter-agency responses to her needs.
 - (3) To establish whether there are lessons to be learnt from this case about the way in which local professionals and agencies carried out their responsibilities to care for Mrs P and to safeguard her well-being as a vulnerable adult.
 - (4) To identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result.
 - (5) To identify whether, as a result, there is a need for changes in single agency or inter-agency policy, procedures or practice in Leeds in order to improve single agency and inter-agency working and better safeguard vulnerable adults.
- 3.3 The scope of the Review identified the following areas for consideration:
- (i) The factual chronology of the events and actions taken by all agencies in relation to the care of Mrs P from the period from February 2007 until her death on 12th February 2008, unless information collated through the internal management reviews suggests that there is a need to include a longer period.
 - (ii) Any reports of critical incident debriefs, complaints investigations or internal case reviews already undertaken.
 - (iii) The roles and responsibilities of the agencies, statutory bodies and professionals involved in the case.
 - (iv) The appropriateness of the Health and Social Care services and any other services provided to Mrs P in the period covered by the review.

- (v) The strengths and areas for development of inter-agency working in terms of the services, protocols and information sharing relevant to the delivery of care to Mrs P.
- (vi) Whether each agency followed its own policies and procedures and/or Leeds' Multi-Agency Safeguarding Adults policy and procedure.
- (vii) To what extent the involvement of these agencies, statutory bodies and professionals promoted or failed to promote the well-being and protection of Mrs P.
- (viii) Any key strengths or weaknesses within the process/approach taken and what areas of good practice can be identified.
- (ix) The views of Mrs P's carers, Mrs C and Ms F.

3.4 Following discussion between the Independent Chair of the Review and the Safeguarding Adult Co-ordinator, it was agreed that the original timeframe for the Review (12th February 2007 until 14th January 2008) was too narrow and did not allow for a proper consideration of agency involvement with Mrs P in the years prior to her death. As a consequence, the timeframe was extended to cover the period February 2002 until 12th February 2008.

4. Procedural Issues

4.1 The membership of the Serious Case Review Panel was as follows:

- ◆ Independent Chair and Overview Report Author
- ◆ Involvement Officer, West Yorkshire Fire & Rescue Service
- ◆ Acting Director of Quality Safeguarding and Customer Engagement, Private Homecare Provider
- ◆ General Manager Out of Hospital Care
- ◆ Interim Head of Service, Access and Inclusion, LCC Adult Social Care
- ◆ Safeguarding Adults Co-ordinator, Leeds Safeguarding Adults Partnership

The Head of Safeguarding Adults, Leeds Safeguarding Adults Partnership, attended one meeting of the Panel.

4.2 The Panel received Individual Management Reviews (IMR's) from the following services:

- ◆ Leeds Adult Social Care (Access and Inclusion)
- ◆ West Yorkshire Fire and Rescue Service
- ◆ Private Homecare Provider
- ◆ NHS Leeds GP Services
- ◆ Leeds Social Care (Community Support Service)
- ◆ NHS Leeds Care Services

The Panel received correspondence from NHS Leeds (District Nurse) Services to confirm that Mrs P had been provided with continence support services in 2006, but that no record of this contact remained. The letter also confirmed that Mrs P had been re-referred in February 2008 for the same service, but that she had died before the service could be provided.

4.3 The Panel had access to copies of relevant policies and procedures from Leeds ASC; records of the two reviews undertaken on Mrs P; the submission to the Gatekeeping Panel on 6th February 2008 and the private provider's documents relating to risk and need assessment.

4.4 There was considerable delay between the decision to undertake a SCR (July 2008) and the commencement of the Review (5th October 2009). This delay impacted on the effectiveness of the review process and will be addressed later in this report.

4.5 The Serious Case Review Panel met on the following dates:

- ◆ 5th October 2009
- ◆ 16th October 2009
- ◆ 9th November 2009
- ◆ 2nd December 2009

All the meetings were of approximately four hours in duration.

5. Family Involvement

- 5.1 Mrs P was a widow, and though she was known to have nieces and nephews, she had no contact with them throughout the period under consideration in this SCR. A number of her relatives attended the Coroner's Inquest in September 2008, but no information was available about how they could be contacted.
- 5.2 Mrs P was supported by her friend, Mrs C, and her neighbour, Ms F, throughout the period covered by this SCR. The Independent Chair of the Panel contacted both of Mrs P's informal carers to inform them that a Serious Case Review was being undertaken into the circumstances surrounding Mrs P's death and to invite them to contribute to the process if they wished.
- 5.3 Both Mrs C and Ms F expressed a wish to make a contribution to the Review and they were seen separately by the Independent Chair prior to the commencement of the review process. Both women provided useful insights into Mrs P's personality – they confirmed her as an intelligent, acute, strong willed and strong minded individual who was determined to remain independent and who resisted most offers of additional help and support. They confirmed that Mrs P was a heavy smoker and said they had concerns about her both in terms of her health and her safety as a consequence.
- 5.4 Mrs C confirmed the significant deterioration in Mrs P's condition following the chest infection that she contracted in early 2008. Both she and Ms F confirmed that the additional responsibilities that this placed upon them (given their own personal circumstances) proved unmanageable and was the reason that a referral was made to ASC for an urgent reassessment on 23rd January 2008.

6. Key Issues

6.1 In the course of the Serious Case Review (SCR) a number of important lessons were identified, both in relation to the way that services were provided to Mrs P and the SCR process itself.

6.2 In relation to the SCR process, the following issues emerged:

- ◆ The importance of conducting Serious Case Reviews in a timely fashion following a critical incident. There was nearly two years' delay between Mrs P's death and the commencement of the SCR. This delay compromised the effectiveness of the review process.
- ◆ The need for all agencies to afford the necessary degree of priority to SCR's; to nominate independent Individual Management Review (IMR) authors and Panel representatives that allows the SCR to be completed within a reasonable timescale.
- ◆ The need for training and support for IMR authors to enable them to produce 'fit for purpose' reports to support the SCR process.
- ◆ The important role played by medical practitioners in the care and protection of older people and the absence of a representative from that discipline on the Leeds Safeguarding Adults Board (LSAB).

6.3 The following issues emerged in relation to the way that Mrs P was provided with services:

- ◆ The need for practitioners from all agencies to be mindful of the issues of both risk and need when working with service users and have the necessary skills to identify risk and initiate appropriate protective action.
- ◆ The need for practice guidance for Adult Social Care staff in relation to the response to urgent requests for services.
- ◆ The need for Private Provider staff and Adult Social Care staff to be aware of the options available to provide immediate increased levels of support to service users in critical or emergency situations.
- ◆ The need for the reviews of services to be rigorous and inclusive of all those involved in the care and support of older people.

- ◆ The need for practice guidance for staff working with older people who have full capacity, but who engage in behaviours that put themselves and others at risk of harm.

7. Summary of Recommendations

- 7.1 Leeds Safeguarding Adults Board (LSAB) amend its policy on Serious Case Reviews to ensure that they are considered within a timescale that allows for a comprehensive and contemporaneous review of events in order to optimise learning. This timescale should not exceed six months from the date that the alert is raised.
- 7.2 Member agencies of the LSAB afford the SCR process the degree of priority required and ensure that IMR authors and Panel representatives are nominated to allow future SCR's to be concluded within procedural timescales.
- 7.3 Member agencies of LSAB ensure that there is a separation of role between IMR author and agency representative on SCR Panels and that both are independent of any case management involving the subject of the Review.
- 7.4 Leeds Safeguarding Adults Board review its policy, procedures and guidance in relation to the production of 'fit for purpose' IMR's reflecting the issues outlined in this report.
- 7.5 LSAB to invite a representative of the medical profession to become a member of the Safeguarding Adults Board.
- 7.6 All agencies make arrangements to ensure that the learning from this SCR is disseminated and this is evidenced through changes in policy and practice. This will require agencies to produce a robust action plan to address the issues raised for their own agency and the LSAB to develop a process to monitor and evaluate progress of such plans against identified desired outcomes and agreed timescales.
- 7.7 LSAB ensure that all agencies have in place policy, procedures and practice guidance in relation to risk recognition and management which are consistent with each agency's statutory duties and responsibilities. This should include (at a minimum) a joint initiative for NHS and ASC staff.
- 7.8 LSAB ensure that each agency has in place adequate training for staff in relation to fire awareness and that this includes regular refresher training.
- 7.9 Adult Social Care develop a policy in relation to responses to urgent requests for services, including threshold criteria, timescales for response and managerial oversight of outcome.

- 7.10 All Private Providers to ensure that their staff are aware of the facility to uplift provision to service users by five hours within any 72 hour period to address immediate increase in need. When this option is exercised, a referral for a reassessment to Adult Social Care must be made and the temporary arrangement confirmed in writing using the extra call log sheet.
- 7.11 Adult Social Care to clarify and reissue guidance to staff on uplifting support packages to service users in urgent/emergency circumstances pending a referral to the Gatekeeping Panel.
- 7.12 All agencies undertaking policy/procedure review must ensure that current procedural guidance remains available pending the outcome of the revision. When the revised guidance is available, this should replace the old material which should be removed to archive by a designated person.
- 7.13 The current review of the Adult Care Reviewing process to proceed to a conclusion. It should take into account the need for rigour in the review of care plans, particularly in relation to pursuing wider safeguarding issues and ensuring that outstanding concerns of service users are resolved as far as is reasonably practicable. Reviews should be inclusive of those people directly involved in the support and care of service users. Reviewing Officers should have access to all relevant information on the service user .Informal carers should be provided with direct contact details of case holders.
- 7.14 The LSAB convene a multi-agency short life working party to consider the issue of addressing concerns about the risky behaviour of adults with full capacity and provide guidance for staff on how to proceed in these situations.

Signed:

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Date: