Surrey Safeguarding Adults Board

Executive Summary Serious Case Review

In Respect of 0002

Died November 2008

Authors: Mary Sexton Jane Lawson

1. Background

1.1 0002 died aged 81 years in a house fire at her home in Surrey in November 2008. She had lived alone since her husband died in 2006 and was supported by her family. She suffered from Chronic Obstructive Pulmonary Disease and mild to moderate dementia with the probable diagnosis of Alzheimer's. She had been known to both adult social care and mental health services since 2005.

0002 had lived in the same district for over 50 years. She had several children, four of whom lived close by, and visited regularly. One of her daughters visited her mother daily. 0002 had many grandchildren, and great-grandchildren. She was very proud of her family. They were very important to her. 0002's family were very concerned for her welfare and actively involved in her care.

2. Purpose of the Review

2.1 The purpose of the Serious Case Review is to establish whether there are lessons to be learned from the circumstances of the case about the way in which professionals and agencies work separately and together to safeguard adults and to inform and improve practice by acting on the learning. Serious Case Reviews are not inquiries into how an adult died or suffered injury or who is culpable.

3. Terms of Reference of the Review

3.1 The following Terms of Reference formed the basis for the review:

- To establish the chronology of events in relation to 0002 between January 2005 and her death in November 2008.
- To examine the adequacy of the collaboration and communication between all the agencies involved in the care of 0002 or in the provision of services to her between January 2005 and November 2008.
- To carry out a review of all interactions and reviews undertaken by the Surrey Safeguarding Adults' Board partner agencies in relation to 0002.
- To prepare an independent overview report based on the findings and make recommendations to the Surrey Safeguarding Adults' Board.

4. Methodology

4.1 The Serious Case Review was instigated at the request of the Surrey Safeguarding Adults' Board in August 2009 with membership of the Serious Case Review Panel made up as follows:

Serious Case Review Chair

Mary Sexton	Director of Nursing, Quality and Governance for Surrey and Sussex Healthcare NHS Trust.

Panel Members

Alan Robson	Detective Sergeant, Public Protection Strategy Unit, Surrey Police
Gabby Alford	Associate Director Strategy Partnerships NHS Surrey
Samantha Farrell	Senior Professional Lead in Social Care, Surrey and Borders Partnership NHS Foundation Trust (SABP)/Surrey County Council
Linda Stewart	Safeguarding Adults' Service Manager, Surrey County Council
Sonya Sellar	Service Manager, E1 Area, Adult Social Care, Surrey County Council
Lynda Winchcombe	Independent Overview Writer

The panel comprised professionals (who had not had direct involvement with 0002), representing the main services involved in 0002's care as well as a representative from Surrey Police. A member of the Surrey Safeguarding Adults' Board chaired the review. An independent overview writer was commissioned to assist in the review.

The Executive Summary was written by Jane Lawson, Making Connections (Isle of Wight) Ltd.

4.2 The Serious Case Review Panel requested Individual Management Review reports from the following agencies:

- Surrey and Borders Partnership NHS Foundation Trust
- Surrey Fire and Rescue Service
- Surrey Police
- Surrey County Council, Adult Social Care

Each was asked to provide a report into their agency's actions and/or the implications of this case from their perspective. These reports and recommendations within them ensure that necessary lessons are learned within agencies as well as contributing to the broader picture and learning set out in this report.

The Serious Case Review Panel considered each report in reaching the broader recommendations contained in this review report.

Other documentation was also provided to the panel:

- Memorandum of Understanding (MOU) between:
    - Surrey Adult Social Care Directorate and Surrey Fire and Rescue Service updated since 2008
    - Surrey Families Directorate and Surrey Fire and Rescue Service 2008

(This MOU is an agreement between the above agencies in relation to identifying risk to individuals, the availability of advice regarding these risks and joint agency working in respect of those risks)

- Letter from 0002's GP practice
- Extracts from 0002's case records held by SABP

The panel met on seven occasions.

All Serious Case Review Panel members were fully consulted, and their views considered although not all were able to attend every meeting.

It was important as part of the review to meet the family of 0002. The Serious Case Review Chair therefore met with three of 0002's daughters in November 2009. Notes of this meeting were made available to the other Serious Case Review Panel members. The review takes account of this important input from the family.

5. Case Outline

5.1 The serious case review considered the period of 0002's life from January 2005 until her death in November 2008. Both Surrey County Council Adult Social Care (ASC) and Surrey and Borders Partnership NHS Foundation Trust (SABP) had involvement with 0002 over that period of time. A chronology of events, taken from agencies involved with 0002, was analysed by the panel.

Aspects of the chronology, which were identified as significant by the serious case review panel, are highlighted in this section. These are set out in the table below. Practice concerns/issues identified by the panel are set alongside the key events/contacts involving statutory agencies. They are germane to conclusions and recommendations set out in sections 7 and 8.

Table 1

Key Events/Contacts relating to the period between June 2005 and November 2008 in 0002's life

Date	Event	Practice Concern/Issue
2 June 2005	Daughter of 0002 reported concerns to Surrey County Council Adult Social Care team (ASC). Her mother's mental state was deteriorating.	
July-Sept 2005	Adult Social Care community care assessment information included that 0002 had twice accidentally left gas on unlit on her gas cooker. Assessment resulted in care package including 3 calls each week and attendance at a day centre. Support accepted by 0002	A risk assessment would be required to identify key risks and ensure care package directly addressed those specific risks. There was no evidence of this. Absence of joint working on fire risk with the fire service. Need for reference to the MOU1 with Surrey Fire Service was indicated and yet there was a lack of awareness as to its existence. This was a recurrent issue.
23 September 2005	0002's care package reviewed, and she declined support. Package of care ceased. 0002's husband continued to receive support from ASC. Both continued to receive family support	Carers' assessment would be required to be offered. No evidence of this. No evidence of supporting 0002 in her decision to decline services or of engagement with the family on this significant issue. No evidence of consideration of the need for a mental capacity assessment or risk assessment in the context of 0002's decision.
April 2006	0002's husband died.	Such a significant event would indicate a need for the risk and needs assessment to be reviewed along with 0002's decision to decline services 6 months earlier. No evidence of such.
August 2006	Surrey Association for Visual Impairment referral to ASC for Occupational Therapy (OT) assessment in view of 0002's poor vision.	
November 2006	OT assessment completed Referral for community care assessment made as 0002 finding it hard to manage personal care needs.	

1 MOU: Memorandum of Understanding between Surrey Adult Social Care Directorate and Surrey Fire and rescue Service (has been updated since 2008)

15 December 2006	ASC assessment takes place. 0002 declines support.	No evidence of a risk assessment or of any steps taken to address the decision to decline services taking into account events and information since the decision to decline services 15 months earlier. No evidence of a mental capacity assessment being considered or of the family being informed and engaged in respect of 0002's decision to decline services.
24 October 2007	GP referred 0002 to Older Persons Community Mental Health Team (OPCMHT) of SABP. Family concerned about deterioration in loss of memory.	
19 November 2007	Community Psychiatric Nurse (CPN) from OPCMHT assessed 0002 and discussed this with consultant psychiatrist. CPN noted: • No risks or concerns at time of assessment • Daughters are concerned re: mother's memory • No services going in except for a gardener.	This reflects a serious lack of co-ordination around risk assessment and risk management and communication failures between agencies. Surrey County Council ASC was aware of risks. There is no reference to these or to longitudinal risk issues. This assessment fails to take account either of risks identified by Surrey ASC or by the family.
29 and 30 November 2007	CPN attempts to contact daughter. No reply.	There was no sustained attempt to discuss this assessment with either the family or ASC.
27 February 2008	0002 seen by consultant psychiatrist. Her 3 daughters accompanied her. Concluded that presentation was of mild to moderate dementia and diagnosis was probably Alzheimer's disease During this meeting daughters gave history of forgetfulness and reported suspicions of friends of 0002 taking advantage of her financially. Daughters advised to contact a solicitor re: Power of Attorney to protect her from exploitation.	Why was the suspicion of financial abuse not reported under the safeguarding adults' procedures? There was a clear lack of awareness of/failure to follow the safeguarding procedures. The police were not informed to allow investigation of a potential offence.
20 May 2008	Daughter reports to OPCMHT further concerns re: gas cooker being left on.	
21 May 2008	Home visit made. No response. Note left to contact OPCMHT.	What were the chances of 0002 responding to a note given her memory deficit and her disinclination to engage with services? This appears a weak response given that the OPCMHT had clearly seen this as a high priority, attempting to visit on the day following the referral of concerns. No evidence of follow up

		with 0002's daughter. No evidence of a further attempt to visit at this time.
5 June 2008	OT home visit • 0002 smokes and gas is left on unlit • Daughter has contacted solicitor to arrange Power of Attorney • Daughter feeling stress of caring as 0002 relying heavily upon her 0002 adamant she does not require assistance and relying heavily on daughter. It was documented that meals on wheels would be arranged and family would arrange to remove cooker once meals service in place.	No evidence of any follow up on whether the concerns about financial abuse are still present.
4 September 2008	OPCMHT receive call from daughter who is concerned for 0002.	No evidence of follow up in the intervening period on significant concerns identified three months earlier. The daughter (rather than professionals) instigates a review of the circumstances.
5 September 2008	CPN visits and records that 0002 is pleasant and chatty; she believes that her husband is still alive; she is regularly sleeping in the armchair in the lounge. Respite care is discussed as an option, but no firm plans made.	No evidence of longitudinal approach to risk assessment, which might have focused on the areas of risk previously identified and which have not yet been addressed. There is no recorded engagement with the daughter following the visit despite her having requested the visit.
7 October 2008	0002's daughter calls – she is concerned for her mother who is deteriorating: • Cooking for her deceased husband • Argumentative with family. • Putting dirty laundry in fridge. • Phoning family during night CPN agrees to make referral to ASC for respite care. ASC ask for request in writing.	
30 October 2008	Request made in writing for respite on grounds of: • Cleaning house • Respite for daughter.	Significant delay in progressing request for respite care despite risks being clear in relation to Gas cooker Carer stress Hygiene Almost 5 months earlier it had been agreed the cooker should be taken away. It is still in the house with its associated risks. There is no evidence of discussion with the family about this.
3 November 2008	GP referral to ASC including reference to danger associated with gas cooker ASC	

	ask daughter to attend to complete (FACS) assessment.	
11 November 2008	0002 assessed as being at "substantial" risk under FACS criteria if services not provided within 12 weeks of assessment. Again daughter refers to her concerns about gas cooker and 0002 leaving rings on unlit and smoking cigarettes.	No record of proactive measures taken regarding gas cooker despite it has now been an issue since July 2005. An action plan in relation to it had been clearly set out in June 2008 but not monitored to support it being carried through.
13 November 2008	Above concerns confirmed. CPN visits: doors open; gas on with pans set over ignited flames; 0002 confused and disoriented. The CPN noted that 0002 was at risk of self-neglect and there are concerns for her safety. No evidence of psychotic thoughts, depressive illness or suicidal ideation CPN discusses with psychiatrist and they decide 0002 has no insight into her difficulties and that an assessment under the Mental Health Act would be appropriate. Consultant phoned inpatient unit. No bed available. CPN to visit 0002 at home the following day.	First mention of mental capacity issues and 0002's lack of insight despite indications much earlier that this might be the case.
14 November 2008	Visit by CPN as arranged previous day. Risk assessment carried out in line with the Trust risk assessment process. It concludes that the medium and long-term risks are low in relation to: violence; self-harm; self-neglect; risk to children. 0002 recorded as being chatty and pleasant. Daughter rang re: outcome of visit and again expressed concern re: gas cooker. Daughter advised to disconnect and order hot meals. Daughter agrees to discuss with family.	Risk assessment is disconnected from key events/concerns. Recorded risk domains assessed by CPN relate to a standard risk assessment proforma more than they relate to the nature of the risks present in 0002's situation. The impetus of concern has been lost from the previous day and no recorded attempt to pick up on the need identified to seek an inpatient bed for assessment purposes.
17 November 2008	Further home visit by OPCMHT. It was noted that there had been no response from ASC re: respite placement, which had been requested on 30 October.	The need for respite care had been formally identified on 7th October due to substantial risks.
21 November 2008	ASC contacted 0002 and arranged to visit on 3 December 2008.	
23 November 2008	0002 died in a house fire. The cause of the fire was a careless disposal of a cigarette, being dropped down the side of the armchair coming into contact with a tissue that started a slowly developing smouldering fire.	

6. Themes underlined in Internal Management Reviews

6.1 There is a clear commitment from all relevant agencies to addressing shortcomings both individually and collectively. This was evidenced in the IMRs submitted by those individual agencies.

6.2 There was a particular emphasis in the IMRs on addressing the following:

- The evident lack of awareness of staff in SABP and Surrey County Council of the existence of the MOU with the Fire and Rescue Service which would have alerted them to the need to refer the fire risks to the Fire and Rescue Service
- More broadly, the need to work in partnership across agencies
- The importance of involving families and carers in assessments and in exploring how needs can be met
- The need to consider use of the safeguarding procedures in all cases where risk of abuse or neglect is an issue
- The need for clarity and communication in identifying all potential risks
- The importance of timely follow up on required actions in response to risk assessments
- The importance of identifying one person who will take overall responsibility in an individual's situation
- The importance of ensuring robust internal systems for investigating and learning from serious untoward incidents
- The need to ensure that workloads are reviewed and managed effectively

6.3 Individual agencies have committed to carrying out a detailed range of internal actions to ensure that there is learning and action as a result of the circumstances surrounding the death of 0002. This is in addition to the recommendations for action set out in this report.

7. Conclusions

7.1 Safeguarding

- There were at least two occasions when safeguarding procedures should have been triggered. Safeguarding issues were not identified by SABP in relation to suspected financial abuse nor did Surrey Police refer a safeguarding issue to Adult

Social Care in July 2005 when 0002 had provided bank details to a stranger. (A police procedure introduced in 2006 would, it is hoped, ensure that a referral would now be made to ASC in these circumstances). On a more general level, it appears 0002 left her doors open leaving her vulnerable to intruders.

- Staff training is essential to ensure that staff apply the procedures appropriately.
- Organisations need to have processes in place to ensure that they know which staff are being trained and that training is transferred effectively into practice.
- Staff need to be clear about the importance of mental capacity issues and assessment within safeguarding. They need an understanding of the circumstances in which it might be appropriate to intervene in individuals' best interests to keep people safe when an individual does not have the mental capacity to make their own decisions.
- In complex situations involving vulnerable adults at risk robust supervision and management oversight of front-line staff is crucial.

7.2 Working Together

- An absence of collaborative working meant that agencies were unable to address all of the risks in 0002's life adequately and in a holistic way. This case highlights in particular the need for clear arrangements and clarity of responsibility and communication between adult social care older people's services and mental health services.
- Care plans and assessments need to be jointly developed, reviewed and monitored.
- Accountability needs to be clearly defined.
- Agencies must also work closely with family and carers on these issues.
- There must be one person taking overall responsibility in complex cases.
- There needs to be clarity around the sharing of information on individual need and risk.
- In some instances, agencies were unaware of vital information that would have enabled them to support 0002. This was particularly apparent in the failure to engage with the fire and rescue service.

7.3 Serious Untoward Incidents

- The absence of timely investigation of 0002's death as a serious untoward incident (SUI) indicates the need for SABP to review its SUI policy.

7.4 Risk Assessment and Risk Management

- Throughout the period investigated there was a clear need to ensure that actions and care plans were a direct and proactive response to robust risk assessments based on information shared across agencies. There was little if any evidence of this. Each assessment (more often than not requested by 0002's daughter)

appeared to react to the presenting issues and failed to take a longitudinal view of the risks present.

- A longitudinal perspective on risk factors would have identified clear patterns, recurrent risks and escalation in risk. There was a lack of reference back to previous contacts/records within and across agencies in order to see those emerging patterns.
- There was a need to address a lack of consistency and relevance in risk assessments within and across agencies. For example, in November 2008 a CPN visited and noted that 0002 was at risk of self-neglect and that there were concerns for her safety. The following day a CPN visited again and concluded that the medium and long-term risks were low in relation to: violence; self-harm; self-neglect; risk to children.
- Lack of timely follow up on issues according to the level of risk was evident. For example, there was a three-week delay between a CPN establishing the need for respite care on 7 October 2008 and putting in the necessary written request on 30 October. This is despite clearly identified risks in relation to the gas cooker; carer stress and hygiene issues. In addition, the removal of the cooker had been deemed to be necessary almost 5 months earlier in June 2008 and yet it was still being identified as a risk in late October with no proactive steps having been taken. Timescales bear no resemblance to level of risk.

7.5 Specific Risk of Fire

- There was a clear risk of fire throughout the period reviewed. There are many references to the risk posed by the gas cooker coupled with 0002's smoking habit. There was evidence of cigarette burns on the floor and on the chair in the downstairs lounge where 0002 often slept. This risk of fire was a significant omission in terms of risk assessment and risk management. The true status of this issue was not addressed nor was there clarity of accountability on this issue. There were insufficient steps taken to minimise this clear risk and no attempt to involve the fire and rescue service.

7.6 Memorandum of Understanding (MOU) between the Fire Service and Adult Health and Social Care

- Agencies' lack of awareness of the existence of the memorandum despite it being launched in 2008 is recognised across agencies as significant. A clear need has now been identified in relation to training on fire risk assessment and on awareness of the MOU so that timely referrals to the appropriate point in the fire and rescue service can be made in the future.

7.7 Mental Capacity

- Issues relating to the mental capacity of 0002 were neglected. There was a lack of any evidence of engagement with the issue of whether she was capable of understanding the risks in her situation or of making the decision to decline services (in the light of the apparent level of risk) until shortly before her death. Despite evidence to suggest that 0002 did not have the capacity to understand the risks and her decision to decline services there is no evidence of support to 0002 to understand the information relevant to the choice she was making and consequently no evidence of any decisions being made in her best interests

7.8 Issues Relating to Carers

- There was an apparent lack of carers' assessments evidenced in the chronology. Carers' assessments must be offered to all informal carers.
- Carers must be fully involved in assessments and care plans and their knowledge and expertise valued appropriately. Their support needs to be harnessed in supporting the service user in understanding the risks. Their involvement in the risk assessment and risk management process is crucial.
- Whilst a discussion took place between the daughter of 0002 and an OT (June 2008) where it was agreed that the daughter would arrange for meals on wheels and thereafter removal of the cooker it was clear from subsequent contacts and concerns regarding the gas cooker that this had not been possible and that the risk still remained. There is no evidence of engaging the family in discussion about how to resolve this particular risk issue and whether the family had met with resistance from 0002 when trying to carry out this action. The advice was simply repeated to the daughter in November by a CPN.

7.9 Service Users who Decline Services

- There was no evidence of supporting and working with 0002 or with her family/carers on the significant issue of her declining support services. In the light of clear doubt about 0002's mental capacity and an apparent significant level of risk (rendering the decision important) this should have been addressed and the family should have been engaged in discussion on it.

8 Recommendations

8.1 Recommendations are set out below. These focus on the following:

- Safeguarding procedures
- Training
- Working together
- Serious untoward incidents
- Risk assessment and management

- Mental Capacity issues
- Service users who decline support services
- Carers assessments
- Mental Health Act admissions
- Fire and Rescue Service Memorandum of understanding

8.2 Safeguarding Procedures

Recommendation 1
Managers to ensure all staff have an awareness and understanding of identifying safeguarding issues

Recommendation 2
Agencies to review their supervisory/management oversight of complex care cases to ensure they are subject to regular review

8.3 Training

Recommendation 3
All agencies to ensure all staff receive appropriate safeguarding training in relation to their role and level of responsibility. This includes medical professionals both within the SABP and Primary Care Services.

Recommendation 4
Safeguarding training to be monitored and evaluated to ensure records are kept of who has completed safeguarding training and the effectiveness of the training.

Recommendation 5
Surrey Safeguarding Adults' Board to ensure appropriate resources are available to support the implementation of the training strategy

8.4 Working Together

Recommendation 6
Consideration to be given to the development of joint protocols on the sharing of information between key agencies in relation to risk and individual needs

Recommendation 7
It is recommended that the service user, carers and families and all professionals involved in a case should have a written copy of the individual's care plan. The care plan to clearly define who is accountable for the delivery of the plan and contingency plans

Recommendation 8
Health and Adult Social Care to move to an integrated model for managing complex cases, which will enable care plans to be jointly developed, reviewed and monitored.

Recommendation 9
All agencies to use a communication book to share information about an individual's care. The book to be completed and left in the individual's home where appropriate. It will detail visits and care completed. Guidance on completion of the book must be developed.

8.5 Serious Untoward Incidents (SUI)

Recommendation 10
SABP to review their SUI policy and ensure that all unexpected deaths are investigated and reported to the relevant PCT as an SUI. Early referral to SCR should be considered at this time.

8.6 Risk Assessment and Risk Management

Recommendation 11
SABP and Adult Social Care to develop a joint approach to person-centred risk assessment and risk management, capable of responding to individual need and circumstances. This approach will underline the need to engage service users and carers/families in risk assessment and risk management. The approach to make clear reference to mental capacity issues.

Recommendation 12
SABP and Surrey County Council to ensure the joint approach to risk assessment and risk management is transferred into practice through attention to training, supervision; management oversight of complex cases; case audit.

8.7 Mental Capacity Issues

Recommendation 13
SABP and Surrey County Council will ensure that staff are aware of when and how to assess mental capacity and of the core principles of the Mental Capacity Act. They will review national Mental Capacity Assessment tools and develop a local tool for use by frontline staff to ensure that assessments are carried out appropriately and in a consistent and effective manner.

8.8 Service Users who Decline Support Services

Recommendation 14
SABP and Surrey County Council will ensure that relevant guidance such as guidance on risk assessment and risk management; mental capacity; safeguarding; sharing of information supports staff in working effectively with service users who decline services. Mental capacity assessments and risk assessments are key in informing judgements about individuals' ability to assume responsibility for making such decisions. Staff training and support must reflect this guidance.

8.9 Issues Relating to Carers

Recommendation 15
Carers' Assessments must be offered to all informal carers who are involved in providing support to an individual. If this offer is declined it should be clearly stated in the individual's case records and subject to further review

Recommendation 16
Develop an information pack for carers of those suffering from dementia. The two agencies should review the information that they hold on dementia care and agree what should be included in the pack. It should include advice and support, details of services available, finances and risk management.