Coventry Safeguarding Adults' Board Serious Incident Review
Executive Summary in respect of Miss G, died 2013 (CSAB/SIR/1)

The purpose of the Serious Incident Review

A serious incident review (SIR) takes place because an adult has died or has been seriously injured or impaired and abuse or neglect is known or suspected to be a factor.

The process is about learning lessons, not about apportioning blame (Care Act 2014)

Background

Miss G was 40 years old when she died. She was part of a loving and supportive family. During the time under analysis for this review, Miss G was supported extensively by her mother and her brother, and was herself a mother to two girls aged 17 and 18 years. Miss G had regular contact with her daughters, they had lived with her mother from a very early age, her mother lived with her stepfather. Miss G's birth father lives in Portugal, and she maintained contact with him.

Miss G developed a long term degenerative neurological disease after the birth of her eldest daughter, 18 years previously, this progressively inhibited her ability to mobilise, cognition, memory function and her behaviour. This condition is also life limiting. The physical effects of the condition also gave rise to problems which meant that Miss G was confined to a wheelchair for most of the time in the period under review.

Miss G enjoyed smoking, and declined to stop as advised by her GP. She managed to reduce her smoking to 7 cigarettes a day. She also experienced significant weight gain to over 20 stone; this resulted in her requiring specialist equipment to support her specific needs. Advice and support on her diet was at times successful in enabling Miss G to lose weight.

Prior to moving into independent accommodation in March 2006, Miss G lived in a specialist residential a care home for younger people with complex needs for a period of 2 years. Miss G moved to a bungalow 2006 where she received 22 hours support a day, which was funded by adult social care. This included periods during the day when the support was doubled to facilitate the use of equipment that required two people to operate it. Miss G was able to go out with support from her carers or family and was compliant and readily agreed with most things. Miss G was very trusting of people, which made her vulnerable. Her speech deteriorated making communication difficult and her hand to mouth coordination was poor affecting her manual dexterity and ability which was frustrating for her and put her at risk, especially from fire, during the 2 hour unsupervised period when she was smoking.

In 2010 her step father developed dementia and her brother took more responsibility for her care, this arrangement lasted until 2012 when her stepfather went into residential care, which allowed her mother to resume caring for her.

Miss G liked the carers being in her home, and did not appear have a problem with someone being there all the time. This was a positive for her, and continuity of care

staff got better as time went on and was important. She and her family, acknowledged the special relationship she had developed with one of her male carers, who was recognised by them all "as going the extra mile".

Her mother said that Miss G did not want to go into a home, as she valued her independence. This was reinforced by Miss G's social worker who agreed that she wanted to be as independent as possible and to continue to make her own choices.

A summary of facts and findings of the case

In March 2006, when Miss G moved out of the care home, the care plan developed by Coventry City Council (CCC), adult social care set out an overall aim to: "enable Miss G to live independently in her own home with an emphasis on developing her current independent living skills further". Miss G was keen to live independently whereas her mother had reservations. Despite ambitious aims and objectives, there is no record of substantial input from her carers in terms of proactive measures in motivating and enhancing her independence. The need to motivate Miss G was identified as a key consideration, therefore, its absence in the records is noteworthy.

A psychology report in 2007 included important insights, which should have been shared across all agencies involved with Miss G's care, and should have precipitated a thorough multi-agency review. The report stated:-

"Across all measures assessed, all appear to have deteriorated to a very significant degree, to the extent that I am concerned that Miss G may require additional support in making everyday decisions and has apparently little insight into her difficulties."

The aim of the care plan remained largely unchanged despite these insights.

Alongside this her mother repeatedly raised concerns about the sustainability of the care plan, and indicated that her own situation meant that she could not sustain the level of demand on her from Miss G. She expressed concerns at a significant number of points that carers were not adhering to the care plan. Reviews did not take place in a timely way when these genuine concerns were raised.

In 2008, despite reservations, her mother agreed to be an agent for the Direct Payment on behalf of Miss G. She was assured of support from Penderels Trust. It seems that her mother had little understanding of the Direct Payments process and the potential that this offered to provide care in a flexible and creative way.

There were recurrent concerns and issues raised by Miss G's mother and brother relating to care provision, risk assessment and record keeping. In 2010, Miss G's mother continued to ask for a change of care agency. The issues and options were not robustly addressed and Miss G's mother and Miss G decided to continue with the existing care agency. At no point was there any creative discussion about how things could be done differently.

During this period there were three safeguarding referrals all relating to concerns expressed about care/carers. These were not adequately addressed, nor progress on actions adequately reviewed or acted on.

When a decision was made in 2011 to withdraw the Health component of funding to Miss G there was insufficient attention given as to whether the existing package of

care needed to continue irrespective of the funding provider. An assessment of need and risk should have followed and a separate multiagency decision agreement developed to address any service gaps. There was an absence of any clear documented risk assessment around the decision that Miss G could, and would, be left alone for a 2 hour period. It was clear that Miss G was deteriorating and was still smoking. Despite this the information and implications were not amalgamated into one holistic assessment in order to assess the advisability of leaving Miss G unsupervised for a 2 hour period.

Risk relating to fire associated with her smoking while unsupervised was not sufficiently explored in the assessments or care plan, despite acknowledgement of Miss G's lack of awareness of hazards coupled with knowledge of her smoking habit and her difficulties in coordination and dropping items.

Analysis

The analysis within this review of the above circumstances that preceded Miss G's death is focussed on the following key themes:

- Practice in relation to assessment, care planning, reviews and decision making
- Working with risk
- Risk of fire
- Person centred outcomes, focussed practice and working with carers
- Recording
- Considerations in respect of the Mental Capacity Act
- Key policy frameworks central to the case of Miss G
    - Continuing NHS Healthcare Assessment
    - Direct Payments
    - Safeguarding Adults

Conclusions

In respect of the areas detailed in the analysis, conclusions were drawn and form the basis of a commitment to action across organisations in Coventry, to learn lessons and aims to prevent such a situation occurring in the future.

Alongside this there needs to be clear guidance and awareness raising around the responsibilities associated with identifying those most at risk from fire and the need for professional agencies to refer these individuals to West Midlands Fire Service (WMFS), and to work with them to develop appropriate safety plans.

Analysis of practice in safeguarding adults from abuse and neglect provided evidence of failure to work in line with local policy. In particular safeguarding investigations were not always sufficiently comprehensive in addressing relevant concerns nor was the monitoring of the agreed actions sustained. There are a number of indications that prevention of abuse/neglect is an area that needs to be strengthened.

In the context of the assessment for NHS continuing healthcare and the decision making and practice regarding the integrated package of care there was a need for interagency working and information sharing, care planning, risk assessment to be included in the records. The need for greater understanding of the roles**,**

responsibilities and accountabilities across health and social care in terms of assessment of on going need and joint decision making was also identified as an issue. Had these factors been acknowledged, alternative decision relating to the Continuing Health Care funding may have been agreed. There were questions too about the extent of Miss G's (and her family's) understanding of, and involvement in, these decisions as well as the failure to include front line carers in the process of gathering relevant information. Since the Continuing Health Care assessments in the case of Miss G took place, policies and procedures in respect of lead commissioner arrangements have been reviewed and strengthened to ensure that they are more robust. The principles at the heart of Direct Payments (which are about creativity and choice and meeting outcomes) seem far removed from the experience of Miss G and her family who had no real understanding of Direct Payments. Miss G's mother was not empowered by the offer of a Direct Payment. The respective responsibilities of social work/care management and the Direct Payment support provider were not understood/not interpreted effectively in practice for Miss G. The guidance is clear that reviews of Direct Payments arrangements must address whether needs are being met and whether they have changed. Implicit in this are considerations of risk. The Care Act, 2014 states:-
"the Direct Payment review is not intended to be a full review of the person's care and support plan. However, if this review raises concerns or requires actions that affect the detail recorded in the care plan, then a full review of the plan would need to be carried out".
A shared understanding across organisations and members of the public as to what can be expected of whom when a person is in receipt of a Direct Payment needs to be an integral part of the decision to use this form of funding support.

Irrespective of the mechanism by which services are purchased, all interventions must be outcomes focussed and outcomes must be robustly reviewed. The current national context and an apparent clear direction and commitment locally towards an outcomes approach will support improvement in this respect There are also indications within the review that there is a need to support practitioners in their practice in the context of the core principles of the Mental Capacity Act, 2005 and in particular in supported decision making (principle 2 of this Act).

The significant care and affection of Miss G's mother for her daughter was apparent. She supported Miss G extensively and advocated tirelessly on her behalf. The degree to which support of Miss G's mother was effective indicates a further area for practice improvement in the context of the Coventry Carer Strategy.

Miss G died in a fire which was intense and took hold rapidly, the likely cause of the fire is from a dropped cigarette or cigarette ignition source. Her lack of mobility significantly affected her ability to react to or escape from the fire. If the fire had been discovered at an early stage, the presence of a carer would have increased the likelihood that the fire could have been dealt with in its infancy and/or the carer could have supported Miss G to escape the fire, however, it cannot be concluded that the absence of a carer or the practice issues highlighted were responsible for Miss G's death. Practitioner understanding of how behaviours and conditions such as smoking alongside limited mobility increases the individuals vulnerability from fire needs to be recognised as a priority area for training.

The legal and policy framework and context (and associated practice experience and case law) was developing across the timeframe scrutinised by this review. The direction of travel in terms of national policy links closely to key lessons from this review. Embracing this locally will support the necessary improvements.

The organisations involved in this SIR are committed to ensuring that the issues presented here are addressed. The recommendations within the report will form the basis of a Coventry Safeguarding Adults Board action plan. The Board will, in addition, monitor the implementation of improvements within individual organisations.

What Happens Next?

The specific actions within the plan aim to change the way organisations work together, and separately, so that similar circumstances experienced by Miss G do not happen again. The action plans will be reviewed regularly by the Coventry Safeguarding Adults Board, in accordance with their local procedures.