Crawley Borough Council

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Report to Cabinet

9 September 2015

Regulation 28 of the Coroners (Investigations) Regulations 2013

Report of the Coroner to Prevent Future Deaths

Report of Karen Dodds Head of Crawley Homes CH165

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1. Purpose

1.1 The Cabinet to consider the Report of the Assistant Coroner of West Sussex issued on 4th August 2015 to prevent future Deaths made under paragraph 7 schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of The Coroners (Investigation) Regulations 2013.

2. Recommendations

That the Cabinet

2.1 Considers the contents of the Coroner's Report, including commenting on the initial Officers response to the issues identified by the Coroner that relate to Crawley Borough Council.

2.2 Delegates authority to the Head of Crawley Homes in Consultation with the Portfolio Holder for Housing to provide a full written response to the Coroner by 29th September 2015.

3. Reasons for the Recommendations

3.1 The Coroners Regulations of 2013 require the Council to consider and respond to the Coroner's report within 56 days from the date of the report. The Council's response must contain details of action taken or proposed to be taken, setting out the timetable for action or if no action is proposed an explanation as to why no action has been taken.

4. Background

4.1 Mr Jeffery Warren (Deceased) was a Council tenant occupying 33 Albert Crane Court, Ifield, Crawley. The property in question is a general needs one bedroom, second floor, self-contained flat.

Council staff had been working with Mr Warren and had issued a safeguarding alert to West Sussex County Council adult social services. As a result of the safeguarding alert the police were asked to visit and found the tenant dead in the flat.

Investigation and Inquest

Following the death of Mr Warren, on 3rd February 2015 the Senior Coroner for West Sussex commenced an investigation into his death the Investigation concluded at the end of the Inquest on 21st July 2015, the conclusion of the Inquest was accident, the medical cause of death being:

1.(a) Bronchopneumonia
1.(b) Broken ribs
2. Hypothermia

5. Information & Analysis Supporting Recommendation

5.1 Pursuant to Regulation 28 of the Coroners (Investigations) Regulations 2013 The Coroner on 5th August wrote to

i. The Chief Executive of CBC and
ii. The Director of Social Services and The Chief Executive of West Sussex County Council

5.2 The Regulation 28 Report is set out in Appendix A. Although the cause of death was considered to be accidental, the Assistant Coroner identified matters of concern in how the Council and West Sussex County Council had handled the matter. The report at paragraph 5 under parts (1) and (2) identifies 2 areas of concern that are relevant to CBC.

5.3 Rule 29 of the Regulations requires the Council to respond to the Coroner within 56 days starting from the date of the Coroner's report was sent to the Chief Executive of the Council (by 29th September 2015)

5.4 The Council's response must contain details of any action that has been taken or which it is proposed will be taken as an explanation as to why no action has been taken.

5.5 Officers have considered the Report, their initial response for Cabinet to consider is set out at Appendix B.

6. Implications

6.1 The Legal implications are summarised in the report.

7. Background Papers

None.

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REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. The Chief Executive, Crawley Borough Council** **2. The Director of Social Services & Chief Executive, West Sussex County**
1	**CORONER** I am Bridget Dolan, assistant coroner, for the coroner area of West Sussex
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 3 February 2015 the Senior Coroner commenced an investigation into the death of Mr Jeffrey Warren The investigation concluded at the end of the inquest on 21 July 2015. The conclusion of the inquest was accident, the medical cause of death being (1a) bronchopneumonia (1b) broken ribs (2) hypothermia.
4	**CIRCUMSTANCES OF THE DEATH** 1. Mr Warren, who was born on 13 December 1928, was a tenant of Crawley Borough Council (CBC). He was vulnerable in that not only was he elderly he also suffered deafness. He had no family and no known friends nor were any neighbours known to take any active part in looking after his welfare. 2. The CBC housing department were aware that Mr Warren was someone who would benefit from support. However Mr Warren was an independent character and reluctant to accept help. With no known family or friends to assist him or encourage him to take the facilities and support that was on offer to him it was left to those employed by public bodies to do so. It was the view of the allocated Tenancy Support Officer (TSO1) that Mr Warren's vulnerabilities were such that he ought to move to a sheltered housing scheme, however he declined this when offered. When his gas heating and cooking equipment was condemned in March 2014 he declined an offer of having central heating installed. He was therefore provided with two electric heaters by CBC. 3. Mr Warren's case was allocated to the CBC Tenancy Support Team. The tenancy support officer (TSO1) described how one of the particular tasks of the tenancy support team was "to engage people'. TSO1 managed to achieve some engagement with Mr Warren, including taking him shopping to purchase a microwave. She stated in evidence that she believed he should be seen for support monthly. However she changed post in April 14 and her replacement recorded Mr Warren's case as "case semi closed" on 28 April 2014.

4. Mr Warren was however referred to the "Older Persons Support team". TSO1 informed the court that the rationale for the referral was that this team could visit Mr Warren more regularly and should try and engage him in accepting services. Mr Warren was reluctant to accept help and so would need extra effort to try and engage him. However the evidence was that after meeting him once in August 2014 Mr Warren was also discharged from that team.

5. Mr Warren was seen briefly again by TSO1 in December 2014 when he agreed to be referred to a service that supports those with sensory impairments and also agreed to the placement of a fire alarm in his flat.

6. On 14 January 2015, after having visited his flat to fit the alarm, the fire officer reported to CBC by email that the flat was unsafe in that the electric heater provided by CBC now had a broken leg and was leaning against non-flame retardant furniture. Replacement with an oil heater was suggested. This electric heater clearly created a continuing fire risk at the property, but this was neither noted as an urgent risk by CBC nor treated as such.

7. On 21 January TSO1 in discussion with her manager determined that a 'vulnerable adult referral' known as a "safeguarding alert" should be made to West Sussex County Council Social Services (WSCC) because CBC were "very concerned for Mr Warren's health particularly given the cold weather".

8. That safeguarding alert was received on 21 January by WSCC, although it was not allocated to a social worker (SW1) until 26 January.

9. On 27 January SW1 decided that she would contact the police to request a welfare check. She informed the police that there was no immediate concern for Mr Warren and so a check could be made "in the next couple of days". The police call handler pointed out to her that this type of welfare check was not normally a service provided by police – nevertheless, the police agreed to conduct a non-urgent 'neighbourhood policing team' visit.

10. A letter was sent to Mr Warren by SW1 on 28 January seeking his consent to refer him to the 'prevention assessment team', SW1 then discharged him from her team's caseload.

11. The evidence of SW1 was that she was relatively new in post at the time and was unaware of the criteria applied by police for welfare checks or how the police graded the urgency of checks. She informed the court that neither before or since these events had she been given any training or provided with any information regarding when it is appropriate to use the police to conduct welfare checks or the protocols the police are then likely to use when categorising the urgency of calls made to them by social services. SW1 stated that although she could have requested a more urgent check to be conducted by a Social Worker from a locality team she referred to police because she thought it was unlikely that the WSCC locality team would have accepted the referral of Mr Warren because he would have been perceived to have had mainly housing needs.

12. On 29th January members of the police 'neighbourhood policing team' conducted the non-urgent welfare check as requested and found Mr Warren deceased at his

	home. His house keys were in the front door and hence anyone attending his flat sooner could have gained access and found him sooner, although it is not possible to establish when he died. 13. It appears, from the circumstantial evidence of the dates on his shopping, that Mr Warren had fallen at his home on or around 24th January and was immobile on the floor with a number of broken ribs. Whilst lying on the floor he contracted bronchopneumonia and he also had physical signs associated with suffering hypothermia. The medical evidence was that he would have suffered distress, pain and stress. 14. No internal review of the events surrounding Mr Warren's care and his death has been conducted by either Crawley Borough Council or West Sussex County Council. At the inquest hearing the Borough Council claimed to be in the process of conducting such a review, but it appeared that the key staff involved in the events were neither aware of that review nor had they, as yet, been interviewed or consulted as part of the review.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) That neither CBC nor WSCC have a yet undertaken any formal review of this case despite the death of someone known to both organisation and subject to a safeguarding alert at the time of his death. An opportunity to learn lessons from the above events has hence been delayed and potentially been lost. (2) That Mr Warren had a potentially hazardous electric fire inside his home that had been supplied by his landlords (CBC) and that was left in situ from 14th January up until his death despite notification of this to the housing authorities; (3) That WSCC Social Work staff sought to use police resources to conduct a non-urgent social welfare check, rather than allocating that check to an appropriate council employee; (4) That WSCC Social Work staff are not aware of, given any training regarding or provided with any information about the criteria likely to be applied by police for conducting welfare checks and/or the circumstances in which it is or is not appropriate to ask the police to conduct a welfare check.
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe your organisations have the power to take such action.
7	**YOUR RESPONSE**

	You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 September 2015. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: The Chief Constable of Sussex, West Sussex Fire and Rescue Service I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**4 August 2015** pp Bridget Dolan

Appendix B

Contact: **Karen Dodds**

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Date:

Ms Bridget Dolan
Assistant Coroner for West Sussex
Coroner's Office,
West Sussex Record Office,
Orchard Street
Chichester,
West Sussex,
PO19 1DD

Dear Ms Dolan

Inquest into the death of Mr Jeffrey Warren – 21st July 2015
Regulation 28 Report to Prevent Future Deaths

I am writing to you to respond to the matters of concern raised in your Regulation 28 Report to Prevent Future Deaths report following the Inquest in to the death of Mr Jeffrey Warren. Your report and the Council's response have been carefully considered by the Council's Cabinet at their meeting on 9 September 2015.

There are some matters of fact which I would like to correct in the Report

- CBC do not have a Tenancy Support Team, there is only one officer (TSO) within a housing management team (Circumstances of Death ref para 3).
- The fire officer did not request an oil heater. The Council had already supplied two new oil filled electric radiators to Mr Warren on 15 April 2014. These have castors on them to aid moving around a room. It was one of the castors that had detached that was observed on the fire officer's visit (Circumstances of Death ref para 6). There was some confusion by Council staff following the visit of the fire officer regarding installing oil filled radiators, however, when records were properly checked it was clear that oil filled radiators had already been supplied. Enclosed with this letter are the Council's record on this matter.
- At the time of the Inquest the Council had carried out a Review, had spoken to the staff involved and reviewed all of the case notes. The manager of the housing management team initially carried out this review as part of the preparation of the report for the Inquest and this was then reviewed by the Head of Service with the service recommendations coming from further discussions. The recommendations were not contained in the report for the Inquest. Recommendations 1 and 2 below had come out of this Review. We are of the view that the line of questioning of the Council witness TSO1 meant that she thought there was something other than the discussion she had had with her line manager.

Following the Regulation 28 Report to Prevent Future Deaths and with respect to the matters of concern the Council has reviewed the circumstances of its involvement and responds as follows:

1. The Council's involvement with Mr Warren stemmed from the need to replace the heating system to his flat. It is the Council's policy to install gas central heating in all of its properties (where possible) as this provides the most cost effective and efficient form of

heating for well-being. Installing central heating was the focus of staff' effort with Mr Warren but where tenants' remain adamant that they do not want such a system installed then other options should be considered and in Mr Warren's case this may have been a replacement gas fire to the wall or storage heaters, which would have provided a permanent solution to the heating problem. While not ideal as a space heating solution it was clear that he was not going to accept a central heating system. This has been actioned, although such circumstances are rare.

2. The Council has reviewed the terms of its contract to provide housing support for older people. One of the eligibility criteria is that "the customer must be willing to accept support as a condition of the support agreement". In this instance Mr Warren was very clear that he did not want the service but we accept that there may need to be more effort to engage people whose very independence can be a barrier to accepting the help they may need. In this case the TSO had maintained a relationship and managed to engage and therefore although difficult more could have been done to assist Mr Warren. This has been actioned although again the circumstances are rare.

3. The fire officer contacted the Council on 14 January 2015 via a generic email address. Although the email was passed to the heating team on the same day it took two days for the repair to be issued to an engineer. We will review all of the generic emails to ensure only those people who can action the requests are recipients and then ensure that all of those staff can input the service request on all work streams. This will be completed by 30 September 2015.

4. The heating engineer visited 5 or 6 times between 16 January and 27 January when he reported back to the TSO that he was unable to gain access. Unfortunately, the engineer did not go beyond the entry phone door after 24 January 2015 so did not observe Mr Warren's keys in the front door. Currently entry phone door keys are not available to our contractors and we intend to change this to ensure that they can access the building and the front door to the property. Initially we will carry out a review of all of the door entry systems, which we intend to complete 30 September 2015, and then we will carry out an upgrade programme so that we can have systems with either a master key or master switch. This will overcome the problem of having to have a large set of door entry keys for all of our properties. This is a longer term plan as there are numerous systems but we will prioritise the older systems. Where there is a known access problem the contractor will be provided with the specific door entry key (linking with 5 below).

5. We also accept that the difficulty in gaining access should have been referred back to the TSO more promptly and where there are concerns this needs to be highlighted within the repairs system. Action will be taken to address this and will be completed by 30 September 2015.

6. Finally, the Council does not have a procedure for immediately reviewing a death where a safeguarding alert has been made. The Council's review was prompted by being contacted by the Coroner's office on 11 February 2015. Safeguarding alerts will be followed and reported to senior managers and any future deaths where a safeguarding alert has been made will immediately be subject to review. This will be actioned forthwith.

Yours Sincerely

Karen Dodds
Head of Crawley Homes