MANCHESTER CITY COUNCIL

Adult's Social Services

Nigel S. Meadows - H.M. Senior Coroner
H.M Coroner's Office
PO Box 532
Manchester Town Hall
Albert Square
M60 2LA

Manchester City Council
P.O Box 532
Town Hall
Manchester
M60 2LA

Date: 6th November 2017

Dear Mr Meadows,

Report to HM Coroner Mr Nigel Meadows in response to the Regulation 28 Report Dated 11 September 2017

Subject: Brian Maclean (d.o.b 20/12/1957), [redacted]

Background

Mr Maclean died in a fire at his home on 19 March 2016. He lived alone and was known to have a long standing alcohol abuse and health problems. On the day of his death, it is understood Mr Maclean had consumed a significant amount of alcohol and had caused a fire. A Fire and Rescue Report by Greater Manchester Fire and Rescue Service's (GMFRS) identified the likely cause of the fire to have been "*carelessly discarded smoking materials*".

The Coroner concluded the inquest into the death of Mr Maclean on 6 September 2017 and recorded that he died from smoke inhalation contributed to by alcohol toxicity. A conclusion of "*alcohol related*" was recorded.

The Coroner identified a number of areas of concern in a Regulation 28 Report to Prevent Future Deaths including: "*That Social Services did not take a more proactive role in pursuing any referral and understanding the risks presented by the deceased. This requires joined up thinking and working with GPs, the NHS locally, the housing provider and finally GMFRS*."

The Coroner directed that action be taken to prevent future deaths, such response to contain details of action taken or proposed to be taken and to set out the timetable for action or, alternatively, to explain why no action is proposed.

Response on behalf of Manchester City Council

A referral was made via an online form to Manchester City Council's (MCC) Contact Centre for Children, Families and Adult Social Care on 26 January 2016 by Mr Macleans support worker from Great Places, a housing provider.

The Contact Centre acts as the initial point of contact for all queries, concerns and referrals raised in connection with a child or adult at risk.

The referral expressed concerns about Mr Maclean's living conditions, personal hygiene, levels of nutrition, mental capacity and rent arrears.

The referral was read and prioritised as 'not urgent' by a Customer Service Officer (Officer A) on the 26 January 2016. This referral was subsequently placed into a non-urgent folder to be processed.

On 12 February 2016 another Customer Service Officer (Officer B) was allocated the referral and began processing it that day. Officer B contacted the referrer (Great Places) to request the GP details of Mr Maclean and to request the referrer contact him back when Mr Maclean was present to enable him to speak to the gentleman as there was no telephone number for Mr Maclean on the referral. This was to enable Customer Services to establish further information and to gain consent from Mr Maclean.

An email was subsequently received from the support worker from Great Places on the 17 February 2016 with the GP details for Mr Maclean. Officer B then contacted Mr Maclean's GP on the 19 February 2016 to establish Mr Maclean's health condition and his capacity to consent to the referral. Following the discussion with Mr Maclean's GP Officer B took the decision to take no further action in respect of the referral. Officer B subsequently recorded onto the electronic recording system: "*no consent/concerns not substantiated by GP/NFA. Letter sent*."

The letter to Mr Maclean stated that contact has been received from Great Places to advise that he may need support, that an officer had attempted to contact Mr Maclean to gather further information without success and Mr Maclean should contact the service again should he wish to access services in the future.

<u>Findings of the management investigation</u>

Following the concerns raised by the Coroner a management investigation has taken place. It is evident from the investigations of the actions taken by Officers A and B that internal procedures were not followed.

Based on the information provided by the referrer the original officer, Officer A, who classified the referral should have identified that an urgent response was required and it should have been placed into the urgent folder to be processed immediately. The concerns expressed in the referral meet the criteria for urgent action in that Mr Maclean was clearly eligible for an assessment under the Care Act and potentially at risk of significant harm.

Officer A's conduct is currently being addressed through MCC disciplinary procedures.

Based on the information provided in the referral by the referrer in respect of Mr Maclean the second officer, Officer B, should have passed it to the Primary Assessment Team for further

assessment once he had established that he was unable to make contact. The referral also indicated consent had in fact been received from Mr Maclean.

Officer B's conduct is also being addressed through MCC disciplinary procedures and the officer is currently on alternative duties

Actions

In response to the concerns raised by the Coroner and the outcome of the management investigation the following actions have taken place or are to be taken:

1. All contacts which have been closed or viewed as non-urgent by Officers A and B have been reviewed.

2. An audit of 20% of all contacts classed as "NFA" (No Further Action) by the Contact Centre between July 2017 and September 2017 is being undertaken

3. Further training will be provided for all Contact Centre staff in respect of the Care Act, safeguarding and consent. This will be arranged immediately and will be provided by MCC's Quality Assurance Team.

4. The Quality Assurance Team are to undertake regular audits of the work undertaken by the Contact Centre.

5. MCC is currently exploring increasing social work supervision and oversight of the Contact Centre officers

6. MCC has considered the recommendations of the GMFRS report and will continue with the work currently underway to raise the awareness of the services offered by GMFRS among adult social care staff. There are regular meeting between the Community Safety Officer from GMFRS and MCC to ensure that all options for extending partnership working are considered.

7. MCC will be referring this matter to Manchester Safeguarding Adults Board for their consideration as to whether this meets the criteria for a Safeguarding Adults Review.

Yours sincerely,

Y. B. Nolan

[redacted]
Deputy Director of Adult's Social Service - Manchester City Council