**IN THE MATTER OF THE INQUEST**
**TOUCHING UPON THE DEATH OF WILLIAM LUGG**

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**Response from the London Borough of Tower Hamlets to the Coroner's Regulations 28 Prevention of Future Deaths Report**

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## Introduction

1. This is the response from the London Borough of Tower Hamlets ('the Council') to the Coroner's Regulation 28 Prevention of Future Deaths Report dated 25 June 2018 following the inquest into the death of William Lugg ('WL').

2. On 12 March 2018 an investigation was commenced into the death of WL, aged 68 years old. The investigation concluded at the end of the inquest on 20 June 2018. The inquest found that WL died on 6 March 2018 at his residence at [redacted] following an unwitnessed fall when he was ascending the stairs at that address, which occurred on / by the morning of 3 March 2018. The conclusion of the inquest was a narrative one. The medical cause of death was found to be head injury.

   The narrative conclusion of death is as follows:

   *"…Mr Lugg lived alone and had not left his residence for several years. He suffered from severe depression. He was under the care of the Tower Hamlets Adult Social Care Team and received daily care visits from staff employed by the Careworld London care agency and also Meals on Wheels. From the morning of 3 March 2018 onwards, the Careworld carer and the Meals on Wheels personnel received no answer upon their daily*

*attendances at the premises. This was unusual. Careworld did not contact the Tower Hamlets Out of hours service or the police over the weekend of 3 – 4 March 2018. They conveyed inaccurate information to Tower Hamlets on 4 and 5 March 2018. The premises were not attended until 6 March 2018 by Tower Hamlets Adult Social Care Staff, when police were contacted for the first time. Once entry was gained, Mr Lugg was discovered, deceased, having fallen down the stairs. It is not clear whether or not earlier intervention, following the fall, would have saved him…".*

**Response to Concerns**

3. The Council has carefully considered each of the matters of concern raised by the Coroner and this response addresses each concern in turn setting out the action taken or proposed to be taken, along with a timetable for the actions.

4. Following the death of WL and prior to the inquest conclusion hearing on 20 June 2018 the Council commenced a safeguarding enquiry on 3 May 2018 and a referral was made for a Safeguarding Adults Review on 9 March 2018 with a view to learning lessons from this case. The Coroner will recall that [redacted], Team Manager for the Assessment and Intervention Team (Adult Social Care) provided both written and live evidence about the steps that are being taken.

***a) Tower Hamlets Failed Visits Procedure was poorly understood and not followed by Careworld staff, in particular (though not limited to): (a) the appropriate means of alerting Tower Hamlets to failed care visits that occurred during a weekend; and (b) use of the Tower Hamlets pro forma Failed Visit Record;***

5. The service specification against which commissioned home care services are to be delivered, and which forms a core element of the contract between the Council and commissioned providers, includes explicit

reference to the importance of compliance with the Failed Visits Procedure as follows:-

***12.8 Failed Visits***

*12.8.1 The Council has revised and updated its Failed Visits Policy and Procedures with effect from January 2016. This Policy and Procedure document is annex 02 to the service specification and must be complied with at all times.*

*12.8.2 For the absence of doubt, a failed visit is defined as a planned visit that has not been cancelled or changed by the Council or service user, and for which the care worker or other professional scheduled to undertake the visit has been unable to gain access to the service user.*

6. The Failed Visits Procedure that was current at the time the Council entered into its contract with Careworld was included with the service specification and its importance has been the subject of discussion in home care provider forums that Careworld participated in on a number of occasions. Other commissioned home care providers have confirmed that they have no difficulty in understanding and operationalising the Failed Visits Procedure.

7. The service specification referred to above also makes clear, in section 11, which relates to workforce issues, *"the service provider will ensure that as a minimum*" a range of workforce competencies are maintained including the following:-

- *All employees are competent and trained to undertake the activities for which they are employed and responsible;*
- *All employees are aware of their Safeguarding responsibilities both for Children and Adults;*

- *All employees are aware of, familiar with and can operationalise the Provider's policies and procedures.*

8. It is the Council's view, that the requirement both to comply with the Council's Failed Visits Procedure and to ensure that care staff are competent in complying with the said procedure is clearly specified.

9. Since the inquest the Council has confirmed with all providers that they have a copy of the current Failed Visits Procedure and those providers have also been consulted on the proposed revisions to the Procedure referenced elsewhere in this response.

10. The Council has reviewed its contractual relationship with Careworld in response to a range of concerns, including those relating to conduct in the provision of care to Mr Lugg, and following Mr Lugg's death. Non-compliance with the Failed Visits Procedure in a number of cases has been one of the themes identified as a result of this review.

11. Based on the findings from this contract review process the Council has determined to terminate our contract with Careworld and the termination notice has now been served. All care services provided by Careworld in Tower Hamlets are therefore being transferred to other commissioned providers on 20 August 2018.

***b) <u>Careworld's own Failed Visits Procedure does not mirror or reflect aspects of Tower Hamlets' prescribed procedure;</u>***

12. The service specification referred to above includes, in section 12, the following requirement:

*12.4 It is for service providers to ensure that the content of their policies and procedures is accurate, up to date and reflects the requirements of the contract, service specification and all relevant legislation and regulatory requirements. The Council will, as part of the*

*ongoing contract management process, expect to review a sample of policies and procedures to ensure compliance with these requirements. There are also a number of specific policies and procedures the Council wishes to draw specific attention to, either to provide additional commentary on content or to make explicit the requirement to comply with existing Council policies and procedures. These are listed below.*

The Failed Visits Procedure is one of five policies and procedures that is explicitly referenced here and the reference is reproduced above (paragraph 12.8).

***c) Vital information regarding the identity of and contact details for the only other keyholder to the premises in this instance was not clearly recorded by either Tower Hamlets or Careworld;***

13. The section 42 safeguarding enquiry into the death of Mr Lugg is almost complete but has not yet been concluded due to a subsequent allegation of financial abuse which is still being investigated. However, some of the key findings are shared in this report.

14. The enquiry recognises that the neighbour being an emergency contact and key holder was not discussed between Mr Lugg and the social worker and that therefore there is no record of the neighbour's details on the Adult Social Care file.

15. The Careworld care plan signed on 26 January 2018 does detail the neighbour as Mr Lugg's emergency contact. Although Careworld had this information on file, it was not shared with the carer when he was trying to locate Mr Lugg.

16. The safeguarding enquiry report recommends that social workers and senior practitioners should ensure that up-to-date front-sheet information including relationships, emergency contacts, key holders, key safe details, warnings and information about mobility issues is kept updated. This will

ensure that accurate information is captured by the Adult Social Care and is accessible when it is needed.

17. The Council's Failed Visits Procedure has been reviewed and following consultation, including with our provider services, it is being revised. The revised policy will be signed off and formally launched with the Adult Social Care and commissioned providers in August 2018.

18. The revised policy addresses the above recommendation. It now includes a section on "being prepared" which highlights the importance of good record-keeping. This section in the procedure aims to ensure that services that may encounter a "failed visit" situation are equipped with the right information to enable them to act quickly and effectively. This includes, for example, the requirement to hold essential information such as the names, addresses and telephone numbers of emergency contacts, family and friends, the nearest key holder, any mobility issues and whether the person is known to leave their property or not. The procedure requires that this information be accessible to those who may need it, any time, day or night.

***d) No adequate record of calls from a carer to the Careworld Care Co-ordinator regarding failed visits was made, leading, in turn, to inaccurate information regarding the client's welfare being disseminated to Tower Hamlets by another member of Careworld staff;***

19. As noted above, Careworld's conduct in relation to the care of Mr Lugg and following his death, is one of a number of factors that have led to the Council determining that it is necessary to terminate our contract with Careworld and the notice of termination has been served.

***e) Neither Tower Hamlets or Careworld's Failed Visits policy gives any sufficient prominence to the possibility of involving the police***

***if other attempts to confirm the individual's welfare following a failed visit have proved unsuccessful;***

20. The Council's revised Failed Visits Procedure now includes a one-page checklist which makes more prominent the requirement to call the Police in an emergency situation, following some quick checks to locate the person:-

*"…If you suspect the person is at risk of serious harm or is critically unwell you should all 999 immediately…".*

This statement is included, in highlighted colour, at the end of a one-page checklist and repeated a further twice throughout the process document.

21. Moreover, the procedure now places emphasis on *any* individual taking the responsibility to call the Police; if their assessment of risk indicates there may be a need to. There is still a requirement for information to be passed to senior staff members and to the local authority, and in most cases the decision as to whether to call the Police will be made by a more senior officer. However, the procedure does not exclude any officer, including carers, from calling the Police in an emergency situation.

***f) The absence of a clear / clearly understood system for the Adult Social Care Team to use on a Monday morning for assessing and deciding the priority of referrals from the Out of Hours service made over the weekend (and for recording this decision-making).***

22. The Assessment & Intervention Team (Adult Social Care) has reviewed its service delivery model and now has additional resources to cover the referral processing section. A First Response Officer is dedicated to managing the email referrals between the hours of 9am – 5pm, every day. This enables any urgent referrals to be picked up immediately. The officer prioritises the Emergency Duty Team (Out of Hours) reports and other failed visit reports each morning, including after a weekend. Any such

reports are saved onto the social care database (Framework-i) and emailed to the allocated officer. The First Response Officer will speak to the allocated officer or in their absence their supervisor, directly, to alert them to the report. Where there is no allocated officer, the First Response Officer will speak to the relevant team's duty section immediately, who will in turn act upon the report. The team has updated their procedures to reflect this.

23. The Referral Processing section in the Assessment & Intervention Team ran a practice session on 2 August 2018 where they looked at the lessons learned from Mr Lugg's case and implementing the new procedure for their section.

**Other Steps:**

24. In addition to the concerns as raised by the Coroner, as per the Witness Statement of [redacted] Team Manager dated 24 May 2018, the Council also notes the following learning points from this case:-

    i) Given Mr Lugg's history and his persistent lack of engagement – there is a question as to whether his mental capacity regarding his personal care, access to health services should have been assessed. I note, however that the social worker in her assessment did note that an Independent Mental Capacity Advocate (IMCA) was not required, indicating that this was at the forefront of her mind but that there was sufficient evidence to presume he had capacity. Indeed, to support her decision regarding the presumption of capacity and recognising that Mr Lugg did need some support, the social worker ensured the presence of an advocate in the form of a Tenancy Advisor / advocate during her assessment.

    Nonetheless, despite the explanation by the social worker as to why a mental capacity assessment(s) was ruled out, there remains a concerning pattern of Mr Lugg continually declining support

especially around his personal care. There is no evidence of any discussions with him about the implications of this or whether he had any insight into the repercussions of his behaviour continuing over an extended period of time and the potential risks to his health and well-being.

ii) There was a gap between November 2017 and February 2018 during which there was no allocated social worker to Mr Lugg. In hindsight, this should have been considered more carefully. Whilst I note that there were no incidents or concerns raised regarding Mr Lugg's care over that time, consideration should be given to Mr Lugg's history of non-engagement and the need for continual support and monitoring. In future, service users who are vulnerable and need continual support will remain allocated to a worker until a clear plan of support is identified.

iii) The internal interaction between the monitoring services from Commissioning and the social work team needs to be reviewed to ensure that there is a more robust way of communication. In this instance, I am of the view that the monitoring officers appeared to carry out their visits with no liaison or feedback to the social worker.

iv) The care agency, over the period between the 3rd and the 6th March 2018, appeared to have sent emails to the 'Adultcare' and 'Brokerage Duty' emails which are only accessed during the working week (Monday to Friday between 9am - 5pm). The care agency and Meals on Wheels would have been required to contact the Out of Hours Emergency Duty Service in the event of a failed visit as well as copying in the emails of Adultcare and Brokerage. The Out of Hours Emergency Duty Services have a social worker on call that can provide support and advice in the event of an emergency to include where there has been a failed visit. This procedure appeared not to have been followed in this case. Our

Brokerage Team now reminds care agencies of the contact details for our Out of Hours Emergency Duty Service.

v) The care providers are required to follow a Failed Visit Procedure which requires them to check with various agencies such as the hospital, police, and next of kin while also alerting the local authority. As this does not appear to have been fully implemented in this case, the local authority now ensures care providers are conversant with the Failed Visit Procedure.

25. A safeguarding review is ongoing and the findings and recommendations will return to the multi-agency group for agreement once the full safeguarding enquiry is concluded.

26. As set out in this report, some immediate actions have been taken in relation to the early learning in this case. Additionally, Tower Hamlets Adult Social Care has been making improvements in areas of practice that address some of the areas of concern in this case. For example:

- Piloting a new carers' assessment and raising the profile of carers in the borough
- Developing a single point of access for health and social care which includes a review of the Out of Hours service. This will cover how the service is accessed as well as case recording which is accessible to those who need to see it.
- Revision of the Tower Hamlets Adult Social Care Failed Visits Policy & Process which now includes emphasis on keeping front-sheet information up-to-date, fewer-hand-offs and highlights the importance of calling the Police if serious harm is suspected. This will be followed by a formal launch of the new policy and process with both Adult Social Care staff and our commissioned providers.
- A review of the feedback loop between the quality monitoring team in Commissioning and Adult Social Care teams.

- The Council has determined to terminate our contract with Careworld and the termination notice has now been served.

27. We have reported this case to the Safeguarding Adults Board ('SAB') subgroup. There will be an independent learning review as a follow up to the section 42 enquiry which will take into consideration other cases where there are similar themes in learning. Whilst more immediate actions have been taken in relation to the learning in this case, the full findings and recommendations of the independent review will be reported to the Safeguarding Adults Board and any further recommendations followed up.

**Conclusion**

28. I hope that the above addresses the concerns raised in the Coroner's report. The Council remains committed to learning lessons from untoward incidents and continually improving the care provided to the most vulnerable sections of our community for whom we are responsible.

Signed: Jerry Cradley Date: 16th August 2018

[redacted]

Corporate Director Health, Adults and Community

London Borough of Tower Hamlets