Devon County Council

Adult Care Operations and Health

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Ms Angela Hyde
Coroner's Liaison Officer
HM Coroner's Court
1 Derriford Park
Derriford Business Park
PLYMOUTH
PL6 5QZ

27 March 2018

Your Ref: CS/AH/18

Dear Ms Hyde,

Re: Kenneth Arthur Brinicombe - deceased

Following on from your letter to Jennie Stephens regarding the inquest into the late Kenneth Brinicombe and the regulation 28 report. Please find enclosed our response in reply to the report.

Please do not hesitate to contact me if I can be of any further assistance.

Yours sincerely

Sarah Cambridge
Principal Occupational Therapist

Encs

IN THE CORONER'S COURT

BEFORE MS CAROLINE SAUNDERS, ASSISTANT CORONER FOR PLYMOUTH TORBAY AND SOUTH DEVON

RE: KENNETH ARTHUR BRINICOMBE DECEASED D.O.D. 31.10.2016

INQUEST HELD ON 25 AUGUST 2017

RESPONSE TO REGULATION 28 REPORT, FILED ON BEHALF OF THE DIRECTOR OF ADULT CARE, DEVON COUNTY COUNCIL

Introduction

1. Devon County Council has carefully considered the matters of concerns and actions raised by the Coroner within the report on action to prevent further deaths produced pursuant to Regulation 28 of The Coroners (Investigations) Regulations 2013 and dated 25th August 2017 (the Report) following the sad death of Mr K A Brinicombe on 31st October 2016 at his home following a fire.

2. Devon County Council would like to offer its sincere condolences to the family of Mr Brinicombe.

Actions raised in the Report

3. The actions highlighted by the Coroner in part 6 of the Report are as follows:

    1. *Confirm the process of undertaking risk assessments in the home of a vulnerable adult, who cannot ensure the safety of his/her environment, and confirm the training the staff have to identify fire hazards*
    2. *Describe what measures should be taken when carers are being asked to facilitate an activity which will endanger the lives of the individual concerned and others.*
    3. *Confirm whether in future, where a vulnerable adult is at high risk of accidental starting a fire, putting himself and others lives in danger, and being unable to take any action if this occurs, that smoke detectors would be fitted that have a direct link to a fire station.*

4. I will respond to each of the actions raised in turn below.

Response

Confirm the process of undertaking risk assessments in the home of a vulnerable adult, who cannot ensure the safety of his/her environment, and confirm the training the staff have to identify fire hazards

5. All Local authority staff who are involved in the assessment and provision of services to support vulnerable individuals, receive comprehensive induction and mandatory yearly update training regarding responsibilities under the Care Act and the care management processes resulting from those responsibilities. The risks for the individual, including those relating to fire, form a routine part of these training courses and are routinely discussed by staff and trainers as part of these sessions.

6. The care management processes and documentation that support the assessment and support responsibilities under the Care Act, include risk based analysis against the Care Act eligibility outcomes as set out in Regulation 2(2) of the Care and Support (Eligibility Criteria) Regulations 2014:

a. managing and maintaining nutrition,
b. maintaining personal hygiene,
c. managing toilet needs,
d. being appropriately clothed,
e. being able to make use of the home safely,
f. maintaining a habitable home environment,
g. developing and maintaining family or other personal relationships,
h. accessing and engaging in work, training, education or volunteering,
i. making use of necessary facilities or services in the local community including public transport and recreational facilities or services,
j. carrying out any caring responsibilities the adult has for a child.

7. All the outcomes listed above will be considered by the assessor as part of their assessment and any subsequent review process. The risk of fire will therefore be considered under the (e) "being able to make use of the home safely" and potentially (f) "maintaining a habitable home environment" should the condition of the home potentially increase the risk of fire. Care and support planning will then take place wherein a clear plan will look at ensuring the outcomes can be met, one of which will be to ensure that any risk of fire is addressed under either of the eligible outcomes discussed, this might, for example, be achieved by the use of carer support or assistive technology.

   Describe what measures should be taken when carers are being asked to facilitate an activity which will endanger the lives of the individual concerned and others.

8. This is perhaps best responded to by the provider in terms of their internal policies and practices and in relation to CQC requirements. I understand that they will be covering this in their response.

9. However, in the circumstances described, DCC would expect a provider to undertake a robust risk assessment of the situation and, if concerns remain regarding the balancing of the person's right to perform a particular act against the safety of that individual and persons in the nearby vicinity, the expectation is that the provider would bring such concerns to the attention of the Local Authority, generally this would be via the relevant social care team in the first instance.

   Confirm whether in future, where a vulnerable adult is at high risk of accidental starting a fire, putting himself and others lives in danger, and being unable to take any action if this occurs, that smoke detectors would be fitted that have a direct link to a fire station.

10. The exact, and most appropriate, solution will depend on specific needs and disabilities of the individual.

11. I understand that the Fire Service do not have facilities to enable them to respond to or monitor individual properties and that they generally suggest the use of assistive technology solutions that raise alerts via a monitored call service. Exploring and identifying appropriate options is established during the assessment and care planning process and will be kept under review.

12. Raising awareness of the options and solutions available with all care management staff and ensuring that the learning from this incident is widely shared and discussed across both local authority and NHS staff groups will help to ensure that alternative alerting methods are available and in place where required. As technology continues to advance further solutions will become available as they are brought to market.

Conclusion and Next Steps

13. Actions to be taken by the LA to further increase awareness of this area of risk:

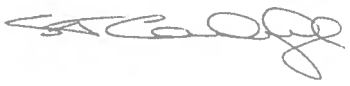
    a) All DCC care management staff to be informed of the learning from this incident and reminded of the need to consider alternative alerting options in any similar circumstances. ***Next monthly DCC staff newsletter due mid april 2018.***

    b) The new NHS and DCC community equipment service contract has assistive technology solutions available for alerting in these situations. We will ensure that all 2000 plus NHS and DCC staff who access this service are informed of the learning from this incident and directed to the solutions available within the service. ***Community equipment service Prescriber Newsletter and Newsflash to be issued by April 2018.***

    c) Learning from this incident to be raised via local and countywide management fora, to include reminders regarding options for alerting. ***By end April 2018***

    d) Learning from the incident, options and solutions will be shared with the Provider Engagement Network (for independent service providers) to include a reminder for the need to produce robust risk assessments and alert the relevant social care team should ongoing concerns arise. ***By end April 2018***

14. Devon County Council is grateful to the Coroner for bringing these concerns to its attention and has duly take on board the concerns raised. It is hoped that the response provided above will reassure the Coroner of the seriousness with which Devon County Council takes this matter and that the actions identified at paragraph 13 will have as their natural consequence the prevention of other deaths



Signed……

Printed……SARAH CAMBRIDGE……

Date……27 March 2018……

Authorised Signatory on behalf of
Devon County Council

Appendix 1

Learning from experience

Case example:

A vulnerable person with extremely poor mobility and very poor sight passed away. They were a smoker who had capacity to make decisions regarding continuing to smoke and to understand the risks.

What were the risks?

- Risk of fire
- This risk was increased due to their poor eyesight
- Risk of not being able to evacuate the premises during an emergency, due to limited mobility
- Risk to others in the vicinity should the alarm not be raised in a timely manner

Learning - What should we do?

- We need to clearly record the risks identified
- We need to consider mental capacity and unwise decision making - ensuring that mental capacity is considered and recorded, particularly where the decision might result in increased risk to self or others
- We need to ensure the risks and any potential mitigating actions form part of a conversation with the individual and any carers. For example, not just the health risks of smoking but the wider risks to the individual and others safety
- We need to ensure we record these outcome focused conversations
- We should consider the use of technology as an outcome, for example a smoke detector linked to a pendant alarm
- We should seek advice from other professionals, such as the fire service
- We need to link all the above into robust risk assessments and planning
- We need to escalate, report and record outstanding concerns where risks remain

In this example, unfortunately the person was unable to successfully call for assistance when there was a fire in their property. The fire resulted in their death.