Inquest into the Death of Shirley Ashelford [redacted]

Response by London Borough of Southwark to the Regulation 28 Report to Prevent Future Deaths dated 17.08.23

1. LBS was surprised to receive a Regulation 28 Report to Prevent Future Deaths (PFD) (the Report/the Regulation 28 Report). The evidence that was heard at the inquest and, the indication at its conclusion, was that any PFD would be made to the Medicine Healthcare Products Regulatory Agency (MHRA) and not to (London Borough of Southwark) (LBS, the Council) in recognition of the fact that the risks of positional asphyxia were not well or widely known at the time of Ms Ashelford's death.

2. LBS understands that it was noted by HM Coroner in open Court in this case that *"the CQC penalise organisations when PFD's are made. That would do an injustice in this case, this is not a failure but an opportunity to learn and to make the use of hoists safer".* It is further noted that HM Coroner had general concerns that individuals who are *"independently minded need to be supported but they need to be aware of that risk and use of hoist as safe as possible".*

3. As a result of the inquest process as a whole, LBS has given further consideration to the issue of self-hoisting service users and made some changes, which are set out below.

4. For ease, this response adopts the numbering from the Regulation 28 report dated 17 August 2023.

<u>Items 1 and 2 - Awareness of Asphyxia Risk – Service Providers and Users and Carers</u>

5. The risk of death or injury would be most likely to occur in the very rare situation where a service user has the skills combined with both the independence and motivation to use a hoist independently. The additional risk of fatal positional asphyxia may specifically be more likely if somebody has a diagnosis that can

be associated with problems with swallowing effectively, such as Parkinson's. At the time of her death Ms Shirley Ashelford was the only service user in the whole Borough who independently self-hoisted. Ms Ashelford became a self – hoister in 2008 and at that time, she was the only self – hoister. This has been the case for the last 15 years.

6. As was explored in the inquest and acknowledged by HM Coroner, the risk of positional asphyxia is not a well-known about risk.

7. Part of the rarity of the risk is that it is unusual to have someone 'self-hoist'. In the vast majority of cases, individuals are supported to use hoisting equipment with a carer and so there is always the safety mechanism by which the equipment is used when there is someone else present and able to help or call for help, if required.

8. Whilst it was accepted during the inquest that LBS had taken steps to protect Ms Ashelford by offering a care package, a pendant alarm and a micro environment in a room downstairs when she started reporting concerns with her hoist, LBS has reflected upon matters that arose in the inquest. As part of this LBS has now developed a policy and checklist, titled *"Self Hoisting Policy London Borough of Southwark"*, which is to be followed in the event LBS is working with a service user who expresses the motivation and demonstrates both the mental and physical capacity to use a hoist independently. As set out above, there are no current service users who fit this categorisation. However, the policy is now in place in the event that such occurs in the future.

9. In such an eventuality, the service user will be advised that there are risks present in the event of using a hoist. This could include asphyxiation (choking) or other sudden onset of illness which could result in serious injury or death. The new policy and checklist will support the Occupational Therapist and resident to agree the mitigating factors to reduce/remove this risk. A copy of the policy with checklist is attached to this response.

10. This new policy (which contains a checklist) will be placed on Adult Social Care's internal case management system and the information will shared by the Occupational Therapy Team Manager and Principal Occupational Therapist with all relevant staff It will also be included in the new starter induction to advise new starters within the service. LBS also proposes to have a training session on the new policy. This training will be provided to the approximately 23 OTs who are currently employed by LBS' Social Care. It will also include OT apprentices and students, team managers and health colleagues (that is, OTs, sitting within Health e.g. the reablement team that will be invited).

11. The outline of the new policy/checklist is structured on the Risks to Service users known to self-hoist and transfer using ceiling track hoists Health and Safety Executive Safety Alert Bulletin FOD WSW2-2010 and includes:
    a) A reminder of the checks necessary before the equipment is used;
    b) Recording of the demonstration of how any lowering equipment should be used;
    c) Information on how to report any adaptation faults;
    d) A recorded plan of how a service user can seek help in an emergency i.e. use of a telecare pendant or mobile phone within reach.

12. The checklist will need to be signed by the service user and any relevant person, even if informally involved in the service user's care. The service user will be reminded to contact Adult Social Care if their needs change, and if they reconsider accepting care for hoisting.

13. In the event LBS works with clients who are known to self-hoist in the future they will not be 'discharged' from Occupational Therapy' and instead will be invited for a reassessment yearly, or sooner if their needs are known to have changed.

14. For the avoidance of doubt, this new process will be used very specifically when working with service users known to self-hoist and transfer.   The policy and checklist will be used as an additional precaution to supplement the moving and handling plans that LBS issues where there is particular/individual moving and

handling advice which needs to be confirmed. The Occupational Therapist will provide demonstrations to the service user and any relevant person even if informally involved in the service user's care, as required and until competency of moving and handling techniques is confirmed.

15. When a contractor installs mobility equipment, which includes hoists, the contractor demonstrates the use of the equipment, and the service user signs to say they have been shown how to use the equipment. The housing adaptations team save this on its case management system against the clients file.

Item 3 Information Sharing – Service Providers

16. The Asset Management/ Engineering Services team (AMT/ES) is responsible for the service, repair, maintenance & inspection of mobility equipment (AMT/ES). Asset Management Home Adaptions Team (AMT/HAT) has responsibility for the survey and installation of Mobility equipment. The Occupational Therapy (OT) team is responsible for recommending the appropriate type of equipment based on their assessment of the person's need.

17. In relation to sharing information between the Occupational Therapy team and the Asset Management Team: this was a deliberate decision. There were, and remain concerns, that the O.T. team will be overburdened by information if they are sent every email or piece of paperwork. The purpose behind having a division of departments is so they can focus their resources on matters where their expertise is. That said: if there are issues with a piece of equipment, of course the Occupational Therapist needs to know.

18. The usual procedure for reporting faults/raising repairs is that a resident would contact the call centre to report a fault and the call centre would raise the order for the contractor to attend. If the matter is escalated, as it appears to have been in this case, the report can be sent by any interested person directly to AMT/ES.

19. When Higher Elevation (contracted by AMT/ES at the time) referred the bedroom ceiling hoist for replacement, it is believed that liaison/communication between OT and AMT/ES and AMT/HAT, in relation to assessing/procuring the new hoist, took place in a reasonable manner. Please refer to paragraphs 38 – 44 of Mr Kitchener's witness statement dated 05.06.23. Bureau Veritas, or indeed any contractor, would normally, at that time only report back to AMT/ES.

20. Under normal circumstances, OT's usual line of communication with AMT is via AMT/HAT, to whom AMT/ES would have fed any relevant information. It is only in exceptional circumstances that OT will communicate directly with ES or vice versa. In this particular case and due to the specific nature of the hoist the contractor was unable to supply a suitable replacement hoist and a re-assessment request was sent directly by AMT/ES to OT. OT sent the re-assessment to AMT/HAT, who then sent an order for installation shortly after. The whole process from the recommendation for replacement to a new proposed installation date took around two months. During this period, the bedroom-ceiling hoist was considered operable and useable and continued to be covered by the AMT/ES repairs contract.

21. It was also established that OT or AMT/HAT did not have direct access to the fault repair records. Steps have now been put in place to remedy this such that both OT and /or AMT/HAT can access relevant fault repair records, as required – this is explained further below.

22. In order to address the issue of sharing information, Engineering Services team (AMT/ES) has set up a Fault Repair Reporting System; this is contained in a folder that will log all call outs for repairs to mobility equipment each month. The information will be kept up to date and located in a shared folder, with access available to both AMT/HAT and AMT/ES. The OT team also has access to this folder however they will not be expected to check the folder on a regular basis. Instead, they will obtain information regarding faults as detailed in paragraph 24 below. AMT/ES currently sends this information to the insurance contractor (formally Bureau Veritas, now replaced by HSB) on a monthly basis until such

a time as access can be provided to them. This folder will enable the insurance contractor to see faults reported to equipment, including re-occurring issues.

23. The detailing of repairs on the excel sheet will enable information to be collated with regards to reoccurring repairs over a period of time and whether the repair is economically viable.

24. Currently, there is a regular quarterly meeting between AMT/HAT and the OT team. Following the inquest, self – hoisting cases and the issues arising therefrom, has become a rolling item on the agenda. AMT/ES will also now be attending these meetings. As part of this, AMT will make OT aware of any engineering concerns regarding equipment in situ, being used by self – hoisters and action that is being taken to resolve such concerns.

Item 5 Inspection of Hoist without background information

25. As the Coroner heard from the evidence called at the inquest, the Bureau Veritas inspector would not have been told of the report of Higher Elevation and Ms Ashelford's' complaint on 9/4/21, because a 'fresh eyes' approach was the preferred industry standard.

26. The recommendation (by the AMT/ES' contractor) for the replacement of the bedroom-ceiling hoist was based on the fact that a number of callouts had been made in previous months; that recommendation was not based on any evidence to suggest the equipment was unsafe or potentially unsafe to use. Job sheets and service sheets from Higher Elevation produced as evidence at the inquest portrayed the condition of the equipment as serviceable, of good working order and that many key parts had been replaced. The last call recorded by Higher Elevation on 09/04/21 recorded the equipment as "working".

27. In a period of 16 months between 22/01/20 to the 09/04/21 there had been five callouts for repairs; three of these occurred in the months March to April 2021.

The last independent inspection report from Bureau Veritas was on 30/06/21, reporting the equipment safe to operate. The evidence the local authority had did not show that any fault was evident or present during the last visits made by both the service provider and the independent inspector. The equipment was confirmed in the last two separate independent visits as working and safe. Under these circumstances, other than the recommendation to replace the unit, there was nothing from the engineer’s report that would have influenced the response from the inspector so as to change the outcome of his report.

28. AMT/ES team has met with the local authority’s current inspection provider, HSB Engineering Insurance Limited (HSB), to discuss the concerns raised by HM Coroner as to the sharing of background information/previous inspection reports. In response to the question about supplying them with service records and operational information, HSB has stated that the provision of additional information other than whether the asset was at the location or is in use would not be of particular relevance for their independent inspection. The reason for this being that these are statutory inspections which are governed by the provisions of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER), safe working practices laid out by industry standard and company method statements. The provision of any additional information would not have not influenced or altered the outcome given that the inspections had to be undertaken to specific requirements.

29. In addition, LBS has asked staff to ensure that they make it clear to third party contractors who supply and install equipment, that they should:
    a) Provide the user and any other member of the household or carer responsible for operating the equipment, a thorough demonstration of the day to day operating process;
    b) Ensure that this process shall include a demonstration by the user(s) to the installer, that they are competent in using the installation;
    c) Provide written confirmation to the Council that the demonstration has been carried out – the written confirmation is to be signed and dated by the user or others responsible for its operation.

d) Collect evidence of resident satisfaction (including any comments) on completion of works and document it on Case Manager.

30. HAT will review all collected and uploaded documentation referred to at paragraph 29 above.

<u>Conclusion</u>

31. The council recognises that steps must be put in place to ensure that in future, any such death can be prevented and that everything must be done to ensure the highest standard of safety and wellbeing of all residents. As set out above, there is no current self – hoister in the borough. The council has reviewed its practices/policies in light of the inquest and the Regulation 28 Report and it has taken, and is continuing to take, steps to ensure that the concerns raised by HM Coroner are addressed. Some of these steps include the following:

i. A number of interdepartmental meetings has occurred with representation from all parties

ii. A new policy, the *“Self Hoisting Policy London Borough of Southwark”*, has been developed

iii. Adding the issue of self hoisters as a standing item to the OT/AMT Quarterly meetings

iv. A monthly Fault Repair Report (in spreadsheet format) containing information on repairs is now made available for the inspection provider and AMT/HAT and OT to view, as required.

v. The lift contract is in transition currently to a new contractor. Once in place the new mobility equipment provider will be requested to supply a regular updated risk register to highlight areas of concern. This will include those sites subject to multiple visits.

vi. The AMT department has procured the services of “True compliance” to deliver an IT compliance solution. This will enable the council to store multiple data information sources against a property file and provide access to a range of users. The intention is that the service reports and inspection reports will be stored and that access can be provided to all stakeholders to include OT and the inspection provider. The system allows access to be via an app, which can be downloaded to handheld devices and used whilst on site. It is expected that it will take at least a year to put this in place. It should be noted that to prevent OT being provided with excessive information they will not access these reports regularly and will instead, be provided with information at the quarterly meetings.

London Borough of Southwark
Date: 31st January 2024