HM Assistant Coroner Ridge
HM Coroner's Court
Station Approach
Woking
Surrey
GU22 7AP

Woodhatch Place
Cockshot Hill
Reigate
Surrey
RH2 8EF

16 January 2024

Dear Assistant Coroner Ridge

Following the Inquest touching on the death of Mr Kevin O'Hara, the Coroner issued a Prevention of Future Deaths Report against Surrey County Council (SCC) and Surrey Fire and Rescue Service (SFRS). This joint response to the concerns raised is provided on behalf of both SCC and SFRS.

Prior to addressing the concerns raised by the Coroner, both SCC and SFRS wish to acknowledge again how tragic Mr O'Hara's death was. Both organisations wish to reassure the Coroner and Mr O'Hara's family that they fully recognise that mistakes were made and that this has been taken extremely seriously. The remainder of this response does not seek to detract in any way from that fact.

The Regulation 28 Report contained the following concerns:

> *Evidence was given that the Safe and Well Visit in November 2022 was conducted by an inexperienced officer. The results of that visit did not seem to be subject to any scrutiny. SFRS do not appear to have in place a system of review or audit by line managers or more experienced staff of completed Safe and Well Visits, with the risk, as in this case, that errors or issues requiring action are not identified.*
>
> *That SFRS reviews of individuals deemed high risk, are usually undertaken by the officer who conducted the initial Safe and Well Visit with the risk that opportunities for oversight and reassessment are missed.*
>
> *Evidence was given that the visit to Mr O'Hara by ASC on 23 January 2023 should have resulted in a risk assessment. Although ASC has policy (some of which predated Mr O'Hara's death) about when to conduct a risk assessment it does not appear to have in*

place a system of oversight to ensure that where appropriate, risk assessments follow a visit.

Both SCC and SFRS are concerned that the Coroner did not receive all of the pertinent information relating to this concern prior to issuing the PFD Report. SCC/SFRS hope that the below response, which includes an explanation of structures and processes already in place and those which have changed since Mr O'Hara's passing, sufficiently allays the concerns that she has raised.

Surrey County Council

The Coroner expressed a concern that:

(1) There appeared to be a lack of managerial oversight in relation to the visits by Adult Social Care staff to Mr O'Hara on23 November 2022 and 23 January 2023, and
(2) The 23 January 2023 visit was not undertaken by a qualified Occupational Therapist or Social Worker.

In relation to the concern regarding managerial oversight, SCC has procedures in place for managerial oversight of such visits, however, the coroner was not provided with evidence of these at the Inquest, SCC apologises for this. Several significant changes have been implemented following the death of Mr O'Hara to ensure robust management oversight following home visits and in relation to decision making around Section 9 assessments is in place and understood by all staff.

All new contacts and referrals are screened by both a Practitioner and Manager through the duty front door process, ensuring that decisions taken, and actions required are clearly recorded. Referrals are prioritised based on the information received, risk and urgency. Referrals are allocated to staff based on the level of expertise and competency required of the Practitioner. Managers and Senior Practitioners are required to have oversight of all work to ensure actions are completed in a timely way. New processes have been implemented to the electronic client database to ensure management sign off is required. There is now direct oversight of visits such as those conducted for Mr O'Hara in November 2022 and January 2023.

The duty and allocation SOP that was in development in 2023 and referred to at the Inquest is currently being reviewed to ensure that it is fit for purpose moving forward.

SCC maintains an audit process as set out in Appendix A. This ensures that assessments are audited to ensure quality in accordance with a robust framework. Once the audit has been completed it will be sent to a Team Manager for review and following this, it is sent to the Senior Manager, adding an additional level of scrutiny and learning.

SCC also maintains a Supervision Policy (Appendix B) that mandates that supervision be conducted by a suitably experienced person (paragraph 5.7). In accordance with the policy, in addition to ad hoc supervision (paragraph 7.3), formal supervision takes the form of 1.5 hour protected time on a regular monthly (or six-weekly for part time staff) basis for all frontline staff and 1 hour for non-frontline roles (paragraph 5.8). Both line management and professional supervision may increase in regularity in support of effective performance management complex case management and/or the supervisee's wellbeing.

All staff consider positive risk taking as part of our overall assessment process. However, the training department ('Surrey Academy') have been directed to commission specific risk training for all staff to include risk identification and escalations. In May 2023, it was also agreed to add a "potential risk including fire" section to the Manual Handling Assessment to ensure Practitioners such as OTs consider fire risk, particularly when prescribing equipment.

The SCC Practice Improvement Board will be established from February 2024 and will have oversight of practice needs and improvements across the whole of ASC. This will be managed by the Principal Social Worker, Principal OT and the Safeguarding Lead and consideration of the risk assessment policy and framework has been confirmed as a priority.

In relation to the concern that the practitioner who visited Mr O'Hara in January 2023 was not a qualified Occupational Therapist or Social Worker, SCC employ registered and unregistered staff to carry out their duties under the Care Act 2014. All new members of staff complete a 6-month probation period and induction programme to ensure they are aware of the requirements for their particular role. All staff receive supervision and appropriate training is provided to ensure the workforce is competent. Performance is regularly reviewed, including observational visits. The steps taken to improve managerial oversight will highlight practice and actions required ensuring the necessary assessments are taken by an appropriate practitioner.

Surrey Fire and Rescue Service

The Coroner expressed a concern that there appeared to be a lack of managerial oversight in relation to the Safe and Well Visit (SWV) conducted on the 17th November 2022.

SFRS does not believe that the Coroner was provided with all necessary evidence pertaining to the conduct and oversight of SWVs during the Inquest and it is hoped that the below explanation and evidence sufficiently allays the concerns raised. SFRS apologises that this information was not provided at the Inquest, but it was not clear until the conclusion of the Inquest that the question of staff competence or managerial oversight was a specific concern.

A concern was expressed regarding the competence of the staff member who conducted the SWV for Mr O'Hara on 17th November 2022 due to her being a relatively new member of staff. This staff member was a relatively new employee, but SFRS maintain that she had received sufficient training to ensure that she was competent to conduct SWVs. The staff member was employed on 20 April 2022 and received 2 full training days with a Watch Commander before completing shadowing of colleagues for 3-4 weeks before her progress was reviewed on 16 May 2022 and was signed off as competent.

All new staff members also complete a New Joiner Programme online. Staff are then monitored continuously for 6 months, and their performance reviewed throughout this time. A performance review was held for this member of staff on the 18th July 2022 which did not raise any concerns. After 6 months the probation period will end unless concerns are raised by the line manager and extension is applied for. Performance Conversations were held with WC Phillip Stonebanks and attendance at an annual mandatory CPD session for all staff, which the staff member attended on the 22nd February 2023.

At the time of this staff member's training, her competency was based on SFRS Policy and Guidance for completing SWV's. The Community resilience Power Point (Appendix C) is the basis that all staff are trained to along with the training being based on the NFCC Person Centred Framework (Appendix D) and use of the NFCC Competencies to support Home Fire safety Visits (Appendix E). The finalised version of this document was not available at the time of the staff member being trained (draft copies were available), as it was only developed over the course of 2023 and is awaiting final approval, however the approaches referred to in the guidance were already adopted within the Service.

Once assessed as competent, SWVs will be carried out by a staff member without being shadowed. However, there is a system of informal support throughout the Community Safety Team and any questions or concerns can be highlighted at any time before, during or after a visit, with assistance being given from the Partnership coordinator or any team member. This is currently an informal process that is not documented in a policy. As a result of the Coroner's concerns and an His Majesty's Inspectorate of Constabularies and Fire Rescue Services (HMICFRS) inspection, a formal Quality Assurance process is now being developed (see below).

In relation specifically to SWVs, staff are provided with comprehensive training (see Appendix F for PowerPoint Presentation). This training was initially developed in August 2020 and at the relevant time was given by Area Commander Andrew Treasure, Station Commander [redacted] and Crew Commander [redacted]. The training focuses on identifying and mitigating fire risks as part of a SWV. Part of this training specifically

addresses the risks posed by smoking and a resident with mobility issues. The training was amended after Mr O'Hara's death to include the following:

> "*If the individual is bedbound, it is SFRS procedure to ensure that they have an additional smoke alarm installed in this room*"
>
> "*Telecare systems should be recommended if not already installed in the property. The linked smoke alarm and call points need to be located in the compartment where the occupant is, so that detection and call for help can be accessed easily."*

In addition, SFRS produces a Guidance Document (Appendix G), last updated in October 2023, for SWVs which is available in all fire stations in the SWV document and leaflet folders and in Section 24 "All SWV documents" on the SFRS SharePoint Community Tool box.

Following Mr O'Hara's death, a Procedural Alert was issued on 28 February 2023 (Appendix H). This alert was sent to all staff with access to Learning Pool (including volunteers). The alert then sits in the learning pool for continued access and access to this is now checked monthly to confirm who has accessed the alert. The Procedural Alert deals specifically with the learning from Mr O'Hara's death and has broader relevance to the nature and recommendations of SWVs for immobile residents.

SFRS have in place a risk-based points system for SWVs. Staff have received training on how to apply this points system and it is embodied in a new form (Appendix I). This system is aligned to the NFCC guidance on persons at risk from fire and the allocated points that are attached to the answers also align with national guidance. This allows SFRS to see those at most risk across the County and will allow SFRS to follow up with any further visits and liaise closely with other support agencies that may be involved with the individual. If further support and engagement is recommended, SFRS can revisit to try and engage, build relations and make progress on behaviour change to improve safety and mitigate risk. This process will be implemented service wide in 2024 when the new system is embedded in the Service.

Quality assurance is currently carried out informally by observation by managers. The manager will speak to the officer who delivers the SWV to ascertain their understanding of what and how they are delivering safety messages. SFRS recognise that there is currently no formal quality assurance system in place that enables formal managerial oversight of the SWV to ensure that services are provided in a consistent and safe way. Whilst SFRS training of its staff has been significant over the last few years, QA is one area that has yet to be implemented. There is an informal process within the small central partnership team to ensure that those conducting SWVs are competent to deliver this service, however a formal process is currently being developed. This area of improvement was also identified by HMICFRS during an inspection in

2023. As a consequence, QA is part of the HMICFRS inspection improvement plan with a project workstream and timeline. This project will be overseen by SFRS governance to ensure that a suitable method of QA is implemented. The timeline is set for January - June 2024.

The formal system of QA will involve the partnership team and managers shadowing each fire station team at least once a year to ensure that the delivery of SWV is safe and consistent with expected standards. This will be recorded on SFRS data systems and will result in a “safe to deliver” certificate for that team. The project to implement this will also explore the feasibility of the fire station manager being tasked with a similar process in the interim six months to ensure that crews maintain competence and to take account of any new personnel on that station. SFRS will continue to review incidents and implement new processes or safety systems in a prompt manner, as happened following the death of Mr O'Hara.

SFRS fully accept that errors were made during the SWV on 17 November 2022 and that these errors were not picked up through managerial observations. SFRS wish to assure the Coroner and the family of Mr O'Hara that this is fully recognised and that the above steps are being taken to avoid such mistakes in the future.

Yours sincerely

[redacted]n
Chief Fire Officer

[redacted]
Executive Director – Adults, Wellbeing & Health Partnerships