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Coventry City Council

Agenda

Cabinet Member (Health and Adult Services)

Time and Date
10.30 am on Tuesday, 14th January, 2014

Place
Committee Room 2 - Council House

Public Business

1. **Apologies**

2. **Declarations of Interest**

3. **Minutes of the Previous Meeting**

   (a) To agree the minutes of the meeting held on 29 October 2013 (Pages 3 - 4)

   (b) Matters Arising

4. **Serious Case Review - Mrs D (CSAB/SCR/2013/1)** (Pages 5 - 20)

   Report of the Executive Director, People

5. **Any other items of public business which the Cabinet Member decides to take as matters of urgency because of the special circumstances involved**

Private Business

Nil

Chris West, Executive Director, Resources, Council House, Coventry

Monday, 6 January 2014

Note: The person to contact about the agenda and documents for this meeting is Su Symonds 024 7683 3069

Membership: Councillor A Gingell (Cabinet Member)

By invitation Councillors K Caan (Deputy Cabinet Member), Councillor H Noonan (Shadow Cabinet Member), Councillor S Thomas (Chair, Health and Social Care Scrutiny Board (5))

Please note: a hearing loop is available in the committee rooms

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Coventry City Council
Minutes of the Meeting of Cabinet Member (Health and Adult Services) held at 10.00 am on Tuesday, 29 October 2013

Present:

Members: Councillor A Gingell (Chair)
Councillor H Noonan (Shadow Cabinet Member)
Councillor K Caan (Deputy Cabinet Member)

Employees (by Directorate):

P Barnett, Resources Directorate
S Brake, People Directorate
M Godfrey, People Directorate
S Harrison, People Directorate
S Symonds, Resources Directorate

Public Business

9. **Declarations of Interest**

There were no declarations of interests

10. **Minutes of the Previous Meeting**

The minutes of the meeting held on 3 September 2013 were signed as a true record. There were no matters arising.

11. **Annual Report of the Coventry Safeguarding Adults Board 2012/13**

The Cabinet Member received a report of the Executive Director, People, which presented the annual report of the Coventry Safeguarding Adults Board 2012/13.

The Board was a multi-agency partnership made up of statutory organisations and non-statutory partner agencies, and had strategic responsibility for the development, co-ordination, implementation and monitoring of multi-agency policies and procedures that safeguard and protect vulnerable adults in Coventry. Each year the Board reviewed progress against actions set for the previous year and established new priorities for the forthcoming year to ensure that safeguarding arrangements in Coventry continue to be improved.

The annual report provided the public record of the significant progress that had been made over the year April 2012 to March 2013, whilst acknowledging the considerable challenges in the year ahead.

RESOLVED that after due consideration of the report and matters raised at the meeting the Cabinet Member endorsed the contents of the report along with the comments made by Health and Social Care Scrutiny Board (5).

12. **Adult Social Care Complaints and Representations Annual Report 1 April 2012 to 31 March 2013**

The Cabinet Member received a report of the Executive Director, People, which presented the annual report of Adult Social Care Complaints and Representations.

Adult Social Care Services had a statutory duty arising from the Local Authority Social Services and National Health Services Complaints Regulations 2009 to provide a system for receiving complaints and representations from people who use its services, or those acting on behalf of users. There was also a duty under the regulations to produce and publish an annual report.

The report highlighted the service improvements and learning from feedback and included information on future developments in complaint handling and reporting.

RESOLVED that after due consideration of the report and matters raised at the meeting, Cabinet Member endorsed the content and approved the issuing of the report.

13. **Any other items of public business which the Cabinet Member decides to take as matters of urgency because of the special circumstances involved**

There were no other items of public business.

(Meeting closed at 10.25 am)

Coventry City Council

Public report

Health and Social Care Scrutiny Board (5) 18th December 2013
Cabinet Member (Health and Adult Services) 14th January 2014

Name of Cabinet Member:
Cabinet Member (Health and Adult Services) – Councillor A Gingell

Director Approving Submission of the report:
Executive Director, People, Brian M Walsh

Ward(s) affected:
All

Title: Serious Case Review – Mrs D (CSAB/SCR/2013/1)

Is this a key decision? No

Executive Summary:

This report presents the findings of a Coventry Safeguarding Adults Board Serious Case Review (SCR).

This Serious Case Review followed the death of Mrs D, a woman in her late 80s, in the summer of 2011. Following a full safeguarding investigation, the Chair of the Coventry Safeguarding Adults Board directed that a Serious Case Review be undertaken as a result of the circumstances of Mrs D's death and the events leading up to it. This review was chaired by the designated local authority senior manager, written by an independent author and supported by a multi-agency panel of senior practitioners, including representatives from Coventry City Council, NHS Coventry (and subsequently Coventry & Rugby Clinical Commissioning Group), Coventry and Warwickshire Partnership Trust, University Hospitals Coventry & Warwickshire NHS Trust and West Midlands Police. Mrs D's General Practitioner also made a significant contribution to the review

Recommendations:

The Health and Social Care Scrutiny Board (5) is recommended to:

Note and consider the contents of the report, and make any recommendations considered appropriate to the Coventry Safeguarding Adults Board and the Cabinet Member (Health and Adult Services)

Cabinet Member (Health and Adult Services) is recommended to:

(1) Note and consider the contents of the report and any recommendations made by Health and Social Care Scrutiny Board (5)

(2) Note and consider the contents of the report and make any recommendations considered appropriate to the Coventry Safeguarding Adults Board

List of Appendices included:

Appendix 1 - Coventry Safeguarding Adults Board Serious Case Review Executive Summary of Case no: CSAB/SCR/2013/1.

Other useful background papers:

None

Has it, or will it be considered by any other Council Committee, Advisory Panel or other body?

Cabinet Member (Health and Adult Services) 14th January 2014

Will this report go to Council?

No

Report title: Serious Case Review – Mrs D (CSAB/SCR/2013/1)

1. Context (or background)

1.1 Commissioning a Serious Case Review is considered when a vulnerable adult has died or been seriously injured or impaired, and abuse or neglect is known or suspected to have been a factor. The purpose of a Serious Case Review is to carefully consider the circumstances surrounding the death or serious injury, in order to learn lessons to avoid a similar situation arising in the future. It is important to understand that this means that most deaths do not lead to a Serious Case Review, only those that meet these criteria.

1.2 Serious Case Reviews are undertaken as part of the overall National Government Guidance "No Secrets" (2000), which provides a framework for Safeguarding Adults, and in accordance with the policies and procedures set out by Coventry Safeguarding Adults Board. Serious Case Reviews are not inquiries into how a vulnerable adult died or who is culpable; the initial safeguarding or police investigation would have considered matters relating to the abuse and made recommendations on actions arising from that investigation.

1.3 Mrs D died following an accident and a brief period of treatment in hospital and the community. The injury which Mrs D sustained falling from her wheelchair in the summer of 2011, resulted in a period of hospitalisation and a decision to treat her neck injury using a supporting neck collar. The collar itself caused friction to her skin resulting in the formation of a pressure ulcer. This ulcer in turn eventually became infected and Mrs D died as a result of the septicaemia, or infection based blood poisoning which it caused. This serious case review examines the underlying causes of Mrs D's death, and considers and recommends actions that will reduce the likelihood of their recurrence in the future.

1.4 Following a full safeguarding investigation, the Chair of the Coventry Safeguarding Adults Board directed that a Serious Case Review be undertaken as a result of the circumstances of Mrs D's death and the events leading up to it. This review was chaired by the designated local authority senior manager, written by an independent author and supported by a multi agency panel of senior practitioners, including representatives from Coventry City Council, NHS Coventry (subsequently Coventry & Rugby Clinical Commissioning Group), Coventry and Warwickshire Partnership Trust, University Hospitals Coventry & Warwickshire NHS Trust and West Midlands Police. Mrs D's General Practitioner also made a significant contribution to the review.

1.5 The executive summary of this case, "Mrs D", will be published on the Coventry Safeguarding Adults Board website (www.coventry.gov.uk/safeguarding), and the actions agreed in the action plan will be monitored, audited and reviewed by the Board's Serious Case Review Committee on a regular basis. Any failure to achieve these actions or the timescales for implementation will be reported to the Board.

2. Options considered and recommended proposal

2.1 The executive summary of the case, including recommended actions, is attached for consideration (appendix 1).

3. Results of Consultation Undertake

3.1 No consultation has been undertaken on this matter

4. Timetable for implementing this decision

4.1 The recommendations of Health and Social Care Scrutiny Board (Scrutiny Board 5) in response to this report will be considered by the Cabinet Member (Health and Adult Services) on January 7th 2014.

5 Comments from Executive Director, Resource

5.1 Financial implications

There are no direct financial implications arising from this report

5.2 Legal implications

None

6. Other implications

6.1 How will this contribute to achievement of the Council's key objectives / corporate priorities (corporate plan/scorecard) / organisational blueprint / LAA (or Coventry SCS)?

The safeguarding of adults at risk is a corporate priority and the Coventry Safeguarding Adults Board oversees arrangements across the City to ensure partner agencies work together to address and prevent abuse and neglect.

6.2 How is risk being managed?

The Serious Case Review overview report makes recommendations which have been formulated into a multi-agency action plan to address specific issues identified, and to minimise the likelihood of such circumstances re-occurring in the future.

5.2 What is the impact on the organisation?

The Serious Case Review process demonstrates the commitment of all partner organisations to learn lessons and to continuous improvement in adult safeguarding.

5.4 Equalities / EIA

There is a need to ensure that adults who are at risk of abuse receive protection and support and that their human rights and dignity are respected. This includes a duty to intervene proportionately to protect the rights of citizens.

5.5 Implications for (or impact on) the environment

None

5.6 Implications for partner organisations?

The Safeguarding Adults Board is part of the Coventry Partnership Structure and the recommendations and action plan relate to the relevant partner agencies of the Adult Safeguarding Board.

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Directorate: People

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Enquiries should be directed to the above person.

Contributor/approver name	Title	Directorate or organisation	Date doc sent out	Date response received or approved
Contributors:				
Susan Harrison	Head of Safeguarding	People	27/11/2013	29/11/2013
Liz Knight	Governance Services Officer	Resources	27/11/2013	28/11/2013
Sara Roach	Deputy Director	People	27/11/2013	04/12/2013
Names of approvers: (officers and members)				
Julie Newman	Solicitor	Resources	27/11/2013	27/11/2013
Ewan Dewar	Finance Manager	Resources	27/11/2013	29/11/2013
Brian M Walsh	Executive Director	People	27/11/2013	29/11/2013
Cllr Alison Gingell	Cabinet Member	Health and Adult Services	27/11/2013	05/12/2013

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Coventry Safeguarding Adults' Board Serious Case Review
Executive Summary of Case no: CSAB/SCR/2013/1

What is a Serious Case Review?

A Serious Case Review (SCR) is held when a vulnerable adult has died or been seriously injured or impaired, and abuse or neglect is known or suspected to have been a factor. The purpose of a serious case review is to carefully consider the circumstances surrounding the death or serious injury, in order to learn lessons to avoid a similar situation arising in the future. It is important to understand that this means that most deaths do not lead to a Serious Case Review, only those that meet these criteria.

Serious Case Reviews are undertaken as part of the overall National Government guidance "No Secrets", which provides a framework for Safeguarding Adults, and in accordance with the policies and procedures set out by Coventry Safeguarding Adults' Board (CSAB). Serious case reviews are not inquiries into how a vulnerable adult died or who is to blame.

This serious case review was conducted in line with the procedures and systems agreed across the city, by the CSAB. These procedures include the appointment of an independent author with significant experience, credentials and, most importantly independence from all of the organisations concerned to write the SCR. There is also the requirement of each organisation involved to undertake an Independent Management Review (IMR), and the submission and testing of those reviews to an SCR committee.

Once the IMRs are all received and analysed, a report is drafted by the Independent Author and considered by the CSAB SCR subcommittee. A final report is then presented to a specially convened CSAB meeting, and an action plan developed by the agencies and organisations concerned, in order to meet all the recommendations in the SCR's conclusions.

The Facts of the Case, Summary & Background

Mrs D died in the summer of 2011, in her late 80s. Mrs D had been admitted to University Hospital Coventry and Warwickshire (UHCW) two months earlier following a fall from her wheel chair. While Mrs D was in hospital it became clear that she had damaged a bone in her neck, although it was unclear whether the damage to the bone was recent and as a result of the fall for which she was admitted, or from a previous, unknown incident. The clinical team felt that conservative treatment rather than surgical intervention was in Mrs D's best interests, and on this basis, a neck collar was fitted and a period of rest recommended. In the hospital records of Mrs D's care, it is clear that several different sorts of collars were tried, some of which caused Mrs D discomfort, and also began to cause pressure ulcers. Despite this, Mrs D was discharged with a neck collar in place. The IMR showed that several aspects of care during this hospital stay were unsatisfactory.

The hospital did not arrange any care for Mrs D on discharge home. Concerned about an ulcer developing on Mrs D's neck, her granddaughter contacted Mrs D's GP about a week and half later, and as a result, some support was provided to Mrs D at home, starting that

day, mainly by the community District Nursing Service, part of Coventry & Warwickshire Partnership NHS Trust (CWPT). As part of Mrs D's treatment, the pressure ulcer on her neck and collarbone was assessed and treated. As part of the assessment, it was graded, in line with the local protocol on pressure ulcers, as a grade 3 pressure ulcer (grades are 1-4, with 4 being the worst). The local protocol requires a referral to the safeguarding team when a pressure ulcer of this severity is identified which could have been caused by poor practice or neglect, but this did not happen.

A week or so after having been seen by the district nursing team, Mrs D attended an Out Patient appointment at the hospital, UHCW, having been referred by the District Nursing team because of friction from her neck collar and the resulting pressure ulcer that had occurred. The district nurse did not make a written referral. The consultant, who (mistakenly) believed this to be a routine follow up rather than a specific referral for additional help, on seeing Mrs D did not recommend any change or alternative treatment, and discharged her from the Hospital's care.

A further fortnight later, Mrs D's condition deteriorated to such a degree that it caused the district nursing team to arrange for her to be readmitted to hospital, where she died 2 days later. The cause of Mrs D's death was recorded as Septicaemia, (or blood poisoning) as a result of a right clavicular (collar bone) pressure sore as a result of cervical spine (neck) fracture, and rheumatoid Arthritis. A referral was made to the Safeguarding arrangements in respect of the Grade 3 Pressure Ulcer on the day of Mrs D's final admission to UHCW, two days before she died. This referral was made by a member of the District Nursing Team. The safeguarding meetings were initiated as required, however they were significantly outside of the timescales required, almost a month beyond the specified 5 days. The Coventry Safeguarding Adults Board subsequently initiated a Serious Case Review.

As is made clear above, a Serious Case Review is not intended to attribute blame but to endeavour to learn lessons and make recommendations for change which will help to improve the safeguarding and wellbeing of vulnerable adults in the future. In this case concerns have been raised about a number of issues including:

- That action taken in relation to the poorly fitting neck collar may have been inadequate or inappropriate, with a failure to properly identify or consider the potentially high risk that Mrs D would develop pressure sores.
- That there may have been poor communication between agencies at various points during the two months between Mrs D's admission to hospital and her death, and that there was no evidence of Social Care support in planning her discharge from hospital.
- That a safeguarding alert did not take place until 2 days before Mrs D died, several weeks after it became clear that a pressure ulcer was developing, and the safeguarding planning meeting which eventually took place, occurred four weeks after the alert was received (which was nearly four weeks after she died).

In the early part of 2011, before Mrs D's fall, she had had contact with the City Council's Social Care department. Mrs D was an elderly lady, in her late 80s, with an extended family of children, grandchildren and many other relatives, having had 16 children.

The City Council's Occupational Therapy, and then Social Services undertook assessments, in early 2011 which finally resulted in no services or provision to Mrs D as she either declined to accept services, or actively refused, not wishing to engage. The review found however that at least one aspect of potential support was not fully explored with Mrs D. Three months or so after her first contact with the City Council, her case was closed.

It is clear from the notes and interviews with staff and Mrs D's family, that she had the capacity to determine her own needs and care, and understood what was being offered, and refused it nevertheless. It seems likely that Mrs D was inclined to under-report symptoms, and refuse help offered. However the fact that Mrs D had capacity in this sense doesn't mean that she wasn't vulnerable. Indeed, as she subsequently developed a grade 3 pressure ulcer, which could have been related to poor practice or neglect Mrs D should have fallen within the City's safeguarding arrangements.

Analysis

Mrs D died following an accident and a brief period of treatment in hospital and the community. The injury which Mrs D sustained falling from her wheelchair in the summer of 2011, resulted in a period of hospitalisation and a decision to treat her neck injury using a supporting neck collar. The collar itself caused friction to her skin resulting in the formation of a pressure ulcer. This ulcer in turn eventually became infected and Mrs D died as a result of the septicaemia, or infection based blood poisoning which it caused.

In their comments to this SCR, Mrs D's family have expressed the belief that the pressure ulcer suffered by Mrs D may have become infected significantly before Mrs D was admitted to hospital for the second time. If this were the case, then treatment with antibiotics would have been the likely best thing. No evidence that this was the case has emerged from the IMRs, although Mrs D's wound was not tested for infection prior to her final readmission, 2 days before she died.

During Mrs D's first stay in hospital at UHCW it was evident that there was a difficulty in finding an appropriate neck collar for Mrs D but this was not properly resolved by gaining the advice of the Surgical Appliance Department. There was also evidence that a friction induced ulcer was developing but this was not properly addressed. Bearing this in mind, the decision to discharge her from hospital without planned follow up in the community increased the risk of complications in her condition. It is also important to note that Mrs D's GP was not advised directly of her discharge, with a patient held letter being the only communication.

At the point of her admission to UHCW, Mrs D was known to Social Care (having been referred, assessed and discharged 5 months previously), and there is also no evidence that Mrs D was visited by a social worker prior to discharge. During the initial contact the Social Worker did not follow up the suggestion of some kind of sitting service which there was reason to believe she might have accepted. Mrs D had refused a number of services which led to the closure of her file. However more should have been done to address the risks which had been identified. Mrs D's right to refuse support was rightly respected . However there were reasons to suspect that whilst having capacity Mrs D's ability to give informed consent may have been compromised by her fears about being taken away from her home. In these circumstances every effort should have been made to find a service option acceptable to Mrs D to help minimize risk, including the possibility of alerting other agencies.

Following her discharge from UHCW, The first and subsequent contacts made by Community Nursing staff also missed opportunities to refer her case to the Safeguarding arrangements and thus for urgent multiagency review of her case. The review found that the local protocol in use at the time was unclearly written.

At the outpatient appointment arranged by a member of the District Nursing Team, a fortnight before Mrs D died, it is clear that a potential opportunity for positive intervention in

Mrs D's case was missed. The District Nurse had made the referral hoping to have the neck collar reassessed and to get advice on its use bearing in mind that it had caused a significant pressure sore. The District Nurse's concerns, which were expressed by telephone (and not in writing), did not reach the Clinical staff reviewing Mrs D for reasons that are not clear, an important failure of communication and record keeping.

The UHCW clinical staff, as part of a consultant–led service, in turn detected no problem and discharged her following what they believed to be a routine follow up appointment. Even without a written referral it is unfortunate that a problem with the neck support sufficient to cause a Grade 3 pressure ulcer was not be picked up during the appointment. An opportunity for effective advice on the management of the effect of the neck collar had therefore been missed.

The use of the existing pressure ulcer protocol failed in the case of Mrs D. Her pressure ulcer was not (on at least two occasions) assessed and considered for referral to safeguarding in the prescribed and agreed manner. When a referral was finally made two days before she died, the safeguarding processes itself was not initiated until almost 4 weeks after Mrs D died, which was well beyond the time limits set and a further way in which services failed Mrs D and her family.

It is extremely difficult to say whether addressing any or all of the issues outlined above would have prevented her death. It seems possible, however, that the risk that her initial injury would ultimately result in her death could have been reduced, and the recommendations in this report will seek to address ways in which improvements could be made.

Conclusions

Mrs D was an elderly woman with a number of disabilities and health concerns prior to the incident which ultimately led to her death. She was extensively supported by her family and it is evident that it was difficult to persuade her to accept changes which may have improved her overall health. It is also clear that whilst staff did not seek to exclude them Mrs D's family felt they were not listened to as much as necessary, and had a valuable contribution to make within formal care environments alongside health and social care professionals. It is clearly important that staff ensure that carers have an opportunity to express concerns and have those concerns responded to .

There were some significant shortcomings in the assessment, care, treatment and services provided to her and some missed opportunities for closer working between agencies providing care to her. These failures were significant in relation to how Mrs D was cared for, and may ultimately have been significant in how, and when she died, although it is impossible to be certain of this.

Learning from this Serious Case Review emphasises that a positive and proactive approach to joint working is in the best interests of those receiving services, as well as basic standards of care being effectively and comprehensively delivered. The philosophy of Safeguarding Adults is based on this principle and arrangements will only be effective where the principle is properly owned by partner agencies and incorporated into their daily practice. The experiences emerging from this review of the circumstances of Mrs D's sad death must lead to improved progress in interagency working and to improvements in care.

What Happens Next?

Recommendations from the review form the basis of an action plan, which is regularly monitored to ensure that the recommendations are put into place. The action plan will be reviewed regularly until all of the agreed actions have been completed and implemented.

Summary of Recommendations

Recommendations have been developed that apply to all agencies, and also that apply specifically to individual agencies. The recommendations below summarise the actions that are needed to reduce the likelihood of the events leading up to Mrs D's death recurring in the future.

Multi Agency Recommendations:

- **Pressure Ulcers**

    - All agencies need to ensure that staff understand their responsibilities in relation to Safeguarding Adults and that the preventative opportunities of Safeguarding referrals are fully recognised and utilised as a positive way of achieving effective joint working in the best interests of vulnerable adults.
    - All agencies need to satisfy themselves that the new Pressure Ulcer Policy is fit for purpose and has resolved the ambiguities and lack of clarity which were evident in the previous Policy, and that there has been adequate multiagency training in the use of this Policy.

- **Commitment to the Philosophy, Policies and Procedures for the safeguarding of adults**

    - The Safeguarding Board and the Partner agencies should satisfy themselves that there is commitment from all Partners to the philosophy and principles of Safeguarding and that this is owned at all levels within the respective organisations and communicated effectively through joint and single agency training. Further, the board should ensure that processes and timescales set out in the joint procedures are audited and monitored effectively.

University Hospital of Coventry & Warwickshire (UHCW)

- **The grading of pressure ulcers**

    - UHCW should ensure that the training in Tissue Viability envisaged in their IMR has been completed. This must ensure that relevant staff are familiar with the process of pressure ulcer grading and the relationship of this to a referral into adult safeguarding procedures.

- **Clinical issues at discharge from hospital and outpatients clinics**

    - UHCW should ensure that any lessons for clinical practice arising from these circumstances, including, proper discharge planning and assessment at outpatient follow-up, have been addressed.

- **Record Keeping in hospital wards**

    - UHCW should ensure that actions proposed within the Independent Management Review to improve record keeping standards are implemented across the organisation.

- **Communication issues within UHCW NHS Trust**

    - UHCW should ensure that the case note recording systems used by medical, therapy and nursing staff link in such a way that risks cannot be missed by any of the groups of staff involved.
    - The Trust should ensure that the referral system for technical support from the Surgical Appliance Department is effective across UHCW.
    - The Trust should ensure that the discharge summary reporting system within UHCW to GPs is effective and that these summaries always sent to GPs.
    - The Trust should ensure that all written guidance identified in the IMR conducted by UHCW, which has been developed since the investigation, is being used and is fit for purpose.

Coventry and Warwickshire Partnership NHS Trust, Community Health Services:

- **The Use of Safeguarding Procedures**

    - CWPT should ensure that any lessons for clinical practice arising from review of these circumstances have been addressed.

- **The grading of pressure ulcers**

    - CWPT should be satisfied that that all agency nurses supplied to them are competent to grade pressure sores and understand the relationship of this to a referral into adult safeguarding procedures.

- **Communication issues**

    - CWPT should ensure that appropriate guidance is now in place for staff making a referral to outpatient clinics and that it is being followed.

Coventry City Council:

- **Ensuring that social work assessments are fit for purpose**

    Coventry City Council should ensure that practitioners are aware of the importance of taking account of all sources of information in making an assessment and explore all reasonable options which would minimise identified risk. The City Council should also ensure that practitioners always consider factors which might limit a person's ability to make informed choices.

If you would like to know more about Coventry Adult Safeguarding please go to:

www.coventry.gov.uk/safeguarding

Coventry City Council

Briefing note

To: **Cabinet Member (Health and Adult Services)** **14th January 2014**

Subject: **Health and Social Care Scrutiny Board (5) consideration of the Executive Summary of the Serious Case Review (Mrs D) (CSAB/SCR/2013/1).**

1 Purpose of the Note

1.1 This briefing note is intended to provide the Cabinet Member (Health and Adult Services) with the outcomes from consideration by the Health and Social Care Scrutiny Board of the Executive Summary of the Serious Case Review (SCR) into the death of a vulnerable adult (Mrs D) .

2 Recommendations

2.1 The Scrutiny Board recommends to the Cabinet Member that the Action Plan outlined in the SCR be approved.

2.2 The Cabinet Member is further asked to note that the Scrutiny Board has requested an additional briefing from the Executive Director - People on the implementation of the Action Plan contained in the Report. The Board has asked for this to be scheduled for a Scrutiny Board meeting in the early summer.

3 Information/Background

3.1 The Scrutiny Board considered a Report and Executive Summary of the SCR into the death of a vulnerable adult, Mrs D at their meeting held on 18th December 2014. The Board were supported in their scrutiny of this matter by the Executive Director People, acting also in his capacity as Chair of the Coventry Safeguarding Adults Board. They were also supported by several members of the Safeguarding Adults Board including representatives of key agencies covered by the SCR as well as the independent author of the review.

3.2 At the beginning of the meeting following a brief summary of the function of a SCR and an introduction to the circumstances covered in the document representatives of the City Council, University Hospitals Coventry and Warwickshire (UHCW) and Coventry and Warwickshire Partnership Trust (CWPT) each expressed their condolences to the family of Mrs D and apologised for any failings which had contributed to her death.

3.3 In considering this matter in detail the Board questioned Safeguarding Board members on a number of issues including:

- Record keeping in general by professionals regarding the interventions they performed with patients.
- Communications between different professionals and how these might be improved to ensure consistent information is provided regarding the needs of vulnerable patients.
- Referral processes and the importance of written referrals identifying clearly the reason for the referral and relevant circumstances (linked to the above).

- The discharge process and how information was shared between different organisations regarding the needs of patients being discharged.
- Nursing practice around care for elderly patients vulnerable to pressure ulcers, processes for recording and monitoring pressure sores in the community and whether this practice was consistent across Coventry and Warwickshire.
- Programmes of training for staff working in the local health economy, particularly in regard to agency staff being ready to operate within established safeguarding processes. Whether or not these training programmes are compulsory for all staff or not.
- The availability and co-ordination of intermediate care for patients leaving hospital.
- The outpatient appointment made for Mrs D and the lack of clarity regarding the purpose of the appointment which resulted in the associate specialist not fully understanding the District Nurses intentions in making the referral, also issues related to whether or not the pressure ulcer would have been noticeable at the time of the appointment.
- The nature of the neck brace supplied to Mrs D and whether appropriate clinical processes had been followed in identifying the most appropriate piece of equipment for her needs.
- Whether appropriate advice was given to family members/carers of Mrs D to support them in meeting Mrs Ds needs in general and particularly related to the neck brace.
- The learning across the Coventry health and social care economy about identification and treatment of pressure ulcers and the role that all staff interfacing with the community have to play in this.
- Issues around the testing for and identification of septicaemia.
- The role of the GP and how communication with him could have improved Mrs Ds care.
- Issues related to the social services involvement with clients having capacity but declining to receive services.
- Whether individual organisations allowed external inspection regimes, targets or data collection procedures to divert from the priority of providing quality care and focusing on the outcomes of individual patients.
- Safeguarding processes and procedures and the lack of prompt reporting and investigation of concerns regarding Mrs D.
- The recommendations in the Action Plan and the role these will play in improving multi-agency safeguarding arrangements.

3.4 The Board received repeated assurances from all of the agencies represented that policies and importantly practice has improved significantly since the events described in the SCR. Many of the recommendations in the SCR already largely implemented. Members were particularly pleased to learn that discharge arrangements at UHCW and referral processes between CWPT and UHCW had been improved and that new arrangements were felt to be working well.

3.5 In concluding all of the organisations present gave an assurance that the recommendations of the SCR would be fully implemented and that all that was possible would be done to ensure that the events described in the SCR were not repeated. The Chair of the Safeguarding Adults Board gave an assurance on behalf of the whole safeguarding community that his Board would lead this work requiring regular updates on this work.

3.6 Representatives of both UHCW and CWPT noted that their Trust Boards had led work on their individual organisational plans to reflect on the circumstances of this case and had led the implementation of the recommendations of the SCR.

3.7 The Scrutiny Board was content with the Action Plan (page 5 and 6 of the Executive Summary) and recommended only that a briefing be provided to the Board in approximately 6 months' time detailing the implementation of the recommendations.

BRIEFING NOTE AUTHOR:

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People Directorate
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Thursday 19th December 2014.

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