
Health and Social Care Scrutiny Board (5)
Cabinet Member (Health and Adult Services)

18th December 2013
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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Enquiries should be directed to the above person.

Contributor/approver name	Title	Directorate or organisation	Date doc sent out	Date response received or approved
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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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