Coventry City Council
Minutes of the Meeting of Health and Social Care Scrutiny Board (5) held at 2.00 pm on Wednesday, 9 September 2015

Present:

Members: Councillor D Welsh (Chair)

Councillor M Ali
Councillor A Andrews
Councillor D Galliers
Councillor J Innes
Councillor J O'Boyle
Councillor S Walsh

Co-Opted Member: David Spurgeon

Other Member: Councillor J Clifford

Other representatives: Joan Beck, Chair of the Safeguarding Adults Board
Sue Davies, Coventry and Rugby CCG
Mark Radford, University Hospitals Coventry and Warwickshire
David Smithson, Chair of Review Board
Glynis Washington, Coventry and Rugby CCG

Employees:

S Brake, People Directorate
V Castree, Resources Directorate
L Knight, Resources Directorate
C Parker, People Directorate
D Watts, People Directorate

Apologies: Councillor K Caan, T Khan, D Skinner and K Taylor

Public Business

14. **Declarations of Interest**

There were no disclosable pecuniary interests declared.

15. **Minutes**

The minutes of the meeting held on 1st July, 2015 were signed as a true record.

With reference to Minute 10 headed ‘Reducing Health Inequalities in Coventry’, in particular the request that the Communities and Neighbourhoods Scrutiny Board (4) considers how the Community Development Team works in the neighbourhoods with particular reference to the hard to reach and disadvantaged communities and individuals, and how support is offered to the most vulnerable, the Board were informed that the item had been added to the Scrutiny Board (4)

work programme and feedback would be provided to Board members at the appropriate time.

16. **Serious Incident Review - Miss G**

The Scrutiny Board considered a briefing note of the Executive Director of People attached to which was the Executive Summary report which presented the findings of a Coventry Safeguarding Serious Incident Review which followed the death of Miss G in the spring of 2013. Appended to the summary report was an action plan incorporating the lessons learnt from the review.

Joan Beck, Chair of the Safeguarding Adults Board and David Smithson, Chair of the Review Group attended the meeting for the consideration of this item along with Mark Radford, University Hospitals Coventry and Warwickshire and Sue Davis and Glynis Washington, Coventry and Rugby Clinical Commissioning Group. The report was also to be considered by the Cabinet Member for Health and Adult Services at his meeting on 12th October, 2015 and Councillor Clifford, Deputy Cabinet Member also attended the meeting.

Miss G was a vulnerable 40 year old who was part of a loving and supportive family. She suffered from a long term degenerative neurological disease and was confined to a wheelchair. She lived in independent accommodation and received 22 hours of support a day which was funded by adult social care. She died in a fire which was intense and took hold rapidly when she was alone. The likely cause of the fire was from a dropped cigarette or cigarette ignition source.

The Chair of the Review Board expressed her condolences to the family and apologised for the length of time that it had taken to reach this stage of the review process.

The summary report highlighted that a serious incident review took place because an adult had died or had been seriously injured or impaired and abuse or neglect was known or suspected to be a factor. The process was about learning lessons and not apportioning blame. The report set out the background to the case; provided a summary of facts and findings of the case; included an analysis of the circumstances; detailed conclusions which formed the basis of a commitment to action across organisations in the city to prevent such a situation occurring in the future; and set out what would happen next. The action plan set out recommendations with actions required, gave target dates and the appropriate lead officers as well as highlighting expected outcomes.

The Board questioned those present on a number of issues relating to the circumstances of the case and responses were provided, matters raised included:

- Concerns about why reviews hadn't been undertaken when the 2007 psychology report should have precipitated a thorough multi-agency review and there had been recurrent concerns and issues raised by the family relating to care provision, risk assessment and record keeping.
- Had the lessons learnt from the case and the resulting actions been implemented already
- When a number of agencies had recommendations to implement, who was responsible for ensuring these were carried out

- A concern that the action plan did not contain a recommendation/action covering a requirement to ensure that regular reviews would be undertaken
- Clarification about why Miss G received 22 hours care and not 24 hours care, in light of the risks associated with her being left on her own
- Details about the regulations relating to the passive smoking from the carers' perspective
- With reference to the evaluations included in the multi-agency audit programme, how would staff on the ground raise their issues to feed into the process
- How would staff be protected when raising concerns
- The importance of all health and social care assessment tools including fire safety risk assessments, with all key staff receiving appropriate training
- The support that can be provided by the fire service to mitigate fire risks
- How can the views of everyone involved in an individual's care be taken into account and the importance of their role acknowledged i.e. front line carers, family, neighbours and friends.

RESOLVED that:

(1) The Cabinet Member for Health and Adult Services, at his meeting on 12th October, 2015 be recommended to request that the Action Plan is amended to include an additional action to ensure that care plans are regularly reviewed, particularly when concerns are raised; that a further action be included to ensure that the views/concerns of everyone involved in a person's care including carers, family, neighbours and friends are always taken into account; and that the reviews are undertake in a timely manner.

(2) The Safeguarding Adults Board be requested to report back to the Scrutiny Board in six months to review the implementation of the Action Plan contained in the report.

17. **System Wide Review - Mrs F**

RESOLVED that consideration of the report and action plan concerning the System Wide Review following the death of Mrs F be deferred to the Board meeting scheduled for 18th November, 2015.

18. **Outstanding Issues Report**

The Scrutiny Board noted that all outstanding issues had been included in the Work Programme for 2015-16.

19. **Work Programme 2015-16**

The Scrutiny Board noted their Work Programme for the current municipal year. The Board were informed that an additional meeting had been arranged for 2.00 p.m. on Tuesday, 3rd November, 2015 to consider a report on Improving Accommodation for Older People and the Director of Public Health Annual Report.

20. **Any other items of Public Business**

There were no additional items of public business.

(Meeting closed at 3.00 pm)