Coventry City Council

Public report
Cabinet Member

Cabinet Member for Health and Adult Services 12th October 2015

Name of Cabinet Member:
Cabinet Member for Health and Adult Services, Councillor Caan

Director Approving Submission of the report:
Executive Director for People

Ward(s) affected:
N/A

Title:
Recommendations relating to Serious Incident Review for Miss G

Is this a key decision?
No

Executive Summary

This paper presents the action plan in relation to a Serious Incident Review carried out on behalf of the Coventry Safeguarding Adults Board. This paper informs the Cabinet Member for Health and Adult Services of the outcome of the Health and Social Care Scrutiny Board (5) consideration of the Serious Incident Review which took place following the death of Miss G.

The Health and Social Care Scrutiny Board (5) considered the Serious Incident Review at their meeting on 9th September 2015. The Board were concerned that the Action Plan accompanying the report did not contain an action to ensure care plans were regularly reviewed, as this had not happened in Miss G's case. The Board were also concerned that the voice of carers, including family and friends as well as paid carers, had not been listened to and felt it was important this be addressed in the action plan. Finally, the Board felt that where reviews needed to be undertaken, the action plan should highlight that these need to be done in a timely manner. These actions formed part of the recommendations made.

Recommendations:

1. That Cabinet Member for Health and Adult Services is recommended to request that Coventry Safeguarding Adult Board amends the Action Plan to include actions:

    a. To ensure that care plans are regularly reviewed in a timely manner, particularly when concerns are raised;
    b. To ensure that the views/ concerns of everyone involved in a person's care including carers, family, neighbours and friends are taken into account

List of Appendices included:
Appendix 1 – Executive Summary
Appendix 2 - Multi Agency Action Plan

Other useful background papers:
None

Has it been or will it be considered by Scrutiny?
No
Although this report has not been considered by Scrutiny, the Health and Social Care Scrutiny Board (5) considered the Serious Incident Review at their meeting on 9th September 2015.

Has it been or will it be considered by any other Council Committee, Advisory Panel or other body?
No

Will this report go to Council?
No

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Report title:
Recommendations relating to Serious Incident Review for Miss G

1. Context (or background)

1.1 Miss G was 40 years old when she died. She was part of a loving and supportive family. During the time under analysis for this review, Miss G was supported extensively by her mother and her brother, and was herself a mother to two girls aged 17 and 18 years. Miss G developed a long term degenerative neurological disease after the birth of her eldest daughter, 18 years previously. This progressively inhibited her ability to mobilise, her cognition, memory function and her behaviour. Miss G enjoyed smoking, and declined to stop as advised by her GP. Risk relating to fire associated with her smoking while unsupervised was not sufficiently explored in the assessments or care plan, despite acknowledgement of Miss G's lack of awareness of hazards coupled with knowledge of her smoking habit and her difficulties in coordination and dropping items.

1.2 Miss G died in a fire which was intense and took hold rapidly, the likely cause of the fire was from a dropped cigarette or cigarette ignition source. Her lack of mobility significantly affected her ability to react to or escape from the fire. If the fire had been discovered at an early stage, the presence of a carer would have increased the likelihood that the fire could have been dealt with in its infancy and/or the carer could have supported Miss G to escape the fire. However, it cannot be concluded that the absence of a carer or the practice issues highlighted were responsible for Miss G's death. Practitioner understanding of how behaviours and conditions such as smoking alongside limited mobility increases the individuals vulnerability from fire needs to be recognised as a priority area for training. The multi agency action plan is attached as appendix 1 to this report.

1.3 The organisations involved in this SIR are committed to ensuring that the issues identified are addressed. The recommendations within the SIR report form the basis of a Coventry Safeguarding Board action plan. The board will in addition, monitor the implementation of improvements within individual organisations.

1.4 The legal and policy framework and context (and associated practice experience and case law) was developing across the timeframe scrutinised by this review. The direction of travel in terms of national policy links closely to key lessons from this review.

2. Options considered and recommended proposal

2.1 Health and Social Care Scrutiny Board considered the Serious Incident Review at their meeting on 9th September 2015. The Board referred the matter to the Cabinet Member for Health and Adult Services, as they were of the view that additional actions should be added to the action plan to ensure that care plans were regularly reviewed, the views / concerns of everyone involved in a person's care, including carers, family, neighbours and friends are always taken into account and that reviews are undertaken in a timely manner.

3. Results of consultation undertaken

No consultation has been undertaken as part of this report. However members of Miss G's family were involved in the serious incident review**.**

4. Timetable for implementing this decision

4.1 Implementation of actions within the Action Plan will be monitored by the Safeguarding Adult Review Sub Group and reported to the Safeguarding Adult Board in accordance with local/national policy guidance.

4.2 Health and Social Care Scrutiny Board requested an update on progress with the implementation of the action plans to be presented to the March 2016 meeting

5. Comments from Executive Director, Resources

5.1 Financial implications
No direct financial impact from the recommendations

5.2 Legal implications
There are no legal implications

6. Other implications

6.1 How will this contribute to the Council's priorities?

http://www.coventry.gov.uk/councilplan

The objectives within the action plan will support the Council deliver their objective to keep vulnerable people safe within their community and to be able to live healthier more independent lives.

6.2 How is risk being managed?

The key risks have been identified within the Serious Incident Review process which led to the production of this report. The action plans have been developed to address these risks. The Safeguarding Adult Review Sub Group are accountable for monitoring the implementation of these plans in practice and for assuring the Safeguarding Adult Board that these have been delivered according to plan.

6.3 What is the impact on the organisation?

None

6.4 Equalities / EIA

No negative impacts are anticipated in relation to this review

6.5 Implications for (or impact on) the environment

None

6.6 Implications for partner organisations?

None

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