Bedford Borough and Central Bedfordshire Safeguarding Adults Board

Report of the Serious Case Review Panel into SCR 2 (Mr S)

1. Background

Mr S died on 24 February 2009 following re-admission to hospital from a home where the Coroner described the nursing care as “woefully inadequate”. The Coroner determined that Mr S ‘whilst incapacitated by rapidly deteriorating physical and mental health, died on this date for want of care by those charged with it.’ The cause of death was (a) sepsis (b) infected multiple pressure sores (c) dementia and (d) Parkinson’s disease.

2. In response to the concerns raised about the care home in question, the Council conducted a review of the support received by all residents of the home, and suspended the funding of places there until satisfied that acceptable standards were operating. The regulator (the then Commission for Social Care Inspection) was fully involved in this process.

3. The Serious Case Review panel identified issues with:

1) The quality of community care assessments which must be recorded promptly and communicated in a timely fashion with copies sent to all relevant parties, including carers where appropriate, and with the consent of the patient.
2) The same standards for assessment, care management and support should be consistently applied to self funding service users as to those requiring an application to adult care services for funding approval. This includes the use of the Continuing Health Care (CHC) decision monitoring tool and timely application for CHC and Funded Nursing Care (FNC) where appropriate.
3) All care home providers should be reminded of the importance of regular reviews and they should make information available to all residents and their carers about reviews and how to ask for one. This should be monitored through contract monitoring visits and regulatory activity.

4. Recommendation

As a result of the Serious Case Review, the Board adopted the 7 point action plan as follows:

- In all future Serious Case Reviews, agencies preparing Internal Management Reviews should comply with the ‘Serious Case Review
Internal Management Review Report Template’. The current process (2010) for the preparation of Internal Management Reviews should be reviewed in the light of the experience of undertaking this Serious Case Review.

- The membership and process of SCR panels should be reviewed to ensure that issues of detail can be addressed and that membership is also of sufficient seniority to support the interagency development and agreement of recommendations.

- In all future Serious Case Reviews, where there is to be a Coroners inquest, discussion should take place with the Coroner about the timing and scope of the review. The responsibility for this should be clearly defined.

- Any Safeguarding Investigation following the death of a vulnerable adult should consider at an early stage if it would be appropriate to offer support to the family/carer either through involvement of a statutory agency or other recognised body. The responsibility for this should be clearly defined.

- In disseminating the learning points from this review, senior managers should give particular attention to reminding staff of the critical importance of responding to safeguarding alerts, and of strictly adhering to safeguarding procedures.

- The Director of Adult Social Services should satisfy herself that there was no act or omission on behalf of any individual that requires further investigation and that appropriate management action has been taken.

- The Crown Prosecution Service should identify a lead prosecutor for cases involving vulnerable adults.