



# Bolton Council

Children's and Adult Services  
Directorate  
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Date: 31 January 2014

Mrs J. Leeming  
Coroners Office  
Ground Floor  
Paderborn House  
Howell Croft North  
Bolton  
BL1 1UA

Dear Mrs J. Leeming,

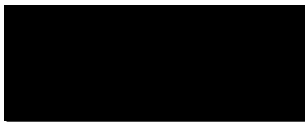
I am writing to you in relation to the Regulation 28 'Report to prevent future deaths' notification issued on 12<sup>th</sup> December 2013 to Bolton Council regarding the death of Mr Keith Peters D.O.D: 12/09/2013.

The Council has taken steps to ensure that the lessons learned from this case have been cascaded appropriately throughout the organisation. The council has also put in place developments and measures to improve where possible systems, processes and officer training.

These matters have been taken seriously and the Council will oversee the full implementation of the enclosed action plan.

Please do not hesitate to contact me should you require any further information or clarification of any aspects of the plan.

Yours sincerely



Assistant Director, Care Management and Adult Provider Services

Direct Line: [Redacted]

Direct Fax: [Redacted]

E-mail: [Redacted]

c.c. Sean Harriss – Chief Executive

[Redacted] – Director of Children's and Adult Services

[Redacted] – Borough Solicitor

Director of Children's and Adult Services [Redacted]



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## Children & Adults Directorate - Regulation 28 Action Plan

The following action plan addresses the concerns as identified in the Regulation 28 notice re. Mr.P 12/12/2013

Area of concern	Service Response	Action	Lead officer	Timescale	Progress (R/A/G)
<p><i>Mr P's case was allocated to a Community Assessment Officer who was on leave at the time, and whose future leave commitments resulted in having limited time to complete MR P's assessment within the required period.</i></p>	<p>The service acknowledges that it could be considered that the allocation of the case to a worker who only had limited time was not realistic, but the presenting information did not suggest this was an urgent case and there was no information to cause the worker to flag this pressure to their manager that they may not complete the task required of them. The available time to the worker should have been sufficient to complete the assessment if contact was successful. The service agrees that the case could have benefitted from being re-allocated at the point when the worker was unable to make contact and went on the 2<sup>nd</sup> period of annual leave.</p>	<p>Staff to be reminded of personal responsibilities to alert their manager to cases where timescales may not be met.</p>	<p>Head of Service - STARS</p>	<p>30<sup>th</sup> January 2104</p>	<p><b>Action complete</b> All staff and managers in STARS have been communicated with regarding personal responsibilities through team meetings and supervision.</p>

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<p><i>During the periods when the Community Assessment officer was available there was no evidence of Mr P's case being prioritised, neither when the twenty eight day period allowed for the assessment to be completed was approaching expiry, nor when that period expired.</i></p>	<p>The service considers that there was significant information that was not shared at the point of referral that could have highlighted risks to the case worker and manager to prioritise actions.</p> <p>During the prolonged unsuccessful assessment period there was no information available to the worker to indicate that any risks were increasing to re-prioritise the assessment or that Mr P would be at a detriment should the assessment go beyond the 28 day timeline. The Community Meals service saw Mr P on a daily basis and carried out routine welfare checks as part of the service offered, they report that they had no concerns. Mr P's reason for cancelling meals was due to wanting a break from the service (3 Sept 2013).</p> <p>The service accepts it is good practice to complete assessments in a timely manner and should endeavour to meet the 28 day timescales.</p>	<p>Improvements will be made to the contact/referral documentation to include mandatory fields to the questions asked and include a section on 'Presenting risks' including recording any health conditions to support the full risk information being ascertained at the earliest point in the process.</p> <p>Actions identified for No. 1 and No. 3 also address system changes for this area of concern.</p>	<p>Head of Service - STARS</p>	<p>1<sup>st</sup> March 2014</p>	<p>Work has commenced with the IT team to make the changes</p>
<p><i>The manager of the North STARS TEAM gave evidence at the inquest that there was no system in place for officers to refer a case back to the manager for re allocation to another officer when it became clear that an assessment was not going to be completed within the</i></p>	<p>The service wishes to clarify this aspect of concern.</p> <p>Staff receive formal supervision on a 6 weekly basis and have access to managers for informal supervision and case discussions on a daily basis if required.</p> <p>The service does accept that a more</p>	<p>The service will develop a monitoring and trigger function within the electronic system for staff and managers to be alerted to cases at risk of missing assessment timescales to enable re-prioritisation or reallocation as</p>	<p>Head of Service - STARS</p>	<p>1<sup>st</sup> April 2014</p>	<p>An interim process has been put in place for staff to receive workload management discussions to</p>

<p>twenty eight days required.</p>	<p>systematic approach would be of benefit to flag to manager and staff of cases reaching the 28 day period to enable reprioritisation/allocation as necessary.</p>	<p>necessary. Action No.1 also addresses this area of concern.</p>		<p>track progress of cases. Work has commenced with the IT team to make the changes</p>
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