MANCHESTER CITY COUNCIL

[redacted]
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[redacted]

Tel: 0161 234 3006

Your ref: J. Keelan (deceased)
Our ref: SSV5002/1954
Date: 16 April 2019

[redacted]

Dear Mr Meadows,

**Janice Keenan (deceased). Response to Regulation 28, Inquest dated 14th February, 2019.**

Thank you for your Regulation 28 Report dated 19 February 2019.

I will address the issues you raise paragraph 1 – 4. In order to do this, Manchester City Council (the Council) co-ordinated a Review on 1st April 2019. The Council is committed to learning from this very sad death.

**Issues to be addressed at paragraph 1:**

1. Fluctuating and impaired cognition:
   The Council has now ascertained that the deceased was not care co-ordinated by Greater Manchester Mental Health Trust (GMMH). The deceased had been cared for by a 'Lead Professional' from GMMH. This means she would be administered a depot injection every two weeks, either at home or at the depot clinic. At the Review, the Council was informed that in January, April and June 2017, her Lead Professional, asked for the deceased to be escalated to a Community Mental Health Team, as the Lead Professional considered that the deceased needed a more comprehensive mental health service.

2. When the GMMH Lead Professional met with the Council's Primary Assessment Team (PAT) on the initial assessment on 21st July 2018, neither party recognised that there was an issue about the deceased's mental capacity. At that stage, a mental capacity assessment should have been conducted. The outcomes from such an assessment would have informed whether or not the deceased could make her own decisions about bathing. Another opportunity was missed in August, when an Occupational Therapist visited the deceased. As you quite rightly point out, to suggest that the deceased should desist from having a bath was unrealistic. It is clear that the deceased had been taking a bath during the night, again as you point out, she had complex needs which her daughter had managed for years.

   **Learning**:

   The Council has devised an Action Plan, which is attached and which highlights:

   1. A recognition that there is a need for multi-agency training for all agencies to ensure co-ordination and clarity around decision making for people with complex needs.

   2. A recognition that had a mental capacity assessment been conducted, it is unlikely this would have been shared across organisations.

   3. That although a Carer's assessment of the deceased's daughter had been completed by GMMH, the Council was not aware of that.

**Action:**

1. Mental Capacity Awareness Training to be reviewed to ensure clarity around Complex decision making.

2. A Safeguarding Adults referral for consideration to whether a Safeguarding Adults Review (SAR) is required pursuant to s 44 Care Act 2014. To be co-ordinated and undertaken to examine this case and its implications. The purpose to consider whether a SAR referral is required (Learning across the partnership).

   The Manchester Safeguarding Adults Board (MSAB) will consider undertaking a SAR when it is known or suspected that:

   a) Actions or omissions in a number of agencies involved in the provision of care, support or safeguarding of an adult, or group of adults, at risk of abuse or neglect have caused or are implicated in the death or serious harm of that individual or group of individuals.

   or

b) An adult or group of adults at risk die or experience serious harm and there are concerns about how agencies have worked together to prevent, identify, minimise or address that harm and there are concerns about how this may place other adults at risk of serious harm.

and

c) There are clearly identified areas of learning and practice improvement or service development that have the potential to significantly improve the way in which adults at risk of abuse and neglect are safeguarded in the future.

The SAR subgroup of the MSAB will consider the issues raised within the case and will carefully examine the potential for learning across agencies/services.

**Issues to be addressed at paragraph 2:**

Manchester's Service for Independent Living (MSIL)'s prioritisation criteria has been reviewed with the fundamental principal of improved communication within the service. What this means is that the service will allocate resources in line with need. In addition, all those on waiting list we will review on a regular basis, identifying those who are at risk and intervening in a timely manner.

**Learning**:

It is essential that we have a continuous overview of our citizens' wellbeing, if people relapse, become unwell or have adverse life events, such as carer breakdown, the service needs to be able to intervene immediately. The waiting list will now be managed i.e. citizens will be contacted on a regular basis and be continually reprioritised if necessary.

**Action**:

Implement overview and assessment of MSIL's waiting list, agreeing a prioritisation process, this will be overseen and implemented by the Head of Service for this service. This will be implemented by 30th May 2019.

**Issues to be addressed at paragraph 3**

GMMH conducted a local 3 day review and a formal review and informed the Council's our review: The Council Led action plan is attached.

**Learning:**

There are agency escalation processes in place for high risk cases but further work is required to ensure adherence.

**Action:**

The Council/GMMH review of agency escalation processes.

**Issues to be addressed at paragraph 4**

1. Neither the Council nor GMMH has had ready access to the other's notes
2. Previously there was limited co-working between the two organisations.

**Learning**

The Council and GMMH should have had an overview of the deceased's well-being.

**Action**:

At the monthly partnership/organisational meeting between the Council and GMMH, there will be standing items on the agenda covering effective joint working and information sharing.

I hope that the above properly addresses all of the issues raised in your report. However, if there is any matter upon which you would like clarification, please do not hesitate to contact me.

Yours sincerely

Joanne Roney
Chief Executive