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Process

Following the death of Mrs A, Hull City Council Adult Social Care determined that an independent management review was required in order to ensure that any improvements in practice were identified, and actions put in place to enable lessons to be learnt. The IMR was completed by a Head of Service and reviewed and approved at Practice Implementation Panel and Divisional Management Team Meeting

Case Study
Mrs. A
Independent
Management Review

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Background

An independent management review after the death of Mrs. A. Mrs. A lived alone in the community with support from her daughter. Mrs. A was assessed as requiring care in the home but due to capacity issues this was not available. Reviews completed in the home by adult social care and some input from health services. Concerns around daughter's mental health and ability to support Mrs. A fully with her care needs but daughter declined support and Mrs. A did not have capacity.

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What does this mean for me?

Do I understand my responsibilities in relation to the [Mental Capacity Act](#) and am I considering Mental Capacity whenever this is in question?
Am I clearly recording Mental Capacity assessments and if required best interest decisions even when the person is assessed to have capacity?
Do I practice professional curiosity by questioning and checking what I am being told for accuracy?
Do I know when and how to escalate concerns to management and am I confident that the support I need will be available?



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Finding 1

No mental capacity assessments and best interests' decision were recording although a recording stating that Mrs. A lacked capacity so this clearly was considered. No mental capacity assessment appears to have been considered for Daughter despite obvious concerns around her mental health and her unwillingness to accept support for herself or Mrs. A. The recording lacked detail and clear actions with realistic timescales.

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Findings 4

Initially there were a significant number of different workers involved and some significant delays in contact being made with no explanation given. Although the case remained open, and an allocated worker involved at all times. There does not appear to have been appropriate escalation to managers despite the increasing and escalating of the concerns and the apparent attempts to block contact with professionals by the daughter.

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Finding 3

The care package requested was not available due to capacity issues and although this was kept under review appropriately there was no consideration re: the provision of a partial care package to manage some of the risks and gather additional information. At one point the package of care was offered but this was declined by daughter. This was accepted without further question and without consideration of Mental capacity although the worker was informed of this for follow up afterwards.

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Finding 2

Professional curiosity needs to be further embedded in practice and staff need to consider the wider situation and where there is a question over the validity of information provided, ask the right questions to determine what the level of risk is and how this is best managed. Where several staff and organisations are involved there needs to be clear communication and sharing of information to ensure the worker has an accurate understanding of the situation.