wakefieldcouncil
Adults, Health & Communities
Corporate Director: Andrew Balchin

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Typetalk calls welcome

Our ref:
Your Ref:

Date: 17 November 2020

Coroner's Office and Court
71 Northgate
Wakefield
WF1 3BS
Email:hmcoroner@wakefield.gov.uk

Dear Mr McLoughlin,

RE: Inquest touching the death of June Mavis Winterbottom, (deceased)

I write in response to your Regulation 28: Report to Prevent Future Deaths which you sent to me on 24th September 2020, following your investigation into the death of Mrs June Mavis Winterbottom which concluded on the 23rd September 2020.

In the report, you raise the following matters of concern:

1) The system for handling urgent referrals within Adult Social Care in Wakefield on 2nd June 2020 was ineffective. Despite being graded as 'urgent', no contact was made with an elderly, isolated, vulnerable lady, who was evidently in dire need of assistance.
2) In consequence, Mrs Winterbottom was left alone without the medical assistance which would probably have been called in had she been seen. It is, however, not possible to say whether her life would have been saved, had she been admitted to hospital on 2nd June 2020.
3) Even the following day, 3rd June 2020, no visit took place, despite the urgency of the situation. The urgent referral system was exposed as deficient.
4) Evidence taken at the inquest indicated that the team in Adult Social Care were now aware of the need to watch out for such cases which had drifted outside of normal hours. Such a generalised instruction serves to diffuse responsibility, rather than establish accountability on the part of an identified manager.
5) There was no safety net in place, whereby an ambulance would have been called in the event the Adult Social Care team were unable to respond in a timely manner for any reason.

In the report, you note that, in your opinion, action should be taken to prevent future deaths, and that you believe our organisation has the power to take such action.

Response

It is accepted that WMDC's Adult Social Care referral system was ineffective in responding to the specific referral for Mrs Winterbottom made on the 2nd June 2020. The referral was received by Social Care Direct, and having been triaged with further information obtained during the day, this referral was transferred to the Urgent Response Dashboard in the early evening, but not identified or made available to the duty social worker on shift.

Initial response to Mrs Winterbottom's needs

WMDC make clear, however, that initial action was undertaken in a timely manner upon receipt of the referral by WMDC's Social Care Direct.

The referral to Social Care Direct was ambiguous as to whether medical assistance or personal care assistance was required. The Social Care Direct worker therefore liaised with Mrs Winterbottom's grandson and it was agreed that he would visit Mrs Winterbottom to ascertain whether it was considered medical assistance was required. Her grandson visited later that day and stayed with her for a period of time. He confirmed to Social Care Direct that he did not believe she required medical attention at that point.

The intention was, nevertheless, for arrangements to be made for a social care practitioner to go out to Mrs Winterbottom that evening to respond to her personal care needs and this did not happen.

On 3rd June 2020 at around 8.45am, it was swiftly recognised that no arrangements had been made for a social care practitioner to visit Mrs Winterbottom as planned, the previous evening. WMDC's Urgent Response team then caused the Warden of the Independent Living Scheme to immediately visit Mrs Winterbottom to establish if she still required assistance. The warden visited, at the request of WMDC, and an ambulance was consequently called.

What went wrong?

At this time, WMDC Adult Social Care had realigned its workforce in order to support the Covid response as directed by the Department for Health and Social Care. In particular, the national guidance required Adult Social Care to facilitate urgent hospital discharges between 8am and 8pm, to ease the mounting pressure on overburdened hospitals. WMDC Adult Social Care had implemented a new system of workers covering referrals outside of usual working hours in the weeks prior to this referral being received. There were also further changes to usual working practices in that significant numbers of staff were working remotely from home due to the Covid situation. Nevertheless, action should have resulted from the referral during the evening of 2nd June 2020 and I offer my sincere apologies to Mrs Winterbottom's family.

Action that was taken to ensure no repeat

On the 3rd June 2020, senior managers worked immediately to improve the system.

Immediate arrangements were implemented to ensure that workers within Social Care Direct had access to the rota showing staff working extended hours, and were provided with the mobile numbers for these staff so that they could directly confirm that any urgent referrals

transferred had been received. Social Care Direct was also provided with the mobile number for a manager, in case there were any difficulties.

Further work was then undertaken over the next four weeks to ensure that the referral transfer process was robust, with the following specific actions being implemented:

- The process for Social Care Direct staff to enter an activity on the Urgent Response Dashboard and also call through to the worker on shift, to ensure they are aware of the activity, was embedded.

- The rota format was revised and simplified so that it is clearer to identify who is working.

- The contact numbers for all workers, managers and teams were added onto the rota.

- A Team Managers on call rota was set up, to ensure that there was always a clearly identified manager responsible for out of hours, whether evenings or weekends.

- A weekly email is distributed across the Adult Social Care service, containing the rota which in turn contains clear working arrangement guidance. It makes it clear who is working and when, and in what role.

- The weekly email also provides clear guidance on what workers are required to do during their shift. This includes the instruction that all staff working out of hours within the hubs should check both the East and West Urgent Response Dashboards.

- We have ensured that all Adult Triage workers in Social Care Direct can view the Urgent Response Dashboards for both East and West to check the progress of any referrals they sent through.

- Additionally, the Social Care Direct Manager has instructed the Out of Hours Approved Mental Health Professionals ("AMHP") to check the Urgent Response dashboard when they come on duty in the evening (although it is recognised that they will always have to prioritise Mental Health Act assessments over other work).

- The Urgent Response workers covering core hours will directly communicate with the extended hours workers regarding anything which needs following up from the day.

These improvements to the systems identified above were undertaken in a prompt manner immediately following the realisation that there had been failure in the handover of the referral between teams on the 2nd June.

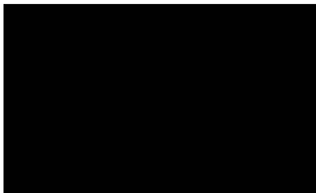
It is unfortunate that the Council were only asked to provide a chronology of events surrounding the death of Mrs Winterbottom for the Inquest rather than a report. If WMDC had been made aware that the Senior Coroner for West Yorkshire (East) had concerns surrounding the handling of the referral we would have expected to be invited to participate as an Interested Person. We would have been able to assist the Senior Coroner to identify the appropriate witness to explain what happened, what went wrong, and what actions had been taken to ensure that it did not go wrong for another vulnerable adult.

Concluding remarks

It is also noted that you raise as a matter of concern that Mrs Winterbottom "*was left alone without the medical assistance which would probably have been called in had she been seen.*" Of course, Mrs Winterbottom was seen by her grandson that evening, who did not feel that medical assistance was required. Social workers are not trained medical professionals. Nor do Social Care Direct operate an emergency service. The response was being coordinated at a time when there was rapid community transmission of Coronavirus and consideration was therefore required around the risks of introducing new people into the household of a vulnerable adult. It is speculative that any different course of action would have been taken had a social care practitioner attended on the evening of 2nd June 2020.

I trust that the above information addresses the matters of concern you raise, and provides sufficient reassurance that Adult Social Care in Wakefield have already appropriately reviewed our systems following the death of Mrs Winterbottom, and taken action to ensure the robustness of our systems. As a consequence, Adult Social Care do not feel that there are any additional actions which need to be taken resulting from your issuance of the Regulation 28 Report.

Yours Sincerely,



Corporate Director – Adults & Health
Wakefield Council