City of Westminster

Regulation 28 Coroners Report – Local Authority Response

Report Response from Westminster City Council concerning the death of Professor Richard Shannon (DoD 19.2.2022)

For the attention of:	**Senior Coroner ME Hassell sitting at St Pancras Coroner's Court**
Date:	**30 January 2023**
Report of:	[redacted] **Chief Executive, Westminster City Council**

Dear Madam

I write on behalf of Westminster City Council ("the local authority"). This is a response to the Regulation 28 report dated 5 December 2022 regarding the death of Professor Richard Shannon on 19 February 2022. The local authority and partner agencies referred to in your report have been working together in an integrated way across the organisations involved in Professor Shannon's care to provide a thorough response covering all nine areas of concern raised in your report, as relevant across the agencies. The other agencies will be providing their own responses to you but all actions to be taken between us have been coordinated and agreed so that there are no omissions.

Several changes to practice and procedure have already taken place since the safeguarding enquiry outcome meeting on 16 June 2022 and we are each committed to continuing to implement the learning and improvements highlighted. This includes both within our individual organisations and between our organisations to improve the co-ordination and communication of care arrangements for our residents and patients which is of paramount importance to us.

The following table provides you with the local authority's response to each of the concerns identified, any actions already considered and taken and those in progress.

Regulation 28: Matters of Concern Actioned by the Local Authority

Concern 1: The discharge team at University College Hospital (UCH) did not seek a pressure relieving bed and mattress to replace Professor Shannon's own before he was discharged on 5 January.	The authority is committed to supporting an integrated hospital discharge process and will ensure social workers are core members of hospital multi-disciplinary discharge planning meetings.
Concern 2: If the district nurses had been invited and had attended the UCH discharge planning meeting,	We welcome the participation of District Nurses at discharge meetings, which will ensure that holistic clinical input is included in plans for the benefit of everybody providing care and support.

this misunderstanding could easily have been identified and the true position understood by all.	
Concern 3: The district nurses expected the carers employed by Kapital Care UK Limited (the Kapital carers) and commissioned by social services at the City of Westminster Council (social services) to check the skin integrity every day. However, there is no record that they issued such an instruction.	**Local Authority Action:** • To support an all-agency approach to discharge planning, social workers now use a checklist to ensure that all aspects of the care plan have been actioned prior to discharge, e.g., equipment delivery, district nurse involvement, care agency fully briefed. This is to minimise the risk of there being any gaps in the discharge process across all agencies.
Concern 4 The form (DTA) raised a number of concerns but did not specifically instruct that carers should check skin integrity every day. That was an omission.	**Local Authority Action:** • The local authority has introduced a new Hospital Discharge Reablement Assessment Form. Implementation has begun and will be fully embedded by 6th February 2023. The new form includes prompts and mandatory fields in medical areas such as pressure care, manual handling, and medication. This information is transferred to the care plan sent to care agencies delivering social care. This tool is in operational use locally and is required to be shared across agencies. • To support implementation of the new form and embed new practice for discharge, workshops were held in December 2022 and January 2023 with UCH discharge staff, CLCH and Central North West London NHS Foundation Trust (CNWL) community NHS staff with Adult Social Care.
Concerns 5: The City of Westminster social worker considering the Discharge to Assess form did not include in her thinking that Professor Shannon had a grade 2 pressure ulcer and was at high risk of developing pressure ulcers	**Local Authority Action:** • Since December 2022 the local authority has arranged and facilitated three social care hospital practice workshops with the staff teams to raise awareness and improve practice. The workshops focused on the key points raised by the coroner at the end of the Inquest with regards to the social workers' understanding of their role in both co-ordinating the care for discharge and information that is shared and communicated with care agencies. • Standard operating procedures are being updated to reflect the outcomes of the workshops. This includes: o a training package for newly qualified social workers entering the service and for experienced social workers as part of their yearly appraisal and continuous professional development. The training package focuses on identifying care needs associated with pressure care, manual handling and equipment, medication, risk management plans and the co-ordination role of a social worker. o an improved tool for discharge including a template checklist to ensure all key areas are addressed. o key escalation points and links with community providers including District Nurses.

Concern 6: When the District Nurse visited Professor Shannon the day after his discharge, his catheter bag was so full it had come detached, and he was demonstrably soiled.	**Local Authority Action:** • The local authority has worked with Kapital Care to support improvements in their practice, as detailed in Kapital Care's response regarding their training, documentation, escalation to us if there is an issue, improved communication with District Nurses and others involved in a person's care. • Local authority contract managers have been meeting regularly with Kapital Care and will continue to monitor delivery of their agreed actions quarterly.
Concern 7. The City of Westminster undertook a safeguarding investigation after Professor Shannon's death. In that investigation, intended to learn lessons for the benefit of others, the City of Westminster investigator accepted, as the social worker had at the time, the explanation given by Kapital that the towels had been brought to the property after the carer's first visit that morning and therefore had not been available to the carer. The investigator did not interview the Kapital carer. He accepted at inquest that he should have done. There was no evidence to support Kapital's assertion and it was in fact completely inaccurate.	**Local Authority Action** • In any safeguarding enquiry, there is a judgement to be made as to whether to speak directly to every individual involved, or whether to delegate some of those conversations to others. In this case, the Safeguarding Adults Manager made the decision to delegate the conversation with the Kapital care worker to the care worker's line manager. On reflection this was a conflict of interest. • The Safeguarding Service has revised its practice so that when reviewing cases in professional supervision, it will explore whether delegated or direct conversations should take place, factoring in whether there are conflicts of interest in individual agencies being asked to conduct parts of the safeguarding enquiry.
Concern 8. The safeguarding investigation was concluded by the social worker from Westminster at the end of June 2022, but I was told that there have been no changes made to systems or training in the intervening five months. The social worker has recently emailed partner agencies suggesting a meeting, but no such meeting has taken place. Apparently, no lessons have been learnt	**Local Authority Action** • A referral for a Section 44 Safeguarding Adults Review by the Safeguarding Adults Board in relation to Professor Shannon was made on 6 December 2022. This multi-agency review process will seek to determine what relevant agencies and individuals involved could have done differently in this case and promote effective learning outcomes and improvements for the future for all involved organisations. • The London Multi-Agency Safeguarding Adults Policy requires all individual organisations to review the recommendations identified in the Section 42 Safeguarding Enquiry investigation report for any lessons to be learned. This has now taken place, but the delay is acknowledged and is a learning that will be addressed by all partners.
Concern 9: What struck me most forcibly throughout the inquest touching the death of Richard Shannon, was that	The local authority has worked with partner agencies to review and enhance our collective approach to integrated discharge, ensuring more robust co-ordination by professionals of a patient's complete care needs.

lots of professionals were charged with his care, lots of professionals attended his home, lots of professional met him, yet still very basic elements of his needs were omitted. Despite all the resources expended, he was not cared for as a whole person.	**Local Authority Action:** • Multidisciplinary discharge meetings are held pre-discharge including the attendance of a District Nurse and social worker. The hospital discharge social worker ensures this planning forms the detailed care plans for domiciliary care services to follow. • The local authority's contract specifications for commissioned services will have an enhanced focus on the delivery of person-centred care.

The authority is addressing the multiple actions required to improve hospital discharge and delivery of co-ordinated care. All future actions and learning arising from Professor Shannon's death will be implemented with whole person care central to any changes. We are absolutely committed to maintaining and embedding those improvements already implemented, prioritising implementation of those in progress and consistently reviewing our practice.

The local authority will continue working with partner agencies to build on the current improvements, which will be further informed by the outcome of the current Safeguarding Adults Review process.

Yours sincerely

[redacted]