PUBLIC

MINUTES of a meeting of the **GOVERNANCE, ETHICS AND STANDARDS COMMITTEE** held on 09 January 2020 at County Hall, Matlock

PRESENT

Councillor C Short (in the Chair)

Councillors K Buttery, J Coyle, K Gillott, L Grooby (substitute), W Major, C Moesby, and J Perkins (substitute)

Also in attendance – Messrs K Jackson-Horner and L Newby MBE (Independent Persons)

There were no apologies for absence received.

The Chairman reported the death of Councillor Alison Fox, all Members were invited to pay tribute.

All Members were invited to observe a one Minute silence.

01/20 **MINUTES** **RESOLVED** that the minutes of the meeting of the Governance, Ethics and Standards Committee held on 03 October 2019 be confirmed as a correct record and signed by the Chairman.

02/20 **REPORT OF THE LOCAL GOVERNMENT OMBUDSMAN ON AN INVESTIGATION INTO COMPLAINT NO 16 00 61 95 AGAINST DERBYSHIRE COUNTY COUNCIL** A recent case had been investigated by the Local Government Ombudsman (LGO) who had made a finding of fault by the Council causing injustice to the complainant.

Mrs C had been discharged to the Grange Care Home in Eckington in November 2015 following an admittance to hospital. She suffered from dementia, type 2 diabetes and osteoporosis.

During her time at the Grange, care home staff recorded finding Mrs C on the floor on 25 occasions and had sustained a number of injuries following these falls. A referral to the falls team had not not made and a risk assessment had not been completed. In December 2015 Mrs C reported that she had been hit by someone and that this happened ‘all the time’. A record of Mrs C’s allegation had been made but no further action was taken. Also in December 2015 Mrs C’s GP visited her as she had a swollen and sore mouth. She was diagnosed with a mouth infection but the GP had not been told that Mrs C may have swallowed paint from the wall. Mrs C went to hospital in January 2016 when staff called paramedics after finding her unresponsive.

Mrs C experienced an unwitnessed fall on in March 2016. Standard procedure had been followed and staff did not find any apparent injuries. Later in that month Mrs C was found unresponsive and she was admitted to hospital. When she arrived at hospital she was found to have four fractured ribs and serious chest injuries. The hospital raised a safeguarding alert with the Council on the day of Mrs C's admission.

Mrs C sadly passed away three weeks later in hospital on 16th April 2016. The safeguarding investigation opened following the alert from the hospital continued to run after Mrs C's death and the handling of this was the subject of part of the complaint.

A complaint had been made by a family member to the Care Quality Commission. This resulted in the CQC prosecuting the Council for breaching regulation 12, failing to provide safe care and support resulting in avoidable harm. The Council pleaded guilty and was fined £500,000 at Chesterfield Magistrates Court on 9th December 2019.

The LGSCO found the following faults, causing injustice in the following areas:

- Failings to carry out an adequate pre-admission assessment.
- Repeat fails to complete a falls risk assessment as well as the falls not being consistently or adequately recorded and the family not being informed of the extent of the pattern of falls.
- The pattern of falls not being acted upon during monthly reviews.
- Failings to complete an adequate nutritional assessment or keep adequate records.
- A lack of clarity around whether or not the Council considered Mrs C's diabetes when managing her diet.
- Not considering whether an allegation made by Mrs C that she was hit by a member of staff justified a safeguarding investigation.
- Flaws in the way records were kept following a GP visit.
- The response to staffing problems following the restructure had been ineffective which meant that mandatory risk assessments were not being completed.
- Failing to consider whether Mrs C's death should have been referred to Derbyshire's Safeguarding Adults Board.

In addition to the above recommendations the following actions had been taken:

- A full and unreserved apology had been offered to Mr B and the Executive Director, and the Service Director were to meet family members in January 2020.

- An agreement had been made to make a payment of £1,000 to a registered charity of Mr B's choice and to pay for a memorial as well as Mrs C's estate being refunded.
- Further reviews of Mrs C's death were being undertaken, as well as a Quality Improvement Board being established.
- A review of all safeguarding policies had been conducted and the Council's Lead for safeguarding had conducted two workshops.
- A new incident form was being finalised with the data feeding in to the Council's 'Dashboard' programme.
- The Service Manager responsible for Mosaic had attended workshops in order to provide guidance about the recording and completion of Personal Service Plans and risk assessments.
- All daily paper logs were now to be uploaded to electronic files at the end of every day. A review was currently being undertaken as to whether the use of handheld tablets would have benefits.
- The Council recognised that it needed to improve the way that directly provided services were monitored. To effect this change three additional officers had been employed to work within the central Quality and Compliance Team.
- Clear process for social workers to highlight any concerns about particular care homes or home care services had been established.
- The Council had improved its ability to monitor which members of staff had completed mandatory training.
- The Council were to include in any restructure the identification of all associated risks and proposed mitigations.

In response to the review into Mrs C's death the Council commissioned an independent expert to review practice at the Grange. There were some minor recommendations which had been addressed but the independent expert concluded that the quality of care provided at the Grange was 'good' in accordance with CQC standards. This had been confirmed at the most recent inspection of the Grange completed by the CQC.

RESOLVED to (1) note the findings of the Local Government Ombudsman and the action which had been taken by the Council in response to the Ombudsman's report; and (2) bring back a further report to the Committee in six months regarding progress.