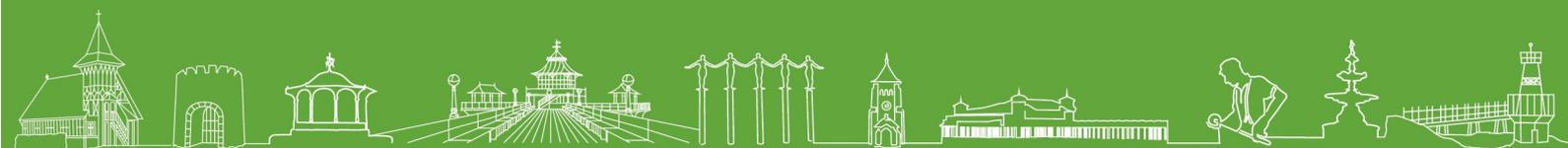


North Somerset Council

Adult Social Services and Housing

Unexpected Death or Serious Incident Involving a Person with
Care and Support Needs Process



Contents

Document information	3
Purpose	4
Scope	4
What is a Serious Incident for the purposes of this process?	4
When does an unexpected death require further review by the local authority?.....	5
Who oversees and coordinates the review?	5
Process.....	6
Accessible information.....	7
Unexpected Death or Serious Incident Involving a Person with Care and Support Needs Flow Chart.....	8

Document information

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Purpose

This process clarifies actions which should be followed when there is an unexpected death or serious incident involving a person with care and support needs who has had recent contact or involvement with Adult Social Services and Housing.

Scope

This relates solely to North Somerset Council's internal processes when an unexpected death or serious incident occurs. Deaths or incidents relating to adult safeguarding should first be considered from a multi-agency perspective in line with the relevant policies and processes of the North Somerset Safeguarding Adults Board (SAB), e.g. Safeguarding Adult Reviews.

Deaths involving someone with care and support needs who was experiencing domestic abuse should be considered for a Domestic Homicide Review.

Deaths involving someone with a learning disability, who is aged over 4, must be considered for a [Learning Disabilities Mortality Review \(LeDeR\)](#). You can [report a death online](#) or call 0300 777 4774.

Serious incidents and unexpected deaths involving people using integrated mental health services will usually be reviewed in line with the Mental Health Trust's policies and processes, which will involve North Somerset councils' staff as appropriate. However, depending on the nature of the case and the individual circumstances North Somerset council may elect to undertake its own investigations and action planning in line with this policy – which would be done in co-operation with the Mental Health Trust whenever possible.

What is a Serious Incident for the purposes of this process?

In broad terms, serious incidents are events where the potential for learning is so great, or the consequences to people with care and support needs, families and

carers, or staff are so significant, that they warrant a review overseen by senior managers with responsibility for quality assurance or quality improvement.

When does an unexpected death require further review by the local authority?

The local authority will consider the need to undertake an internal review when someone with care and support needs dies suddenly and unexpectedly and:

- The person has had recent contact or involvement with adult social services;
- There are questions surrounding operational service delivery or professional practice;
- It is thought that an internal review is likely to contribute to learning and service improvement.

Who oversees and coordinates the review?

This will depend on the circumstances of the unexpected death or serious incident.

The coordination of an internal review is to be overseen by the Head of Service for Safeguarding when:

- There was an open s.42 enquiry when the incident or death occurred; or
- The person is believed or suspected to have been experiencing, or at risk of, abuse or neglect, including acts of omission, when the incident or death occurred; or
- Where s.44 Care Act might reasonably apply; or
- Where there is a need for multi-agency coordination via the SAB

The coordination of an internal review is to be overseen by the Principal Social Worker or Principal Occupational Therapist when:

- The person has had recent contact or involvement with operational adult social services; and

- NSC's operational response needs to be reviewed to assure quality and standards; and
- There is no reason to believe the person was experiencing, or at risk of, abuse or neglect when the incident occurred; and
- Where the conduct of a registered professional may require a referral to the registered body.

Examples when internal reviews might be overseen by the PSW or POT include incidents or deaths relating to serious self-harm, suicide, and/or substance misuse, where self-neglect is not thought to be a significant contributory factor.

Internal reviews will always involve close partnership working with Heads of Service, Team Managers, and other relevant practitioners to ensure information is gathered in a timely way and appropriate support is provided.

The Assistant Directors and Director for Adult Social Services and Housing must always be fully briefed.

Process

1. Where an Adult Social Services and Housing staff member becomes aware of a serious incident or unexpected death, an email must be sent with relevant details to the [Adult Services QA](#) inbox, copying in the Principal Social Worker, Principal Occupational Therapist, Head of Service for Safeguarding, and the Assistant Directors and Director of Adult Social Services and Housing.
2. A meeting is then convened within an appropriate and proportionate timeframe (taking account of potential risks to others) between the Assistant Director of Adult Social Services and Housing, the Head of Service for Safeguarding and PSW / POT to decide whether an internal review is required and the most appropriate review pathway.
3. If further risks to other people with care and support needs are identified, consider the need for a s.42 enquiry in their name(s), and ensure a safety plan is in place.

4. The Head of Service for Safeguarding or PSW/POT (whoever is most appropriate – see above) oversees the coordination of a proportionate review, working closely with Heads of Service and Team Managers, ensuring a clear chronology and relevant information is gathered and emerging issues and themes are analysed and explored.
5. If at any point during an internal review overseen by the PSW/POT, it becomes apparent that the person was experiencing abuse or neglect, including acts of omission, a further meeting must be convened between the Head of Service for Safeguarding and the PSW / POT to discuss whether the review should be coordinated under the auspices of the SAB.
6. Following the review, a report is produced with clear recommendations and a SMART action plan agreed with relevant Team Managers and Heads of Service.
7. Recommendations and actions stemming from the review might include:
 - a. A case for enhanced resource,
 - b. Additional wellbeing support for staff,
 - c. Further thematic audit in specific areas of practice,
 - d. Revision or implementation of policy and guidance,
 - e. Additional training
 - f. Further multi-agency collaboration
 - g. Appropriate communication with the Care Quality Commission
8. Learning is disseminated appropriately, e.g. via SAB, SWOT, workshops, learning briefings, staff forums etc.

Accessible information

Council documents can be made available in large print, audio, easy read, and other formats. Documents on our website can also be emailed to you as plain text files.

Help is also available for people who require Council information in languages other than English. Please email asshsstrategyandpolicyteam@n-somerset.gov.uk or ring 01934 888 888.

Unexpected Death or Serious Incident Involving a Person with Care and Support Needs Flow Chart

