Outlook Care response to: Sydney Piper; Prevention of future deaths report 10 May 2023

Background

- Date of report: 15/03/2024
- Ref: 2024-0145
- Deceased name: Sydney Piper
- Coroner name: Graeme Irvine
- Coroner Area: East London
- Category: Alcohol, drug and medication related deaths

Full report [Sydney Piper: Prevention of future deaths report - Courts and Tribunals Judiciary]

The **MATTERS OF CONCERN** are as follows.
1. The support worker who accompanied Mr Piper on the day of his disappearance claimed that she did not constantly supervise Mr Piper as alternatively; she did not wish to crowd him, she was allergic to cigarette smoke, and finally that she needed to rest her legs. The witness accepted that she had neither read Mr Piper's support plan, nor the relevant policies and procedures relevant to her duties that day.

I am concerned that there is no clear evidence before me that the risk of a similar incident of inadequate supervision of a vulnerable person has been effectively mitigated.

Response:

1. Following the initial safeguarding alert being raised and the issuing of notice for a Section 42 Enquiry, in partnership with key stakeholders on notification of death of Mr Piper, we implemented an action plan, appendix 1, which in summary consisted of:
   - External feedback continuing to contribute to our reviews and improvement plans for services.
   - Continued inclusion of feedback from stakeholders, London Borough of Waltham Forest (LBWF), in management reviews and how it meets the support and oversight of service delivery in local areas, ensuring feedback is evident in management decisions taken.
   - Collaborative working with LBWF to ensure management decisions will benefit from the feedback and experience of LBWF/North-East London Foundation Trust (NELFT) partners.

- Continued close working with LBWF to share opportunities and their wider experience/resources that can enhance the quality of the support provided by services.
- Raising awareness of LBWF Safeguarding Team and their role in ensuring customer safety from Abuse or Neglect. Local Safeguarding Information to be recirculated to raise awareness. All noticeboards reviewed and local Safeguarding information clearly displayed.
- Induction and Probation management reviewed to see what areas can be more effective.
- Supporting staff learning regarding their 'Duty of Care' including review of policy on Care and Support with a view to strengthen the focus on 1:1 support.
- Shared learning in teams to review how we evidence engagement and learning for customers using 1:1 support in the community and safeguarding best practice.
- Increase emphasis on Positive Behaviour Support principles evident in delivery and review of staff training and development to strengthen duty of care for customers using individual support.
- Share learning across the whole of the organisation at a learning event from this lived experience following conclusion of Organisational Safeguarding and MISPER Incident for the Management Team.
- Safeguarding Training for Managers with all Managers refreshing their Level 3 Safeguarding Training for Managers. Managers to supplement by attending their Local Authority Safeguarding for Managers training when it becomes available.
- Application of Missing Person's Policy to strengthen how it is reflected individual's risk assessments, support guidelines and Missing Person Information. Any recommendations to be made to Director of Care and Support with Chief Executive.
- Review potential risk for individual support and MISPER for all customers by identifying Risk Profiles for current customers and ensuring future customers are identified when they start to use our services. This will be subject to ongoing monitoring of customer's changing needs.
- Staff awareness of Duty of Care when providing support to people at risk of MISPER is increased.
- GDPR Policy implementation is monitored at all stages of service closure to ensure there is secure storage available during decommissioning of service and transport of archiving to secure archive.
- Feedback from Customers on consultation during service closures will be more detailed.

2. A full briefing was issued to our Board of Trustees who continue to provide scrutiny and oversight of our progress. The action plan implementation is led by the Chief Executive and real time reporting to the Board of Trustees continues alongside regular briefings issued to all of the workforce.
3. We participated in the Safeguarding Adults Board review led by the London Borough of Waltham Forest, appendix 2. We revised our action plan accordingly based on learning from this process.
4. In response to the Regulation 28 Notice issued by the Coroner and the matters of concern noted, the following actions have also been implemented:
    - Staff briefings held with all staff led by Chief Executive, Director of Care and Support and Managers.
    - Discussions with all staff during staff meetings.
    - Further review and relaunch of Missing Persons Policy, appendix 3.
    - Workforce review of understanding of the Missing Persons Policy, see appendix 4. To date we have a >90% response rate evidencing good understanding.
    - Further review of updated risk assessments for all service users supported in relation to Herbert Protocol, missing persons process and delivery of 1:1 support in the community.
    - Training for all staff in mitigation service user risk of going missing and managing the process should a service user go missing, emphasising:
        - the role of day-to-day risk assessment as a preventative measure for service users at risk of going missing.
        - the critical nature of the golden hour should a missing person incident occur.
    - The use of a day to day, app based, risk assessment completed every time a service user is supported in the community, appendix 5. This process was implemented on 22 March 2024 and to date 1098 risk assessments have been completed and records stored securely, reviewed monthly by the Director of Care and Support to identify trends or areas of concern. To date the risk assessments have been completed by 458 staff.
    - Spot checks on 1:1 support being delivered to service users in the community to check for both safety and quality as well as validating that our action plan is being implemented in practice, appendix 6. To date 21 spot checks have been completed and reported on to the Executive Management Team. Where performance of staff has fallen below our standards, staff are undergoing further training/performance management and cease to deliver community-based support until they reach the required competency level.

- Guidance on the delivery of 1:1 support and the importance of maintaining a 'line of sight' has been issued, in form of video briefing, written guidance, posters, key facts cards issued to staff name badges, see appendix 7.

5. Further actions scheduled for completion by end of June 2024 include:
    - Completion of an unannounced Business Continuity Management test in relation to a Missing Person incident, to be repeated annually.
    - Including audits of risk management process in relation to Missing Person and delivery of community support to mitigate risk of service users going missing into our annual audit schedule, to be completed twice per year on an ongoing basis. Outcomes will be reported to Board of Trustees for scrutiny and oversight.
    - Revised induction and handover formats that include specific reference to Missing Person risk and mitigation of such risk, see appendix 8.

Finally, in October 2024, we will be hosting a learning event for all stakeholders, partners and other providers, to share our learning and revised procedures, stemming from this tragic incident.

Please do not hesitate to contact me if you have any questions.

Yours sincerely

[redacted]

Chief Executive and Trustee

<u>Supporting documents*:</u>

- Appendix 1: Section 42 Enquiry Action Plan
- Appendix 2: Safeguarding Adult Board Review Final Report
- Appendix 3: Missing Persons Policy
- Appendix 4: Missing Person Policy Survey Sample
- Appendix 5: Sample Risk Assessment Form
- Appendix 6: 1:1 Support Delivery Audit Sample
- Appendix 7: Sample Guidance Documents/Video

*The above listed documents can be provided at the Coroners request.