Adults and Health (DASS)
London Borough of Newham
1000 Dockside Road
London
E16 2QU

Mr G Irvine
Senior Coroner
Walthamstow Coroner's Court
Queens Road
Walthamstow
E17 8QP

10th May 2024

[redacted]

Dear Mr Irvine

Re: Regulation 28 Report concerning Regina Olufunmilola Ademiluyi (Ref: 22689174)

Response from the London Borough of Newham

Thank you for sharing the conclusion of your Inquest into Mrs Ademiluyi's death, and the subsequent Regulation 28 Report. May I start by expressing my sincere regret and disappointment to learn of the circumstances surrounding Mrs Ademiluyi's passing. On behalf of the Council I wish to place on record our deepest condolences to her family and friends and all those that knew her. We fully acknowledge the findings from the Inquest and are firmly committed to putting actions in place to address the concerns raised in the Prevention of Future Deaths report to ensure that a similar situation is not repeated.

A core group of Senior Officers from within the department have reviewed Mrs Ademiluyi's case in detail and have developed a series of direct actions in response. I have summarised the key elements below with associated timescales, and grouped this against the thematic areas from the Regulation 28 Report. I hope this addresses any unanswered questions, the areas for improvement and gives assurance on the actions we are taking.

1. Reflection and Learning

	Action:	By who:	By when:
1.1	Immediate s.44 Safeguarding Adult Review (SAR) Referral completed and submitted for presentation at the next SAR subcommittee of Newham's Safeguarding Adults Board on 7th May 2024	Team Manager Neighbourhood Team	27.03.24
1.2	Review and improve training and awareness of pressure care and risks for ASC staff. This will include: • Incorporating mandatory pressure care refresher training for all Operational ASC staff into 2024/25 training plan.	Strategic Safeguarding, Practice and Workforce Development Team	July 2024

	• Session content to include overview of pressure sore reporting and notification processes, and its interface with Safeguarding Adults.		
1.3	Convene focussed reflective practice sessions for frontline operational staff based around circumstances highlighted in Mrs Ademiluyi's care, thematically orientated around "professional curiosity" and "cultural needs vs. risks" (reinforcing the message that risk management comes first).	Strategic Safeguarding, Practice and Workforce Development Team	December 2024
1.4	Creation of an anonymised '7 minute briefing' note concerning the lessons learned from this case for circulation across all Adults and Health staff groups at LBN.	Strategic Safeguarding, Practice and Workforce Development Team	June 2024

2. Continuity of Care Funded via Direct Payments

	Action:	By who:	By when:
2.1	Desktop reviews of all current DP users with double-handed packages for indicators of under-utilisation of care. *Through 2022/23 work took place to review and improve DP monitoring processes with a series of changes coming into effect from August 2023. This included an increase to the number of established posts for DP Monitoring Officers. This has allowed for faster feedback to operational teams on any future monitoring issues/irregularities* *In addition to this, the new DP set up process provides additional 'hand holding' support for the first 6 weeks to ensure that DP recipients and their representative(s) fully understand how to utilise their DP.*	Direct Payments Team	End of May 2024
2.2	Undertake a review of the Council's Direct Payment Policy, and develop associated practice guidance (including a practitioner checklist). This will encompass: • Non-transfer of DP cases for annual reviews where PAs are not engaged and a mental capacity assessment / best interest decision has not been completed.	Direct Payments Project Group	December 2024

	• The recording of mental capacity / best interest decisions pre-agreement of DP (explicitly in relation to managing/coordinating care and not solely payment administration). • Triggers for further mental capacity assessment / best interest decisions if the person's DP circumstances have changed (for existing DP users). • Explicit processes for DPs for individuals with double-handed care needs, including assisting and moving assessment and training requirements for PAs. • Processes for hospital discharge to existing DP packages without full PA coverage. An interim process has been implemented by the Discharge and Assessment Team to ensure evidence is seen that PAs are in place before DP packages are increased from hospital. • The interface of quality in care concerns and Safeguarding Adults thresholds.		
2.3	Implement a defined process for 3rd Party Fund Managers to escalate issues relating to PA sourcing to LBN, within specified time bands.	Direct Payments Team	July 2024
2.4	Enhancements to be made to the AzeusCare case management system to make double-handed care packages more prominent for system users and reportable. The longer-term solution will require development from the software supplier; in the short term other local options are being considered including flags and additional question(s) in core forms.	Head of Brokerage and Transaction Management	December 2024

3. Mental Capacity and Decision Making

	Action:	By who:	By when:
3.1	Improve consistency of MCA practice and decision making in the context of best interest decisions which override family where appropriate (including the use of Independent Mental Capacity Advocacy). This will encompass: • Themes from Mrs Ademiluyi's case being shared with the borough's MCA Oversight Group. • Reviewing MCA training and refresher offers for staff to ensure it encompasses all	Strategic Safeguarding, Practice and Workforce Development Team	July 2024

	professional groups in ASC (including non-qualified frontline staff, Social Workers and Occupational Therapists). • Developing specific training interventions for Occupational Therapy staff regarding the application of the Mental Capacity Act in practice – this has been planned as a topic for the borough's cross-organisational OT Peer Learning session in May 2024. A separate formal training date is being planned.	Principal Occupational Therapist	

4. Support for Informal/Family Carers

	Action:	By who:	By when:
4.1	An all-age Carers Strategy is in place for the borough and overseen by a multi-agency delivery board. Further work has taken place through 2023/24 to update carer definitions, improve recording processes and enhance documentation used by frontline staff with carers. In addition, a suite of new public-facing videos and improved carer information resources have been created. These will go live in May 2024. An updated round of refresher training on carer awareness for all frontline ASC staff is being rolled out in May 2024.	Carers Strategy Delivery Board	End of May 2024
4.2	Develop specific guidance for frontline ASC staff on informal/family carers and Safeguarding Adults.	Strategic Safeguarding, Practice and Workforce Development Team	End of June 2024

In addition to this summary of internal action, we also recognise that further activities need to be considered with our system partners at East London NHS Foundation Trust (ELFT). Regular Safeguarding meetings have now been established between ELFT Community Health Newham and the Council's Neighbourhood Teams for Older People and Disabilities (mirroring the same processes which are in place in Mental Health services and have been shown to be successful in improving communication between professional groups). This space will be used to address issues such as the quality of referrals, thresholds and reoccurring safeguarding themes. Attendance at these meetings will also be reviewed to consider involvement from the Council's Safeguarding Adults Team who are responsible for screening referrals.

We also intend to work with ELFT to jointly review the information provided to families and informal carers about pressure care, the associated risks and exacerbating factors (for example, friction and

double incontinence). Alongside this we are eager to convene a shared learning event with multi-disciplinary staff from across both organisations to explore the themes identified in Mrs Ademiluyi's case from a clinician/practitioner perspective. These discussions are being progressed separately with our counterparts at the Trust.

Governance and Oversight

The Directorate Management Team (DMT) for Adults and Health and the departmental Quality and Governance Board have been sighted on the action points identified here. All elements of the full plan are now linked to named senior officers with accountability for their delivery. Oversight of the action plan is being held by the Practice and Workforce Development Team who will monitor progress against the stated timescales and then report back to the Quality and Governance Board. We also recognise that the overall plan will need to remain agile and be adapted if further information comes to light, particularly if Mrs Ademiluyi's case is the subject of an independent Safeguarding Adults Review (SAR).

Thank you again for raising this matter with us. I hope this response gives adequate assurance on the actions we have taken on the improvements required.

Please do not hesitate to come back to me if you require further information or updates.

Yours sincerely,

[redacted]

[redacted]
Head of Older People and Disabilities

CC:

[redacted] Chief Executive
[redacted] Corporate Director of Adults and Health
[redacted] Director of Operations (Adults)
[redacted] Director of Change, Improvement and Control
[redacted] Director of Quality Assurance, Safeguarding and Workforce Development
[redacted] Head of Law (Community)