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PRIVATE AND CONFIDENTIAL

Isobel Thistlewaite
His Majesty's Assistant Coroner for Leicester
City and South Leicestershire
Town Hall,
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LE1 9BG

[redacted]

1 July 2024

Dear Miss Thistlewaite

Regulation 28: Report to Prevent Future Deaths

Inquest into the death of Ash Bannister

I am writing in response to the Regulation 28 (Coroner's and Justice Act 2009) Report to Prevent Future Deaths issued on 25 April 2024, following the inquest into the sad death of Ash Bannister. Ash was a loved resident and part of our family at The Laurels and all of us have been deeply saddened by their death. On behalf of everyone at United Children's Services, I would like to express my deepest condolences to all those who loved Ash.

I take the matters of concern identified in section 5 of your report in turn and respond to these as follows:

1. Risk Assessments

You heard evidence at the inquest from the Registered Manager at The Laurels that there is a Ligature Risk Assessment in place at the Laurels at all times. The Home Ligature Risk Assessment applies to all young people in residence and reminds staff of the sorts of items that young people might use to ligature, as well as informing them of all potential ligature points that have been identified around the home. The Home Ligature Risk Assessment clearly sets out all of the steps that staff should take in case of an emergency involving ligature. Staff are reminded that the Home Ligature Risk Assessment applies at all times to all young people, no matter what their individual risk profile may be.

In addition to the overarching Home Ligature Risk Assessment, United Children's Services (**United Health**) completes individual risk assessments for all of the young people that we support. These risk assessments cater to individual need and are expected to evolve and be updated, depending on the specific risks that are present for the young person at that time. The nature of our service means that, sadly, the young people who reside with us tend to have complex emotional and psychological needs, most often as a result of significant past trauma. As explained by our Registered Manager in her evidence at the inquest, the complexity of the differing and evolving needs of our young people means that, in practice, our staff are constantly undertaking dynamic risk assessments for each young person, sometimes on an hourly basis. Their vulnerabilities and triggers are not straightforward and our staff, who come to know our young people very well, learn what tools are most effective and how to meet the needs of each young person at any given time.

Ash was not subject to an individual Ligature Risk Assessment at the time of their sad death on 7 August 2021. Ash was, at all times at the Laurels, subject to an individual Self Harm Risk Assessment, which was reviewed and updated every three months. Ash presented as being at risk of self-harm by cutting when they experienced high anxiety. Staff at the Laurels would search Ash's bedroom when there were any indicators that Ash may self-harm, to try to ensure that Ash had no access to any sharp objects. As our Registered Manager explained at the inquest, the extent to which staff can legally intervene to mitigate these risks is always balanced with ensuring that the freedom of our young people is not restricted such as to deprive them of their liberty. The Laurels is not a secure unit, young people like Ash attend work and college independently and the goal is to support our young people in their independence insofar as it is safe to do so. It is therefore not always possible, within the scope of our service, to prevent young people from obtaining items which they might use to harm themselves.

Ash had an individual Ligature Risk Assessment in place between 26 December 2020 and April 2021. This had been implemented following an incident on 25 December 2020 where staff noticed red marks on Ash's neck and suspected they may have ligatured as a form of self-harm. This was the only incident where Ash was suspected to have used a ligature during their 13 months at the Laurels, until their death on 7 August 2021.

On review in April 2021, Ash's risk of ligature was downgraded from 'medium' to 'low'. This assessment considered numerous factors, including but not limited to the fact that Ash had not ligatured since the December 2020 incident. You heard evidence at inquest that this downgrading of risk meant that staff effectively considered this particular risk assessment to be inactive, meaning it would not be reviewed again unless a specific need was identified. The Home Ligature Risk Assessment and Ash's individual Self Harm Risk Assessment remained active at all times however, meaning that staff were aware and alert to the possibility that Ash might engage in behaviours that could put them at risk. Such behaviours included ligaturing.

We understand the concerns that you have raised around the need to document the careful decision-making that we undertake around risk assessments, specifically how we conclude the appropriate risk level allocation. In response to your concerns, we have taken the following steps:

- We have streamlined our risk assessments. Prior to the inquest we maintained separate risk assessments for each risk relevant to a young person, for example separate risk assessment documents for self-harm and ligature. United Health now captures all risk assessments for a young person in one document. This ensures that staff have immediate access to all risk information for the individual, including both presenting risks and those risks which have been calculated as non-presenting at that time.

- We have always relied on a formula to calculate the risk level for each young person on any assessment and this results in a numeric output, which then accords to a category of 'high',

'medium' or 'low'. We have now updated our documentation so that staff record this raw score alongside the risk allocation category. This is designed to ensure that we fully capture the process behind each risk level decision.

- We have always required staff to record the date on which every review has been carried out, however we have updated our documentation to require staff to also confirm whether the review has resulted in a change in the risk allocation. This allows staff to easily identify where there has been as escalation or a downgrade in any risk category.

- United Health shares information with the other agencies involved in the care of our young people in accordance with the Government's Working Together to Safeguard Children Guidance 2023. All reviews of any risk assessment are sent to the young person's social worker and, as they have primary responsibility for that young person, the social worker cascades this information to any other relevant professionals as needed. This means that all agencies have the opportunity to comment and to start a discussion if they have any concerns about a risk allocation decision.

- To improve record keeping, we have now included an additional column in our risk assessment documentation to state which agencies have been informed of that specific review and risk decision.

The above changes were communicated to all United Health staff across all of our homes on 24 April 2024. It is the responsibility of the manager of each home to implement the risk assessment process. This responsibility is monitored through our governance procedures which consist of internal audits and internal reviews of service every six months which are submitted to Ofsted. In addition to this, our risk assessments are reviewed as part of the Local Authority assurance visits. We also have the required monthly independent inspection carried out by an independent person appointed in accordance with Regulation 44 of The Children's Homes (England) Regulations 2015. Part of the inspection includes review of our records including risk assessments.

2. Documentation and communication

Ligature Risk Assessment

Please see our response concerning Ligature Risk Assessments at section one above.

Care Plan

Please see section four below for our response concerning Ash's Care Plan.

*Communication of Child Sexual Exploitation (**CSE**)*

You heard evidence at the inquest that, when Ash moved from the Oaks to the Laurels in July 2020, Ash's documentation transferred with them. United Health carries out comprehensive transition planning for every young person that either joins the service for the first time or moves from one of our residences to another. This process takes place over normally a two-week period and includes activities with the staff team that will be supporting the young person to start building connections,

visits to the proposed home and thoughtful communication with the young person to gain their feedback and to ensure that any concerns they might have are carefully addressed. The Residential Manager at the proposed home will work closely with the young person's social worker to ensure that all information about the individual has been shared, which allows United Health to formulate detailed risk assessments. Before the young person moves into the residence, these risk assessments are shared with, and require approval from, both the relevant social worker and the placing authority.

Ash's transition from the Oaks to the Laurels included documentation regarding historic concerns around CSE, which derived from an incident in 2018 when Ash was residing with their paternal family. The Registered Manager at the Laurels, as well as all staff who supported Ash, fully reviewed this documentation and were aware of the historic risk of CSE. You heard evidence from Croydon Social Services at the inquest that CSE was not a presenting risk to Ash during their time at the Laurels from July 2020. There were no incidents relating to CSE whilst Ash was resident at the Oaks or the Laurels.

3. Waking Night Cover

You heard evidence at the inquest that some young people have waking nights funded within their care packages. This is the case when the placing local authority and social services assess that the young person's risk profile requires waking night care. If a young person without waking night provision subsequently presents with new or changing needs in this regard, United Health will recommend to their social worker that waking nights be introduced. The social worker then seeks approval from the relevant commissioning team for waking night care to be added to their care package. This is a lengthy approval process, and, in those circumstances, United Health introduces waking night provision for that young person whilst the decision is being made. United Health fund these waking nights.

As a service we also provide ad hoc waking nights to young people if we have any particular concerns about their safety. We implement these ad hoc waking nights as an additional safeguarding measure and staff are trained to dynamically risk assess our young people and to identify when these may be necessary. Staff make these decisions in discussion with each other and with the approval of the Registered Manager in the context of knowing the young people very well and being able to identify changes in their behaviour. We therefore do not agree that decision making around ad hoc waking nights is heavily dependent on which staff member is on duty at the relevant time.

Ad hoc waking nights either comprise of a staff member sitting in a child's doorway all night or a staff member carrying out 15-minute checks on the young person. The staff team, as authorised by the Registered Manager, or manager on call during that specific shift, determine what type of waking night is required depending on the presenting risks and behaviours.

At the time of the inquest the procedure for ad hoc waking nights was not detailed within our Sleeping and Night Supervisions Policy, albeit staff were undertaking ad hoc waking nights where appropriate. We accept that this information should be set out within that policy, and this has now been updated. This updated policy was shared with every service operated by United Health on 24 April 2024 and all staff have signed the policy to confirm that they have read and understood it.

We agree that it would also be beneficial to introduce a formal process to wean young people off ad hoc waking night cover. Our Sleeping and Night Supervisions Policy now includes the implementation of a "step down" procedure to allow for this gradual reduction of additional support overnight. This requires that, following the introduction of an ad hoc waking night, the Residential Manager holds a safety planning meeting with the young person's social worker. During this meeting the waking night support will be discussed, and the next steps will be agreed. Consideration will be

given to whether it is appropriate to transition the waking night to, for example, reduced check-ins, or whether it is appropriate to remove it completely. This meeting will be documented and, until such time as it has occurred, the ad hoc waking nights will remain in place.

4. Care / Support plans

We note your concern regarding the deviation from Ash's care plan on the morning that Ash sadly died. You heard evidence during the inquest acknowledging that the care plan had not been updated to reflect Ash's sleeping pattern. We accept that this should have been done.

Ash often faced significant struggles with falling to sleep. Staff knew from living with and talking to Ash that Ash often couldn't fall sleep until the early hours of the morning. It was therefore usual for Ash to be allowed time to rest and to be first woken by staff for medication between 8.30am and 9am. As you heard at inquest, staff try insofar as possible to recreate a safe family home environment. Our staff consider the best interests of our young people, including whether or not they have been able to rest, and there were no presenting concerns or indications that Ash was at any heightened risk of harming themselves on the morning of 7 August 2021. Ash had complex needs, including self-harming when triggered, and was under the care of CAHMS for mental health support. At no point was Ash sectioned and, in August 2021, they were in the process of preparing for semi-independent living.

Staff are empowered to assess the presenting needs of the young people and to make decisions that are most beneficial to their wellbeing at that particular time, provided that risk assessments and all policies and procedures are followed. We accept that Ash's care plan was not updated as it should have been, but we do not agree that Ash had demonstrated any behaviours or indicators that they needed to be checked on in the early hours on 7 August 2021.

5. Staff training

All staff complete induction training within the first month of joining United Health. On the first day of that induction all inductees are provided with copies of the United Health safeguarding policies. This includes our policies on both Child Sexual Exploitation and Child Criminal Exploitation. Both the inductor and inductee are required to sign to confirm that these policies have been provided, read and discussed. This means that *all* staff are made aware of Child Sexual Exploitation and the corresponding United Health policy on day one.

In addition to this core induction programme, extensive additional training is completed across a six-month probation period. If for any reason a staff member has not completed all 54 training modules by the end of the six months, they will not pass probation. The training modules differ in length and complexity; some are full days and take place in person, whilst others are shorter and can be completed online.

The learning objectives for the detailed Child Sexual Exploitation module that all United Health staff complete are as follows: to understand Child Sexual Exploitation, to be aware of child trafficking, to know the signs of Child Sexual Exploitation, to understand the impact on victims of Child Sexual Exploitation and to be aware of strategies to support young people who are being sexually exploited. This course satisfies the Children's Home Regulations (England) 2015 and the Children's Homes Quality Standards 2015.

A staff member who has not yet passed probation is always rostered to be on shift with a staff member who has passed probation. This means that there is a staff member with this extensive training on shift at all times.

We note your concern that staff members have six months to complete their full training. The training mandated by our regulatory body, Ofsted, is completed within the first month of induction to the service. United Health chooses to provide additional learning for the benefit of both the staff and the young people we support, and therefore engages in elective courses to strengthen knowledge. It is this additional learning that takes up to six months, not the mandatory learning required by the regulator.

6. Investigation policy and process

We understand the need to clarify what investigations United Health undertook in response to Ash's sad death. United Health carried out its own internal investigation, as well as contributing to the Local Authority's Safeguarding Investigation.

We carried out our internal investigation in accordance with the organisation's Death and Serious Incidents Policy. This sets out the procedure that must be followed in the event of a death or serious incident concerning one of our young people. We initiated the investigation a few weeks after Ash died. A key part of that process is considering lessons that we can learn as an organisation. We regret that we did not document the investigation and our conclusions. The senior management team, who are responsible for such investigations, have been reminded that the full and proper procedure as set out in the Death and Serious Incidents Policy must be followed. We have also made a change to the Policy which now requires that an independent third-party conduct the investigation in line with the procedure set out in the Policy.

We engaged fully in the Local Authority's Safeguarding Investigation following Ash's death. You heard evidence from the Registered Manager at the Laurels that United Health completed a Rapid Review Report on 18 August 2021 as requested by Croydon Safeguarding Children Partnership (CSCP). We also attended the Rapid Review meeting, along with more than ten other organisations, on 23 August 2021. Following the meeting, CSCP issued a report to confirm that the Rapid Review Panel agreed that the National Panel should not be asked to consider a National Review. It was also confirmed that no specific learning for United Health was identified by CSCP.

7. Policies and processes in general

We trust that we have addressed your concerns regarding each of the United Health policies you have outlined above. The improvements made were first shared with Registered Managers on an individual basis and then each Registered Manager instructed their staff members on the changes through team meetings and briefings and individual staff supervisions. All the implemented changes were active from 24 April 2024.

Finally, I would like to take the opportunity to assure you that United Health recognises the learning from Ash's sad death and is committed to the changes made in its policies and procedures as a result.

Yours sincerely

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Company Director
United Children's Services