Leicestershire County Council

Miss Sophie Lomas
His Majesty's Assistant Coroner for Derby and Derbyshire
St Katherine's House
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Date: 06 January 2025
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PRIVATE AND CONFIDENTIAL

Dear Miss Lomas,

Regulation 28: Report to Prevent Future Deaths

Inquest into the death of Alison Binyon – concluded on 31 October 2024

I am writing in response to the Regulation 28 Report to Prevent Future Deaths (RPFD) made under paragraph 7, schedule 5 of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 on the 11th November 2024, following the inquest into the sad death of Alison Binyon.

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

1. Communication

"Whilst consideration had been given to conversations with the service user in this situation, the court heard evidence from those supporting Alison (including community mental health nurses) that they were unclear on the stage the process had reached, the specific steps of the process and the likely timescales involved. This affected the type of support they could provide. There was a lack of evidence of a specific approach or policy addressing how the process can be clearly communicated to those supporting service users in the community of a specific approach or policy addressing how the process can be clearly communicated to those supporting service users in the community."

It is acknowledged that a change in accommodation can result in period of uncertainty in any individual's life and this can be particularly unsettling where that individual has a history of significant mental health difficulties and has spent a period residing in a specialist residential setting, as was the case here. In such circumstances any proposed or actual changes in accommodation require very careful management and consideration alongside clear and effective communication with both the individual and the professionals or multi-disciplinary team (MDT) supporting that individual. A lack of clear communication between professionals supporting an individual can impact on the type and effectiveness of professional support provided to them.

The Adult Social Care Team have carefully considered this matter and reviewed my department's current processes and policies around communication with individuals and other agencies supporting accommodation moves proposed and actual. As a result, the team are improving our current processes by creating a visual flowchart of the accommodation process from beginning to end so that all those involved can clearly see what the next steps are and how close the individual is to any proposed move. Within the flow chart, Adult Social Care workers will be reminded that they must include the MDT working with the individual concerned (including care providers and Community Mental Health Teams) so that accurate information can be shared regarding future plans, and appropriate actions taken. To improve communication with those supporting or close to an individual, this flowchart will be shared with an individual, their current care provider, family or friends' representatives so that uncertainty around the process is minimised. This flow chart is in the planning stages; it will be introduced in February 2025.

It should be noted that timeframes for any change of accommodation can often be unpredictable due to a range of factors including availability of a particular property, procurement processes to identify support providers and legal or administrative steps to begin a tenancy. Communication at each step of the process needs to be clear, and where uncertainty arises there is a plan in place with all involved to provide reassurance to the individual at the centre and those supporting the individual.

The Adult Social Care Workers will be provided with communication from the department within our weekly internal newsletter, which directs them to our key goal: that staff are aware of the need to reassure individuals at each stage of the process, check for clarification of understanding, and ensure that providers and other professionals are made aware of any raised anxiety levels. The newsletter will also direct staff to be person-centred when considering the date or timescales of a move and to avoid any periods of time where an individual may already be experiencing stress or anxiety. This information will be included in the newsletter circulated week commencing 13th January 2025.

2. <u>Internal Review</u>

"Further, no internal review was carried out at Leicestershire County Council following Alison's death. If such reviews are not conducted this could lead to inadequate learning from deaths which creates a risk of further deaths."

My understanding is that on the fourth day of the inquest, clarification was sought from, and provided by Counsel representing Leicestershire County Council on the fact that

Leicestershire County Council had not carried out an internal review in this case and the reasons for the same, but that during the course of the inquest witness evidence and submissions were not sought on Leicestershire County Council's internal investigation processes.

Nevertheless, in light of this concern being raised in the RPRD, I have considered this matter and consultation has occurred within the department around the internal review process for when an unexpected death occurs.

There are existing policies and procedures already in place in line with the statutory duties on local authorities to make safeguarding adults enquiries under s42 of the Care Act 2014 including responding to Safeguarding Alerts and undertaking Safeguarding Enquiries. As explained during the inquest, in Alison's case, Derbyshire County Council's adult social care department were the lead authority for the s42 enquiry. However, we acknowledge that there is a need to communicate clarity around roles and responsibilities for Leicestershire County Council as the commissioning authority where an individual is living outside of this authority's geographical area, as was the case here. Furthermore, staff have been reminded that strategy discussions and meetings should clearly detail any elements of a Safeguarding Enquiry that are being delegated by the host authority to any other parties.

The RPRD has identified the need for an internal review process also. Accordingly, a procedure has been developed for all Adult Social Care managers which will go live in January 2025 to ensure that where an unexpected death occurs, an internal review takes place to consider the departments involvement, the views of those involved, and whether there are any specific learning points or amendments to policies or processes required.

Yours sincerely

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Director of Adults & Communities • S0001 Adults & Communities