

Private and Confidential

28 May 2025

For the attention of the coroner,

Please find below the responses to the points raised by you, via [REDACTED]. This relates to the prevention of future deaths notice concerning Linda Sitch. We have highlighted the points you raised, and our response follows these.

a) Although not determined to be probably causative of the death, by the date of Linda's death ASC had failed to respond substantively or at all to the Adult Safeguarding Referral dated 29th September 2023; the referral for a Carer's Assessment for Linda herself, received by ASC on 2nd October 2023; the concerns reiterated by Linda's family when chasing the 2nd of October referral on 16th October 2023. These failures were explained as 'human error'

We have reflected and as a learning organisation we have identified three specific areas of learning which are:

- Delay to the safeguarding concern being triaged and progressed
- Downgrading of the priority level without recording a clear rationale for doing so by the team manager. The manager no longer works for Essex County Council.
- Failure of the deputy team manager in responding to the escalation of the risk following the phone call from the family member. The deputy team manager has undergone reflective supervision and has undertaken additional training to support development in the role.

Considering these issues there have been significant changes in Adult Social Care since Mrs Linda Sitch, died through completing suicide which includes the following:

The Central Safeguarding Triage Team has undergone transformative change, which has included increasing the resource of the team, implementing an initial screening check of all safeguarding alerts raised and those which are deemed to meet the criteria for safeguarding are then progressed to a safeguarding concern for further enquiries. As a result of these changes, 96% are triaged for a decision as to whether to proceed to safeguarding section 42 enquiry within 72 hours, with outcomes shared back with referrers and next actions agreed. The remaining 4% take a little longer with continuous oversight, whilst waiting for information at the triage stage to enable decision making. Therefore, there are no longer significant delays in progressing safeguarding referrals received.

Adult Social Care has reviewed our essential training offer, which follows the National Competency Framework for Safeguarding, which includes:

- 1-day basic awareness training for all operational and non-operational workers
- 2-day enquiry officer training for enquiry officers for all operational workers
- 2-day safeguarding adult manager training for all team managers and deputy team managers
- 1-day Mental Capacity Act (MCA) in Practice for all operational workers
- New Carers practice guidance for Adult Social Care operational workers to support better and more timely outcomes for carers.
- New Core Practice Guidance in March 2024, which includes guidance on Care Act assessments, carers assessments, reviews, support planning and safeguarding
- A new Risk Priority Matrix for carers assessments and reviews was implemented in 2023, which was being embedded throughout the year.

This training ensures that all operational workers including team managers, service managers and directors are clear on their responsibilities.

b) The oral evidence of the ASC Service Manager at the inquest (though not mentioned in her statement prepared for the purposes of the inquest), confirmed that the Team Manager responsible for downgrading the Priority 1 status of the carer's assessment referral on 2nd October to Priority 2, without recording a rationale, had likely done so without undertaking the required consideration of either the readily available ASG referral of the 29th September, or the Mental Health Act assessment of Linda herself from the previous year. She agreed that, had an estimated "ten minute" review of the "slim files" for both Linda and her husband been undertaken, as should have happened, the Priority level could not and would not have been reasonably downgraded. She accordingly accepted that, in fact, (and contrary to her witness statement) the decision to downgrade to Priority 2 was capable of being determined, by her as an ASC Service Manager, to be 'inappropriate'.

c) Nonetheless, the ASC Service Manager remained personally “reassured” that a change in Team Manager - along with reminders to personnel of best practice - had sufficiently addressed issues identified by the inquest proceedings.

We recognise an error occurred and that we should have taken actions to allocate a social worker sooner. We also recognise that there was human error by the specific team manager and deputy team manager involved as highlighted above. We can confirm that the Team Manager no longer works for Essex County Council and the deputy team manager has undergone reflective supervision and additional training.

Adult Social Care is satisfied that the current Team Manager who returned to the team in November 2023, is very experienced, has reviewed the process within the team and has oversight of decisions.

Adult Social Care has an audit schedule where individual casework is reviewed and alongside this there is a more focused scheduled of Appreciative Reviews, which focuses on how individual teams operate. This team had an Appreciative Review in May 2024, which highlighted strengths in multi-agency practice, with further focus on embedding this; coupled with good oversight of work from both the team manager and service manager.

Adult Social Care have scheduled an audit cycle within the next three months, specifically focused on how referrals are progressed when an initial referral is received, through to point of allocation. Following analysis and outcomes of this, we will consider issuing further practice guidance to confirm expectations about making good, defensible decisions around priority levels, including expected timescale for the allocation of work.

In Spring 2024, Adult Social Care commissioned an external review of the end-to-end safeguarding process. There were several recommendations, that we are implementing to improve the customer journey and safeguarding practice.

There is a priority matrix in place to support determination of level of risk for carers. There is also a risk priority matrix for safeguarding, issued in September 2023, which was in the process of being embedded across Adult Social Care at the time of Linda Sitch’s suicide.

By introducing the measures highlighted in this response we have enhanced the tools required to support better practice decisions. Our practice audits demonstrate our workforce are clear on recording expectations.

d) In contrast to this view, I remain concerned that ASC continues to lack a robust system to ensure sufficiently rigorous oversight, including active auditing, capable of identifying the kind of sub-optimal managerial level performance as has been brought to the fore in this case. A change in personnel and moves towards “embedding best

practice” do not, in my opinion, sufficiently address this systemic lacuna given that the effectiveness of such changes will still rely very substantially upon the performance of any Team Manager and/or a Deputy Team Manager. There appears to me to be a continuing lack of robust Service level oversight of those managers themselves, (including the appropriateness of their decision making), absent which any sub-optimal performance by said managers may well not be identified.

We are satisfied that Adult Social Care has robust oversight in place. We created a data and insights team in August 2024, who provide detailed reports on performance. Directors / service managers / team managers receive a weekly report in relation to safeguarding activity across all teams. There is also a weekly report which details people waiting alongside a dashboard, these have team manager /service manager and director oversight.

Furthermore, there is a monthly quality, performance and accountability meeting (QPAM) within each locality area, where data information reports are scrutinised by service managers and directors, which ensures greater accountability and oversight of all work and what stage it is at.

Adult Social Care have also implemented an improved supervision framework in 2024. There are four main elements to supervision which are to:

- (i) reflect upon our practice and our emotional response to the situations we encounter.
- (ii) clarify our work priorities.
- (iii) support our general wellbeing.
- (iv) consider our development and learning needs.

This also enables greater oversight and scrutiny of work held at all levels of the operational workforce.

Time to Reflect sessions are held on a quarterly basis for operational teams and focus on key themes and areas of practice for learning for example, in June 2024, the session was dedicated to practice in relation to Valuing Carers.

Adult Social Care has a Practice Governance Board, which is chaired by our Principal Social Worker. There are several subgroups have a specific focus lens and report into the six weekly Practice Governance Board. These are:

- SAR/DARDR/Inquests Subgroup to ensure robust actions and learning is taken from recommendations
- Compliments, Complaints and Local Government Ombudsmen Reports Subgroup
- Learning and Development Steering Group
- Practice, Policy and Guidance Subgroup

- Research Governance Panel

All groups have a focus on learning and best practice to support our wider workforce.

e) Absent a sufficiently robust system for providing oversight and identifying and significantly mitigating (if not entirely removing) such individual human error, alongside, for example, the inclusion of simple auditable check lists of matters to be accessed, reviewed and documented whenever a referral is received, then there is a continuing risk of urgent future referrals being inappropriately graded as Priority 2 (and/or being downgraded from Priority 1) without the requisite thorough and 4 professional review, adequately documented, being undertaken. This gives rise to a concomitant risk of future deaths

Adult Social Care's approach to quality assurance has been reviewed and enhanced since 2023 and is twofold.

There is a Quality Control focus on the accuracy of the information that we capture, with an expectation on all levels of our operational workforce to ensure Data Quality:

- Individuals, managers, or supervisors are responsible for ensuring data entry is completed correctly and on time.
- This data feeds into performance data and reporting as per the Quality Assurance framework.
- Emphasizes the importance of getting things right the first time.
- Provides Adult Social Care (ASC) with quantitative intelligence.

Team managers, deputy team managers and supervisors undertake quality control checks as part of their responsibilities for oversight of work in their teams daily.

Alongside the Quality Control measures in place, Adult Social Care refreshed its Quality Assurance Framework in 2024 and there are now eight audit cycles in place throughout every year. These focus on care act assessments/reviews, carers assessments, mental capacity assessments and safeguarding. Audits are analysed and reports are presented to the Practice Governance Board.

Deep Dive thematic audits are also undertaken as and when requested/required to ensure continuous learning in specific areas of practice.

Adult Social Care's Principal Social Worker and Principal Occupational Therapist, along with The Essex Social Care Academy (training department) and Adult Social Care's dedicated Practice Quality Team recognise there is a critical role between learning from assurance, development and practice quality activity. Therefore, they work closely together to ensure

learning and intelligence from assurance activity and continued professional development programmes, informs the approach of both, to ensure a rounded overview of practice quality in Adult Social Care.

If you have any further queries, please do not hesitate to contact me directly.

Yours sincerely,

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Director, ASC Alliance (Mid), Safeguarding, MCA and DoLs

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