Safeguarding Adult Review – 'Lou' Learning Briefing

Telford and Wrekin Safeguarding PARTNERSHIP

1. Background - This case review considered the death of a 40 year old person who resided within supported accommodation. They received full-time care due to having disabilities and underlying health conditions including severe epilepsy which was eased with the use of a Vagus Nerve Stimulation (VNS). Sadly, the person passed away suddenly in late 2022.

4. Positive and proactive steps taken to address the recommendations so far -

In response to the initial recommendations, partner agencies within the Safeguarding Adults Review (SAR) Panel have taken meaningful and proactive steps to strengthen multi-agency collaboration and enhance safeguarding practice.

- **Strengthening Collaboration in Complex Cases:** Partner agencies are actively working to improve joint planning for individuals with complex needs. There is a shared awareness of Section 42 safeguarding duties, including the importance of timely communication of investigation outcomes.
- **Enhancing Risk Assessment through Shared Knowledge:** Updates to the social care risk assessment process are already underway, with a focus on clearly incorporating information from all relevant agencies. This ensures that risk assessments are comprehensive and person-centred.
- **Improving Care Plans and Quality Assurance:** Reviews of safeguarding assessment and referral forms are progressing to ensure Care Plans accurately reflect individual needs. Quality assurance engagement with care providers is ongoing to uphold and continuously improve the standard of care delivered.
- **Collaborating on Assistive Technology Assurance:** The Assistive Technology Team is partnering more closely with care providers to strengthen oversight and support around assistive technologies, helping ensure continuity of safe and effective care for those who depend on such equipment.
- **Raising Awareness Around Critical Incidents:** A guidance note is being prepared and will be shared with care providers to clarify responsibilities following unexpected deaths and in situations involving police investigations. This will help ensure appropriate actions are taken with sensitivity and professionalism.

2. Process

Following receipt of the referral in Winter 2022 scoping information was requested which informed the decision to progress to a Safeguarding Adult Review (SAR) in Spring 2023. Immediate safeguarding actions were implemented and an independent author was sourced in early summer 2023. This review was run alongside a LeDeR review process which avoided duplication of work for agencies and reduced the impact on the family. The review panel was made up of practitioners involved with the case alongside managers from across the partnership and met formally four times throughout the process, with additional theme specific meetings taking place in between. Contact was maintained with the family throughout to update them on the progress and allow opportunity for them to contribute at their own pace.

3. Recommendations and Learning

The following recommendations were made following the independent review:

1. Assurance should be sought around procedures reinforcing the need for a single multi agency plan to be developed in complex cases. If single agency reviews have taken place these should be shared with other agencies involved with the person. This should be audited regularly to ensure this is happening.
2. Assurance should be sought that the outcomes and recommendations from Section 42 enquiries are being shared at the earliest opportunity with all relevant organisations, including care providers.
3. Social Care should ensure that all guidance and templates address the issue of suitability of the care plan, taking into account identified risks such as fire or medical emergency.
4. The CQC and Social Care should use the findings of this review for future quality assurance of Home farm trusts provision Telford.
5. The assistive technology team should ensure clarity on roles and responsibilities of provision and maintenance of the equipment in cases where the care providers have their own technical support team, along with ensuring there is a contingency plan in place in case of equipment failure
6. Assurance should be sought that all care providers and community based professionals are aware of the 'acid test' in relation to DoL's criteria and the process to follow for identified cases.
7. Telford and Wrekin Safeguarding Partnership should remind care providers and agencies not to initiate any investigation following a death where there is police involvement.