Safeguarding Adult Review

[Adam]

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1. INTRODUCTION AND METHODOLOGY

Background

In April 2021, the West of Berkshire Safeguarding Adults Board considered the case of Adam who had died in January 2020. Adam had been supported by services over a long period of time, which at the time of his death were responding to concerns about the standards of his care and his treatment by carers. The safeguarding board recognised the potential to improve the way agencies worked together and commissioned this Safeguarding Adults Review (SAR)[1].

The review aimed to use the experiences of Adam to identify learning and to continually improve the way that agencies support the wellbeing of adults at risk. A wide number of agencies from the safeguarding partnership took part and four key findings were identified. These are outlined in this report as follows:

a) Out of Area Placements – Understanding and Responding to Safeguarding Concerns
b) Information Sharing
c) Management of Complex Enquiries
d) Family Engagement

Methodology

An independent lead reviewer was appointed to work alongside a panel of local professionals to undertake the review. Terms of reference were provided, identifying the key date parameters as January 2017 to the date of Adam's death. Chronologies and single organisation reviews were provided by each agency, analysing practice events and considering how changes to practice may deliver future improvement. The National Health Service also provided a Learning Disabilities Mortality Review (LEDER).

Adam's family met with the independent reviewer to ensure that their views were considered and that the voice of Adam was captured. The safeguarding board is very grateful for their participation and their valuable contribution.

Practitioners and senior representatives from each agency met for a further analysis of events and to identify the systemic reasons as to why better outcomes were not achieved. All were then involved in identifying potential improvements for consideration by the Safeguarding Adults Board. This overview report detailing the analysis and findings of the review panel was then prepared, which has passed a quality assurance process by the review panel.

About This Report

This report outlines the recommendations in a concise format. It is written with the intention of publication and as such does not contain information which may identify those involved. The document aims to be as succinct and practical as possible and therefore does not contain a detailed chronology of events, or the 'working out' process for the review findings. The detailed analysis of events and the evidence underpinning this report are held in additional documents retained by the West of Berkshire Safeguarding Adults Board.

[1] http://www.sabberkshirewest.co.uk/practitioners/safeguarding-adults-reviews/

2. CASE SUMMARY & KEY EVENTS

Adam – An Overview

Adam was 33 years old at the time of his death, having died in hospital of Bronchopneumonia. He had been living for a number of years in the Wokingham area, in supported accommodation commissioned by the Borough of Barnet and supplied by a private care provider specialising in supporting adults with complex needs.

In his early childhood Adam had been diagnosed with acute autism and a number of health disabilities which became more evident during his adult life. Adam had complex needs and from an early age he and his parents were supported by Barnet Children's Social Care, subsequently becoming a looked after child. At times Adam was described as displaying distressed and aggressive behaviour, which his carers found difficult to manage. A number of long term placements failed and there was disruption to his childhood and early adult life.

At the age of 22yrs, Adam was admitted to a psychiatric hospital and subsequently accommodated in its specialist autism unit. His parents quickly raised concerns about the way his condition was managed and the way he was treated. Physical restraint was used frequently and safeguarding concerns were raised about the volume of physical injuries which he had suffered.

In 2009, Adam moved to his home in Wokingham, a placement which had been found by his mother following concerns about him remaining in the hospital specialist unit. Adam's father explained that he enjoyed living in his new placement and his wellbeing quickly improved. He was particularly fond of his main carer, James, who was seen as a positive influence in his life. Adam's formal advocate outlined how the use of restraint had been significantly reduced in his new placement and that Adam had consistently said he liked living there, talking positively about James. This view was not however shared by Adam's mother, who had raised concerns about the way he was treated and how the care provider sought to blame him for his behaviour when distressed, rather than accepting that this was due to the standards of his care.

In 2017 there were concerns raised about a significant change in Adam's behaviour, which coincided with Adam starting to suffer a pattern of physical injuries. Whilst his carers explained that the injuries were caused by Adam's own behaviour, his mother raised concerns that he was being abused by his carers.

In late 2018, Adam's mother placed a covert recording device in his residential accommodation to monitor the actions of his carers. This identified that he was being abused and this was reported to the police who immediately informed Wokingham Adult Social Care. A police investigation into the allegations commenced, in addition to a safeguarding response led by Wokingham Adult Social Care and following the principles of Section 42 of the Care Act 2014.

In January 2020, Adam was admitted to hospital and treated for community acquired pneumonia. His condition quickly deteriorated and he passed away whilst in hospital.

Key Events

a) In 2010, Adam moved into his new home in Wokingham, a placement which was commissioned by the Borough of Barnet and whose Adult Social Care service remained responsible for supporting Adam's care needs. Within a short period of time Adam's mother developed concerns about the way in which he was being treated and that his carers had caused him physical injuries. She raised these concerns with both the care provider and Barnet Adult Social Care.

b) During the period of 2012 to 2014, there were a number of concerns raised with Wokingham Adult Social Care about Adam's wellbeing, mainly in respect of physical injuries and allegations of assault by carers. This included fifteen incidents detailed in their case notes and a further two safeguarding referrals. After September 2014 the reporting of concerns stopped, there were no further reports of physical injuries and Adam's care appeared to be settled.

c) In March 2017, Adam's care provider raised concerns with the Community Learning Disability Team about changes in his behaviour and a deterioration of his wellbeing. They explained that they did not know the reason and asked for support to identify and address the underlying cause.

d) In April 2017, the pattern of Adam being seen by professionals with physical injuries recommenced. In April he was seen by his GP with facial injuries and in August he was seen with a head injury. His carers had explained to the GP that Adam scratched himself and that the head injury had been caused following a fall due to his deteriorating eyesight. The pattern of physical injuries being seen by the GP continued throughout the remainder of the year. During Adam's psychiatric review that year, comment was made that his behaviour was deteriorating and that he was having sudden aggressive episodes.

e) During 2017, a pattern also emerged of Adam not being taken to his medical appointments. This included Adam not being taken to two ophthalmology appointments, which resulted in him being discharged from the service despite his deteriorating eyesight.

f) In the latter part of 2017, Adam's mother became increasingly concerned about him remaining in his care placement. This was due to her concerns about standards of care and ill treatment, a view not shared by Adam's father. This led to an application being made to the court of protection to examine a number of issues in relation to Adam's care. There was subsequently a number of hearings held, and orders made, during 2018. This included an order made on the 9th July 2018 that Adam should continue residing in his care placement. This was the start of a number of contested court hearings which continued throughout 2019, due to a continued disagreement between Adam's parents as to what was in his best interests.

g) In January 2018, Barnet Adult Social Care completed a review of Adam's care needs. Whilst the review noted Adam's change in behaviour, it was not aware of the information known to other agencies. Particularly the pattern of physical injuries and the concerns about his behaviour raised with the community learning disability team.

h) In July 2018, Adam's care provider again highlighted that his behaviour was deteriorating and asked for support in identifying the reason. They requested that the Learning Disability Intensive Support Team should be commissioned to work with Adam, however this was not progressed as Adam's mother specifically objected to them working with her son. The care provider made further requests for this support in October 2018 and January 2019, however a referral for the services was not progressed due to the objection. This was despite professionals and Adam's father believing that it would be in his best interests. This issue was subsequently presented at the court of protection, who ordered that a referral should be made. This was however only resolved shortly before Adam's death and these services were never provided.

i) On the 13th November 2018, a safeguarding referral was received by Wokingham Adult Social Care after Adam had reported being locked in the bathroom and hurt by his carers. The care provider denied that this had happened and provided an explanation. This was accepted during the referral assessment stage and it was decided that no further action was required. A strategy meeting was not held and the information known to other agencies was therefore not considered during the assessment of the safeguarding referral.

j) At the end of 2018, Adam's mother placed a covert recording device in his residential accommodation to monitor the actions of his carers. She explained that she resorted to this as she did not feel listened to by the various safeguarding agencies. Despite having repeatedly raised concerns that Adam was subject of abuse, she felt that agencies had chosen to believe the explanations provided by the care provider rather than examine the standards of his care.

k) On the 30th January 2019, Adam's mother made a criminal complaint that Adam had been abused by a number of his carers. She produced the covert recordings as evidence and the police commenced a criminal investigation. Adam's mother also reported the abuse to the Care Quality Commission (CQC), who informed Wokingham Adult Social Care that an allegation had been made about at least seven carers.

l) During February 2019, a number of strategy meetings took place to coordinate the response to the allegations. At this time the precise nature and extent of the allegations was unclear as a review of the recordings had not been completed. Initial safeguarding actions were put into place, which included asking the care provider to ensure that any carer suspected of involvement in the abuse did not work with Adam and that they were subject of further restrictions in respect of their work with other vulnerable people. Whilst the police wished these carers to be suspended, they refused to share with the care provider any information as to the details of the allegations. This decision was taken to prevent the criminal investigation from being compromised, before the alleged perpetrators and witnesses could be interviewed. Wokingham Adult Social Care disagreed with this decision and made representations for the greater sharing of information, this was however declined by the police. During the following eight months this was continually challenged by Adult Social Care, however the police declined to authorise the sharing of any information whilst the investigation continued. By this time it was apparent that the investigation would take many months to complete, something that was recognised and acknowledged by the police.

m) In February 2019, the care provider was asked to remove James from supporting Adam and to place restrictions on a further six members of staff. They requested the disclosure of information to understand the allegations and to safeguard Adam, however were not supplied with this information. They outlined how they received conflicting information about the actions of their staff and that this made it extremely difficult to respond to the safeguarding concerns. In order to continue the delivery of Adam's care agency staff were employed on short term contacts.

n) Towards the end of February 2019, Wokingham Adult Social Care requested that the police share the recordings with them, in order to assess the information and ensure an effective safeguarding response. This was denied by the police, who following legal advice believed that sharing the information would be in breach of data protection legislation. Over the subsequent months this decision was unsuccessfully appealed on a number of occasions by a senior manager in social care, who explained that without this information the Section 42 investigation could not effectively proceed. During wider discussions about information sharing, the police stated that they could not share information for the purpose of safeguarding as it would compromise their investigation. It was therefore agreed that actions to progress the Section 42 investigation could not proceed. In March 2019, the police deferred the responsibility for all risk assessments to social care, but declined to provide the information needed to complete this responsibility.

o) During March 2019, Adam's father expressed his concerns that the lack of information sharing between agencies and a lack of coordinated activity was having a detrimental impact upon Adam. In May 2019, Adam's advocate made similar representations. He outlined that Adam needed a consistency of staffing and urged all professionals to 'see the bigger picture' and progress the safeguarding investigation. He explained how as a result of the agencies' response to the allegations, Adam had effectively been removed from a stable and successful placement.

p) Throughout the remainder of 2019, and whilst the investigations progressed, the pattern of Adam being seen with physical injuries continued. This included eight incidents of injuries being recorded by the GP and a further two incidents of Adam disclosing to his doctor that he had been assaulted. These allegations were not referred as safeguarding concerns and social care were not aware that they had been made. During this period Adam's mother reported that abuse was continuing and provided further tape recordings to the police.

q) In September 2019, Wokingham Adult Social Care met with the police and highlighted the need to share information with the care provider, questioning the decision to prioritise the criminal investigation over safeguarding. The police replied that the investigation would continue to be police led and that the local authority should not make any further enquiries as this may impact upon their investigation. This was challenged by social care, making use of the formal escalation process which existed within the safeguarding partnership.

r) On the 25th September 2019, Wokingham Adult Social Care received a number of audio tapes from Adam's mother, having sought permission from the court of protection for her legal advisors to share them. A review of the information was immediately conducted and safeguarding allegations relating to eight members of staff were substantiated.

s) On the 26th September 2019, Wokingham Adult Social Care received an update from the police about the escalation process. The police accepted that the safeguarding of vulnerable people should outweigh any risks to the criminal investigation and that a greater level of information should be shared. Despite this they only agreed for a limited amount of information to be shared with the care provider, extending only to the names of the staff involved and not any details of the abuse.

t) On the 16th October 2019, all allegations against James were found to be unsubstantiated and a plan developed to return him to Adam's care. This decision was however appealed by Adam's mother, which caused a delay in allowing James to resume his work with Adam. This was eventually resolved at the end of November 2019 and all restrictions were removed.

u) On the 12th January 2020, Adam was admitted to hospital suffered from repeated vomiting and a cough. He was treated for community acquired pneumonia, however his condition deteriorated quickly and he passed away on the 13th January. His cause of death was determined to be bronchial pneumonia.

v) On the 27th February 2020, the police submitted a file to the Crown Prosecution Service (CPS), who subsequently authorised criminal charges in relation to three persons. They were charged in May, however the prosecution was later discontinued by the CPS before the matters went to trial. One person received a police caution in lieu of prosecution.

3. CRITICAL ANALYSIS AND LEARNING

Finding 1 – Out of Area Placements – Understanding and Responding to Safeguarding Concerns

Learning:

Out of area placements make it more challenging to identify emerging safeguarding concerns and to provide an effective response. In order to improve this a person centred approach is required, in addition to a greater level of multi-agency working.

Throughout 2017 and 2018, concerns were raised about Adam's wellbeing. He had become visibly distressed and the frequency of aggressive episodes had increased. This coincided with a pattern of Adam being seen by his GP with physical injuries, each of which had been subject of an explanation

by his carers and when taken in isolation did not meet the threshold to raise a safeguarding concern. At this time Adam's mother had increasingly raised concerns that he was being abused by his carers.

One of the key issues in Adam's case was the way agencies were unable to understand what was happening in his life and how the underlying reasons for the change in his behaviour were not identified and responded to. In examining the reasons for this, it was ascertained that whilst Barnet Adult Social Care was responsible for supporting Adam's care needs, they were not aware of key information held by other agencies, particularly the emerging pattern of injuries seen by the GP. Whilst the annual review of Adam's care plan included the participation of his parents and the care provider, this did not include professionals from the agencies who were working with him. This led to a lack of information sharing and prevented the opportunity to develop a joint understanding of what was happening in his life. Had there been a greater multi-agency involvement in the review, then it is likely that safeguarding concerns would have been understood at an earlier stage.

The annual care plan review process appeared to focus on what practical measures were needed to deliver Adam's changing care needs, rather than taking a more holistic approach to reviewing his wellbeing. The process may have been more effective if it had taken a person centred approach to first of all understanding what was happening in his life, before then considering what further support he needed. For example Adam had not been taken to a number of medical appointments and had been discharged from the ophthalmology service despite his badly deteriorating eyesight. Addressing the reasons for this and then meeting his medical needs may have helped to improve his overall wellbeing.

During the review it was explained that had Adam's residential placement been within the Barnet Local Authority area, then the review meetings would have had a greater level of multi-agency participation due to the way services are structured. It was accepted that the arrangements for reviewing out of area placements needed to be improved. It is therefore recommended that Barnet Adult Social Care develop an enhanced process for the annual review of residential care placements commissioned outside the Borough of Barnet.

Any new guidance should be person centred and involve the key professionals involved in the specific case. It should aim to improve information sharing and to develop a diverse approach to understanding what is happening in a person's life. The participation of the GP should be seen as essential. The ethos of these meetings should have a greater emphasis on understanding the person supported, rather than merely focussing on any practical measures to deliver care needs. For a fuller safeguarding context, the annual review process should also consider information known about the care provider to help identify emerging concerns.

In November 2018, Wokingham Adult Social Care received a safeguarding referral outlining that Adam had been hurt by his carers. The subsequent assessment only considered the information contained within that specific referral and did not fully review the information known to Wokingham or Barnet Adult Social Care. Following an explanation provided by his carers the matter was closed with no further action. Wokingham Adult Social Care accept that the assessment should have involved a greater level of professional curiosity and an opportunity to identify abuse was missed. Since Adam's case a single hub to manage all safeguarding referrals has been introduced and the assessment process now has an emphasis on understanding a person's history whilst making a threshold decision. The review panel agreed that this has led to an improvement in the quality and consistency of assessments, and the use of strategy meetings.

Had these new procedures been in place at the time of Adam's safeguarding referral, then it would likely have resulted in a greater amount of information sharing and a more effective response to the

concerns. As such there would be great value in testing these new procedures to ensure that they are robust and also to share the newly developed best practice with the other Local Authorities in West Berkshire. As such it is recommended that the safeguarding board seeks assurances from its Local Authority partners, that there are adequate systems in place to fully gather and consider a person's history in their response to safeguarding referrals. This should include:

a) Details of current procedures.
b) A quality audit as to how a person's history is considered and the effective use of strategy meetings.

Recommendation 1:	*An enhanced process for the review of out of area care placements should be developed by Barnet Adult Social Care. This should embrace a person centred approach and involve the key professionals involved in the specific case.*

Recommendation 2:	*The West of Berkshire Safeguarding Adults Board should seek assurances from its Local Authority partners, that there are adequate systems in place to fully gather and consider a person's history in their response to safeguarding referrals.*

Finding 2 – Information Sharing

Learning:

The lack of information sharing affected the quality of safeguarding and reduced the ability of agencies to protect Adam from further abuse. A greater understanding of the need to share information is required for the effective management of future complex cases.

Following the criminal allegations being raised in January 2019, the issue of information sharing became a critical factor in the effectiveness of the multi-agency response. At an early stage the police made two decisions which affected how Adam and other vulnerable people could be safeguarded from further abuse. These being:

a) A decision that Adult Social Care should not share details of the abuse allegations with the care provider, in case this alerted the alleged perpetrators and harmed the investigation. For this reason it was agreed that the Section 42 investigation could not be progressed until the criminal investigation concluded.
b) That details of the covert recordings provided by Adam's mother could not be shared with Adult Social Care as this would breach data protection regulations (GDPR). Whilst they accepted that GDPR allowed the disclosure of information for safeguarding purposes, they formed an opinion that this did not apply in Adam's case as the carers had been removed from working with him and therefore could not cause further harm.

The decision not to involve the care provider more fully in the safeguarding response meant that they were prevented from understanding what was happening to Adam and were unable to address the underlying cause of their staff's behaviour. It allowed the abuse to continue, even when new staff were employed to work with Adam. This decision also led to a culture of mistrust between the care provider and the safeguarding agencies. They explain how they felt that there was a hidden agenda to shut the business down and this led to an adversarial relationship, rather than one of a partnership which would have been far more effective.

The decision not to share the recordings with Adult Social Care prevented them from making informed risk assessments and from quickly progressing the Section 42 investigation. This delay had a negative impact upon Adam, who lost the continuity of carers with whom he had previously enjoyed spending time and had responded well to. Both Adam's father and his advocate outlined the detrimental impact that this had upon his wellbeing.

The overriding objective of any police investigation should be to safeguard vulnerable people and protect people from harm. Whilst this is widely understood and practised in cases of child protection, it is not so widely understood in adult safeguarding. Recommendations to address this issue are dealt with in the next section of this report.

Whilst the safeguarding partnership has an information sharing protocol[2] and further guidance in relation to information sharing, these agreements do not specifically cover the issues identified in this review. It is therefore recommended that the Safeguarding Adults Board consider developing a protocol to clarify how information should be shared during complex multi-agency enquiries. Options for how this may be done include:

- Amending existing protocols to ensure that this issue is included in current agreements.
- The development of specific guidance. This could be included as part of recommendation 4 which is considered later in this report and recommends the development of guidance for complex enquiries.

Recommendation 3:	*The West of Berkshire Safeguarding Adults Board should develop a new information sharing protocol for use in complex multi-agency enquiries.*

Finding 3 – Management of Complex Enquiries

Learning:

A new partnership protocol for the management of complex enquiries would greatly improve the efficacy of multi-agency safeguarding investigations. This should be supported with a training and development programme for professionals involved in such multi-agency enquiries.

The terms of reference provided to the review, required an examination of how agencies were equipped with the expertise and resources to manage complex enquiries. In doing this the review identified two key areas which provide the potential to improve future practice. These being:

a) The development of a partnership protocol to coordinate multi-agency complex enquiries.
b) The training and development of professionals who are involved in such enquiries.

Partnership Protocol for the Management of Complex Enquiries

The one thing that would have made the most difference in response to the criminal allegations, would have been the existence of a strategic oversight group to coordinate the response from the outset. Formed by senior representatives from the different agencies, this would also have provided support to those professionals delivering the operational activity. This is something that is widely

[2] https://www.berkshiresafeguardingadults.co.uk/media/1059/pan-berkshire-sab-information-sharing-protocol-v10.pdf

used throughout the public sector for multi-agency operations and is often referred to as a Gold Group[3]. Had this been in place it could have quickly:

- Set strategic priorities for the multi-agency response and agreed information sharing protocols, whilst ensuring that the operational leads worked within the agreed parameters.
- Provided a forum for the immediate resolution of any disagreement.
- Ensured that sufficient resources were in place to progress the enquiry in a reasonable timescale.

Not only would this have improved the efficacy of the safeguarding operation, it would also have removed a great deal of pressure from the operational leads and allowed them to focus on delivering the agreed priorities.

It is recommended that to improve the efficacy of future practice, a multi-agency protocol is developed to provide guidance and a structure for the management of complex multi-agency enquiries. This should not only include arrangements and membership requirements for a strategic group, but also consider how a tactical group is formed and led to deliver the operational activity. Once complete there would be great value in sharing this with each of the adult safeguarding partnerships within the Thames Valley Police area.

Training and Development

Adam's case highlights the benefit in continuing to invest in the training and development of professionals who will be involved in future enquiries. Not just in how they deliver their own objectives, but in understanding different agencies and how they can work in partnership. This need is well illustrated through the police decision to prioritise their investigation at the expense of the duty to safeguard. Both objectives could have been achieved by adapting the timing of investigative action, enabling the sharing of information without creating a risk to the wider investigation. This is something that is common place in child safeguarding cases, where processes for joint investigations are more mature and which have been developed over time.

Should the safeguarding board develop new protocols for the management of complex enquiries, then it would provide an ideal opportunity to also develop a multi-agency training programme to embed the new arrangements. Adam's case provides the perfect basis for a case study which could be used to support this training.

Recommendation 4:	*The West of Berkshire Safeguarding Adults Board should develop a new protocol for the management of complex multi-agency enquiries.*

Recommendation 5:	*The West of Berkshire Safeguarding Adults Board should develop a multi-agency training and development programme for professionals involved in complex enquiries.*

[3] https://www.app.college.police.uk/app-content/operations/command-and-control/command-structures/

Finding 4 – Family Engagement

Learning:

Professionals did not understand the underlying reasons for Adam's mother's concerns and why she had developed a different opinion to others about what was in Adam's best interests. This prevented a consensus being developed, affecting the services provided to Adam.

During the last few years of Adam's life, a difference of opinion developed between his mother and others about what was in Adam's best interests. She had formed a different view from his father, his advocate, and the professionals working with Adam as to where he should live and what services should be permitted to work with him. Barnet Adult Social Care worked with both parents to seek a full agreement of opinion, however this ultimately failed and resulted in a number of court hearings to decide on what was in Adam's best interests. This not only caused a significant delay in services being provided to Adam, but it also caused distress to both parents and further complicated the work of professionals. A key area of learning highlighted during this review was how agencies worked with Adam's mother to understand why she had developed these views and how to best resolve conflict in a way that supported Adam's best interests.

Adam's mother explained that over a number of years she had raised a high volume of concerns about the way in which he was being treated, but these had always been dismissed. She felt that this was because agencies wished to protect the care provider and as a result, she lost confidence in their ability and their will to protect Adam. It was clear that her perception of the safeguarding agencies contributed to the difference in opinions which developed over time. During the review it was fully accepted that the reasons for Adam's mother's differing views had not been fully understood. Had they been, then this may have resulted in different outcomes.

In future cases involving a difference of views, there would be great value in taking a trauma informed approach to identifying and understanding the concerns of family members. This should seek to understand the underlying reasons for any concerns and work to address them. In complex cases, this work would be greatly enhanced with the appointment of a social worker to support individual family members.

It is accepted that a consensus of opinion will not be possible in every incidence and Adam's case also provides learning as to how this may be managed. Once it was clear that agreement could not be reached, it would have been beneficial for professionals to have been more positive in making earlier best interest decisions. This may have prevented the delay of services being provided to Adam, which was subsequently caused by the court process. Consideration may also have been given to the appointment of a personal welfare deputy[4], to prevent future disagreement.

It is recommended that Barnet Adult Social Care reviews the way they engage with families, particularly in cases where conflict exists as to what is in a person's best interest. Any future guidance should be based on the principles of a trauma informed approach and include guidance as to how a person's best interests may be protected where a consensus of opinion cannot be reached.

Recommendation 6:	*The Borough of Barnet should develop new guidance for family engagement when considering the best interests of adults with care needs. This should be based on a trauma informed approach and also*

[4] https://www.gov.uk/become-deputy

	provide guidance for professionals to manage cases where a consensus cannot be reached.

4. PARALLEL REVIEWS

Whilst this review has focussed on multi-agency safeguarding arrangements, there has been an additional single agency review conducted into Adam's case. This was a 'Learning Disabilities Mortality Review' conducted by the National Health Service. It made a specific learning recommendation in relation to advanced care planning which is summarised at Appendix A of this report.

5. CONCLUSION AND SUMMARY OF RECOMMENDATIONS

Concluding Comments

This safeguarding adult review has identified key learning for both the Borough of Barnet and for the agencies within the West of Berkshire Safeguarding Adults Board. Both should now consider the recommendations outlined in this report and how they intend to deliver improvements to safeguarding practice.

In addition to addressing the multi-agency recommendations, the West of Berkshire Safeguarding Adults Board should hold individual agencies to account for delivering the single agency recommendations.

Summary of Recommendations

Recommendation 1:	An enhanced process for the review of out of area care placements should be developed by Barnet Adult Social Care. This should embrace a person centred approach and involve the key professionals involved in the specific case.
Recommendation 2:	The West of Berkshire Safeguarding Adults Board, should seek assurances from its Local Authority partners, that there are adequate systems in place to fully gather and consider a person's history in their response to safeguarding referrals.
Recommendation 3:	The West of Berkshire Safeguarding Adults Board should develop a new information sharing protocol for use in complex multi-agency enquiries.
Recommendation 4:	The West of Berkshire Safeguarding Adults Board should develop a new protocol for the management of complex multi-agency enquiries.
Recommendation 5:	The West of Berkshire Safeguarding Adults Board should develop a multi-agency training and development programme for professionals involved in complex enquiries.
Recommendation 6:	The Borough of Barnet should develop new guidance for family engagement when considering the best interests of adults with care needs. This should be based on a trauma informed approach and also provide guidance for professionals to manage cases where a consensus cannot be reached.

6. Appendix A – Single Agency Review Recommendations

Learning Disabilities Mortality Review – Summary of Recommendation

Recommendation

The review identified that at the time of his death Adam did not have any advanced care planning in place. It recommends that GP's support families and carers to make advanced care plans for those patients who present with co-morbidities.