OLDHAM SAFEGUARDING ADULTS BOARD

Derek Safeguarding Adult Review Overview Report

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Contents

1. Legal Context

1.1. The Care Act 2014, Section 44[i], requires that Safeguarding Adults Boards must arrange a Safeguarding Adults Review when certain criteria are met.

1.2. These are:

- When an adult with care and support needs has died because of abuse or neglect, or has not died but experienced serious abuse or neglect, including self-neglect whether known or suspected, and;
- There is a concern that partner agencies could have worked more effectively to protect the adult.

1.3. Safeguarding Adult Reviews are required to reflect the six safeguarding adults' principles, as defined in the Care Act. These are empowerment, prevention, proportionality, protection, partnership, and accountability.

1.4. The aim of a Safeguarding Adults Review is to contribute to the improved safety and wellbeing of adults with care and support needs and, if possible, to provide a legacy and support family and friends.

1.5. There are clear review objectives which have been addressed to achieve these aims. Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the facts (what happened), an analysis and findings (what went wrong and what went right), the recommendations to improve services and to reduce the risk of repeat circumstances, and a shared action plan to implement these recommendations. It is not the purpose of the review to re-investigate the suspected abuse or neglect, or to apportion blame to any party.

1.6. The inquest into Derek's death is pending and this review will be shared to aid the process.

2. Introduction

2.1. Derek was 69 when he was found dead in his own home on 6 December 2019. He had a diagnosed Learning Disability and number of other health conditions including hearing impairment, Type 2 Diabetes Mellitus, Diverticular Disease, Essential Hypertension, Obesity, Arrhythmia, Retinitis Pigmentosa and Glaucoma. Derek was known to a range of services relating to both his medical and wider housing and social needs.

2.2. The post-mortem examination concluded that he died as a result of ketoacidotic state and hyperglycaemia.

2.3. In October 2021, OSAB commissioned a Safeguarding Adult Review (SAR) in relation to 'Derek'. The case was referred by the LeDeR Panel to the SAR screening subgroup in August 2021.

2.4. Concerns raised in the LeDer focused review, and the SAR referral focused on Derek's non concordance with diabetes treatment and agencies identified that there did not appear to be a clear care plan or risk assessment between agencies. There were also concerns of possible self-neglect.

3. Rationale for carrying out a Safeguarding Adult Review

3.1. Derek's death was initially reviewed as part of the Learning Disability Mortality Review Programme (LeDeR). The LeDeR programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives. In 2019 the LeDeR programme was delivered by the University of Bristol and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.

3.2. To note, from June 2021 the LeDer programme changed to become "Learning from Life and Death Reviews" and the Integrated Care Systems are responsible for ensuring that reviews are completed for people with a learning disability and people with autism[ii]

3.3. On initial consideration of the referral in October 2021, it was agreed that that the criteria for a SAR was met as wider consideration of safeguarding was required. The information from family and that provided in the LeDeR report indicated that agencies involved with Derek could have worked more effectively together with regards to safeguarding, risk assessment and care planning.

3.4. As articulated above, the Oldham Safeguarding adult Board has a statutory duty to arrange a Safeguarding Adult Review (SAR) where:

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, including self-neglect or an adult is still alive, and
- there is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

3.5. In addition to the above, SABs might select cases for either of the reasons noted in the statutory guidance:
- Where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults.
- To explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

3.6. The purpose of the SAR is to promote effective learning and improvement to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.

3.7. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future. The purpose is not to allocate blame or responsibility but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

3.8. The Independent Chair of the Oldham Safeguarding Adult Board agreed that the criteria for a Safeguarding Adult Review was met on that grounds that the agencies involved with Derek could have worked more effectively together with regards to safeguarding, risk assessment and care planning.

3.9. Additionally, that there were missed opportunities related to Derek's health needs which may have been a contributing factor to his earlier than expected death.

3.10. Following appointment of the Independent Chair, the review commenced in December 2021

3.11. The role of the review panel is to contribute to and scrutinise information submitted as part of this review. The review panel was made up of representatives of the agencies involved in the care of Derek as well as key representatives of the OSAB:

- Designated Nurse Safeguarding Adults, NHS Oldham CCG
- Safeguarding and Mental Capacity Act Lead, Adult Social Care, Oldham Council
- Detective Sergeant, Serious Case Review Unit, Greater Manchester Police
- Principal Homelessness Strategy Officer, Oldham Council
- Safeguarding Specialist Practitioner, Northern Care Alliance NHS Foundation Trust
- Named Professional Safeguarding Adults, Pennine Care NHS Foundation Trust
- Locality Manager, Rochdale and Oldham Active Recovery, Turning Point
- Safeguarding Adults Board Business Manager, OSAB
- Safeguarding Adults Board Business Coordinator, OSAB
- GP & Clinical Director for Mental Health and Learning Disability, NHS Oldham CCG
- CLDT Team Manager, Pennine Care NHS Foundation Trust
- Head of Service for Learning Disabilities, Oldham Council
- Named Nurse Learning Disabilities, Northern Care Alliance NHS Foundation Trust
- Associate Director of Nursing / End of Life Integrated Care Lead, Northern Care Alliance NHS Foundation Trust
- Support Manager, North West, KeyRing Living Support Networks
- Team Manager Diabetic Lead, Northern Care Alliance NHS Foundation Trust
- Senior Commissioning Business Partner – Mental Health and Learning Disability, NHS Oldham CCG
- Learning Disability Commissioning, NHS Oldham CCG.

3.12. In addition to the Review Panel, drafts of the report were shared with the Clinical Director of Hope Citadel, the Oldham Focused Care Service Provider, and their comments and feedback requested.

4. Review Process

4.1. **Terms of Reference**: The SAR Subgroup identified several key lines of enquiry for the review, these were then discussed and finalised following the first panel meeting:

- Multi-agency approach and the lead professional role
- Legal literacy and risk formulation management instead capturing professional curiosity and indictors of concern (poor management of health conditions, hoarding and indicators of self-neglect).
- Capacity to understand, and application of the principles of the Mental Capacity Act
- Reasonable adjustments and communication including consideration of accessible information

- Interface between all services in managing diabetes and what that meant for Derek
- Terminology and formal diagnosis of Learning Disability and the impact on access and delivery of services
- Housing provision
- Understanding the family's role and how they were supported by agencies

Taking into account:

- Any changes to system practice since 2019 and how current policy and procedures may have an impact in a similar situation in 2022
- The principles of Making Safeguarding personal which will be applied through exploration of each of the terms of reference

4.2. **Methodology:** A methodology was agreed that would recognise good practice and strengths that can be built on, as well as areas that require improvements. The process was agreed to be proportionate, collaborative, and analytical, actively engage all agencies/organisations involved and family members.

4.3. A bespoke panel was convened to oversee the process and individual agency reports were submitted by the agencies represented on the panel

4.4. Considering the existing review work completed as part of the LeDeR process, the SCIE Rapid Review process was utilised with a practitioner event, focused on assurance and improvements that had been made since 2019, new learning and how this has been embedded.

4.5. The review process to meet these aims and objectives has followed a clear path. The Independent Reviewer chaired an initial panel meeting to agree the review terms of reference, facilitated a practitioner event, conducted research by critically analysing agency learning summary reports, chronologies and relevant records held by involved agencies and additionally, by interviewing representatives of agencies and family members. Subsequent panel meetings were held culminating in a planned Safeguarding Adults Review panel meeting and presentation to a joint meeting of the Oldham Safeguarding Adult Board and Oldham Learning Disability Partnership.

4.6. The transparency and reflections of the panel members, analysis of the chronologies and perspectives of the family has facilitated a rounded view of events and practice.

5. Family Involvement

5.1. The statutory guidance requires early discussions with the individual (where possible), family and friends to agree how they wish to be involved. It further requires that families should be invited and understand how to be involved, with their expectations managed appropriately and sensitively[iii].

5.2. Derek's niece Janet was very involved in his life and was invited to contribute to this review. Janet provided significant insight into his life, feelings, wants and needs which will be reflected throughout this review. Janet is to be commended for her role in Derek's life and her contributions to this review.

5.3. Janet has expressed that Derek died before he needed to, and she would like this review to provide insight and learning into Derek's experience in the months prior to his death as she does not want this to be repeated.

6. About Derek

6.1. Derek was 69 when he died, he was initially considered to have a learning disability during his school years, and this was the basis that his learning disability was understood for the rest of his life. Derek worked during parts of his earlier life and functioned quite independently with support required in some aspects of his life.

6.2. Janet was able to provide insight into Derek's personality. She described him fondly as "old fashioned" and quite set in his ways, he liked things to be done in a certain way, he always wanted to maintain control of his own life and choices. He enjoyed meeting friends at church or for a coffee at the Salvation Army. He really liked to go swimming or on day trips with his best friend Carole[1], to interesting places like the Lake District, or watching trains. Therefore, he was active and sociable in the places that he felt most comfortable.

6.3. Derek had a very positive and meaningful relationship with his niece Janet and her children. Janet described how he doted on her children, and he would see them most days, going to their house for meals or out for dinner with them. He was always good fun and "bubbly" and formed an important part of their family life. He would phone each night to speak to them in turn before they went to bed to say "goodnight, god bless" and Janet described him fondly and said how she misses these regular little things that Derek would do that meant so much to them.

6.4. Janet, with some support from a friend and her eldest daughter supported Derek practically with the things he needs help with. This is very relevant to the review and will be explored within the terms of reference.

6.5. There were several factors that are described by Janet to have distressed Derek in the months leading up to his death, these were reiterated by agency information. These factors significantly affected his quality of life, independence, and happiness:

- His physical health significantly deteriorated; his mobility was reduced.
- He did not feel safe and happy in his flat.
- The conditions of his flat were not of an acceptable standard.
- He felt like decisions were being made "about" him and he began to distrust people.
- He declined the support of some agencies and was reluctant to engage with others.
- He felt out of control of his life and he said on two occasions to Janet that he felt like a burden and he wanted to die.

7. Background and Narrative

7.1. Derek was 69 when he was found deceased by his niece Janet in his own home on 6 December 2019. Derek had a diagnosed Learning Disability and number of other health conditions including hearing impairment, Type 2 Diabetes Mellitus, Diverticular Disease, Essential Hypertension, Obesity, Arrhythmia, Retinitis Pigmentosa and Glaucoma. He was known to a range of services relating to both his medical and wider housing and social needs.

[1] Carole is an anonymised name

7.2. Although there were previous concerns about Derek being non concordant with his diabetes management, the period of time between August 2019 until he died, presents several concerns and incidents which will be considered throughout this review. Namely there were risk factors and concerns that emerged during this time that presented an opportunity for agencies to work more effectively with Derek.

7.3. Derek received support from KeyRing[2] until October 2019, in addition to his niece and the Community Learning Disability Team (CLDT). Also involved where primary and secondary care services. He had increasingly started to refuse support and he was not always concordant with his diabetes treatment plan. There were emerging concerns about "hoarding" in his flat and overall, his physical health and mobility deteriorated resulting in less independence and an abrupt halt to his social network of support. He had two hospital admissions (September and October 2019) due to a urinary tract infection and further concerns about concordance with his diabetic management.

7.4. There was an incident in between hospital admissions where the district nurse reported that Derek was suicidal and had become aggressive during a home visit, this resulted in him being taken to the Emergency Department in an ambulance, he was assessed by the mental health liaison team and a safeguarding referral made.

7.5. During this period of time Derek also told his Niece on two occasions that he felt like a burden, and he wanted to die.

7.6. There were concerns about Derek's housing as his flat was in need of repair, there was evidence of hoarding and at times he expressed that he wanted to move closer to his niece.

8. Analysis of Practice

8.1. Multi-agency Approach and the Lead Professional Role

8.1.1. This review has found that with the right support Derek had previously been able to have a fulfilling and active social life, manage his physical health needs, financial needs and his home. There had been concerns at times over the years about Derek, for example in 2018 he suffered a fall and there was a concern about how well he was complying with his medical treatment plan. The management of his diabetes was a concern over the years, at some points he was managing better than others. However, in 2019 there became a point where risks escalated, Derek's health significantly deteriorated, and multiagency responses were required.

8.1.2. Considering the agency reports, the practitioner event and the panel discussion there is little evidence of a multi-agency approach to Derek. This is confirmed by Janet. The lack of a shared perspective led to agencies responding in different ways and a lack of overarching coordination and planning. Panel members agree that this was the case.

8.1.3. Practitioners and panel members reflected on practice to understand why this was the case and there was a view that each agency viewed Derek with a limited scope

[2] KeyRing is an adult social care provider working with people with Learning Disabilities.

which did not prompt a wider viewpoint and they did not see themselves in a lead professional role. They were not all cited on the same information.

8.1.4. Panel members considered who may have been the most appropriate person to coordinate an initial multi agency meeting. Whilst there was not a definitive conclusion to that, it was agreed that there was a need to do this due to the general deterioration and increasing risk factors. However, there were also several distinct key practice episodes that could have triggered a Team around the Adult meeting when there was clear indication and opportunity to bring agencies together. These are:

- When Derek refused support from KeyRing.
- Discharge from Hospital on both occasions.
- The safeguarding referral from the hospital to the Adult Social Care
- The incident at home when the District Nurse reported Derek to be aggressive and expressing suicidal ideation.
- A GP home visit in November 2019
- The expression of suicidal ideation (at hospital and to his niece). This was shared with the Focused Care Nurse who discussed this with Derek.

8.1.5. These were all opportunities where agencies could have come together with Derek and Janet to understand what he wanted and how he could be supported with his concordance with treatment plans and his overall care and support needs. This would also have afforded the opportunity to discuss risk, capacity and safeguarding.

8.1.6. The absence of Derek's voice in the evidence indicates a lack of person-centred planning, and challenges in communication between the services which negatively impacted on identifying the appropriate practitioners to include in multi-agency care planning and coordination. The six principles of Adult Safeguarding are therefore not apparently evidenced in a collective way[iv].

8.1.7. Similarly, the findings in this review are also aligned to the thematic areas identified in the National SAR analysis[v]:

- Information sharing and communication
- Coordination of complex, multiagency cases
- Hospital admission and discharge arrangements
- Professional roles and responsibilities.

8.1.8. As concerns about Derek's concordance with treatment, self-neglect and physical health deterioration became more apparent, the GP practice identified a Focused Care Nurse to visit Derek, this was good practice unfortunately this was shortly before his death. This was facilitated by the practice after a home visit by the GP in November 2019.

8.1.9. Janet informed the Focused Care Nurse about Derek's suicidal ideation who subsequently talked to Derek about this. However, there was no discussion with any other professionals, including the GP- this was an opportunity to put this into the context of the other concerns and prompt multi-agency consideration.

8.1.10. Considered in the context of multi-agency coordination and identification of a lead professional, is the question of safeguarding action. Individually, practitioners did have worries and concerns about Derek but the opportunity for collective consideration was missed.

8.1.11. A key question related to risk is whether safeguarding procedures were appropriately used. In this case the risk was around self-neglect as Derek's physical health was significantly deteriorating and thus a safeguarding referral would have been warranted.

8.1.12. It should be noted that a safeguarding referral was made in September 2019 from the Emergency Department however this was not in view of collective sharing of information/ identification of risk, instead this related to an "episode". Therefore, the ongoing situation as well as some of individual key practice episodes were simply not seen through a 'safeguarding lens'.

8.1.13. This safeguarding referral was related to fluctuating capacity, concerns about next of kin who was identified as a nephew and whom Derek alleged was taking money from him. The case was allocated early due to the safeguarding concern, and this was recorded in the case notes. Additionally, the hospital Social Worker met with Derek to specifically discuss the issue of financial abuse. This included consideration of MCA and whether Derek was capacitous around the issue. Although not recorded in the safeguarding module on the Mosaic system, this was evidence of appropriate application of the MCA.

8.1.14. On discharge the case was allocated to a worker from the LD and Autism team, but the safeguarding concern was not followed up. This is because the enquiry process was closed at "fact-finding" stage based on the discussion with Derek about his money and family.

8.1.15. Handover from the hospital based social worker to the community learning disability team appears limited, especially with regards to the safeguarding concerns and wider context. It should be noted that parallel communication between the hospital diabetes team and the community district nurses did not include any of this information.

8.1.16. This was an opportunity to have called a 'Team around the Adult' meeting with all agencies involved. This would have facilitated an MDT risk assessment and identification of a lead professional. This is important in this case as we know that Derek felt 'overwhelmed' by people coming into his house. This would also have allowed for his expressions of suicidal ideation to be followed up and explored in the community.

8.1.17. At that time there was not a shared process for risk assessment and management and the approaches to "risk" whilst contained in the Safeguarding Adult procedures, were not as collaborative as the current approaches which are articulated in section 11 of this report.

8.1.18. The question of capacity and family involvement are also pertinent to the multi-agency discussion and will be picked up in subsequent terms of reference.

8.1.19. To conclude, there is little evidence of multi-agency working or risk formulation despite evidence that this should have been facilitated. This is a finding of other reviews and a thematic review in Oldham. **This is key finding 1.**

8.2. Legal Literacy and Risk Formulation Management capturing Professional Curiosity and Indictors of Concern (poor management of health conditions, hoarding and indicators of self-neglect).

8.2.1. Effective adult safeguarding involves all agencies and staff involved having a clear understanding of when legal rules may have a contribution to make towards prevention of protection from abuse and neglect. Recommendations therefore focus on understanding and application of legal rules involving, for instance, mental capacity, information-sharing, care and support assessments, and provider concerns.

8.2.2. In Derek's case there were concerns about his deteriorating health, indications of non-concordance with treatment, reports of hoarding behaviour, expressions of suicidal ideation, reports of aggressive behaviour and refusal of some services that were there to support him.

8.2.3. The most common type of abuse identified in the National SAR analysis was self-neglect[vi]. In addition, the analysis identifies that self-neglect was the most common type of abuse in SARs relating to people of Derek's age group.

8.2.4. A coherent view of the distinct changes to Derek's functioning was required however each agency only ever had their own snapshot of information. It is noted by panel members and within the agency reports that there was a definite recognition of indicators of self-neglect, but it was little understood and not fully explored.

8.2.5. Examples may be the absence of more safeguarding referrals, multi-agency discussion, detailed personal history and exploration of his home conditions or health management. Refusal of services was not fully explored or understood and there was an assumption of capacity which will be fully explored later.

8.2.6. Professional curiosity was not always evident and assessments, particularly in the hospital context and discharge processes, relied heavily on self-report, with home circumstances not observed and family members or general practice staff not consulted.

8.2.7. There is little evidence of risk assessment and on the basis of this it can be observed at that time, there may not have been assurance that agencies were able to recognise and understand the risks related to self-neglect, the legislative frameworks available to use in these circumstances should engagement fail, or their duty to report concerns to the local authority under the provisions of the Care Act 2014. Partnership progressions relating to this area will be outlined in section 11.

8.2.8. There were local self-neglect policies and procedures available at that time, but they have not been effectively used in Derek's case, this could be because professionals were not aware of them, or they didn't recognise that they needed to use them. That meant that self-neglect was not referred as a safeguarding concern.

8.2.9. A Care Act assessment (section 9)[vii] was carried out in 2018 in order to facilitate the Keyring service offer. This may have been one of the key opportunities to capture a picture of Derek's aspirations about how he wanted to live his life, who and what was important to him and any circles of support that were key to his independence.

8.2.10. Knowing and using legal powers and duties in the pursuit of practitioner goals is a central element of practice. Utilising these as tools could have facilitated several different outcomes for Derek. For example, needs were not considered holistically through observation of prevention and wellbeing principles. The Care Act assessment could have been reviewed or reassessed in response to the changing circumstances and increasing concerns that the niece was trying to articulate to agencies.

8.2.11. Consideration of Making Safeguarding Personal (MSP) should mean “No decision about me, without me.” MSP means that the process of safeguarding adults at risk should be person-led and outcome focussed; it engages the person in a conversation about how best to respond to his/her safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety[viii].

8.2.12. Considering Derek’s situation against MSP and the 6 principles of adult safeguarding he was not supported to take control of his own life and there was not an appropriate balance between safeguarding him and enabling him to manage his own risk.

8.2.13. The panel considered professional curiosity which when used effectively can unlock reasons for refusal of care and support or healthcare, for the neglected state of a home, or the impact that an individual’s life experience might have on their current decisions. In Derek’s case we know that his deteriorating physical health was affecting his quality and enjoyment of life considerably and that he felt out of control.

8.2.14. This review found limited evidence of professional curiosity in relation to risk assessment, carers’ needs, rapidly escalating health needs, increased hospital admission, refusal of services and poor concordance with medical management.

8.2.15. Effective professional curiosity is a crucial part of safeguarding practice and is developed through regular and effective reflective supervision both formally and informally.

8.2.16. Panel members identified the need for robust communication and information sharing and the need to “join the dots” and have “the right conversations and ask the right questions”.

8.2.17. In conclusion, the review finds that there was inadequate recognition of triggers and steps that could have led to the right legal tools being used such as professional curiosity and sharing of information to collectively lead to a meaningful understanding of Derek’s risk factors and needs. **This is key finding 2.**

8.3. Capacity to Understand and Application of the Principles of the Mental Capacity Act

8.3.1. The review has identified that professional curiosity, collective risk assessment and assessment of need was not often evident in Derek’s case. Although capacity was considered by the North West Ambulance Service (NWAS), then NCA when Derek was in hospital and by ASC when Derek declined support from KeyRing there is no evidence of ongoing consideration. Therefore, we are not able to definitively conclude whether Derek had capacity to refuse support and treatment.

8.3.2. Although Adult Social Care (ASC) and Northern Care Alliance NHS Group (NCA) undertook assessments, these were not repeated, and other agencies did not undertake any. ASC had deemed Derek to have capacity around his engagement with Keyring and NCA had deemed him to have fluctuating capacity in terms of his care and treatment, he had been on a Deprivation of Liberty Safeguards (DoLS) while in hospital.

8.3.3. It appears that Derek’s capacity to make decisions about his care and support was not explored regularly and there is no evidence of how professionals communicated

with him to ensure he understood the risks and consequences of his unwise decisions.

8.3.4. Relating to these occasions, there was no discussions about the risks/concerns with his niece who provided significant support.

8.3.5. There is little evidence of the sharing or recording of capacity assessments – even if someone is deemed to have capacity in a specific area, how that decision has been made needs should be recorded accurately by applying the test of capacity.

8.3.6. Considering the points above, there is lots of evidence that there were known risks factors across the agencies and with more robust professional curiosity should have led to questions about Derek's ability to make certain decisions at certain times.

8.3.7. Therefore, there was escalating risk without a risk-aware responses from agencies. Examples include the risk implications of not complying with medical management plans, escalating frequency of hospital admission, serious deterioration in physical health, missed appointments and refusing support at home especially in the context of hoarding and other self-neglect indicators.

8.3.8. The panel considered the issue of assumption of capacity. The correct application of the presumption of capacity in s.1(2) MCA[ix] is a difficult question and often misunderstood by those involved in care. It is sometimes used to support non-intervention, lack of engagement or non-concordance with treatment but this can leave people with care and support needs exposed to risk of harm.

8.3.9. There was enough evidence in Derek's case that agencies had concerns that provided enough opportunity to think about capacity, for example his non concordance with treatment and wise decisions such as declining support.

8.3.10. Albeit difficult to conclude without hindsight bias, agency experience of Derek is that he was fairly independent, and his decision making had not been of significant concern previously. Therefore, there was an emerging chain of events in the months prior to his death of which there was no precedent and as already explored, the risks were not fully understood due to the lack of multi-agency working.

8.3.11. There is reference within Community Learning Disability team records to capacity in view of Derek ending his support from KeyRing but this was not further documented, explored or discussed with other agencies. Throughout, there is little evidence of communication between services supporting his learning disability and health services supporting his diabetes.

8.3.12. Considering the assumption of capacity for Derek served to close down awareness of the need to monitor decision making ability in the face of escalating risk. A comment was noted at the practitioner event that asked how concerned they should be before an assessment is warranted. There is evidence in Derek's case that the question of capacity was considered, but that the assumption appeared to override this.

8.3.13. This raises the question of really finding Derek's voice, involving his family and seeking to understand his perspective thus not making an assumption about his behaviour and choices due to unconscious bias of knowing him previously, this is conjecture but may have been a factor in how professionals viewed Derek.

8.3.14. In conclusion there was a lack of risk assessment and an inconsistency about application of the Mental Capacity Act inclusive of seeking the family views. There

was some indication of fluctuating capacity but no evidence that it was assessed regularly. **This is Key finding 3.**

8.4. Reasonable Adjustments and Communication including Consideration of Accessible Information

8.4.1. The understanding of Derek's learning disability was not clear in part because this was a historical diagnosis as far back as his school days. Therefore, there was never a formal assessment of Derek's cognitive ability. This will be explored later in the review. Suffice to say, the baseline of Derek's functioning and understanding is not ascertained.

8.4.2. Further compounding the issue is that the GP thought Derek had a "learning difficulty" (rather than learning disability) and the hospital staff and District Nursing team did not know that there was any potential barrier to understanding.

8.4.3. Agencies generally considered Derek's communication to be good and that he retained information that was provided for him.

8.4.4. Janet has been able to provide insight into this term of reference. According to Janet, relationships and building rapport was essential for Derek to establish trust and in turn then use those positive relationships as a vehicle for intervention.

8.4.5. Janet has identified that there were a lot of people involved and they all had good intentions however Derek did not easily trust people and he felt that he was being "talked down to". He did not like to be told what to do, he did not like unexpected visits and Janet observed that agencies were not prepared to work and communicate with Derek in the way that he could respond to.

8.4.6. Janet also explained that Derek was becoming increasing more unwell and unable to do the usual things, he became confused at times which was unusual and this distressed him greatly. In fact, this led Derek to say that he wanted to die.

8.4.7. Janet's view is not so much that Derek needed any specific adjustments or accessible information, more so that he just wanted to be listened to and heard, he felt out of control which made him agitated and confused and unable to process multiple pieces of information that he was being given, this included appointments and/or people turning up at his door.

8.4.8. An example of this may be the incident whereas the District Nursing team had visited Derek after his discharge from hospital. Derek became very distressed and was described as aggressive, threatening the Nurse and resulting in Police and ambulance being called to the property. The District Nursing team were not aware that Derek had a learning disability and reasonable adjustments were not considered.

8.4.9. Janet's perspective on this situation is that if she had been made aware of the appointment, she could have been there to support him, and it could have been prevented. She said he did not know what was going on and didn't like unplanned appointments at his home. She described the incident as being out of character for Derek, and when arrived at his home he was frightened and crying and to further compound matters he was sent to hospital without being told that this was where he was going.

8.4.10. It can be observed that around this time there was confusion between the hospital team, the community team and the GP about medication decisions and if the professionals involved did not know what the treatment plan was, one can only imagine how confusing that must have been for Derek.

8.4.11. The transfer to hospital via NWAS (Northwest Ambulance Service) was not communicated truthfully to Derek, he believed he was being taken to his GP practice. NWAS report that they responded to the incident and completed a capacity assessment form and did not feel that Derek had capacity at that time. Therefore, they made a best interests decision to take Derek to hospital.

8.4.12. It is notable that several agencies have articulated that Derek liked to feel in control with consistent approaches, however it is not evident that this was considered in care planning. Declining support should have been explored further with consideration of reasonable adjustments and strengthened engagement and exploration of capacity.

8.4.13. It is not evident within the GP records whether Derek understood the information he was presented with, particularly with regards to his diabetic management, diet and medications. Staff from the practice spoke to Derek about his condition, about the monitoring required to ensure the medication was effective. However, this does not demonstrate that Derek understood the impact of poorly controlled/unstable diabetes on his long-term health and the consequences of not taking his medication as prescribed.

8.4.14. The community Learning Disability team used standard communications with Derek and did not identify any requirement for reasonable adjustments.

8.4.15. It is difficult to conclude whether Derek did need any reasonable adjustments and whether he understood and retained the information that was given to him. What can be concluded is that inadequate weight was given to how Derek liked to be communicated with.

8.4.16. In summary it would be easier to understand what adjustments Derek may have required through the enaction of the principles of making safeguarding personal. For example, working at his pace in a person-centred way. Janet has advised that Derek didn't feel listened to and therefore if he had felt that his views, wishes and feeling were being considered he may have made different decisions if he had felt actively involved in them.

8.4.17. It is of note that there have been significant progressions in Oldham which will be identified in section 11.

8.5. Interface between all Services in Managing Diabetes and What That Meant for Derek

8.5.1. The management of Derek diabetes was generally coordinated by his GP, and he was regularly seen in the practice for review and blood tests, Janet would always accompany Derek to ensure that she was cited on any areas of concern. Part of the standard for his management included an annual health review. Although management of this condition had been a concern previously, there was a distinct concern about his physical wellbeing in February 2019 which escalated in August 2019 and continued until the time of his death.

8.5.2. Janet has identified that she helped Derek to make some lifestyle changes in terms of diet, she also advised that due to deteriorating mobility he was less able to exercise at this time. It is noted that Derek attended his GP practice in August 2019 with knee pain however there is no further information recorded about this.

8.5.3. For clarity, in terms of diabetes management, there was input from the GP and Northern Care Alliance (Acute and Community) during 2019.

8.5.4. The GP prescribed Glicazide for Derek and his dose was increased in February 2019. His HbA1c blood test at the time, was high and it was noted he required a further blood test in 3 months' time. The blood test wasn't repeated by the GP practice. The responsibility to come back for the planned blood test sits with the patient. In this case Derek did not return for his blood test and it was not followed up. In the context of Derek's overall presentation, knowledge in the practice of "learning difficulty", concerns about self-neglect and deteriorating health this reflects that the clinical pathway was not applied flexibly to reflect these issues.

8.5.5. Derek was admitted to hospital on two occasions (September and October 2019). During his first admission the inpatient diabetes team assessed Derek and commenced insulin therapy, he was provided with a "new patient appointment" and discharged with visits from the District Nursing team who were visiting Derek daily to monitor his blood glucose levels as well as to administer his insulin. The blood glucose readings were communicated back to the GP but the clinical decision-making regarding medication is confusing.

8.5.6. After the second hospital admission, Derek was prescribed oral medication again. Derek had stated that he didn't want to re-start the insulin and he didn't like people coming into his property. This decision was made in the Emergency Department, and therefore another department involved in clinical decision-making.

8.5.7. From September to December 2019 the clinical management of Derek's diabetes is ambiguous. The GP appears to be the lead until the hospital admissions, when his treatment is changed, from thereon it is changed again, and he had a missed "new patient" appointment with the Oldham Diabetes Service which was not communicated to his GP.

8.5.8. There was a disconnect between the community and inpatient diabetes team, the district nursing team and the GP who all had access to pieces of information, but this was not put together into a coherent plan that Derek and his next of kin could contribute to. The communication between these services was inconsistent.

8.5.9. It is unclear even with the benefit of the review process, how his diabetes and lack of concordance with his treatment was being coordinated or addressed, professional curiosity could have led to a more coherent approach. There are several interventions and decisions from his hospital admissions and discharge plans where health professionals could have facilitated a multiagency meeting. This was at the time when the risk to Derek was significantly escalating.

8.5.10. Derek did not attend his initial appointment with the community diabetes clinic and therefore he was discharged. This was not communicated to his GP due to an administrative error. Additionally, the clinic did not know that Derek had a learning disability which may have warranted a different approach. The Did Not Attend (DNA) process and administrative management are being considered with NCA.

8.5.11. It should be noted that not every person with diabetes is under the care of the Diabetes team, only those who need additional or specialist support, thus if a patient does DNA, they are referred back to the care of the GP in accordance with the Oldham Diabetes Service Referral Guide.

8.5.12. Recording and IT systems can sometimes impede information-sharing. Different recording systems can compound the issues with communication across providers and services. In this instance the example is of communications between different services in primary care using different systems, an absence of a shared flagging system- although Derek was inconsistently flagged, if at all by his health providers.

8.5.13. It is not the remit of this review to monitor the clinical effectiveness of a Long-Term Condition clinical pathway (in this case, the Diabetes pathway) as the oversight of this sits elsewhere in the system. However, it is the conclusion of this review that the pathways didn't work effectively for Derek, and this was due to his additional needs and a failure to communicate these between the various health services. His cognitive impairment and non-concordance with his treatment plan were not considered and responded to, resulting in a worsening situation for Derek.

8.5.14. Therefore, the review concludes that there is a lack of assurance of the management and oversight of people with Long Terms Conditions who may be self-neglecting.

8.5.15. To summarise, at the time when Derek's diabetes management was of most concern and he was most unstable, the clinical plan was confusing and there is lack of clarity as to who the lead professional was for management of his diabetes. If this was confusing to organisations, one could conclude that it was even more confusing for Derek. **This is key finding 5.**

8.6. Terminology and Formal Diagnosis of Learning Disability and the Impact on Access and Delivery of Services

8.6.1. Derek was understood to have had a learning disability and was open to the Integrated Community Learning Disability Team. Derek was recorded by his GP as having a learning "difficulty" and was not flagged as either when he went into hospital or when he was discharged from hospital.

8.6.2. There is a difference between an individual with learning difficulties and one with learning disabilities and identifying this correctly can aid access to the right support. For clarity MentalHealth.org differentiates between the two as follows:

- a learning **disability** constitutes a condition which affects learning and intelligence across all areas of life
- a learning **difficulty** constitutes a condition which creates an obstacle to a specific form of learning

8.6.3. To understand the context of this, historical records from health and social care determined that Derek was identified as having a learning disability many years ago when he attended a "special school" and therefore when he was referred to the Oldham Integrated Community Learning Disability Team (CLDT), his eligibility was established on that basis. According to practitioners who worked with him, Derek associated himself as having a learning disability.

8.6.4. The panel discussed eligibility and assessment and found that the number of referrals for people who do not have a confirmed diagnosis of learning disability has

increased over the past decade. The CLDT has responded to this by introducing more robust screening processes and will complete a cognitive assessment when eligibility for the service is unclear. However, it is worth noting that there are many people who have been known to the team for a long time may not have a formal diagnosis. Therefore, there could be other people such as Derek who have been supported by the team without clear evidence of eligibility.

8.6.5. On this basis however, no one clearly understood his cognitive ability and therefore there was not a baseline understanding of need which may have informed how services should and could have worked with Derek in the right way. This may have informed consideration of capacity, reasonable adjustments and needs assessment.

8.6.6. For Derek, the role of the CLDT was not extensive and the last occasion that Derek was opened to them was from 2018 to the date of his death. They had become involved after concern in 2018 when Derek had fallen and was not taking his medication. Derek was very reluctant for the team to be involved and said he didn't want people in his home. There were some gaps in care within this period due to staff sickness when Derek was not reallocated to another professional- for reference this prompted a formal caseload review which is now audited.

8.6.7. The panel debated at length the importance of a "label", in Derek's case he was identified as a person with learning disability prior to the Care Act and he did not have an assessment against the eligibility criteria. This raised the question of whether he should have had a re-assessment and diagnosis.

8.6.8. Due to Derek not having the correct diagnosis within some agency records, this may have impacted on how services perceived his level of understanding and how they should communicate with Derek. Although it was widely recognised that a service should respond and treat a person in line with their presentation rather than a diagnosis.

8.6.9. There have been multiple conversations across the Oldham partnership since 2019 regarding the interchangeable terminology used by professionals of learning disability and learning difficulty and the impact that the terminology has on the care and services a person is able to access. Whilst it is recognised that a better understanding of cognitive ability would have been helpful, it is not a finding of this review that an incorrect "term" was significantly detrimental to Derek, and it is noted that there has been work done to aid these processes and these are articulated in section 11.

8.6.10. There will however be a recommendation related to this term of reference.

8.7. Housing Provision

8.7.1. Derek resided at the same flat for a number of years and was happy and settled there. However, there were a number of reasons why he became unhappy and why his niece Janet tried to advocate for improvements to be made and later for him to move closer to her.

8.7.2. Janet described his property and said it was in a state of disrepair, there was mould and damp to some walls, and he struggled to maintain the property himself. It is reported that she had raised concerns regarding his property, standard of living, and his wish to move to a new house to be nearer to her. It is not known to whom Janet raised the concern with at that time. This does not appear to have been actioned or

followed up in a meaningful or effective way, or passed to the appropriate service/ worker; in this instance the Guinness Partnership.

8.7.3. It is difficult to ascertain whether Derek wanted to move or not, his expressed wishes appeared to fluctuate, he seemed to be quite attached to his home at times, whereas at other times he expressed that he wished to live closer to Janet. This is another example where a capacity assessment would have been paramount. A best interests meeting could have been put into place to ascertain Derek's views and understanding of his housing situation.

8.7.4. Derek liked a structured approach when it involved people coming to his house, Janet had tried to facilitate maintenance visits when she could take Derek out however processes and systems did not always allow for this to happen thus resulting in people turning up and Derek refusing entry. This was perhaps perceived as Derek refusing to engage with people. For clarity, it is not known precisely whop Janet liaised with.

8.7.5. The other issue with the flat was its surrounding environment. Derek did not like loud noisy environments, in fact he liked to sit in his garden calmly and had not been able to do so. In recent years there has been a change in the surrounding residents and Janet stated that he was often frightened at the noise and elements of anti-social behaviour such as drug dealing.

8.7.6. In 2018, Keyring raised concerns about the conditions of the flat and hoarding. They wanted to help Derek to clear out his flat and he was reluctant to do that. Practitioners described the flat as cluttered with bags full of papers that Derek wanted to keep. This issue seems to have been considered as a "breach of tenancy agreement" issue rather than a potentially serious indictor of a safeguarding concern

8.7.7. Keyring outlined how they attempted to address the conditions by arranging deep clean support and looking at de-cluttering; the team also provided support with cleaning when they initially started to work with Derek. He would agree to this initially but then decline the input.

8.7.8. Panel members and agency reports highlight various concerns about hoarding. It is difficult to get a true sense of the extent of this with some agencies noting more concern than others. Suffice to say it was a definite and recognised factor in Derek's presentation that was not managed via a safeguarding route. Significant work has progressed in Oldham related to hoarding and this will be described in section 11.

8.7.9. From the records it does not appear that the Guinness Partnership ever went into Derek's property. They have a record of an emergency plumbing repair being done but no documented concern about Derek in relation to hoarding or any other issues. The Guinness Partnership recognise that they have a more reactive approach to their residents, for example if they are contacted, they will respond however they could do more to work proactively with residents in a flexible and person centred way.

8.7.10. There was sufficient concern from professionals about the state of the property, hoarding concerns, Derek's fluctuating desire to move and his niece raising concern, to have prompted scrutiny about the suitability of the flat and its location for Derek. There is not a specific finding for this as the issues are captured in Key Findings 1,2,3.

8.8. Understanding the Family's Role and How They Were Supported by Agencies

8.8.1. Derek's main source of support was his niece Janet with whom he had a positive, close and loving relationship.

8.8.2. Derek had a Care Act assessment prior to the Keyring service being facilitated and although Janet was mentioned in this, she wasn't described as a carer, this may be part of the reason why a carers assessment wasn't facilitated at this point. However, there were subsequent opportunities for agencies to recognise this.

8.8.3. Janet, her friend and her 18-year-old daughter helped Derek with a range of tasks such as going to clean his flat, shopping, laundering, paying bills, making dietary changes, supporting him with medical appointments and many other things that Derek required some support with. This amounted to a significant amount of daily support. To note, during the time they were involved Keyring supported Derek with some of these elements but were not aware of the level of Janet's involvement.

8.8.4. It is important to consider the context that Janet was providing this amount of support in. In the months leading to Derek's death, she had 4 children, one being a new-born premature baby. She did not drive and had to navigate children to school, hospital appointments for her baby and public transport as well as helping Derek daily. One cannot underestimate the level of stress she must have been under to provide all that she did for Derek.

8.8.5. It does not appear that the extent of care and support that Janet was providing was recognised. She was rarely asked for information regarding Derek's past and present living situation when she would have had important information and significant insights. For example, during his hospital admissions, she could have supported Derek and the hospital staff in understanding his situation and her concerns about him. On the occasions when Janet tried to volunteer information, she did not feel that she was listened to.

8.8.6. It should be noted that the information provided on hospital admission may have been confusing for the hospital staff to understand, particularly as they did not know Derek. For example a different relative was recorded as next of kin.

8.8.7. To some extent it can be considered that Janet's input into Derek's care and support disguised the difficulties that he was experiencing in the months leading to his death. No one understood Janet's role because a carers assessment was not facilitated.

8.8.8. Janet did not receive a carers assessment, nor did she ask for one because she simply did not know what to ask for and within what agency. She has articulated some clear views on what she thinks would have been helpful including Occupational Therapy assessment and improvements to the property- but she felt she did not know where to go or who to ask.

8.8.9. It is important to note that this situation was not something that Janet was familiar with, and she did not know how to navigate her way around the health and social care system. She did not know where and how to access support, nor was she aware of any assessment process that would explore Derek's needs or consider what she or Derek may have been entitled to receive.

8.8.10. Janet describes how she had to resort to “googling” to try and find out where she could access help for Derek as she knew she could not do this all by herself. The things that she would have liked to be taken into account are:

- **For Derek to have been asked what he wanted rather than be told**
- **For her to have been able to ask for support and contribute with Derek to a plan that would have made Derek feel happy and in control.**
- **For his housing situation to have been addressed**
- **For all of the agencies to have got together and for someone to take the lead.**
- **For agencies to have recognised how ill Derek felt and how this was significantly impacting on his mental health and his quality of life**

8.8.11. Janet expressed that through the timeframe of this review, she felt like a “nobody”, yet she knew Derek best. She acknowledges that professionals were trying to do their best but feels that no one listened.

8.8.12. In Oldham there is a Specialist Carers service, however it was not identified in Janet’s case that an assessment should be facilitated. Therefore, the provision is there but it was not recognised that it was indicated. This suggests that there was a lack of insight and understanding of the term “carer”, and of Derek’s daily routine and who was important to him.

8.8.13. It can be noted that a previous safeguarding review has identified that there is a gap in communication to family and carers in promoting a carers assessment. **This is Key Finding 6.**

9. Key Findings

9.1. Key Finding 1- Multi-agency Coordination

9.1.1. There were at least 7 key practice episodes that should have prompted multi agency coordination. This would have facilitated a Team Around the Adult meeting, the identification of a lead professional and collective consideration of risk, capacity, and safeguarding concerns.

9.1.2. The newly embedded TRAM protocol contains practical guidance on how to coordinate this approach, however there may be agencies that may need more support in implementing this into practice. In terms of this protocol, effectiveness measures are paramount.

9.1.3. This approach would have provided the platform for Derek’s voice to be clearly heard and the 6 principles of adult safeguarding to be enacted.

9.1.4. This is not a new finding, and a recommendation will be made to the OSAB.

9.2. Key Finding 2 - Professional Curiosity

9.2.1. Professional curiosity is the capacity and communication skill to explore and understand what is happening within a person’s situation rather than making assumptions or accepting things at face value.

9.2.2. Curiosity is required to support practitioners to question and challenge the information they receive, identify concerns and make connections to enable a greater understanding of a person's situation[x].

9.2.3. This review found that there was an absence of professional curiosity that resulted in inaction rather than action. There will be a recommendation to the OSAB.

9.3. Key Finding 3 - Risk Assessment and Management and Application of the Mental Capacity Act

9.3.1. This finding relates to the absence of collective risk assessment and in turn consideration of when to apply the mental capacity act as part of that. In Derek's case there was little evidence that he was aided in his decision-making to identify areas that might have been potentially harmful and little exploration of what made him unhappy. With the right risk assessment and timely application of capacity assessments, risk may have been reduced and independence promoted.

9.3.2. At this time of Derek's death there was not a collective approach to risk assessment in Oldham, the review has demonstrated considerable progress in the implementation of a Tiered Risk Assessment and Management Protocol (TRAM) which is designed to support any practitioner working with adults where there is a high level of risk that would benefit from joint multi-agency management and senior oversight of risk management strategies.

9.3.3. Application of this protocol will support the existing work that OSAB has taken forward in promoting awareness of the Mental Capacity Act. This is further enhanced by the implementation of the Risk Huddle Standard Operating procedure for Integrated Health and Social Care teams which will support a consistent approach to people where there is risk indicated. There will be a recommendation related to this.

9.3.4. In terms of application of the Mental Capacity Act, the Author recognises the learning, training and resources that have been put into practice but notes that this is a finding from previous reviews and there is limited assurance that the workforce is consistently competent. There will be a recommendation related to this.

9.4. Key Finding 4 - Diabetic Management Pathways

9.4.1. Whilst oversight of clinical effectiveness of the diabetes pathway (alongside other Long-Term conditions) is monitored via the usual contractual measures for quality and performance, this review has found an absence of assurance of management and oversight when people with long terms conditions such as diabetes are self-neglecting.

9.4.2. There are multifactorial issues in Derek's case including poor communication between clinical teams, IT systems errors, administrative processes, lack of consideration of capacity, lack of clarity about Derek's cognitive functioning.

9.4.3. These factors in the context of clear indictors of self-neglect resulted in inconsistent and confusing clinical oversight and a lack of proactive response, including consideration of reasonable adjustments relating to Derek's non concordance with treatment. There will be a recommendation related to this.

Key Finding 5 - Carer's Assessment

9.4.4. Derek's niece provided a significant amount of informal care which was never recognised and thus she was not offered or aided to access a carers assessment. This could have been facilitated by any of the agencies involved and has been raised in previous reviews. This suggests that there is a lack of awareness and there will be a recommendation relating this this finding.

10. Lessons learned and progress

10.1. There are 7 recommendations to be made in this review against key areas of safeguarding practice. However, it is encouraging to see the areas of improvement where learning has already been taken forward and implemented. These developments are all relevant to Derek's circumstances and ongoing assurance of effectiveness should sought on a continual basic.

10.2. Progress to note is as follows:

10.3. **OSAB-** implementation of a **"Multi-Agency Strategy and Guidance for Self-Neglect and Hoarding**". This has been implemented across all agencies via a range of learning and training.

- Self-neglect/Hoarding guidance and tool kit for professionals written.
- Self-neglect/Hoarding training has been developed and is being rolled out to all agencies/partners.
- A multi-agency hoarding taskforce has been set up to explore good practice and models of approach for self-neglect/hoarding cases.

10.4. **OSAB-** implementation of the **TRAM (Tiered Risk Assessment and Management) protocol,** this is currently being implemented.

10.5. **OSAB-** Implementation of level 3 training in Legal literacy, self-neglect, hoarding and professional curiosity.

10.6. **OSAB-** refreshed Safeguarding Workforce Development and Training Strategy (2021/2022)

10.7. **OSAB-** 7-minute briefing "**Carers assessment under the Care Act (2014)",** launched March 2022

10.8. **Integrated Health and Social Care teams-** Implementation of the Risk Huddle standard operating procedure

10.9. **Integrated Health and Social Care teams-** Implementation of the Traffic Light Hospital Passport

10.10. **Integrated Care System/ Oldham CCG-** commissioning of two Exemplar nurses to provide additional support to primary care in order to ensure patients with a learning disability have an annual health check.

10.11. **The Northern Care Alliance**- implementation of a "non-concordance" policy.

10.12. **Health Systems-** NHS electronic systems to improve information sharing are now in place (Graphnet and System 1).

11. Conclusions

11.1. This SAR Overview Report is the Oldham Safeguarding Adults Board's response to the death of Derek, to share learning that will improve the way agencies work individually and together.

11.2. Derek had a complex presentation with comorbidities and was known to different agencies for different reasons. All agencies who contributed to this review, with the exception of The Guinness partnership (Housing), were aware of risk factors, concerns and physical health deterioration but there was not one occasion in this case that all those who knew Derek were convened to share information, consider risks and to understand how best to work effectively with him. Derek and Janet's contribution to this should have been essential to promote the six safeguarding adult principles which should always underpin safeguarding practice.

11.3. The last year of Derek's life was a confusing and distressing time for Derek. There are statutory, national and local frameworks that could have been considered and facilitated in different ways by the agencies involved. This includes the support of Janet who provided a significant amount of care for Derek.

11.4. Derek's cause of death related to his diabetes and his non concordance was known to agencies as a risk factor in the context of deteriorating physical health. The clinical pathways for diabetes management failed for Derek because they gave insufficient weight to his additional care and support needs, self-neglect and his capacity, these were not considered between the health providers.

11.5. Considering the findings of this review, if all if the frameworks, tools and standards had been followed effectively this may have facilitated an improved quality of life or a different outcome.

11.6. An important element to consider in this review was the absence of Derek's voice. To quote his niece, **"Derek just wanted to be listened to and to be heard".**

11.7. It is hopeful that the outcomes from this review will enhance and sustain support for people with learning disabilities and their carers. The findings and recommendations should be monitored for compliance, implementation and assurance by the OSAB.

12. Recommendations to the Board

12.1. It is noted that progress has been made in all areas of findings by the OSAB collectively and by individual agencies. Recommendations have been made against those areas were there have been previous finding and those where deeper and continual assurance is required.

12.2. Arising from the analysis in this review the following recommendations are made to the OSAB:

Recommendations:
1) Multi-Agency Working and escalation: The OSAB are asked to consider its approaches to multi-agency working to include guidance for the workforce and: - Assurance of its effectiveness - Escalation processes both single agency and multi-agency - Managerial and professional supervision - Coordination and decision making - Alignment with risk management processes and protocols
2) Professional Curiosity: The OSAB should continue to promote professional curiosity in practice and: - Consider its effectiveness measures to continually seeks assurance that professionals are routinely applying professional curiosity in their practice and that this is proactively informing decision making. - Strengthen single and multi-agency supervision models and reflective practice opportunities.
3) Risk Assessment: The OSAB should seek ongoing assurance that the TRAM protocol is effectively embedded in frontline practice and: - Seek assurance that professional curiosity, supervision/ reflective practice and a multiagency response will trigger professionals to utilise the TRAM were indicated. - Seek assurance that the various multiagency systems and processes that form part of the TRAM continuum are aligned and understood across the partnership.
4) Application of the Mental Capacity Act: It is recommended that the OSAB adopts an MCA competency framework approach that can standardise practice and training and allow different professionals working at different levels in agencies to consistently apply the statutory requirements of the MCA in practice. In addition: - Its effectiveness should be regularly reviewed to provide an oversight of whether practice is working - Additionally, the OSAB should seek assurance and evidence from commissioners and service providers that: o All staff who support people with a learning disability must be able to identify when an advocate is required and how to refer to one

○ staff supporting people with a learning disability have clear policies, procedures and support to escalate concerns where the mental capacity framework is not being followed.
5) Diabetes Pathway/ Long Term Condition Clinical Pathways: The OSAB should seek assurance that commissioners and providers have agreed and effective processes in place to support identification, escalation, and management oversight when people with long terms conditions such as diabetes are self-neglecting. Additionally, to ensure that: - there are effective processes in place to share information to aid consideration of reasonable adjustments when managing people with long term conditions. - When people do not attend appointments, they are not discharged from services without consideration of additional needs.
6) Carer's Assessment: The OSAB should strengthen communication and seek assurance that agencies are aware of the specialist carers service, able to apply consideration under MSP to trigger a referral, and to know how to refer this.
7) Learning Disability Assessment: The OSAB should seek reassurance from Commissioners regarding assessments and diagnostic pathways for people who are referred to the Learning Disability service to ensure that there is a correct understand of a person's cognitive ability to ensure access to appropriate services and adjustments.

13. References

[i] Section 44, The Care Act (2014)
[ii] Changes to LeDer - Learning from Life and Death Reviews of people with a learning disability and autistic people | Local Government Association
[iii] Department of Health and Social Care (2020) Care and Support Statutory Guidance: Issued under the Care Act 2014. London: The Stationery Office (section 14.165)
[iv] The Care Act, 6 principles of adult safeguarding (2014)
[v] National analysis of safeguarding adult reviews
[vi] National analysis of safeguarding adult reviews
[vii] Section 9, Care Act 2014
[viii] Making Safeguarding Personal outcome measures (2018)
[ix] MCA (2005)
[x] Professional curiosity in safeguarding adults: Strategic Briefing (2020) (researchinpractice.org.uk)