Liverpool Safeguarding Adults Board

Briefing Note

SAR 16 "Mr A"

Liverpool Safeguarding Adults Board are today publishing a Safeguarding Adults Review (SAR) regarding 'Mr A' (not his real name) who died on 13th June 2018, age 61.

In 2005, Mr A moved to Liverpool however his ordinary residence was classed as Islington, his ongoing living arrangements and social care needs therefore remained the responsibility of the London Borough of Islington.

Mr A had a moderate Learning Disability, long-term mental health illness and a number of long-standing physical health conditions that impacted on his life. Mr A sadly died on 13th June 2018 after a large quantity of food obstructed his airway. This incident occurred after Mr A had experienced an earlier choking incident in January 2017. Following the initial incident Mr A was assessed to be at a high risk of choking and a SALT plan was prepared to provide clearer guidelines on the type of food that he could eat, how it should be prepared, and the supervision required. At the time of the incident Mr A was unsupervised despite having an agreed care package which included: 1:1 care, 24 hours per day in his supported living accommodation.

The SAR panel agreed that the key line of enquiry would focus on how agencies responded to specific areas highlighted below in Mr A's case, to gain a greater understanding of the increased risk of choking presented to individuals with learning disabilities. A key focus would be on the agencies systems and process to identify opportunities for learning, and identification of best practice.

The SAR panel also identified particular themes for analysis

- How services responded to Care Plan Arrangements/ Section 117 Aftercare arrangements
- How services responded to earlier Choking Incidents and known risk
- How services considered MCA/Best Interest and whether any formal mental capacity assessments had been completed
- How services responded to manage Mr A's Health Needs and Learning Disabilities
- Whether there were missed opportunities to share information to safeguard Mr A from abuse/neglect, particularly in response to Mr A's risk of choking
- Whether there were opportunities to share best practice.

The board wishes to record their condolences to Mr A's family.

The Liverpool Safeguarding Adults Board and its partners fully accept the report and its recommendations, which have been reviewed and strengthened by Liverpool SAB to incorporate a greater focus on multi agency improvements since the review was completed. Liverpool SAB and Islington SAB is now working on addressing the recommendations and a multi-agency improvement plan is in process to secure improvements in how professionals work with adults with Learning Difficulties who have an increased risk of choking in Liverpool and Islington retrospectively.

Duncan Dooley-Robinson

Independent Chair
Liverpool Safeguarding Adults Board