Liverpool Safeguarding Adults Board

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Safeguarding Adult Review

‘Mr A’

‘Executive Summary’

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1. SUMMARY

1.1 This Safeguarding Adult Review (SAR) concerns the care and treatment of a 61-year-old white British man who will be referred to in this report as Mr A. Mr A had a moderate Learning Disability, a long-term mental health illness and a number of long-standing physical health conditions that impacted on his life.

1.2 Mr A suffered a serious choking incident in January 2017 and was subsequently referred to Speech and Language Services[1] (SALT). He 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. Despite this, Mr A sadly died on 13th June 2018 after a large quantity of food obstructed his airway.

1.3 A sub-group of Merseyside Safeguarding Adult Board assessed the case in April 2021 and decided that the circumstances met the criteria for a SAR[2] to be undertaken; Mr A had died, it was suspected that the death resulted from neglect and there were concerns that partner agencies could have worked together more effectively to protect Mr A.

2. PURPOSE OF A SAFEGUARDING ADULT REVIEW (SAR)

2.1 A Safeguarding Adults Board (SAB) has a statutory duty[3] to arrange a Safeguarding Adults 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,
- or an adult is still alive and the Safeguarding Adults Board knows or suspects that they have experienced serious abuse or neglect, and
- there is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

A Safeguarding Adults Board may also arrange for a SAR of any other case involving an adult in its area with care and support needs (whether or not the local authority has been meeting any of those needs).

2.2 The purpose of a SAR, as described very clearly in the Statutory Guidance[4], is to ensure *"lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account".*

2.3 There is no single prescribed method to conduct a SAR. The Statutory Guidance[5] places emphasis on local decisions with a focus on *"what needs to happen to achieve understanding, remedial action and very often, answers for families and friends of adults who have died or been seriously abused or neglected".*

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[1] Speech and Language Therapy (SLT) - Is a science degree-based, health and social care profession, regulated by the Health and Care Professions Council. SLTs work with babies, children and adults who have various levels of speech, language and communication problems, and with those who have swallowing, drinking or eating difficulties. Speech and language therapy | RCSLT

[2] Sec 44 (1) of the Care Act 2014 Care Act 2014 (legislation.gov.uk)

[3] Care Act 2014 (legislation.gov.uk) Sections 44(1)-(4)

[4] Care and support statutory guidance - GOV.UK (www.gov.uk)

[5] Chapter 14.170 Care and support statutory guidance - GOV.UK (www.gov.uk)

2.4 This particular SAR was conducted using a systems methodology that:

- Recognises the complex circumstances in which practitioners work together to safeguard adults;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Makes use of relevant research and case evidence to inform the findings.

2.5 A Panel of senior staff from across the partnership were drawn together to guide the SAR and take responsibility on behalf of Liverpool Safeguarding Adults Board; to ensure proper process was followed and to support the preparation of the report and the agreed recommendations.

2.6 Agencies who had involvement with Mr A during the relevant time period submitted individual chronologies and additional supporting documentation. This information was the basis of reflective discussion with key practitioners.

3. TERMS OF REFERENCE

On the basis of the initial multi-agency information collected, the Safeguarding Adult Review Panel agreed the Terms of Reference[6] (as set out below), and the main time period for the review from 26th January 2017, when Mr A suffered a choking incident until his death on 13th June 2018. It was also agreed that any significant events which took place prior to January 2017 which were considered relevant to the time period and opportunities for learning should be included in the SAR report.

Key Lines of Enquiry

The following key lines of enquiry were agreed:

1. **Care Plan Arrangements/ Section 117 Aftercare arrangements**
   Was there appropriate multi-agency engagement, review, and supervision of Mr A's care plan arrangements?
2. **Choking Incidents**
   - How well did agencies respond and work together to safeguard Mr A after he suffered a choking incident on 26th January 2017?
   - Were Mr A's subsequent risks and needs appropriately considered and addressed?
   - How effective were agencies in dealing with the immediate choking incident on 13th June 2018?
3. **MCA/Best Interest**
   - How effectively was the Mental Capacity Act 2005 applied in this case?
   - Were Best Interest Principles followed in this case?
4. **Managing MR A's Health Needs and Learning Disabilities**

[6] In setting the Terms of Reference, consideration was given to the Care and Support Statutory Guidance issued under the Care Act 2014, including the six key principles which underpin all adult safeguarding work, (set out at 14.13 of the guidance). Consideration was also given to promoting effective learning and improvement to prevent future deaths or serious harm as per 14.164. Care and support statutory guidance - GOV.UK (www.gov.uk)

- How effectively was Mr A's different health needs and disabilities understood and managed?

4. BACKGROUND OF THE CASE

4.1 Mr A

Mr A was a 61year old male who had a moderate learning disability, long-term mental health problems and a number of longstanding physical health conditions that impacted on his life. He attended regular consultations with a range of medical practitioners for his various illnesses. These included Bipolar affective disorder, anxiety, ventricular cardiac failure, high blood pressure, high cholesterol, parathyroidism and epilepsy, which were all managed through medication. He also suffered from a curvature of the spine in addition to Obstructive Sleep Apnoea and Obesity Hypoventilation Syndrome and as a result received BiLevel Positive Airway Pressure therapy (BiPAP) for approximately 12 hours a day, (mainly at night, although additional hours were required during the day).

4.2 Mr A was also overweight and this reportedly impacted on certain aspects of his health, although it is understood that he had lost a considerable amount of weight in the years leading up to his death.

4.3 As a young adult, Mr A lived with his parents and older siblings in the London Borough of Islington. In the mid 1980s, he spent some time in Harperbury Hospital, Hertfordshire under the Mental Health Act 1983 and in 1987 moved to a community facility in Gloucestershire for individuals with a learning disability. Mr A continued to receive ongoing psychiatric treatment and medication for his Mental Health condition, however his behaviour became challenging and aggressive at times. Although generally a sociable individual Mr A also had regular disagreements with other residents.

4.4 In 2005, Mr A moved to Liverpool to be nearer to his sister and as his 'ordinary residence'[7] was classed as Islington, his ongoing living arrangements and social care needs remained the responsibility of the London Borough of Islington.

4.5 Mr A was subsequently admitted to a Liverpool Mental Health Hospital and discharged under Section 117 of the Mental Health Act 1983[8]; which places a joint statutory responsibility on Local Authorities and Clinical Commissioning Groups (CCG) to deliver mental health aftercare arrangements. NHS Liverpool Clinical Commissioning Group retained clinical responsibility (delivered by Mersey Care NHS Foundation Trust), whilst social care responsibility including care and support needs remained with the London Borough of Islington.[9]

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[7] Chapter 19 Care and Support Statutory Guidance issued under the Care Act 2014. 43380_23902777_Care Act_Book.indb (publishing.service.gov.uk)

[8] Section-117-Protocol-reviewed-Dec-2018.pdf (londonadass.org.uk)Section 117 Mental Health Act 1983 places an enforceable duty on both Health (Clinical Commissioning Group (CCG)) and Social Services (local authority/Council) to provide aftercare services on discharge from hospital to individuals who have previously been sectioned under treatment sections of the Mental Health Act on discharge from hospital.
The purpose of Aftercare Arrangements is to reduce the risk of deterioration of the person's mental condition and the risk of the person requiring admission to hospital for treatment.

[9] Camden & Islington NHS Foundation Trust Aftercare - Section 117 Policy
Aftercare Section 117 Policy | Camden and Islington NHS Foundation Trust (candi.nhs.uk)
Section-117-Protocol-reviewed-Dec-2018.pdf (londonadass.org.uk)
The test for determining which local authority is responsible for section 117 aftercare is based on where the individual was ordinarily resident at the time they were detained under the relevant section.

Mr A's mental health care and support were managed by a Psychiatrist and a Community Learning Disability Nurse (Care Coordinator) under Section 117 arrangements and he was subject to regular assessments and reviews. A dedicated social worker from ILDP was responsible for Mr A's care needs, although a member of ILDP did not always attend Section 117 review meetings.

4.6 It is understood that Mr A had issues with food/ eating since he was a young child. His sister advised that she could recall Mr A's tongue constantly protruding from his mouth until he had his tonsils and adenoids removed around 4yrs of age. She can also recall that Mr A always ate his food too fast and crammed his mouth with food, however, it has not been possible to ascertain what if any medical intervention Mr A received either as a child or in his adult life for these issues.

4.7 At the time of his death, Mr A received 1:1 care on a 24/7 basis in supported living accommodation. Mr A used a BiPAP machine for 12 hours a day and mainly used this at night whilst asleep and also for several hours during the day while resting in his chair in the sitting room. Mr A required the support of carers to fit the oxygen mask and also required help with certain aspects of his personal care such as getting in and out of the bath (using a hoist) and shaving.

4.8 From the information available it would appear that Mr A was very content in his own supported living accommodation and was happy with the arrangements in place to care for him. It is acknowledged that caring for Mr A could be challenging on occasion as he was known to get agitated and aggressive and there were several known triggers which exacerbated his behaviour. This was generally managed by the carers in discussion with Mr A's sister.

5. FAMILY INVOLVEMENT

5.1 Mr A's sister and her partner lived in the Liverpool area and had frequent and close contact with Mr A. Mr A's sister acted as Mr A's informal advocate and both her and her partner took an active part in Mr A's care and support arrangements with either one or both of them attending all of Mr A's review meetings and also many of his medical appointments.

5.2 Mr A's brother who lived in London took a lesser part in his day-to-day care arrangements but was kept regularly updated and had daily telephone contact with Mr A.

5.3 It is of note, that Mr A's sister considers that her brother had a long-term disordered maladaptive eating behaviour which was not considered or addressed by an appropriately qualified medical practitioner at any time during the period covered by this review.

5.4 Mr A's sister provided two written statements to the Coroner and her observations have been summarised as follows:

- She was surprised and alarmed that the Care Provider did not seek additional support after the serious choking incident in January 2017. As a result, she personally intervened by advising carers not to give Mr A bread (although she

was aware that she had no authority to compel the staff to comply) and contacted Mr A's learning disability nurse.
- She felt Mr A's issues with food were an 'accident waiting to happen'.
- She was surprised that no meetings were convened after the SALT assessments to discuss the risk assessments and mitigation implemented.
- Although the SALT referral was mentioned at the subsequent Section 117 meeting in December 2017, no discussion took place in relation to this and she did not receive a copy of the minutes.

6. TIMELINE AND DETAILS OF THE INCIDENT

Date	Details
26th January 2017	• Mr A choked whilst eating a piece of pitta bread, despite his carer being with him at the time and taking steps to reduce the choking risk by cutting up his food into smaller pieces. • Mr A was unresponsive on the arrival of paramedics and a suction pump was required to clear his airway. • Mr A was conveyed (in the company of his carer) to an Accident and Emergency Department, where he remained for several hours for observation before returning to his home address.
Few days after the incident	Mr A's sister contacted the Community Learning Disability Nurse (CLDN) to share her concerns about her brother's continued risk of choking due to overfilling his mouth and eating too quickly.
2nd February 2017	CLDN visited Mr A, obtained his agreement and referred him for a Speech and Language Therapy (SALT) assessment.
15th February 2017	• A Speech and Language Therapist (SALT) consultation took place at Mr A's home address. • Mr A was considered to have capacity to consent to a SALT assessment and an initial assessment[10] took place. • The SALT practitioner assessed that Mr A did not have dysphagia[11], however, he was at a high risk of choking due to his eating habits: "*He ate his food too fast, cramming food into his mouth without chewing properly or swallowing the previous mouthful, leading to coughing and indicting food in the airway"*(sic).[12] • An initial *'swallowing plan'* was prepared and agreed with Mr A which provided care staff with guidance in respect of the type of food that Mr A could eat and the supervision required.
February 2017	The Care Provider prepared a new Personal Support Plan[13] in consultation with Mr A.

[10] 'New Jays Observational Assessment of Dysphagia for People with a Learning Disability'. HIBBERD, J., and TAYLOR, J., 2005, Birmingham: Quest Training. Quest Training | Speech Therapy Training, Birmingham and West Midlands (thespeechtherapypractice.com)

[11] Dysphagia is the medical term for swallowing difficulties. Some people with dysphagia have problems swallowing certain foods or liquids, while others can't swallow at all. Dysphagia (swallowing problems) - NHS (www.nhs.uk)

[12] Sentence is a direct transcript from the available documentation. The word 'indicting' should possibly be 'ingesting'

[13] A support plan is a detailed document that contains everything about the individual being cared for that a carer needs to know when they are providing care. It includes details of their next of kin, medication, health condition(s), hobbies and interests, meal preparation and personal care, as well as information on their property and general likes and dislikes.)
What goes into a live-in care support plan? | Helping Hands (helpinghandshomecare.co.uk)

	The document records that Mr A lacked capacity and a number of support measures had been implemented in his 'Best Interests'.
27th February 2017	• Further SALT consultation at Mr A's home address. • During the consultation, the SALT practitioner carried out an Asphyxiation Risk Assessment and assessed Mr A to be at a 'High Risk'.
27th March 2017	• A follow-up SALT consultation took place.
3rd April 2017	• A SALT assistant attended Mr A's home address and provided a support worker with a Speech and Language Plan and Mr A's case was closed by SALT. • Some of the detail contained in the SALT plan included: ***Food:*** • *Mr A has normal texture food that has been finely chopped (1/2 cm or smaller). This should be done prior to giving Mr A his meal.* ***Assistance Required**:* • *It is important that a member of staff is present at all times when Mr A is eating and drinking.* ***Posture and positioning**:* • *Mr A should sit at the kitchen table when eating and drinking.*
April 2017	Mr A's Personal Support Plan updated by the Care Provider; a copy of the SALT Plan was attached and the following additional information added: *"Staff must be present at all times when I am eating & my food must be cut into pieces approximately ½cm in size".*
11th October 2017	• Mr A was subject to a psychiatric review of his mental health by the Consultant Psychiatrist responsible for his S117 care. • There was no discussion or consideration that Mr A's issues with food were behavioural and required additional psychiatric/ medical intervention.
May 2018	• The Care Provider completed a separate 'My Risk and Needs Assessment' and 'Eating and Drinking Risk Screening Tool'. Both these documents are comprehensive in content and support Mr A's Personal Support Plan and SALT plan. It is of note that the following information was included under 'Getting ready to eat': *"It is important that a member of staff is present and monitoring Mr A at all times when he is eating and drinking at meal and snack times"* • It is not clear if the content of these additional documents were disseminated to staff.
13th June 2018	• Mr A sadly died, his airway had been obstructed by a large quantity of food. • Mr A had been left on his own to prepare his own supper. • A subsequent post-mortem examination revealed that Mr A had died of an impaction of foodstuff in the upper airway.

7. ANALYSIS, LEARNING and RECOMMENDATIONS

Circumstances surrounding Mr A's Death

7.1 Mr A sadly died after a large quantity of food obstructed his airway, having been left on his own by a care worker to prepare his own food. In documentation made available to the Coroner, the carer on duty at the time advised that he had opened a packet of ham for Mr A and then left him on his own in the kitchen to eat it. It was

subsequently established that Mr A had consumed the majority of the ham in the pack (only one slice remained).

7.2 By his own admission, a period of at least 10 to 15 minutes had elapsed between the carer leaving Mr A in the kitchen eating ham and finding him unconscious on the floor. The exact time that Mr A was left unsupervised cannot be determined, however evidence from the attending paramedics would tend to corroborate that there had been a period of time since Mr A was last seen alive.

7.3 The actions by the carer were clearly contrary to Mr A's SALT plan and personal support plan, in respect of food preparation, supervision whilst eating and the requirement for Mr A to have continuous 1:1 care.

7.4 Post-mortem evidence made available to the Coroner also provided that Mr A had consumed food much earlier on the day he died, which had not been cut into small pieces in adherence to the SALT Plan and risk assessment.
These findings demonstrate there were aspects of non-compliance by at least two carers responsible for Mr A's care.

7.5 In documentation made available to the Coroner, the carer involved in Mr A's care at the time of his death advised that he was unaware of Mr A's dietary requirements, had not had sight of Mr A's Support Plan and had not been advised to cut up his food into small pieces. He also advised that Mr A had ready access to his own kitchen on a 24/7 basis and regularly went into the kitchen to help himself to snacks.

7.6 The Care Provider was unable to specifically account for all care workers being advised of the content of the SALT plan or having read and being fully cognisant with Mr A's Personal Support Plan.
It is however understood that a copy of Mr A's SALT Plan (highlighted on two A4 pages) was affixed to a kitchen cupboard in a prominent position above the kettle. It is therefore highly unlikely that the carer concerned did not read the content of these two pages in the 14-month period it had been in place.

7.7 Sadly, these issues highlight the need for care providers to have robust management processes in place to ensure that all care staff are fully cognisant with Medical Plans including SALT plans and Personal Support Plans and the associated risks for those individuals they are charged with caring for. There should also be formal processes in place to ensure continuous reinforcement of individual plans and risk assessments, including thorough follow-up supervision of staff and all processes require to be fully recorded.

Response to earlier choking incidents and known risk

7.8 Mr A's community care plan review in 2005 and 2009 (pre–Care Act 2014 legislation completed by ILDP) document that he ate too quickly and as a result his food had to be 'cut into small pieces' and he required to be supervised when eating as he was at a substantial risk of choking. These behaviours were also identified by the Care Provider shortly after Mr A's transfer from Gloucestershire in 2005 and immediate steps were taken to prevent him eating so quickly, however, it is believed

that these interventions were instigated by the Care Provider and there was no medical intervention, including the involvement of SALT professionals.

Response after a choking incident on 26th January 2017

7.9 The choking incident that took place in January 2017, was particularly serious as Mr A could have died without the prompt intervention of care staff and paramedics.

7.10 Mr A was conveyed to an Accident and Emergency Department where he was assessed. It is not known if medics gave any consideration to the significant medical research available to support the link between individuals with a learning disability and their higher risk of choking[14] however, Mr A was found to be alert and orientated and did not require further medical intervention or treatment. As is current practice, a letter was sent to the named GP advising of Mr A's attendance at Accident and Emergency Department. However, this case highlights a disconnect in current communication processes between the various medical professionals involved. It is understood that in the circumstances presented it would not be expected practice for an A&E professional to make a specific request for further medical intervention to take place, and a GP would only respond to hospital communication if a specific medical intervention was requested.
Work is already on-going by Cheshire and Merseyside Health and Care Partnership to improve communication channels and eliminate gaps in the service provided between primary and secondary care.[15]

7.11 No immediate action was taken by the Care Provider after this serious choking incident. It is understood that the care worker involved submitted an Incident Report Form to the Care Provider Management as was expected practice but there is no documentation or information available to support the Care Provider carrying out any immediate internal investigation, reviewing Mr A's risk assessment or taking steps to report the incident to ILDP, NHS Mersey Care or Mr A's GP nor was the incident reported to Liverpool City Council as a safeguarding concern.[16] As this was a 'near-miss' choking incident where Mr A almost died; it would also be expected practice for the incident to have also been reported to CQC[17].
Since this incident, ILDP have reviewed and amended their reporting processes for all care providers, this included redrafting a Serious Incident Reporting Procedure in 2018, which was disseminated to all new and existing providers. Additionally, ILPD now require all care providers to complete a pro-forma detailing all significant incidents and safeguarding concerns prior to a Care Act 2014 annual review taking place and this procedure is outlined to care providers at the start of a placement.

Recommendation 1

Liverpool Safeguarding Adults Board (LSAB) should seek assurance from NHS Liverpool Clinical Commissioning Group[18] that there is continuity of medical care for individuals with a Learning Disability who present at A&E due to a choking incident.

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[14] Thacker (2007) Samuels (2006)
[15] Consensus on the Primary and Secondary Care Interface - Cheshire & Merseyside Health & Care Partnership (cheshireandmerseysidepartnership.co.uk)
[16] As the adult involved was 'in its area' at the time the choking incident took place, Liverpool City Council would have been the local authority responsible for conducting a safeguarding enquiry. Section 42 (1)-(3) Care Act 2014 (legislation.gov.uk)
[17] Regulation 18: Notification of other incidents | CQC Public Website
[18] Now part of NHS Cheshire and Merseyside Integrated Care System. NHS Cheshire and Merseyside

Recommendation 2
LSAB, in partnership with Islington Safeguarding Adult Board (ISAB) should seek assurance from Health and Social Care Commissioners that all care providers have:

i. robust auditable processes in place to ensure care plans and risk assessments are updated where appropriate
ii. mechanisms in place to report serious incidents to Commissioners, local Social Services and CQC.

Recommendation 3
Given the available research that people with a learning disability have a higher risk of choking and subsequent death from choking, it is imperative that all staff employed in care settings are knowledgeable about when to refer an individual with eating difficulties to a medical practitioner. LSAB, in partnership with ISAB should:

i. consider increasing carer and staff awareness of the risk of choking for individuals with a learning disability by commissioning a learning document providing advice and guidance. This should include the need for medical advice to be sought where an individual with a Learning Disability has a tendency to put large quantities of food into their mouth and eat too quickly.
ii. seek assurance from Health and Social Care Partners that 'near-miss' incidents from choking in individuals with a learning disability are audited and a clear action plan implemented to prevent future incidents.

7.12 SALT Referral and Assessment
It is of note that Mr A's referral to SALT and the subsequent consultations and assessment by a SALT practitioner are in accordance with NHS Mersey Care's Assessment and Management of Choking (Adults) Policy[19] and Choking Risk Pathway, in respect of both the risks and factors Mr A presented and the delegated professional responsibility for such a presentation. In addition, the assessment, treatment and development of personalised plans to support people who have eating and swallowing problems is part of the defined role of a SALT practitioner set out by the Royal College of Speech and Language Therapists[20].

7.13 It is understood that the SALT assessments and subsequent plan were based on the most recent choking incident and background information obtained from Mr A and his support staff with regard to medical history and eating behaviours. SALT practitioners did not have immediate access to patient's medical records and were reliant on obtaining additional information from a GP at a subsequent stage.

[19] **NHS Mersey Care – Assessment and Management of Choking (Adults) (SD52)**
Who to refer to:
Psychologist
- Deliberate attempts to block airway
- PICA Taking food from others
- Secretive binging on food (BED – Binge Eating Disorder)

Speech and Language Therapist
- Deterioration or change in physical ability, eating very fast or slowly, cramming food, excessive coughing or complete lack of a cough, difficulty or absence of chewing, food stored in the mouth, food textures have had to be changed due to inability to manage hard, dry, chewy foods etc.
- Also, if swallowing problems have not previously been assessed, the individual takes sudden intakes of breath, talks or laughs when eating, eats despite having poor levels of alertness or being distracted or continuing to eat high risk foods despite being advised not to, where food is found in mouth or cheeks after swallowing, food or liquids come out of the nose or mouth, history of choking

[20] rcslt-what-is-slt-factsheet.pdf

However, this practice has now been addressed and SALT practitioners now have immediate access to patient's medical records.

7.14 A final SALT plan was provided to a care worker in April 2017 by a SALT practitioner with the expectation that this member of staff would promulgate the information to all other care workers. However, it is understood that there was some ambiguity with regard to the responsibility placed on this particular member of staff. The process of simply providing a SALT plan to a carer and requesting they disseminate the information to other members of staff does not appear to be proportionate or adequate for the level of risk involved. However, this response is not unique to Mr A's case and is standard practice within NHS Mersey Care.

7.15 Findings from five SARs in Hampshire[21] between 2005 and 2010, highlight a clear link between individuals with a learning disability who had previously been identified to be at risk from choking and their subsequent deaths as a result of their care plan not being followed. (In respect of eating, drinking and supervision).

7.16 All of these factors sadly contributed to Mr A's death and whilst it is not current practice for a SALT practitioner to provide an informed presentation/training to carers responsible for an individual with a learning disability who is at a high risk of choking, the author would submit that the available evidence of causal factors and risk would support a change to current practice to allow all care staff involved in the care of an individual at risk of choking and in receipt of a SALT Plan to fully understand the expectations placed on them, the risks involved and serious consequences of not prescriptively following it.

7.18 SALT Follow-up

Whilst the processes and timescales adapted by the SALT practitioner are in accordance with NHS Mersey Care practices and procedures, the author would suggest that the level of risk would merit the case being reviewed by a SALT practitioner after a designated period of time. However, in making this suggestion, the author must also acknowledge that Mr A's SALT plan had been in place for over a year before his tragic death.

Recommendation 4

LSAB should consider requesting Mersey Care NHS Foundation Trust to review their current guidance for treating individuals with a learning disability and at a high risk of choking (in consultation with the Royal College of Speech and Language Therapists) to include:

i. whether high risk cases should be reviewed after an appropriate period of time
ii. how SALT Plans are disseminated and understood by care staff responsible for an individual's care
iii. attendance at/ facilitating of MDT meetings at the earliest opportunity

[21] *Hampshire Multiagency Review Sept 2012.pdf

7.19 Training
It is understood that care staff involved in Mr A's care received face to face training in basic life support on an annual basis, however it has not been possible to ascertain if any of these staff received additional training after the serious choking incident in January 2017

7.20 A Thematic Review of Adult Serious Adverse Incidents in Northern Ireland[22] highlighted the importance of all care staff with the responsibility for an individual with a learning disability and at a high risk of choking receiving bespoke training specifically tailored to the needs and risk of the individual, and in May 2020, the Royal College of Speech and Language Therapist (RCSLT) introduced an Eating, Drinking and Swallowing Competency Framework[23] with an expectation that all care staff working directly with people who have swallowing problems achieve a minimum of Level 2 training.

7.21 Since Mr A's death, the care provider has reviewed their practices and procedures and now ensures support staff are qualified in basic Life Support and Safe Swallowing if they are responsible for an individual at risk of choking and have also applied the International Dysphagia Diet Standardisation Initiative Framework[24]. The care provider has also provided de-choker devices[25] to all facilities where there are individuals at a high risk of choking.

Recommendation 5
LSAB, in partnership with ISAB should receive assurance from NHS and Social Care Commissioners that:

i. all care staff working directly with people who have eating and swallowing problems have been trained to Level 2 of the RCSLT's Eating, Drinking and Swallowing Competency Framework. Training should be consistent and standardised across the region, using a common language and should include recognition of risk, food preparation, CPR and First Aid.
ii. de-choking devices have been considered for all individuals with a learning disability who have been identified to be at risk of choking.
iii. The Chair of LSAB should also consider raising this recommendation through the National Safeguarding Adults Board Chairs' Network in order to be taken forward at a national level.

7.22 Multi-agency involvement
It is acknowledged that despite some records documenting that Mr A's care was managed through a multi-disciplinary approach there is little or no evidence of a coordinated approach to his care during the period of time under review.

7.23 The lack of a joined-up approach clearly impacted on the care Mr A received. Taking the seriousness of the incident and Mr A's assessed 'High Risk' of choking into consideration it would have been appropriate immediately after the choking

[22] *Report on the Regional Choking Review Analysis.pdf (hscni.net)
[23] EDSCF_UPDATED_FINAL.pdf (rcslt.org)
[24] The IDDSI Framework provides a common terminology to describe food textures and drink thickness. IDDSI - IDDSI Framework
[25] designed to dislodge and remove food from a person's windpipe

incident and also at the time of the SALT discharge to have coordinated a multi-disciplinary team meeting (MDT).[26]

Recommendation 6
LSAB, in partnership with ISAB should seek assurance from NHS and Social Care Commissioners that a coordinated multi-agency approach is in place for all service users in receipt of Section 117/ social care arrangements. This should include holding regular MDT meetings, collectively reviewing risk assessments and ensuring synergy between care plans and risk assessments.

Care Plan Arrangements/Legal Frameworks

7.24 Mental Capacity Act 2005

The Mental Capacity Act 2005 (MCA)[27] confirms an individual's right to make decisions for themselves where they have the capacity to do so.
From the available documentation it is evident that there was ambiguity and confusion between the various professionals in respect of Mr A's capacity and ability to make all or some decisions about his life.

7.25 As far as can be ascertained, no mental capacity assessments were undertaken for Mr A since the Mental Capacity Act 2005 was enacted in 2007 despite the number of assertions by professional that he did not have capacity. The Mental Capacity Act 2005 makes it explicit, if there is any doubt that an individual does not fully understand the decision he is being asked to make or the consequences of that decision a formal assessment should be undertaken to assess that individual's capacity. Unfortunately, in this case despite doubt and documented assertions that Mr A did not have capacity, formal assessments were not undertaken by any professionals involved in his care.

7.26 Mr A's sister clearly believed that her brother did not have capacity to make decisions about the food he could eat, as she advised the Coroner during the Coronial process that she'd never raised the issue of Mr A's capacity with professionals as it hadn't occurred to her that anyone might think he had the capacity to weigh up the issue and control his eating.

7.27 As part of the initial SALT consultation, Mr A was considered to have capacity to consent to the consultation, and with the support of his carers to understand and verbalise that his food required to be cut up. However, despite information being recorded in Mr A's support plan to suggest he did not have capacity to make decisions about the type of food he ate (this assertion was also supported by care staff at the SAR learning event), no mental capacity assessment was undertaken to establish if Mr A had the ability to understand, retain and weigh up the risks involved in making specific food choices or understood the potential risks associated with eating certain foods.

[26] Multidisciplinary teams (MDTs) are the mechanism for organising and coordinating health and care services to meet the needs of individuals with complex care needs. The teams bring together the expertise and skills of different professionals to assess, plan and manage care jointly.
Multidisciplinary teams working for integrated care | SCIE
[27] Mental-capacity-act-code-of-practice.pdf (publishing.service.gov.uk)

7.28 Significant research[28] [29] provides that assessing the mental capacity of an individual can be incredibly complex as it is ultimately based on an interpretation of an interaction between the assessor and the assessed person. Braye et al[30] assert that capacity not only involves the ability to understand the consequences of a decision but also the ability to execute that decision.

7.29 The lack of a documented legal framework under the Mental Capacity Act 2005 caused confusion and difficulty for the staff responsible for Mr A's every-day care who were required to follow the recommendation/ actions in both the SALT plan and Mr A's personal support plan which included intervening to withdraw food from Mr A when he did not respond to prompts. Although these measures were clearly designed to keep Mr A safe, the reality was it placed certain restrictions on his rights and freedoms without the legal framework in place to do so.

7.30 There would also appear to have been confusion and misunderstanding amongst some professionals involved in Mr A's care about who was responsible for undertaking Mental Capacity assessments. The Mental Capacity Act 2005 provides that any appropriate person can undertake an assessment under the Act and helpfully provides examples of an 'appropriate person' which includes:

- a carer in relation to day-to-day care and support decisions;
- a social worker in relation to social care decisions
- a doctor for medical decisions.

7.31 Deprivation of Liberty

As far as the author can ascertain no application has ever been made to the Court of Protection to seek a deprivation of liberty authorisation[31] for Mr A whilst he resided in supported living accommodation. Once again, the fundamental issue relates to whether Mr A had the capacity to make autonomous decisions about his care and support and whether he was free to leave his accommodation on his own to access the wider community without continuous support and supervision.

7.32 Article 5 of the European Convention on Human Rights (ECHR) guarantees the right to liberty and provides that no one should be deprived of their liberty on an arbitrary basis. Any deprivation of liberty must be carried out in accordance with a procedure prescribed by law and proper safeguards must be in place.

7.33 In March 2014, the UK Supreme Court set out the 'acid test' for the meaning of a Deprivation of Liberty via a decision known as "Cheshire West"[32]. This states that an individual who lacks the capacity to consent to the arrangements for their care and treatment is objectively deprived of their liberty if they are:

- subject to continuous supervision and control
- not free to leave

[28] Keene, A R ; Is mental capacity in the eye of the beholder? | Emerald Insight

[29] Hutchinson, C, Dalton, D and Banks, R; Mental Health Act Restricted Patients and Conditional Discharge: Practice Considerations. MM-practice-Guidance-FINAL.pdf (bild.org.uk)

[30] Braye, S; Orr, D; and Preston-Shoot, M; 2011 Social Care Institute for Excellence paper. Self-neglect and adult safeguarding: findings from research (scie.org.uk)

[31] Sections 4A(3) and 16(2)(a) of the Mental Capacity Act 2005 Mental Capacity Act 2005 (legislation.gov.uk)

[32] P v Cheshire West & Chester Council https://www.supremecourt.uk/cases/uksc-2012-0068-judgement.pdf

7.34 There is no evidence to suggest that Mr A was not entirely content with his care and living arrangements, however, the legislation is explicit*; "although the person may seem happy with their arrangements the determinant factor is how staff would react if the person was to try to leave".*

7.35 Documentation recorded by professionals would support that Mr A did not have the capacity to leave his accommodation on his own and required continuous supervision for his own protection. This would tend to suggest that Mr A should have been subject to a Mental Capacity assessment and an application (COPDOLS11),[33] made to the Court of Protection for the court to authorise a deprivation of liberty.

Recommendation 7
LSAB, in partnership with ISAB should consider commissioning a multi-agency audit of Mental Capacity assessments in the context of SALT assessments to ensure capacity has been fully explored and with partner agencies, agree an action plan to address the findings.

Recommendation 8
LSAB, in partnership with ISAB should review/revise current Mental Capacity Act 2005 training delivered to practitioners across the partnership, to include:

i. much greater consideration and awareness raising of 'executive function' within an MCA assessment.
ii. reinforcing the responsibility placed on Care Providers and their staff to carry out mental capacity assessments when capacity is in doubt.
i. reinforcing the responsibility placed on Care Providers to ensure legal frameworks are in place to support an individual in their care (including Deprivation of Liberty).

7.36 Managing Section 117/ Care Act 2014 responsibilities
It is clear that the distance between Mr A and his designated social worker contributed to a lack of joined up approach between the two key agencies involved in his care, namely, ILDP and NHS Mersey Care. This was acknowledged by ILDP staff at the learning event who spoke of the difficulty in balancing a significant case load with managing a client who resided a considerable distance away. As a result, there was ambiguity and confusion between professionals in respect of some of the arrangements in place this included:

i. Section 117 arrangements[34] - there was no consistent ILDP attendance at annual Section 117 care plan review meetings. This clearly placed the legality of the joint responsibility in question.
ii. Section 27 Care Act 2014[35] - there was no documentation available to support IDLP carrying out an annual Care Act review of Mr A's case in recent years.

[33] copdol11-eng.pdf (publishing.service.gov.uk)

[34] Sec 117 - place a joint statutory responsibility on local authorities and CCGs to provide mental health aftercare services and this includes a requirement to carry out a joint annual review of a Section 117 care plan.

[35] Central to the principles of the Care Act 2014 is the concept of wellbeing and it places a statutory responsibility on a local authority to conduct a review of an individual's care and support plan on an annual basis. This should not only consider if an adult's needs and outcomes continue to be met but should also respond to changing circumstances.

iii. Mr A's 'out of authority'[36] placement was obtained in 2005 as a 'SPOT' purchase and there was no formal contract or contract monitoring in place. It is understood that the London Borough of Islington Commissioning and Contracts staff are in the process of reviewing and ensuring formal contracts are up to date and in place for all spot providers.

iv. Deprivation of Liberty application - there appears to have been confusion between the various organisations involved in Mr A's care with regard to who was responsible for making a formal deprivation of liberty application to the Court of Protection and unfortunately this was never addressed.

Recommendation 9

i. LSAB, in partnership with ISAB should receive assurance from Health and Adult Social Care Services that where individual cases are being managed by different organisations through different legal processes – clarity of the role, purpose and responsibility of each individual agency are fully documented and reviewed annually.

ii. The Chair of LSAB should also consider raising this recommendation through the National Safeguarding Adults Board Chairs' Network in order to be taken forward at a national level.

Recommendation 10

LSAB, in partnership with ISAB should seek assurance from the London Borough of Islington that:

i. they have reviewed their processes and staff guidance in relation to the management and recording of individual case files, including the need to record all information/involvement with clients and the necessary supervision required.

ii. they have conducted an audit of all cases where they are jointly managing an individual under Section117 aftercare arrangements to ensure that necessary Care Act 2014 assessments and annual reviews are in place.

iii. they have conducted a review of all clients to ensure that there are formal provider contracts in place for all external placements.

Managing Mr A's Health Needs and Learning Disabilities

7.37 Annual Health Review

Mr A's last annual Learning Disabilities health review[37] was in December 2016, some 18 months before his death. Although he did not receive a full LD health check between 2016 and his death in 2018, Mr A was well known to the surgery and received a GP desk top review as well as a pharmacist-led medication review and a nurse-led health check.

7.38 During this review process, health professionals recognised that in light of Mr A's complex physical and mental health needs, it would have been appropriate for him to have received a regular review of his long-term health conditions. Health Commissioners advised that the lack of a review of complex long-term conditions is

[36] Independent care & support being delivered in a local authority that is different from the local authority with the statutory responsibility for the provision of that care and support. Advice note - commissioning out of area care and support services (local.gov.uk)

[37] 25936_RCGP Training Guide_PROOF4 (oxleas.nhs.uk)
Annual Health checks were introduced by the Department of Health in 2009 due to individuals with learning disabilities having disproportionately poorer health than the general population, but less likely to access healthcare.

not unique to this case and they have already taken steps to ensure that such complexity is considered in future Learning Disability Annual Reviews.

Recommendation 11
Given that research/evidence demonstrates the clear correlation between taking preventative action to reduce choking incidents in individuals with a learning disability and a reduction in fatal incidents:
LSAB should seek assurance from Health Commissioners that a separate assessment of 'choking risks' will be introduced as part of a Learning Disability Annual Health Review/ (through a short proforma questionnaire).

Recommendation 12
LSAB should seek assurance from Health Commissioners that long-term complex health conditions are reviewed during an annual Learning Disability Health Review.

11. CONCLUSION

11.1 The Coroner concluded that Mr A's death was "*an accident contributed to by the SALT recommendations not being adhered to".*

11.2 The author of this Safeguarding Adult Review has been unable to ascertain if the carer on duty at the time of Mr A's death was fully cognisant with the content of the SALT plan and the risks involved in not prescriptively following it (despite SALT guidance being prominently displayed in the kitchen area). She believes that fundamental learning must be drawn from this case to prevent another untimely death in such tragic circumstances.

11.3 Despite the omission that led to Mr A's death, there is considerable information available to confirm that on the whole Mr A received careful, person-centred, non-intrusive intervention and support which was balanced with managing his serious health issues, medical intervention and sometimes challenging and difficult behaviour.

11.4 Although it is clear that steps were taken in an effort to prevent Mr A suffering further choking episodes after the incident in January 2017, the author would suggest that there wasn't always heightened professional awareness of the increased risk associated with individuals with a learning disability and already at risk of choking or a proportionate response to these increased risks, despite the significant research and statistics available to support that people with a diagnosis of learning disability are at a higher risk of choking than the wider population.[38] [39]

Recommendation 13
There is limited information available on a local and national basis on the prevalence of individuals with a Learning Disability dying as a result of a choking incident and as

[38] Predictors of asphyxiation risk in adults with intellectual disabilities and dysphagia. Journal of intellectual disability research, vol. 50, no. 5, pp. 362-370 Samuels, R. Chadwick, D. (2006)
Predictors of asphyxiation risk in adults with intellectual disabilities and dysphagia - PubMed (nih.gov)
[39] Indicators of choking risk in adults with learning disabilities: A questionnaire survey and interview study. Disability and rehabilitation, 30 (15): 11312-1138. Thacker, A. Abdelnoor, A. Anderson, C. White, S. Hollins, S.(2007)
Indicators of choking risk in adults with learning disabilities: a questionnaire survey and interview study - PubMed (nih.gov)

far as can be ascertained there is no multi-agency approach in place across Merseyside to prevent such incidents.

i. LSAB in partnership with Merseyside and Cheshire ICS and the other safeguarding boards across the region may wish to consider commissioning a Thematic Review of Choking across the ICS footprint with a view to establishing the prevalence of such incidents and a common framework and approach to prevent future tragedies.
ii. The Chair of LSAB should also consider raising this recommendation through the National Safeguarding Adults Board Chairs' Network in order that the issue can be discussed and considered at a national level.

Appendix A
BEST PRACTICE

1. The SALT practitioner involved in Mr A's case specialised in treating individuals with a Learning Disability and had considerable experience of individuals with a learning disability eating too quickly and placing too much in their mouth.

2. It is known that Mr A became agitated and upset in the days leading up to hospital or clinic visits, therefore considering his needs and conducting the SALT assessments in his own home is assessed to be best practice.

3. The SALT Plan produced was comprehensive in content.

4. Care staff worked in partnership with Mr A's sister to ensure that he received person centred care.

5. On the whole, Mr A received consistent, person-centred care from a long-standing care team who knew and could respond to his needs. This included responding and respecting his social needs and ensuring he was taken out regularly to the places he liked to frequent.

6. Mr A's complex health needs were well managed. He attended regular appointments for a range of co-morbidities and also attended regular appointments with his GP.

7. From the documentation available it is evident that the Section 117 arrangements in place for Mr A were person centred and focused on managing his mental health treatment and support in the community, to prevent his re-admission to hospital under the Mental Health Act 1983. Mr A's arrangements continued to be financially supported by both the London Borough of Islington and the CCG.

8. Mr A's placement in supported living accommodation in Liverpool was arranged by the London Borough of Islington to meet Mr A and his family's <u>needs</u> as opposed to that of the local authority. This demonstrates a person-centred approach to his care and support needs.

Appendix B
SUMMARY OF RECOMMENDATIONS

Recommendation 1
Liverpool Safeguarding Adults Board (LSAB) should seek assurance from NHS Liverpool Clinical Commissioning Group that there is continuity of medical care for individuals with a Learning Disability who present at A&E due to a choking incident.

Recommendation 2
LSAB in partnership with Islington Safeguarding Partnership Board (ISAB) should seek assurance from Health and Social Care Commissioners that all care providers have:

i. robust auditable processes in place to ensure care plans and risk assessments are updated where appropriate
ii. mechanisms in place to report serious incidents to Commissioners, local Social Services and CQC.

Recommendation 3
Given the available research that people with a learning disability have a higher risk of choking and subsequent death from choking, it is imperative that all staff employed in care settings are knowledgeable about when to refer an individual with eating difficulties to a medical practitioner. LSAB, in partnership with ISAB should:

i. consider increasing carer and staff awareness of the risk of choking for individuals with a learning disability by commissioning a learning document providing advice and guidance. This should include the need for medical advice to be sought where an individual with a Learning Disability has a tendency to put large quantities of food into their mouth and eat too quickly.
ii. seek assurance from Health and Social Care Partners that 'near miss' incidents from choking in individuals with a learning disability are audited and a clear action plan implemented to prevent future incidents.

Recommendation 4
LSAB should consider requesting Mersey Care NHS Foundation Trust to review their current guidance for treating individuals with a learning disability and at a high risk of choking (in consultation with the Royal College of Speech and Language Therapists) to include:

i. whether high risk cases should be reviewed after an appropriate period of time
ii. how SALT Plans are disseminated and understood by care staff responsible for an individual's care
iii. attendance at / facilitating of MDT meetings at the earliest opportunity

Recommendation 5
LSAB in partnership with ISAB should receive assurance from NHS and Social Care Commissioners that:

i. all care staff working directly with people who have eating and swallowing problems have been trained to Level 2 of the RCSLT's Eating, Drinking and Swallowing Competency Framework. Training should be consistent and standardised across the region, using a common language and should include recognition of risk, food preparation, CPR and First Aid.
ii. de-choking devices have been considered for individuals with a learning disability who have been identified to be at risk of choking.
iii. The Chair of LSAB should also consider raising this recommendation through the National Safeguarding Adults Board Chairs' Network in order to be taken forward at a national level.

Recommendation 6
LSAB in partnership with ISAB should seek assurance from NHS and Social Care Commissioners that a coordinated multi-agency approach is in place for all service users in receipt of S117/social care arrangements. This should include holding regular MDT meetings, collectively reviewing risk assessments and ensuring synergy between care plans and risk assessments.

Recommendation 7
LSAB in partnership with ISAB should consider commissioning a multi-agency audit of Mental Capacity assessments in the context of SALT assessments to ensure capacity has been fully explored and with partner agencies, agree an action plan to address the findings.

Recommendation 8
LSAB in partnership with ISAB should review/revise current Mental Capacity Act training delivered to practitioners across the partnership, to include:

i. much greater consideration and awareness raising of 'executive function' within an MCA assessment.
ii. reinforcing the responsibility placed on Care Providers and their staff to carry out mental capacity assessments when capacity is in doubt.
iii. reinforcing the responsibility placed on Care Providers to ensure legal frameworks are in place to support an individual in their care. (Including Deprivation of Liberty)

Recommendation 9

i. LSAB in partnership with ISAB should receive assurance from Health and Adult Social Care Services that where individual cases are being managed by different organisations through different legal processes – clarity of the role, purpose and responsibility of each individual agency are fully documented and reviewed annually.
ii. The Chair of LSAB should also consider raising this recommendation through the National Safeguarding Adults Board Chairs' Network in order to be taken forward at a national level.

Recommendation 10
LSAB in partnership with ISAB, should seek assurance from the London Borough of Islington that:

i. they have reviewed their processes and staff guidance in relation to the management and recording of individual case files, including the need to record all information/involvement with clients and the necessary supervision required.
ii. they have conducted an audit of all cases where they are jointly managing an individual under S117 aftercare arrangements to ensure that necessary Care Act assessments and annual reviews are in place.
iii. they have conducted a review of all clients to ensure that there are formal provider contracts in place for all external placements.

Recommendation 11
Given that research/evidence demonstrates the clear correlation between taking preventative action to reduce choking incidents in individuals with a learning disability and a reduction in fatal incidents:
LSAB should seek assurance from Health Commissioners that a separate assessment of 'choking risks' will be introduced as part of a Learning Disability Annual Health Review (through a short proforma questionnaire).

Recommendation 12
LSAB should seek assurance from Health Commissioners that long-term complex health conditions are reviewed during an annual Learning Disability Health Review.

Recommendation 13
There is limited information available on a local and national basis on the prevalence of individuals with a Learning Disability dying as a result of a choking incident and as far as can be ascertained there is no specific multi-agency approach in place across Merseyside to prevent such incidents.

i. LSAB in partnership with Merseyside and Cheshire ICS and the other safeguarding boards across the region may wish to consider commissioning a Thematic Review of Choking across the ICS footprint with a view to establishing the prevalence of such incidents and a common framework and approach to prevent future tragedies.
ii. The Chair of LSAB should also consider raising this recommendation through the National Safeguarding Adults Board Chairs' Network in order that the issue can be discussed and considered at a national level.

Appendix C
CONTEXT OF CHOKING IN INDIVIDUALS WITH A LEARNING DISABILTY

1. As part of this SAR, research literature and medical information has been considered in relation to the cause and effects of choking, in addition to preventative measures.

2. Research provides that adults with a learning disability are at greater risk of eating, drinking and feeding difficulties than the general population[40]. People with learning disabilities are also more likely to present with behaviours which increase the risk of choking whilst eating and drinking, such as eating quickly or impulsively or experiencing difficulty in swallowing (dysphagia).[41]

3. A Thematic Review of Choking Analysis in Northern Ireland in 2018 estimated the range of people with learning disabilities and who had swallowing problems ranged from 36% (based on speech and language therapy caseloads) to over 70% (based on inpatient populations). It also highlighted that approximately 15% of adults with a learning disability require support with eating and drinking and 8% of those known to learning disability services will have a diagnosis of dysphagia.

4. A review by the Ombudsman of New South Wales found choking incidents to be the main cause of death for adults with Intellectual Disabilities living in residential care.[42] However, it has also been recognised that choking incidents and choking-related deaths in the population are under-recognised and under-reported, with deaths often being recorded as "pneumonitis due to inhalation of food/ vomit" [43]

5. Findings from five SARs in Hampshire[44] between 2005 and 2010, highlight a clear link between individuals with a learning disability who had previously been identified to be at risk from choking and their subsequent deaths as a result of their care plan in respect of eating, drinking and supervision not being followed.

6. Research and analysis[45] supports the Hampshire findings and highlights the importance of joint assessment and management within a multidiscipline team; good communication; effective supervision and clear unambiguous care plans.

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[40] Indicators of choking risk in adults with learning disabilities: A questionnaire survey and interview study. Disability and rehabilitation, 30 (15): 11312-1138. Thacker, A. Abdelnoor, A. Anderson, C. White, S. Hollins, S.(2007) Indicators of choking risk in adults with learning disabilities: a questionnaire survey and interview study - PubMed (nih.gov)

[41] Prevalence and Risk Factors of Choking in Adults with Intellectual Disability: Results from a National Cross-sectional Study . Manduchia, B. et al (2022) Microsoft Word - Manduchi, et al., in press.docx (tcd.ie)

[42] Ombudsman New South Wales. Report of Reviewable Deaths in 2014 to 2017. Deaths of people with disability in residential care Report of reviewable deaths in 2014-2015, 2016 and 2017. Deaths of people with disability in residential care. 31 August 2018. (nsw.gov.au)

[43] Trollor, J., Srasuebkul, P., Xu, H., & Howlett, S. (2017)Cause of death and potentially avoidable deaths in Australian adults with intellectual disability using retrospective linked data | BMJ Open

[44] *Hampshire Multiagency Review Sept 2012.pdf

[45] Samuels, R., & Chadwick, D. D. (2006). Predictors of asphyxiation risk in adults with intellectual disabilities and dysphagia. Predictors of asphyxiation risk in adults with intellectual disabilities and dysphagia - PubMed (nih.gov)

7. A thematic analysis of fatal choking incident narratives in England and Wales[46] identified the following factors influenced the risks of choking in individuals with an intellectual disability and/or mental ill health:

- Time of day (40% of local incidents were at the evening meal);
- Food types;
- Medication (including antipsychotic side effects);
- Behaviours (e.g. cramming or rushing food);
- Familiarity of staff.

[46] Care Staff Perceptions of Choking Incidents: What Details are Reported? (wiley.com) Guthrie et al., 2015

Appendix D
OTHER PROCESSES

1. Police Investigation
A police investigation took place into the circumstances leading to Mr A's death and a report was submitted to the Crown Prosecution Service. A subsequent decision was made by the Crown Prosecution Service that the matter would not be prosecuted.

2. LeDeR
Learning Disabilities Mortality Review (LeDeR) is a national programme to address the premature deaths of people with a learning disability.
As Mr A's death was an unexpected and premature death, a LeDeR was commissioned by NHS Liverpool Clinical Commissioning Group however, it has been paused pending the outcome of the SAR report.[47]

3. Coroner's Inquest
At an Inquest held in October 2020 the Coroner concluded that Mr A's death was an accident contributed to by the Speech and Language Therapy recommendations not being adhered to.

4. Care Quality Commission (CQC)
The Care Quality Commission (CQC) carried out an unannounced inspection of the Care Provider on 16th August 2018 (just over two months after Mr A's death in June 2018). The inspection team found the service to be 'Good' in all 5 key areas (Safe, Effective, Caring, Responsive and Well-led).

5. During this inspection, specific attention was given to care and treatment plans for individuals requiring support with clinical conditions. CQC inspectors found that relevant risks had been appropriately assessed, people's health conditions were clearly recorded and staff followed specific care and treatment plans to support overall health and well-being, including nutrition and hydration risk assessments, speech and language therapist (SALT) guidance, eating and drinking screening tools, dysphagia (swallowing difficulties), eating and drinking training and competency assessments.

6. A previous CQC inspection in November 2016 also rated the provider as 'Good.' It is of note that both inspections did not take place in the complex where Mr A lived at the time of his death, as Mr A had been the sole resident in this supported living accommodation for some time.

[47] A LeDeR review can be paused at any stage should it be determined the case requires escalation and or subject to other statutory and parallel processes. These include; serious incident investigations, coronal process, police investigation, Safeguarding Adult Reviews.

Appendix E
ADDENDUM TO RECOMMENDATIONS

The recommendations highlighted below have been reviewed and reconfigured by Liverpool Safeguarding Adult Board following the conclusion of the Safeguarding Adult Review Report being finalised. The recommendations detailed below will supersede previous recommendation points and will be taken forward into Improvement Planning by LSAB. The Board is satisfied that by reviewing the recommendations this has strengthened the learning from this review which will have a greater impact on multi agency safeguarding and support the objective of the Safeguarding Adult Review to improve multi-agency working and ultimately improve safeguarding for adults at risk of abuse or neglect.

Recommendation 2
LSAB in partnership with Islington Safeguarding Partnership Board (ISAB) should seek assurance from all relevant agencies in this case that they have:

i. robust auditable processes in place to ensure care plans and risk assessments are updated where appropriate
ii. mechanisms in place to report serious incidents to Commissioners, local Social Services and CQC.

Recommendation 5
LSAB in partnership with ISAB should receive assurance from NHS and Social Care Commissioners that:

i. all care staff working directly with people who have eating or swallowing problems have been trained to Level 2 of the RCSLT's Eating, Drinking and Swallowing Competency Framework. Training should be consistent and standardised across the region, using a common language and should include recognition of risk, access to food, food preparation, CPR and First Aid.
ii. de-choking devices have been considered for individuals with a learning disability who have been identified to be at risk of choking.
iii. The Chair of LSAB should also consider raising this recommendation through the National Safeguarding Adults Board Chairs' Network in order to be taken forward at a national level.

Recommendation 8
LSAB, in partnership with ISAB should review/revise current Mental Capacity Act training delivered to practitioners across the partnership.