Islington Safeguarding Adults Board response to 'Mr A' SAR, completed by Liverpool SAB

Partners working across the Islington Safeguarding Adults Board ['ISAB'] have long understood the increased risks posed by choking for adults with learning disabilities. Previously this had been identified as learning from the LeDeR research. As a partnership we have published local guidance and raised awareness of national guidance to seek to reduce risks.

Sadly, we were notified that in June 2018 'Mr A' (his name has been anonymized out of respect) died following a second choking incident. Whilst he lived in Liverpool, Mr A's care was the responsibility of partners in Islington in line with duties under the Care Act. Liverpool SAB, in consultation with ISAB were satisfied that the circumstances of his death met the criteria for a mandatory safeguarding adults review. Partners from Islington's adult social care department supported the review and, in February 2023, ISAB members heard from the reviewer about her investigation, her findings and the report's recommendations for actions to prevent future harm. This report provides us with an understanding of what happened to Mr A. It is particularly helpful to have had input from Mr A's sister, who expressed her concerns regarding the lack of behavioural management input that may have reduced risks for Mr A. The report also enables us to see how partners across the whole safeguarding system could better work together to prevent harm from choking.

The ISAB accepted the recommendations from this report and our prevention and learning sub-group have been working to implement these and share the learning from this case. As a partnership we have raised the findings in this review at various partnership meetings, including those responsibility for the design and delivery of health and social care integrated support so that it is widely understood why it is necessary to have in place auditable processes to ensure care and risk management plans remain updated. We are working with our ICB colleagues to develop ways in which near-miss choking incidents can be reported in a way that helps us to better understand strategic need for our residents, including those placed out of area. We have also received assurances that this case will be used to inform our local workforce training offer.

I would like to take this opportunity to thank all the practitioners who supported this review. Equally, I want to take this opportunity to thank ISAB members who have supported the development of an action plan to take forward the important recommendations from this review. It is clear there is extensive continued commitment to take forward this learning by addressing the recommendations both as a partnership and within each partner agency.

As with any SAR, the publication of the report is only the start of the process. The Board will now, through our planned activities and regular assurance reports monitor the implementation of these recommendations. Progress made by the ISAB and each agency to address the recommendations will be reported in our Annual Report.

Yours Sincerely,

Fiona Bateman
Independent Chair, Islington Safeguarding Adults Board