Multi-Agency Reflective Review
Learning Brief – Ben

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BLACKPOOL SAFEGUARDING ADULTS BOARD

Background

Ben had Foetal Alcohol Syndrome and complex learning disabilities. He had been in Local authority care from the age of 5 weeks until the age of 18 and was then supported by adult learning disability services. Ben lived in his own property with 24-hour support delivered by one of the council's contracted care providers. Ben lived in this setting for a number of years; he had a high level of support with day-to-day tasks and had a variety of health and care needs.

During August 2023 Ben became unwell and his mobility deteriorated, he began to have some skin issues and was admitted to hospital. Ben died in hospital, aged 30. His cause of death was pneumonia with a liver problem as a contributing factor.

What have we learned?

Complex needs and vulnerability

Ben's circumstances highlight the complexity of supporting individuals with profound and multiple needs. Ben required highly skilled care and a comprehensive risk management plan to address vulnerabilities such as skin integrity and choking risks linked to PEG feeding. These physical health challenges were further complicated by cognitive limitations, which reduced Ben's ability to make decisions and increased the importance of professional judgment and advocacy.

Concerns in Care Delivery

Despite awareness of these risks, there were gaps in care delivery and escalation. Concerns about Ben's skin integrity were identified, but his condition continued to deteriorate over several days without escalation. While multiple contacts were made with health services and the community learning disability team, timely medical intervention did not occur. A planned GP visit was missed, and Ben was taken to A&E only when his condition had significantly worsened. Sadly, he later died in hospital. This sequence of events highlights the need to review responsiveness and strengthen escalation processes.

Organisational Culture and Safeguarding

Organisational culture played an important role in this case. The care provider's internal review highlighted areas where openness and challenge could be strengthened. Safeguarding and whistleblowing policies were not sufficiently clear, which may have impacted staff confidence in escalating concerns promptly. Additionally, managerial oversight and quality assurance processes required improvements to ensure effective care delivery and timely intervention.

Systemic Improvements

In response to learning, systemic improvements have been initiated. Safeguarding, serious incident, and investigation procedures have been revised to strengthen clarity and accountability. Staff training has been enhanced, with competency checks introduced for key areas such as moisture lesion care. An electronic care management system is now in place to enable real-time monitoring and alerts, reducing the risk of delayed responses. Leadership structures have been strengthened, with increased managerial presence and clearer escalation pathways. Additionally, an external agency has been appointed to oversee safeguarding improvements and ensure that recommendations are implemented effectively.

Good Practice

Examples of good practice were evident in Ben's care prior to his death. Ben's annual health checks were completed as planned, demonstrating consistent attention to his routine care. When difficulties arose in accessing primary health services, the care provider continued to advocate strongly on Ben's behalf. Their persistence ensured that Ben was admitted to hospital when his condition became a serious concern. Senior managers responded promptly once aware of the situation, offering effective support to frontline staff. Throughout Ben's hospital stay, his support

team remained by his side and were present at the time of his death, ensuring continuity of care and emotional support. Following his passing, the Learning Disability team carried out a thorough safeguarding adults enquiry, which was well coordinated by the safeguarding lead.

The Multi-Agency Reflective Review highlighted that, following the incident, several examples of good practice have been implemented across partner agencies in response to learning from single-agency investigations. Health services demonstrated proactive measures through the use of hospital passports, which are uploaded patient records prior to admission, and the introduction of Learning Disability Support Plans for all inpatients, ensuring care tailored to individual needs. The Hospital Trust has achieved 96% compliance with mandatory learning disability training and appointed Disability Champions, supported by regular workshops and engagement with community teams. The care provider has strengthened its governance framework by revising safeguarding and whistleblowing policies to include clear escalation pathways, introducing competency-based training on moisture lesion care, and implementing an electronic care management system to enable real-time monitoring and alerts. The Local Authority has enhanced safeguarding practice through reflective supervision, redesigned recording systems to improve clarity and decision-making, and disseminated anonymised lessons learned to promote organisational learning.

What do I need to consider?

If you are supporting an individual with similar circumstances, consider:

Safeguarding Guidance: Ensure Escalation thresholds are clearly understood and applied promptly. Ensure that staff are confident in knowing when to raise concerns, and how to do this.

Risk Management: Use multi-agency forums to regularly review complex cases, ensuring shared understanding, responsibility and coordinated action.

Professional Curiosity: Look beyond presenting issues, act quickly on signs of deterioration and question assumptions.

Capacity and Advocacy: Assess decision-making capacity early and secure advocacy support where needed to ensure the individual is appropriately supported and their rights are protected.

Escalation Routes: Verify that urgent health concerns have clear, tested pathways for rapid medical intervention, and that staff feel confident using them.

Ask yourself…

- Are safeguarding concerns being raised promptly and appropriately?
- Is there a clear escalation route for urgent health issues?
- Are staff trained and competent in managing complex care needs?
- Is organisational culture open to challenge and whistleblowing?
- Are you sharing information effectively across agencies?

Keep in touch

For queries or feedback, contact the Blackpool Safeguarding Partnership Business Unit: BSAB@blackpool.gov.uk
Visit Blackpool Safeguarding Partnerships for training and resources.