Partnership response to the safeguarding adult review for 'Ivan'

Introduction

'Ivan' was a single 69-year-old white British man who loved the outdoors. He had become estranged from his family and was described by some as a bit of a 'loner'. He was found deceased in Epping Forest in March 2023 after a brief period of being missing. Following his death, it was agreed by the Safeguarding Adults Board (SAB) that there was learning about how agencies worked together whilst providing care and support under the deprivation of liberty safeguards.

The Safeguarding Adults Board notes that the subsequent safeguarding adults review has sought to understand why things happened in the way that they did, and what Ivan's experiences tell us about how systems work. This systems approach focuses on multi-agency professional practice and is not about blame. It is about learning and improving practice for the future.

Response by the Safeguarding Adults Board

The SAB accepts the reviewer's findings and acknowledges what needs to change to improve practice, which we commit to taking forward by:

- Developing a new protocol and toolkit to support practitioners with safeguarding vulnerable adults who go missing
- Exploring how the SAB can improve its line of sight and monitoring of the effectiveness of safeguarding measures for vulnerable people in residential care, particularly those at risk of going missing
- Improving the culture around safeguarding concerns, both submissions and responses
- Ensuring residential care providers have appropriate checking mechanisms in place for people who are escorted by staff outside the setting and who may be at risk of going missing. This will be factored into commissioning and monitoring of residential care services.

The details of these actions are laid out in the action plan below and will be reviewed accordingly to gather what difference is being made as a result of this SAR.

Action plan for SAR Ivan			
What needs to change? What is the objective?	*How might this be achieved?*	*By when and by whom?*	*How might we know it's made a difference?*
i. A swifter response to vulnerable adults who go missing	Liaise with London Safeguarding Adults Partnership about developing a regional protocol / toolkit as per below.	August 2024 – Strategic Partnerships	Regional resource in use
	A new protocol and toolkit is developed to support practitioners with safeguarding vulnerable adults who go missing which is also shared and made available to residential care providers (as per no. iv below)	August 2024 - Strategic Partnerships / Mental Capacity DoLS subgroup	Shareable resource available for the partnership Number of hits when shared through spotlight
	Protocol and toolkit to be widely disseminated with practitioners	September 2024 - Strategic Partnerships	Benchmarking activity or audit? - Police report improved timescales in relation to missing individuals
	7 minute briefing about SAR Ivan	March 2024 – Strategic Partnerships	Confirmation by teams that this has been shared and digested
	Learning from practice briefing to practitioners to include resources and the key points for improving practice (eg. Escalation)	May 2024 – Strategic Partnerships / LBWF Organisational Safeguarding	Number of practitioners whose knowledge and understanding has improved
	Promote the importance of escalation both internally and between agencies via 7 minute briefing and 'spotlight' e-bulletin ensuring this is passed on to practitioners	May 2024 - Strategic Partnerships	Reach of spotlight / resources Feedback from managers
	Explore the range of less restrictive methods available when depriving people of their liberty that balances their autonomy with their safeguarding needs	June 2024 – LBWF Safeguarding & DoLS service	Feedback to June 2024 SAB about how this has been considered and / or being delivered in practice
ii. Better oversight by the SAB of the effectiveness of safeguarding measures for vulnerable people in residential care,	Taken to SAB BMG for further discussion about how oversight can meaningfully take place, whether through • Data • Deep dive • Questionnaires to residential care providers (perhaps alongside no. iv below)	May 2024 - Strategic Partnerships / SAB BMG	Minutes of meetings Through any further action taken

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particularly those at risk of going missing	Have as an agenda item at June 2024 SAB	June 2024 – Strategic Partnerships / SAB BMG	
iii. Improve the culture around submitting and responding to safeguarding concerns through the MASH	Produce a resource that outlines the principles for submitting safeguarding concerns which includes ensuring that this has been received by MASH and also illustrates what makes a good referral (findings from previous learning). This to be done through either a 7 minute briefing or refreshing the MASH protocol for submitting / responding to safeguarding concerns.	September 2024 – MASH Strategic Group	Audits? Survey?
	Explore which agencies do not receive an automated response from MASH for safeguarding concerns and why, with a view to addressing the issue	June 2024 – MASH Strategic Group	All agencies confirm receipt of safeguarding responses
iv. Ensure residential care providers have appropriate checking mechanisms in place for people who are escorted by staff outside the setting and who may be at risk of going missing.	The findings from this SAR to be shared with commissioned residential care providers at forthcoming Residential Care Provider Forum	April 2024 – LBWF Organisational Safeguarding (Gill Nash)	Feedback from residential care providers
	Residential Care Service specifications to include standards for reducing risk and responding appropriately when vulnerable people go missing (and new protocol / toolkit as per no. i to be shared and made easily available to use which will include Herbert Protocol style resource)	September 2024 - LBWF / NEL ICB Integrated Commissioning (Maggie Jeffrey) and Strategic Partnerships	Appropriate monitoring evidences that standards are in place for all residential care services. When there is an incident, checking mechanisms are implemented -