Brent Safeguarding Adults Board

Response to the Safeguarding Adult Review – Leocardo (Adult E)

Today sees the publication of the Brent Safeguarding Adult Review concerning Leocardo (Adult E). We are using his given name with the permission of his two daughters to whom all members of the Safeguarding Adults Board offer their sincere condolences. This is a distressing case of a man who should have been safe whilst being looked after in an extra care setting but who left the home where he was living and was not found until he had passed away.

There are clear lessons to be learned from this case. Central is how social workers and care providers work with family members when, as in Leocardo's case, the person does not have the mental capacity to determine where and how they live. Leocardo had developed Lewy Body Dementia but continued to enjoy walking around the areas he knew well. Whilst some measures were put in place, designed to keep him safe, the risks involved in him leaving the care setting should have been more thoroughly assessed, working with his daughters to make decisions in his best interests that kept him safe and happy.

There are other lessons also, including use of the Herbert protocol so that, when people go missing, there is information immediately available about possible routes they may follow. Social workers and social care staff need to fully understand the role of those who hold Lasting Power of Attorney for health and welfare and/or a person's finances. Preventive measures, such as door alarms, designed to keep people safe, should be fully operative and regularly tested. Close cooperation is required between care providers, clinical and social care staff, and those commissioning placements to ensure pro-active oversight.

Brent Safeguarding Adults Board commissioned audits of extra care provision whilst the Safeguarding Adult Review was being prepared. The purpose of the audits was to evaluate the quality of care being provided to adults at risk. The audits have provided assurance to the Board regarding the appropriateness and effectiveness of extra care provision. Nonetheless the audits have also highlighted where provision can be further enhanced.

An action plan has been agreed by the Brent Safeguarding Adults Board to ensure that all the recommendations in the Safeguarding Adult Review have been implemented and the necessary changes to policy and practice fully embedded. Future meetings of the Brent Safeguarding Adults board will seek reassurance that implementation of the recommendations has resulted in changes to how adults with dementia and other disabilities in care settings are supported, well cared for and enabled to achieve a meaningful quality of life.

The learning from this Safeguarding Adult Review will be disseminated widely across all organisations within Brent with roles and responsibilities for safeguarding adults in care settings. They will be required to give an account of how they have disseminated the learning within their staff groups and ensured that policy and practice have changed to reflect the recommendations in the review.

Professor Michael Preston-Shoot

Independent Chair