

## **Brent SAB response to Adult G Safeguarding Adult Review**

On behalf of the Brent Safeguarding Adults Board, I offer condolences to Adult G's family and thank them for their patience during the time it has taken to finalise the Safeguarding Adult Review.

Despite the delays in publication, the learning identified in the SAR has been taken forward. There is still more work to be done and this will continue to be monitored by the SAB.

The SAB acknowledges the SAR findings in relation to:

- Multi-Agency management of high-risk cases
- Pressure Ulcer management and identification of safeguarding concerns.
- Hospital discharge and the need for the right equipment to be with the individual at the right time.
- Commissioning and quality monitoring of nursing and care placements
- Personalisation of Mental Capacity Assessments and ensuring equality for those with learning disabilities
- Cross border communication and quality assurance of care provision

I am grateful to the North West London Integrated Care Board for taking forward a review of the health aspects identified in the SAR. I have received a letter providing assurance that the learning is being embedded into health practice. This was reinforced at my first SAB as Independent Chair, on 5<sup>th</sup> March 2024, when the refreshed national protocol for pressure ulcers was discussed and the SAB heard how health agencies have been working on how they gain greater assurance, through data reporting, regarding prevention and the assessment of pressure ulcers when they do occur, to prevent deterioration.

Following a review by the Medical Examiner, the SAB acknowledges the ICB view that, although pressure ulcers contributed to Adult G's death, the death certificate does not place them as the primary cause.

Adult Social Care have also provided an update on the progress they have made since Adult G's death in respect of the commissioning and oversight of care placements.

The SAB and its subgroups will continue to work on gaining assurance that practice is improving in the areas identified within the SAR, over 2024-2025. The evidence of the learning will be set out in the annual report for 2023-2024 and subsequently that for 2024-2025.



Nicola Brownjohn

Independent Chair for brent Safeguarding Adults Board