WOLVERHAMPTON SAFEGUARDING TOGETHER

Learning Lessons Briefing published after safeguarding review

Released: Friday 31 January 2025

A Learning Lessons Briefing has today (Friday 31 January 2025) been published by Wolverhampton Safeguarding Together to share key findings from a recent Safeguarding Adults Review.

The review was commissioned by Wolverhampton Safeguarding Together to examine the experiences of a young man, referred to in the review as ‘Thomas', who passed away at the age of 29.

Thomas, who had mild learning disabilities, autism and Emotionally Unstable Personality Disorder, was given care and support by a number of local agencies.

After Thomas’ death, a Serious Incident Review was completed by West Midlands Ambulance Service, and a Learning from Lives and Deaths - People with a Learning Disability and Autistic People Review was also carried out.

Wolverhampton Safeguarding Together commissioned the Safeguarding Adult Review to look at how agencies had interacted with and supported Thomas and to address any additional learning not covered by the earlier reviews.

It makes a total of seven key findings, and an action plan has been developed which will be overseen by Wolverhampton Safeguarding Together’s One Panel.

Alison Hinds, Chair of Wolverhampton Safeguarding Together Executive Board, said: "Thomas was described as the life and soul of the party, bubbly, and a friendly character, and our condolences go to his family and friends, along with our commitment to ensure any lessons are learnt from his passing.

"The Safeguarding Adult Review highlighted a number of areas of good practice, but also seven areas for development, and we have put an action plan in place to address these without delay.”

The Learning Lessons Briefing has been published on the Wolverhampton Safeguarding Adults Board website. For more information, please visit www.wolverhamptonsafeguarding.org.uk.

ENDS

Notes to editors:

1/ A Safeguarding Adult Review is a multi-agency review process which seeks to establish the circumstances around an individual's death and determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place. The purpose of a SAR is not to apportion blame; it is to promote effective learning and improvement to prevent future deaths or serious harm occurring again.

2/ Section 44 of the Care Act 2014 requires a SAR to be carried out "where an adult with care and support needs (whether or not those needs are met by the local authority) in the Safeguarding Adult Board's area has died as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult".

3/ Wolverhampton Safeguarding Together Board provides strategic leadership for safeguarding work to ensure there is a consistently high standard of professional response to situations where there is actual or suspected harm. For more information, please visit www.wolverhamptonsafeguarding.org.uk.

4/ For more information or to arrange an interview, please contact Paul Brown, Communications Manager, City of Wolverhampton Council, on 01902 555497 or email paul.brown@wolverhampton.gov.uk.

- **Issued by the City of Wolverhampton Council's Corporate Communications Team on behalf of Wolverhampton Safeguarding Together.**