Bury Safeguarding Partnership
Working together to safeguard adults and children in Bury

Safeguarding Adult Review
Jacob

Presented to the Bury Safeguarding Partnership on
the 30th of October 2023

Independent Author: Allison Sandiford

Contents

1. Introduction to the Review and Methodology

1.1. Jacob sadly died in hospital on the 28th of November 2021 following a suicide attempt. This succeeding Safeguarding Adult Review was commissioned by Bury Safeguarding Partnership in accordance with the guidance provided in the Care Act 2014[1].

1.2. The report has been authored by Allison Sandiford. Allison is an independent safeguarding consultant with a legal background, who gained experience in safeguarding whilst working for a police service. Since 2019 Allison has conducted serious case reviews and safeguarding practice reviews in both children's and adults safeguarding, and domestic homicide reviews. Allison does not have any current links to Bury Safeguarding Partnership or any of its partner agencies.

1.3. A multi-agency review panel[2] met on the 27th of April 2023 and considered the scope of the review. The panel agreed that the review should focus upon the period from the 30th of June 2021, when Jacob's mother requested an assessment of Jacob for supported living, until the 28th of November 2021, when Jacob died. The panel agreed the Terms of Reference[3], and additional information was requested from the agencies involved to aid the review process.

1.4. The panel met on two further occasions to discuss the case and learning and to monitor the progress of the review. The review has also incorporated a practitioner learning event which was attended by professionals from the key agencies who had worked with Jacob[4]. Contribution from the participants generated positive discussion around both good practice and areas of practice that could be developed and improved; this has formed the basis of this report.

1.5. It was agreed by panel members that the review would follow a question-based learning format in place of traditional recommendations. The questions developed during this Safeguarding Adult Review process are outlined at section 9 and will drive Bury Safeguarding Partnership, and its partner agencies, to develop an action plan that will respond directly to the identified learning.

1.6. Panel members had an opportunity to review the final draft of the report and discuss the learning prior to its presentation to Bury Safeguarding Partnership.

2. Family Engagement

2.1. The Board, reviewer and panel members would like to extend their condolences to all members of Jacob's family.

2.2. Family engagement is an important part of the review process as family members are best placed to contribute their knowledge of a loved one. The Bury Safeguarding Partnership contacted Jacob's father and explained the Safeguarding Adult Review process. The reviewer is grateful to Jacob's father for his willingness to speak and to help others through his reflections. His voice is woven into the body of this report.

3. Parallel Processes

3.1. Following notification of Jacob's death to HM Coroner, an inquest held in April 2022, concluded a verdict of suicide.

3.2. Following Jacob's death Greater Manchester Mental Health undertook an internal review of Jacob's care. The review actioned:

[1] The Care Act 2014 states that Safeguarding Adult Boards must arrange a Safeguarding Adult Review when an adult in its area dies 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. This is a statutory responsibility.

[2] The panel consisted of representatives from Pennine Care Foundation Trust, Adult Social Care, Integrated Care System, Bury Safeguarding Adult Board, Future Skills College, The Fed and Greater Manchester Mental Health.

[3] Refer to Appendix 1

[4] Staff/Representatives from The Fed, Bury Safeguarding Partnership, Early Intervention Team, Adult Safeguarding Team, GP Practice, Mental Health Liaison Team, Future Skills College, and Bury Access Team.

- Additional training for staff, with clinical risk sessions to include an emphasis on increased suicide risk amongst those with autism.
- The introduction of a template for initial contacts which prompts the clinician to contact the carer and reminds the Mental Health Liaison Team of the importance of making contact.
- The creation of guidelines around choosing a private therapist and to request a review to be undertaken by Greater Manchester Mental Health psychology.

4. Limitations

4.1. There have been some limitations to the review. Neither the Social Care Officer who worked directly with Jacob during the scoping period or care staff from Focus Foundation were able to be present at the practitioner learning event. However, with thanks, a one-to-one virtual meeting was managed with the team leader at Focus Foundation later in the review process.

5. Consideration and Analysis of the Case

To enable the review to understand who Jacob was, and the care and support he was offered, professionals explored his background and the following key practice episodes[5] with the Independent Reviewer.

Key Practice Episodes
Professional response to mum's request for support.
Jacob's presentation to the hospital Emergency Department.
Jacob's diagnosis of Autism from a private provider.
Events leading to the fatal incident

Jacob's Background

5.1. Jacob's father describes Jacob as a very talented and intelligent young man with a caring and kind nature. He enjoyed photography, walking and spending time with his family. Jacob is very much missed.
5.2. Jacob's parents had concerns regarding Jacob's traits and characteristics as a child. When he was 8 years old, they paid for an assessment and described to the assessor how he was *'stubborn'*, *'difficult to manage'*, and had '*outburst of temper tantrums'*, difficulty remembering things, restlessness, poor concentration, poor reading skills, and a low self-esteem. Jacob performed above average in some areas of the assessment but there were concerns for some motor and visual responses.
5.3. No professional support was offered to the family at this time, but over the next few years Jacob, in his parents words, 'blossomed'. He began to make some friends and achieved in his learning. Though he found high school difficult, he attained GCSE's, but later confided in his father that the '*whole thing was an act',* and that *'he was camouflaging himself as neurotypical*'.
5.4. Between the ages of 15 and 18 years, Jacob studied in Yeshiva Shaarei Torah[6]. The Yeshiva schedule started at 7:45am and ended around 10 or 11pm with a 2 hour break at lunchtime. It involved intensive learning with other people, delving into complex topics. Jacob became overwhelmed by the yeshiva programme and subsequently did not complete the course.

[5] Practice episodes are periods of intervention that are deemed to be central to understanding the work undertaken with Jacob. The episodes do not form a complete history but are thought key from a practice perspective and summarise the significant professional involvements that informed the review.
[6] A yeshiva is a traditional Jewish educational institution focused on the study of Rabbinic literature, primarily the Jewish law, while Torah and Jewish philosophy are studied in parallel. The studying is usually done through daily shiurim (lectures or classes) as well as in study pairs.

5.5. Jacob's GP referred Jacob to two private Clinical Psychologists. One Psychologist told Jacob that he only dealt with very complex cases, and referred him to a private Psychotherapist[7], who attempted Cognitive Behavioural Therapy[8], Mindfulness[9] and Acceptance and Commitment Therapy[10] with Jacob. Jacob worked with the other Clinical Psychologist a few times but chose not to continue as he didn't believe the therapy suited him.

5.6. Around this time Jacob also tried anti-depressant tablets and various herbal medicines. However, although he was now doing well on his access course at college, he continued to be incredibly anxious and in August 2019, Jacob's GP referred him to the Early Intervention Service - with whom Jacob undertook a full Mental Health and Risk Assessment and a Cognitive Assessment At Risk Mental State[11]. Jacob[12] was deemed to not meet the criteria for 'At Risk Mental State' or 'First Episode Psychosis' and was advised to seek support from the GP in the future regarding any concerns.

5.7. In September 2020 Jacob commenced a Business and Management degree course.

5.8. Jacob's parents have informed the review that around 2021 they started to suspect autism, and during communication with their doctors it became clear that some professionals did too. Parents also report that when Jacob started to research autism, it resonated with him. His father has described how following research, Jacob '*started going into it in a huge way, screaming and shouting. He spent hours crying. He would not go out of the house, and when he did, he wore dark sunglasses and noise cancelling earphones. He bought lots of "stimmy toys." He then reverted to a young child and wanted to be treated as one. He wanted to process his past and relive all the trauma that he felt after being in the completely wrong environment for such a long time. He called this process unmasking'*. Jacob's behaviour proved very difficult for the rest of the family[13], but on the positive side Jacob was optimistic that once he was able to process his trauma, he would get better,

5.9. In April 2021, Jacob's course tutors received an email from him which explained that he had received a diagnosis of autism and dyslexia. He wrote of feeling relieved that he had an explanation for a range of personality/behaviour traits that he had been aware of throughout his life. In response, the pastoral and student services lead contacted Jacob with Disabled Students' Allowance information and following some discussion with Jacob, a Personal Mitigating Circumstances application was successfully made allowing for an extension for the completion of the course.

5.10. Around this time Jacob saw his doctor (who prescribed diazepam and reportedly described Jacob as *emotional*) and attended the Emergency Department of the hospital (where he was assessed by the Mental Health Liaison Team[14] as having capacity and no clear mental illness) before starting to meet with a professional who was an accredited member of the British Association for Counselling and Psychotherapy.

5.11. Jacob's parents have described how the sessions with this professional left Jacob confused and how in their opinion, the techniques used by the therapist were not good for Jacob who saw some statements as an attack rather than support. Jacob found it very hard to process these therapy sessions and would spend hours trying to work out their content, even months afterwards.

5.12. Following this, Jacob's parents arranged support from other private therapy providers which they report to have been helpful. Jacob's parents also contacted the GP several times, one GP agreed to fast-track a referral to LANCuk[15].

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[7] Jacob worked with this Psychotherapist over the next few years.

[8] Cognitive Behavioural Therapy is a short-term form of behavioural treatment that can help people problem-solve and understand the relationship between beliefs, thoughts, and feelings, and the behaviours that follow.

[9] Mindfulness is the practice of purposely bringing one's attention to the present-moment experience without evaluation.

[10] Acceptance and Commitment Therapy can help patients battle mental disorders like anxiety and depression without using medication. It teaches patients to change the way they relate to their negative thoughts and emotions so that these thoughts don't take over.

[11] At Risk Mental State is a set of criteria that suggest high-risk for psychosis. It is possible to identify individuals at high and imminent risk of developing a first episode of psychosis through the use of the At Risk Mental State criteria.

[12] Jacob felt the therapy he was accessing privately was sufficient to improve social anxiety.

[13] Jacob has 4 siblings.

[14] Jacob and his parents contacted the team on two further occasions in the same month requesting support around getting a diagnosis.

[15] LANCuk are an administrative centre who supports a team of multi-disciplinary professionals to provide assessment and management of individuals with neurodevelopmental conditions.

Professional response to Mum's request for support.

5.13. On the 30th of June 2021, Adult Social Care received a referral from Jacob's mother requesting support for Jacob. On the 1st of July 2021, Jacob's mother consulted with Jacob's GP practice and requested an urgent referral to the crisis team. The GP offered a face-to-face consultation for the following week[16], sent an expediting letter to LANCuk regarding the referral, and signpost mother to the Greater Manchester autism consortium website for further support. Later in the month, on the 22nd of July 2021, Jacob's father contacted the Mental Health Helpline with concerns for Jacob's behaviour. He was advised to speak with the GP or the Emergency Department at the hospital, and to contact the Early Break Helpline[17] for Bury.

5.14. Adult Social Care allocated Jacob's case to a Social Care Officer on the 27th of July 2021. A Care Act Assessment which concluded that Jacob had eligible care and support needs, was carried out within days.

5.15. A few days after the Care Act Assessment, Jacob was assessed over the telephone by a Nurse Practitioner from LANCuk. The assessment concluded that Jacob would benefit from a further discussion with their Consultant Physiatrist to establish whether he met the criteria for a formal diagnosis of Autistic Spectrum Disorder or Attention Deficit Hyperactivity Disorder and to discuss further options.

5.16. It is important to note that despite Jacob struggling with his mental health throughout this period of time, Jacob continued to work on his degree assignments, and he submitted them all by August 2021.

5.17. On the 16th of August 2021 the Social Care Officer visited Jacob again to discuss and agree a support plan. The Social Care Officer recorded that there was a high risk of carer breakdown due to a difference of opinion between Jacob and his parents relating to Jacob moving into independent living accommodation. Jacob stated that he did not feel ready for this, and his parents stated that they felt it was needed.

5.18. Following the assessment, whilst options were still being explored for support workers to work with Jacob, Jacob's parents contacted the Social Care Officer and requested urgent respite. Unfortunately, none was able to be found but the situation calmed without intervention. Jacob's family then began to contact providers outside of the ones identified by the Social Care Officer and chose a provider[18] themselves. This provider was not yet registered with the council.

Professional response to Jacob attending the hospital Emergency Department.

5.19. On the 26th of September 2021 while waiting for an agreed date for the care provider to start work with Jacob, Jacob began to express suicidal ideations and became aggressive towards his parents. His parents took him to the Hospital Emergency Department where he was seen by the Greater Manchester Mental Health Liaison Team.

5.20. Jacob told the practitioner that he had been engaging in an online Eye Movement Desensitisation and Reprocessing course[19] and the trigger for his current presentation was that his father had interrupted a session the previous day. Jacob considered the interruption to have left him in a trance-like state. He denied having any current suicidal ideation but said that he had experienced fleeting thoughts within the last 2 weeks with no intent to act. Jacob was risk assessed as a low risk to himself.

5.21. Before Jacob was discharged home, a plan[20] was agreed to manage Jacob's symptoms and to reduce fixation on the Eye Movement Desensitization and Reprocessing. The practitioner recorded that there was no rationale to refer Jacob to urgent care services, but that Jacob had been advised to use the crisis line and to

[16] This was later cancelled by mum who stated it was no longer needed.

[17] Early Break provides a confidential helpline for all residents in Bury who are experiencing difficulties with their mental wellbeing.

[18] Focus Foundation – established in October 2021 to transform the lives of adults with learning disabilities and those on the autistic spectrum. The Focus Foundation is CQC registered and has been approved by Bury Metropolitan Borough Council and Salford City Council.

[19] Jacob informed that he was spending up to 4 hours a day trying to resolve childhood trauma.

[20] Plan: to limit time participating in unsupervised Eye Movement Desensitization and Reprocessing therapy, to spend time engaging in activities he enjoys, to continue to speak with parents re thoughts and feelings, to continue engaging in private therapy and for the GP to review mood and mental state within 2 weeks.

re-present to the Emergency department if he felt unable to maintain his own safety or if his mental state deteriorated.

5.22. Around 10:00 hours the following morning, Jacob's dad telephoned the 24/7 Mental Health Helpline requesting help and support for Jacob. He reports that he was advised to speak with Jacob's GP and to contact social services if he felt his son needed *sectioning* and to attend the Emergency Department at the hospital if he felt his son was in danger.

5.23. Also on this morning, Jacob's parents informed the Social Care Officer of Jacob's decline in mental health. The Social Care Officer visited Jacob the same day. During the visit Jacob denied thoughts to end his life but expressed that he needed 'clinical help' for his mental health. The Social Care Officer made an urgent referral to the mental health single point of entry requesting a mental health assessment.

5.24. At 15:50 hours, Jacob contacted his GP and during a telephone consultation expressed that he was struggling with what he described as 'PTSD' from two therapists. Jacob agreed to a referral to the mental health team and the GP gave safety netting advice regarding crisis support. Several hours later, Jacob and his father presented at the surgery stating that they felt unable to wait for the crisis team to contact them the following day. The GP advised Jacob to re-attend the Emergency Department at the hospital which they agreed to do but there is no record of Jacob attending the hospital at this time.

5.25. Meanwhile, the referral from the Social Care Officer was received by the Access and Crisis team on the same day[21]. Whilst the service had no direct contact with Jacob, the service did have contact with the Social Care Officer and the Mental Health Liaison Team and requested a copy of the hospital discharge letter as part of their triage process. All of the information gained was reviewed by two Access and Crisis Team Mental Health Practitioners, who referred to the Teams Consultant Psychiatrist for ongoing management advice. The Teams Consultant Psychiatrist requested that the outcome of the Autism Assessment be known before any plan be formulated.

5.26. Around this time Jacob's parents moved Jacob (with his father) into another property owned by family for a period of time.

Jacob's diagnosis of Autism.

5.27. On the 30th of September 2021 Jacob was formally assessed for Autism by LANCuk[22].

5.28. On the same day the Social Care Officer updated the Access and Crisis Team of the assessment and the Teams Consultant Psychiatrist agreed to offer Jacob an appointment in the Outpatient Department with the Sector Consultant Psychiatrist. An internal referral was sent to the Outpatients Department, and the case was closed to the Access and Crisis Team.

Events leading to the fatal incident.

5.29. At the beginning of October 2021, Jacob decided to defer his second year of studies due to on-going mental health issues. His tutor agreed to maintain contact in order that Jacob would remain informed up until re-enrolment in 2022 and the withdrawal from the college was made on the 12th of October 2021.

5.30. Support workers from Focus Foundation commenced work with Jacob on the 14th of October 2021[23]. Initially Jacob was introduced to several staff members so he could choose who he wanted to support him, and discussions commenced regarding what type of activities he would like to do. It soon became apparent that life skill activities, such as cooking, were going to prove difficult as, by now, Jacob was living in his grandfather's address with an uncle who had come to the United Kingdom from abroad. Jacob told Focus Foundation how his uncle found 'mess' difficult and consequently Jacob was limited to what he felt

[21] 27th of September 2021

[22] Professional case notes report that Jacob was diagnosed with autism on this day, but Jacob's father told the review that a formal diagnosis was not received until November 2021.

[23] Adult Social Care has acknowledged a delay between completing the assessment and the support plan being agreed and has attributed it to there being difficulties in commissioning providers to support adults living with autism, and also in part to Jacob's parents being set on the specific provider.

comfortable doing inside the house. Activities were therefore undertaken either away from the home or in a shed. On the 22nd of October 2021 Focus Foundation emailed the Social Care Officer to express concerns for Jacob and the limitations to the work that they were able to begin. The Social Care Officer was not in work, and subsequently the email was not immediately picked up. In the meantime, Focus Foundation did not contact the Social Care duty team because Jacob had expressed that he was only comfortable with Focus Foundation sharing the information about his uncle with his Social Care Officer. When, after five days, the Social Care Officer returned to work, she attempted to contact Focus Foundation by telephone on five occasions, but her calls initially went unanswered. The Social Care Officer did not contact Jacob or his family, and it wasn't until the 11th of November 2021 that contact was finally made between the Social Care Officer and Focus Foundation. At this time Focus Foundation advised that Jacob's grandfather had passed away.

5.31. Around this time, via a Zoom call, LANCuk informed Jacob that he had been formally diagnosed with autism.

5.32. On the 19th of November 2021, a worker from Focus Foundation took Jacob on a visit to his family home in order to do some cooking. It is reported that Jacob became very distressed when he discovered that his things had been moved from his bedroom and that his sister was now using the room.

5.33. Early in the morning of the 24th of November 2021, Jacob contacted his GP surgery via the AskMyGp[24] message service and requested to speak with a GP regarding his medication as he was struggling with his mental health. The message was not received by the clinicians until after capacity had been reached for that day and, because the message was in keeping with similar presentations of Jacob and there was no suggestion of risk, a telephone consultation was triaged for the following day.

5.34. That night Jacob hung himself. Paramedics took Jacob to hospital, but he sadly passed away on the 28th of November 2021.

6. Thematic Analysis

Following the multi-agency discussions of the Key Episodes and Terms of Reference, the following themes were identified for practice and organisational learning:

Theme 1 - Agencies Understanding of Jacob's Lived Experience

6.1. In order to ensure that the professional support offer to Jacob accommodated his beliefs, values, and traditions, professionals needed to have a good understanding of Jewish life and of what Jacob's home and community would have meant to him. Some professionals working with Jacob, for example his GP, were part of the Jewish community and consequently had a level of understanding, but others were not, and there is little reference to these professionals striving to gain a cultural competency of Jacob (by learning more about his experiences and viewpoints and appreciating how he thought and conducted himself whilst taking his background into consideration).

6.2. Professionals may worry that acknowledging cultural differences could be perceived as negative stereo typing and be considered discrimination. But better understanding of Jacob's culture may have offered insight into his and his family's interpretation of support services and interventions. If professionals do not acknowledge and explore cultural differences, they will be unable to offer a person-centred support package which does not put the receiver at any disadvantage. To example, Jacob's father has told this review of being offered an appointment on a Saturday, yet in Judaism, Saturday is a weekly day of rest and one of the most important rituals. Also many Ultra-Orthodox Jewish people do not access the internet. Jacob did, but had he (or his parents) not, their support would have needed to be adapted to reflect that.

6.3. Furthermore, a key issue regarding what support Jacob required was around where he lived. Jacob told the Social Care Officer that he did not feel ready to move out of the family home. But his parents, trying to

[24] AskmyGP is an online consultation and workflow system that helps GPs manage patient caseload.

juggle the needs of all of their children, thought it best if he was supported to live independently. This review has not seen any documentation or case notes that explore this further in any detail, but culturally, the home is the place where Jews will often pray and worship, even if they attend synagogue each evening. In addition, many celebrations and traditions are observed within the home such as the weekly Shabbot. In the absence of further professional curiosity and understanding of what the Jewish culture meant to Jacob, it remains unknown whether this had any significance upon Jacob's unease about moving out.

6.4. Also, regarding Jacob's autism. It would have been useful for professionals to explore how autism was potentially received by members of the Jewish community. A poor understanding of autism by some Jewish professionals is evidenced in the chronology. For example, Jacob contributed to online autism communities and wrote of how misunderstood he felt. In particular he referred to a Jewish therapist he had seen who he described as *ultra-orthodox,* and who had told Jacob to mould to society, described him as manic, and suggested that autism was in his imagination. Jacob also referred to a GP who had told him not to *go into autism too much* because autistic people get *obsessed over things*. Such ignorance of autism and negative attitudes could have potentially caused Jacob to develop a feeling of stigma.

6.5. Due to a lack of research on the subject, David Ariel Sher, Jenny L Gibson, and Hannah Ella Sher shaped a study[25] which asked adults within a Jewish community in the United Kingdom (who were closest to autistic children), two questions:

- What are the experiences of rabbis, parents, and educators of autistic Jewish children regarding stigma towards autism?
- What steps have and can be taken to reduce stigma towards autism?

6.6. The study concludes that *while some stigma remains, there have been considerable strides made in reducing stigma towards autism in United Kingdom Jewish communities. In particular, the formation of communal specialist autistic schools and organisations has raised awareness and helped reduce stigma. The fact that people from across the Jewish community have chosen to volunteer in such organisations and schools has helped ensure diffusion of awareness of autism issues and has been effective in combatting stigma. Similarly, the promotion of positive religious and rabbinic narratives concerning autistic people is a powerful resource employed by autistic people's families and other advocates to promote respect and understanding. '*

6.7. However the research revealed the need for *greater awareness and training for teachers and parents on autism and autistic children's experiences,* and *more sophisticated knowledge* was *deemed critical to further reduce stigma within the community* - evidencing some of the challenges Jacob could have experienced.

6.8. Cultural curiosity is a current theme within many Safeguarding Adults Reviews across the Greater Manchester area. Consequently, many agencies working within the locality will have already commenced work to promote professional cultural curiosity.

Learning 1: *Professionals need to be curiously alert to cultural differences and incorporate this vital information into their support plans.*

6.9. Jacob's father told the review how he had worried that it may prove difficult for Jacob to talk to professionals outside of their community. Similarly, much discussion was had at the practitioner learning event about how members of the Jewish community can be reluctant to seek support from outside of their community.

6.10. Fortunately, this does not seem to have been the case for Jacob who, during the scoping period of this review, developed a trusting relationship with his Social Care Officer and some of the workers from the Focus Foundation. And any problem accessing professionals outside of the community appears to have been borne from an unsurety of what support was available rather that an inability to accept support from professionals outside of his community.

[25] 'We've come a very, very, long way' Overcoming stigma of autism: An interpretative phenomenological analysis within the UK Jewish community - PMC (nih.gov)

6.11. Jewish communities commonly have centralised communal organisations called Federations. The Federation is a charity, and the leading provider of social care services to the Greater Manchester Jewish Community. It is described as the Community's safety net - there to ensure that there is always somewhere for people[26] to turn to in times of need.

6.12. There are two main strands to The Federation's work: Community Services[27] which support people living in their own homes, and care for older people (at Heathlands Village[28]). The Community Services provide social work support in times of urgent need such as homelessness, mental health crisis, poverty, or domestic abuse.

6.13. In addition to the Federation, the 'Jewish Representative Council of Greater Manchester and Region' is *representing, protecting, uniting, defending, and serving* the Jewish community of Greater Manchester and the surrounding regions. Their focus is to strengthen and support their affiliate members and the wider diverse community whilst ensuring concerns are recognised and acted upon. The Jewish Representative Council also coordinates the Greater Manchester Jewish Strategic Group, which brings the community together with key individuals from wider society. The group meets regularly to promote collaboration and coordination with internal organisations, whilst amplifying a collective voice to government.

6.14. This review has been assured that both the Federation and the Jewish Representative Council are making inroads into the matter of supporting members of the Jewish Community to access agencies and organisations outside of their community (and vice versa) and that work is ongoing.

6.15. This review must also consider how the Coronavirus, which was identified as pandemic in December 2019, could have affected Jacob's lived experience. The first lockdown, initiated in March 2020 – prior to the start of the scoping period, started to be lifted in May 2020, but in an attempt to contain the virus, there followed months of restrictions across England. The restrictions developed into a "four tier system", and at times affected further closure of non-essential retail and hospitality, and personal restrictions of movement. On the 6th of January 2021, a rising number of coronavirus cases saw national restrictions being reintroduced. It wasn't until the 8th of March 2021, that England began a phased exit with a plan, known as the 'roadmap' out of lockdown. England moved through the roadmap as planned, but step four was delayed until the 19th of July 2021 (6 weeks into the scoping period) to allow more people to receive their first dose of a coronavirus vaccine.

6.16. Consequently, whilst this review has been told that there is no evidence to suggest that Covid had any detrimental effect upon the offer of support to Jacob during the scoping period, professionals were still adapting to everchanging working conditions introduced to manage the virus and agencies were susceptible to staff shortages as staff who had been exposed to the virus, still had to self-isolate[29], and staff who had been unfortunate enough to contract Covid-19 were off work.

6.17. However, unquestionably, Covid restrictions had a significant impact upon all religiosity, including the Jewish faith. Religion became harder to practice as it impacted upon the ability of families and communities to come together to pray, celebrate and mourn - whether that be in a public place of worship or a private home.

6.18. In addition, whilst lockdown upended the lives of everyone in the United Kingdom, its removal of routine and structure would have made it harder in particular for a person living with autism to manage daily life. This is because given that consistency helps to reduce their anxiety, many autistic people find changes to routine difficult. In line with this, Jacob's father informed this review of how Jacob struggled in Covid because he liked to keep busy.

6.19. During the national lockdown between January and March 2021, Jacob had accessed his university lessons remotely, often from a study pod in the University of Salford. It was when Jacob returned to in-person study, that his tutors identified that there were some changes in his physical and mental presentation. For

[26] The Federation is there for any Jewish person, of any age, who is vulnerable or suffering hardship.

[27] The Community Services support 1 in 7 Jewish homes and over 6,500 people every year across Greater Manchester.

[28] The care village has 150 residents and tenants.

[29] It wasn't until the 24th of February 2022 that people who tested positive for Covid were no longer legally required to self-isolate at home.

example, tutors said that Jacob would now arrive late to classes with an unkempt appearance. This could further reinforce that the lockdown had a distinct effect on Jacob personally, but further consideration of the time Jacob returned to face-to-face classes brings into realisation that this was also when Jacob's mother had first approached the subject of autism with him.

Theme 2 – Parent-Carer Support

6.20. It is possible that because Jacob's parents had always cared for Jacob (as their son), they may not have realised the changing nature of their roles as they developed into carers. It is also known that professionals are less likely to identify parent-carers, as carers, but in line with the requirements of the Care Act 2014, local authorities must actively seek to identify carers and provide information to support them. Carers should be told of their right to a carer's assessment, what such an assessment is, the benefits of having one, and how to obtain one.

6.21. There is no doubt that Jacob's parents were under stress during the scoping period of this review – it is evidenced in September 2020 when Jacob's mother emailed the Social Care Officer requesting urgent respite care. In response the Social Care Officer worked hard contacting possible care providers but without success, and four days later, Jacob's mother emailed stating that respite was no longer required.

6.22. Potential carer breakdown was understandable – parents were caring for and supporting Jacob who was living with autism and mental health problems, but they also had to provide emotional support, positivity, and practical help to all of their children who were living in the home.

6.23. There is no record of Jacob's parents being encouraged to recognise their caring role, or of a carer's assessment ever being offered to either of them (or to members of the extended family when Jacob was residing with them). A carer's assessment would have provided the opportunity to record the impact caring for Jacob was having on his parents' lives and what support or services were required. Had the assessment concluded that Jacob's parents had needs (because of caring), a multi-agency support plan would have been drawn up.

6.24. Of course, it must be acknowledged that Jacob's parents may have declined a carer's assessment, and had this been the case, best practice would have seen information about how to access support still being provided and a professional revisiting discussions over time - several times if needed.

6.25. Jacob's parents could have been signposted to:

- the Bury Carers' Hub which is commissioned by the Community Commissioning team and is the primary resource for adult carers in Bury to provide information, advice and a wide range of specialist support services designed to help adult carers caring for another adult to continue in their caring role for as long as they choose and reduce the impact the caring role can have on their own health and wellbeing, and
- The Time For You project, which is based within The Fed's Volunteer services, and supports carers in the Jewish Community. This project has been providing this culturally appropriate service to carers for over 20 years.

Learning 2: ***The caring needs of Jacob's parents were not sufficiently explored.***

6.26. To support parents further and in line with a Whole Family approach (and had Jacob agreed), a combined assessment could have been undertaken to look at everyone's needs in the family. This would have been good practice as Jacob's father has informed the review of how the whole family was in crisis during the scoping period - Jacob's behaviours were affecting the other children and there was a divided opinion as to whether Jacob should be at home or not. Jacob's father said that he and his wife would have felt further supported if Social Care had talked to the individual family members to assess what support they needed in their own right to manage the home situation or could have benefitted from.

6.27. Similarly, when Jacob was experiencing suicidal ideations, Jacob's father has said that he would have appreciated a more joined up approach, which would have included the family. He said that no advice was ever given to either him or his wife regarding what practical steps they could take to help keep Jacob safe or what warning signs to look for[30]. Jacob's father has said that help was needed to support the family to understand Jacob's mental health and suicide ideations, alongside practical guidance in how to reduce risk.

6.28. Given that in 2021, the North West (12.9 per 100,000 people) had the second highest suicide rate[31] it is crucial that professionals are giving this advice.

6.29. All local authorities have a suicide prevention action plan. In 2017/2018 section 1.2 of the Bury Action Plan[32] prioritised developing an appropriate, accessible training offer for family, friends and colleagues concerned about someone who may be at risk of suicide. The most recent action plan (produced in October 2021 – October 2022) has identified that between 2019 and 2021, 33 Suicide Prevention Courses were delivered as part of a Public Health project and funding was awarded to The Big Fandango[33] to continue suicide prevention training in 2022. Sadly this funding has now ended, but this review has been assured that the Bury Directory[34] continues to detail free online training, including 'shining a light on suicide[35]'.

6.30. Regrettably there were missed opportunities to signpost Jacob's parents to local training programmes and to support them to keep Jacob safe when:

- Jacob presented at the Emergency Department of the hospital,
- Jacob's father contacted the mental health helpline,
- The Social Care Officer made an urgent referral to the mental health single point of entry requesting a mental health assessment,
- Jacob presented with his father at the GP Practice stating that they felt unable to wait for the crisis team to contact them, and when,
- Jacob's case was closed to the Access and Crisis team, and he was awaiting an appointment with the Outpatients Department.

Learning 3: ***Jacob's parents/carers did not feel sufficiently advised about how to support Jacob with his mental health when he was experiencing suicide ideations.***

Theme 3 - Information Sharing

Multi-agency information sharing

6.31. Towards the end of September 2021, Jacob presented with the hospital Mental Health Liaison Team who completed a Mental Health Assessment and agreed a plan with Jacob. Jacob's discharge was then shared with his GP Practice as per procedure.

6.32. The following day, the Social Care Officer (having been informed of the hospital attendance by Jacob's father) attended Jacob at his home address. It was good practice that the Social Care Officer responded quickly and made an urgent referral to the Access and Crisis team. To assist the referral, the Access and Crisis team requested a copy of the aforementioned discharge letter, spoke with the Social Care Officer, and requested GP information, before further requesting the outcome of the autism assessment be forwarded as soon as it was completed. Upon receipt of the autism assessment information, an Access and Crisis team

[30] Consent, confidentiality, and the sharing of information, both between agencies and with families/carers, is a difficult yet vital aspect of mental healthcare. However, in the case of Jacob there is no evidence of him ever refusing for his information to be shared with his parents.

[31] Suicides in England and Wales - Office for National Statistics (ons.gov.uk)

[32] suicide prevention action plan V8.pdf (bury.gov.uk)

[33] The Big Fandango is an Arts and Crafts centre to support Mental Wellbeing, open to anyone in the community over the age of 14 who wishes to take part in arts and crafts activities or to learn a new skill.

[34] Suicide Prevention Training | The Bury Directory

[35] Learn to Save a Life - Shining a Light on Suicide

Consultant Psychiatrist agreed to offer Jacob an appointment with the Outpatient Department and the case was closed to the Access and Crisis team.

6.33. Whilst at this time of crisis, many professionals sought and received information from other agencies, individual professionals involved with Jacob didn't have his full picture. For example,

- the Access and Crisis team hadn't spoken with Jacob in order to understand his lived experience,
- the Social Care Officer hadn't had contact with the hospital Mental Health Liaison Team,
- LANCuk had no contact with any of the professionals working to support Jacob,
- education hadn't shared their experience of Jacob, or been made aware of other agency concerns, and
- many professionals remained unaware of the private therapists that Jacob had worked with.

6.34. Whilst LANCuk no longer provides its NHS services for Greater Manchester[36] during the scoping period of this review it was providing diagnostics and treatment for adult patients with possible autism spectrum disorders and Attention Deficit Hyperactivity Disorders in the Bury area. Despite the LANCuk website stating that a full report is written and sent to the referring GP, there is no evidence on the GP Practice's clinical system of LANCuk sharing any information (other than a letter dated August 2021, confirming Jacob's need to see a consultant to establish if he meets criteria for formal diagnosis of autism spectrum disorder). In particular, it would have been helpful for the professionals working to support Jacob to know that Jacob had, upon receiving the diagnosis, declined coaching from LANCuk[37].

6.35. The safeguarding system is not designed for professionals/agencies to work in silos. Instead, the multiple professionals who play a part in meeting a person's needs, whilst being accountable for their own work, are also accountable for ensuring that other professionals can see what they are doing. Jacob's mental health crisis, though not deemed to meet the threshold for section 42, could have prompted a multi-disciplinary meeting - which would have provided a platform for all agencies to share information and to collectively consider the risk to Jacob, Jacob's wishes, and plan how support could be offered.

6.36. For example, multi-agency information sharing around,

- Jacob's behaviours,
- the risk of carer breakdown, and
- Jacob's reports of thoughts of not wanting to live,

could have potentially affected mental health support being offered to Jacob whilst he was awaiting his appointment with the Outpatients Department (a referral to the Home Treatment Team could have been considered). This would have ensured that Jacob received support and that a mental health service could continually monitor Jacob's presentation prior to his outpatient appointment.

6.37. Sadly, due to the Social Care Officer who worked directly with Jacob not being present at the practitioner learning event, this review has been unable to explore any barriers to convening a multi-agency meeting further with her. However, it is not the sole responsibility of Social Care to convene meetings and any of the other professionals involved with Jacob could have led the process and created a robust inter-agency infra-structure.

6.38. The fact that no other professional led this process suggests a lack of understanding of each other's roles and potentially an expectation of Social Care to lead. Addressing this could improve the frequency of multi-disciplinary team meetings and support professionals to feel confident to lead the process.

6.39. The GP, present at the learning event, clarified that many internal discussions had taken place about Jacob, but conceded that the practice hadn't ever considered a multi-disciplinary team meeting. He acknowledged that further training was required to ensure that GP's understand when and how to co-ordinate a multi-disciplinary process, particularly when there are ongoing concerns for a person's mental health.

6.40. Agency chronologies evidence that with the exception of Focus Foundation commencing their care package, no professional had face-to-face[38] contact with Jacob throughout the following two months

[36] Arrangements for patients of LANCuk are now being made to ensure they have continuity of care with an alternative provider.

[37] Attempts to engage LANCuk with this review process have unfortunately been unsuccessful with correspondence not being responded to.

[38] Email correspondence was had between Jacob and his college tutor to defer his course.

(October or November 2021), after this crisis period. As previously mentioned, within this timeframe Focus Foundation did attempt to contact the Social Care Officer with concerns, but unfortunately this communication was delayed, and contact was not attempted with the Adult Social Care Duty team as Jacob did not wish for the concern to be shared with anyone other than his Social Care Officer - with whom he had built a good relationship.

6.41. On the 18th of November 2021, Jacob cancelled his outpatient appointment with the Consultant Psychiatrist over the telephone. Whilst the GP was informed of the discharge and asked to review Jacob, there is no evidence to suggest that risk was explored with Jacob or that the Social Care Officer was informed.

6.42. In the absence of multi-agency information sharing, Jacob was afforded a disjointed service provision, which continued due to a lack of oversight of the support being offered. Although all the practitioners involved in supporting Jacob were professional, conscientious, and strived to help him, their focus was predominantly on their own service remit and consequently a holistic approach, which could have been gained under multi-agency practice, was foregone.

Learning 4: ***The support offered to Jacob was without agency oversight after a multi-agency opportunity to share information was missed.***

Information Sharing between Statutory Agencies and Private Providers.

6.43. When Jacob's access to NHS mental health services is explored, It is not surprising that Jacob used the services of multiple private therapy providers. Jacob's father informed this review of numerous requests he and Jacob made to healthcare professionals requesting referrals to services. And a GP explained how their referrals are often rejected on the basis that such referrals must come from the school. However, GPs are then told of a lack of resources in Jewish Private Schools to complete such referrals. In addition, Child and Adolescent Mental Health Services have long waiting lists meaning that many teenagers remain unseen by the time they reach adulthood. Consequently, people turn to private providers because they don't know where else to go.

6.44. Anyone can call themselves a counsellor and set up in private practice and Jacob's father spoke of *not knowing what you are getting* and described how Jacob, and his family had little choice but to trust that the people who Jacob saw were fully qualified and worked to professional standards.

6.45. In the United Kingdom, a profession is regulated by law where there is a legal requirement to have certain qualifications or experience in order to undertake certain professional activities or use a protected professional job title. Whilst there are nine different protected titles for practitioner psychologists (which the Health and Care Professions Council does regulate), the job titles psychologist, counsellor, psychotherapist, and therapist are not protected by law. However, such individuals can still be subject to an accredited voluntary register and the Professional Standards Authority recommends that the public only use practitioners on either an accredited or statutory register.

6.46. The chances people take when using private therapy are evidenced when we consider the negative impact some private therapy had upon Jacob's mental health - as described in many conversations he had with professionals, and within a post[39] Jacob wrote on the National Autistic Society website. Also, besides the risk of an individual using a private therapist who proves non-compatible with their needs, there is further risk associated of an individual developing an over reliance or dependency – as was a concern around Jacob's use of the online Eye Movement Desensitization and Reprocessing. The ensuing problem being that private therapists don't routinely share information with a person's GP (or any other professional working to support a person), and consequently any information regarding an adverse response to a therapy type or style, or a developing dependency, remains unknown.

[39] Hoffic experience with autistic therapist! Trigger warning, very disstressing! - Mental health and wellbeing - Home - National Autistic Society - our Community (autism.org.uk)

6.47. This review is assured that the aforementioned *creation of guidelines around choosing a private therapist* and the request of a *review to be undertaken by Greater Manchester Mental Health psychology*, actioned within the internal review undertaken by Greater Manchester Mental Health will serve to improve community experiences with private therapists.

Information Sharing between Professionals and Further Education.

6.48. Records show that when Jacob returned to in-person study, a few months prior to the start of this review's scoping period in March 2021, his tutors identified changes in his physical and mental presentation. Jacob would arrive late to classes with an unkempt appearance and tutors specifically recall Jacob having an ungroomed beard and behaving in a manner that was sometimes erratic. Routinely, Jacob started to remain with tutors after classes and speak about his autism and dyslexia, often recounting his actions in class and demonstrating increasingly pronounced behaviours during conversation. Jacob started to make a range of demands in terms of interactions with him that the tutors strived to meet, such as writing emails to him in lower case and without punctuation. Jacob told tutors of his online autism research and they felt that Jacob had become consumed by the dyslexia and autism diagnoses. Jacob also started to refer to having a lot going on at home. The college tutors suggested that Jacob contacted the 'AskUs' welfare service offered by the university.

6.49. In May 2021, Jacob disclosed to tutors that he had undergone a very bad experience with a private therapist. He stated that the therapist had implied that he was a '*waste of space*' and had damaged his mental well-being. Jacob described the encounter with the therapist as *traumatic* and, on the 2nd of June 2021 is reported to have said *'I had a nasty experience with a therapist which just knocked me out for the past couple of weeks, and I wasn't able to do much work'*. In response, the pastoral and student services lead recommended a referral to the college counsellor. Jacob attended a virtual assessment with the counsellor but cancelled the following appointment because he felt that he needed an autism specialist. The counsellor and pastoral lead recommended that Jacob visit his GP to obtain the specialist intervention and on the 24th of June 2021, Jacob informed that he had *'found someone outside of college with the required knowledge'*.

6.50. Jacob's university website states that their safeguarding is everyone's responsibility, and *all staff receive training and support to ensure that the safety and wellbeing* of their students remain a *top priority*. To help achieve this, a number of Designated Safeguarding Officers have been appointed to work across different departments. It is the job of the Designated Safeguarding Officers to *offer advice, guidance, and support around safeguarding issues and to promote a safe environment for all our students and staff to work and study in*. Jacob was not brought to the attention of the Designated Safeguarding Officers because he didn't ever disclose any suicidal ideation or exhibit behaviours that suggested he was at risk of harm or presenting a risk to others. Whilst he was consumed by his diagnoses, he was never deemed to be incapacitated and the only concerns he raised were connected to his learning differences. Even in his meeting with the counsellor, Jacob made no safeguarding disclosures, and the counsellor did not therefore raise any safeguarding concerns with the Designated Safeguarding Officers.

6.51. The university did not have any information regarding Jacob in his younger years and did therefore not know his education history or the concerns his parents had raised over the years. It could be considered that there was a missed opportunity to learn more about Jacob by requesting Jacob's consent[40] to contact his parents and discuss his concerns. But again, Jacob's presentation wasn't one that suggested that he was at risk of harm. To the contrary the university has told the review that even though Jacob became fixated on the traits and the diagnosis, he was satisfied and pleased to have received a diagnosis and was glad to have been given a reason for his emotions/behaviours in the present and past.

6.52. This review has been reassured by the university that had the Pastoral Lead or teaching staff had concerns about Jacob's safety, they would have contacted his parents in line with their safeguarding practices. A commitment to contacting a named primary contact in the case of a safeguarding concern is discussed

[40] Had Jacob refused consent, staff would have then needed to make (and record) a risk-based decision whether to involve his parents.

with students at enrolment and the university has said that they would not have hesitated to communicate with parents and the adult social care team had it been felt that Jacob was unable maintain his safety and/or had expressed at any time that he was not safe.

6.53. It would have been valuable for the social care team and/or any other professional who was aware of Jacob's deteriorating mental health and experience of suicidal ideation to have shared that information with the university, but it is recognised that around the same time, Jacob was already contemplating deferring his next year of studies.

Learning 5: ***Jacob's presentation at university was not (on its own), an indicator that he was at risk of harm, but in the absence of information sharing between the university and professionals working to support Jacob outside of the university, the risk could not be fully determined.***

Theme 4 - Professional Understanding of Autism

6.54. Jacob's parents had been seeking advice and support to manage Jacob's traits and characteristics since his childhood. When he was around six or seven, they were referred to a Parent and Child Centre in Bury and were told to improve their parenting skills and put more rules in place. When Jacob was eight, they paid for an assessment which deemed some concern around his motor and visual responses. This was not taken any further at the time but by the time Jacob was ten, his parents had noticed some improvements in how Jacob was able to concentrate, and he had started to make a few friends. It was after Jacob found himself unable to manage the yeshiva schedule that his GP suggested Clinical Psychology. Jacob's father recalls how after years of therapy, one of Jacob's GPs admitted that he had suspected Jacob was autistic from the first time he had seen him.

6.55. In 2021, Jacob's mother discussed autism with Jacob and Jacob began his own research online and commenced a process known as 'unmasking' that refers to revealing one's autistic identity and traits, particularly when they have been concealed or suppressed due to social pressure, stigma, or lack of diagnosis.

6.56. It wasn't until November 2021 that Jacob received a formal diagnosis of autism from LANCuk. Jacob's father has informed this review that despite the GP admitting having suspected autism for a long time, other than a link to a webpage which had been provided by a GP, little support had ever been offered to the family whilst they were waiting for a diagnosis. In fact, Jacob's father recalled how one Clinical Psychotherapist had even told him that he (the Psychotherapist) didn't have specific knowledge of autism and didn't like labels.

6.57. Upon diagnosis, Jacob was told by LANCuk that they could offer coaching in a few weeks' time. Jacob declined stating that he didn't want to be coached but Jacob's father has wondered whether professionals could explore such negative responses to services with a person further, and better attempts to encourage them to access support could be had.

6.58. The Autism Act (2009) was enacted with the aim of addressing the multiple social disadvantages and health and care inequalities autistic adults faced. Since then, the government has published two adult autism strategies, which have resulted in greater awareness of autism across society and improvements in the priority placed on autism across government. In 2019, the government committed to a review of the existing autism strategy, Think Autism. The work being undertaken includes the National Autistic Society's research on developing a tailored Improving Access to Psychological Therapies model and the development of Oliver McGowan Mandatory Training for health and care professionals.

6.59. Professionals in attendance at the learning event for this review unanimously agreed a need for autism training. And in line with this, Jacob's father informed the review that in Salford Royal Hospital there is a sign up that states all staff must be trained properly in the Autistic Spectrum Disorder. He asked why therapists and schools do not have basic training in this important condition.

6.60. Whilst the Oliver McGowan Mandatory Training[41] in Learning Disability and Autism was rolled out to health and social care staff in England on the 1st of November 2022, further discussion with panel members highlighted that some agencies offer autism awareness training, but that it is not always mandatory.

6.61. Beyond training, the problem identified by professionals involved with this review is that since the decommissioning of LANCuk, if an individual is seeking a diagnosis, there is confusion regarding where assessment and diagnosis can be offered. There was general agreement that individuals would be referred to their GP and some research concluded that an organisation called Optimise has now been commissioned to offer alternative support. Little else was known.

6.62. Though this review has been assured by panel members that all agencies assess their clients on their presenting needs and consequently, not having a formal diagnosis would never affect the support offered to a person, it is notable that the Access Team's Consultant Psychiatrist recommended that they await the outcome of the LANCuk Autism assessment before a plan was formulated which affected a delay of two days. This review would suggest that this practice is brought to the attention of the Access Team with a request to consider and identify any single agency learning.

Learning 6: ***Some professionals felt in need of more training and support to assist them to achieve best practice when working with individuals with neurodevelopmental conditions, and all professionals demonstrated confusion around specialist services able to offer assessment of Autism Spectrum Disorders.***

7. Good Practice

7.1. The agency information submitted to this review and the discussions around Jacob, have highlighted examples of good practice[42] from professionals involved with Jacob and his family. Some examples are included in the body of this report, but others include:

7.1.1. The allocated Social Care Officer developed a good relationship with Jacob, and his family, and had knowledge and experience of working with adults living with autism.

7.1.2. The Social Care Officer worked quickly to complete assessment, recorded Jacob's views and feelings, identified, and reacted appropriately to Jacob's anxieties, and worked hard to identify a suitable care provider.

8. Developments to Systems and Practice since the Scoping Period of this Review

8.1. Agencies have already made some important amendments to practice since the scoping period of this review. Some of these developments have been included in the body of this report but in addition:

8.1.1. Northern Care Alliance has recently updated its policy in relation to Learning Disabilities to include Autism, and it now incorporates a hospital screening tool to potentially identify if a patient has or suspects a diagnosis which requires the reviewer to ask questions and identify specific needs for the person.

9. Learning and Questions for Bury Safeguarding Partnership

9.1. In order to address the learning identified within the report, the review would ask Bury Safeguarding Partnership to deliberate the following questions. It is the responsibility of Bury Safeguarding Partnership to use the ensuing debate to model an action plan to support improvements to systems and practice.

[41] The Oliver McGowan training on Learning Disability and Autism is the government's preferred and recommended training for health and social care staff.

[42] Good practice in this report includes both expected practice and what is done beyond what is expected.

Learning 1: *Professionals need to be curiously alert to cultural differences and incorporate this vital information into their support plans.*

Question 1: How can partner agencies assure Bury Safeguarding Partnership that work is being undertaken to remind and encourage professionals to practice an open-minded awareness of the differences that cultural background can produce?

Learning 2: *The caring needs of Jacob's parents were not sufficiently explored.*

Question 2: How can partner agencies assure Bury Safeguarding Partnership that their professionals are recognising carers and offering assessment, information, and advice and support?

Learning 3: *Jacob's parents/carers did not feel sufficiently advised about how to support Jacob with his mental health when he was experiencing suicide ideations.*

Question 3: How can Bury Safeguarding Partnership assure themselves that their suicide prevention action plan is up to date and effective?

Question 4: How can Bury Safeguarding Partnership be assured that suicide prevention information:

- **is encompassed within professional training, and how can its incorporation into practice be evidenced,**
- **being offered to family/carers/friends of people experiencing suicide ideation, and**
- **is reaching the community?**

Learning 4: *The support offered to Jacob was without agency oversight after a multi-agency opportunity to share information was missed.*

Question 5: How can Bury Safeguarding Partnership be assured that practitioners from all partner agencies understand their own responsibilities to lead on multi-agency meetings, in order to support more effective multi-agency information sharing and affect better risk management and case oversight?

Learning 5: *Jacob's presentation at university was not (on its own), an indicator that he was at risk of harm, but in the absence of information sharing between the university and professionals working to support Jacob outside of the university, the risk could not be fully determined.*

Question 6: How can partner agencies assure Bury Safeguarding Partnership that their information sharing policies include further education organisations and that further educational organisations are included within the partner agencies umbrella?

Learning 6: *Some professionals felt in need of more training and support to assist them to achieve best practice when working with individuals with neurodevelopmental conditions, and all professionals demonstrated confusion around specialist services able to offer assessment of Autism Spectrum Disorders.*

Question 7: How can Bury Safeguarding Partnership and partner agencies achieve a better understanding of the available support and diagnostic pathways for adults presenting with signs and symptoms in line with the neuro diverse community.

Question 8: How can the commissioners assure Bury Safeguarding Partnership of effective diagnosis and post diagnosis services?

Question 9: How can Bury Safeguarding Partnership ensure that the learning regarding neurodiversity within this Safeguarding Adult Review is considered against the action plans produced in response to the other Safeguarding Adult Reviews currently being undertaken in Bury, which are also considering autism?

10. Appendix 1 – Terms of Reference

Specific Areas for Consideration:

- The Voice of Jacob
- Information Sharing by Private Therapists/Centres
- Further Education Safeguarding and Information Sharing
- Cultural Understanding