The Oxfordshire Safeguarding Adults Board partnership is committed to ensuring that people with learning disabilities have the same opportunities during their lives as anyone else.

Oxfordshire Safeguarding Board established a subgroup three years ago to review the deaths of all people with learning disabilities, encompassing the Learning Disabilities Mortality Review (LeDeR) Programme. This panel meets regularly and includes service providers, commissioners and representatives of those that use services and family carers, currently this is Oxfordshire Family Support Network (OxFSN). Notifications of all deaths come from any agency, or the public through this link: LeDeR notification Link .

Individual reviews are undertaken including contributions from family and carers with summaries and themes being used to develop learning that can inform how services are developed.

During the COVID-19 pandemic this review process has been enhanced with a rapid (within 2 weeks) review of all cases. Locally this has been completed for every notified individual. We are not able to share data for fewer than five individuals as this may be identifiable.

The following points have been identified:

- In the first four months of 2020 there has been no increase in notifications of deaths of people with learning disabilities.
- All those reviewed who have presented with symptoms of COVID 19 have had care and treatment plans with full access to specialist support when this has been needed.
- There have been examples of clear planning between services to ensure that the individual can go home, with any additional support they may need.

If you would like to know more about the LeDeR reviews, please email occg.vamoxfordshire@nhs.net.