Worcestershire Safeguarding Adults Board

DOROTHY

A Safeguarding Adults Review (SAR)
V10 January 2023

Author: Karen Rees

Presented to Worcestershire Safeguarding Adults Board (WSAB) 30th March 2022

CONTENTS

1. INTRODUCTION

1.1. Dorothy was a 77-year-old lady of White British origin who had has been diagnosed with dementia which is a progressive degenerative disease. Dorothy's daughter had found it increasingly difficult to care for Dorothy at home. After a period of 5 weeks in hospital during which she was assessed for her care needs, Dorothy was placed in the Care Home. Dorothy died following a fall that occurred as a result of an altercation with another resident (Leonard) in the care home. Following the incident Dorothy was taken to hospital. During the journey to hospital Dorothy deteriorated and died 10 days later in hospital.

1.2. A safeguarding concern was reported regarding the incident; the safeguarding enquiry highlighted concerns regarding the suitability of the care home to manage residents with behaviours that challenge that both Dorothy and Leonard presented with. Dorothy was to be self-funded for support services and ongoing care until the UK Government's COVID-19 Hospital Discharge Service Requirements were put in place due to the pandemic response; Leonard was self-funded. Both had only recently moved to the care home following completed assessments

2. PROCESS AND SCOPE AND REVIEWER FOR THE SAR

2.1. The Terms of Reference, scope and methodology for the SAR can be found in Appendix 1. The review set out to cover a four-month period prior to the death of Dorothy. WSAB commissioned an independent reviewer to chair and author this SAR[1].

3. FAMILY INVOLVEMNT IN THE REVIEW

3.1. A key part of undertaking a SAR is to gather the views of the family and share findings with them. The lead reviewer and the board manager met with Dorothy's daughter and Leonard's wife. Their thoughts and comments are included within the report as appropriate to the learning.

4. BACKGROUND PRIOR TO SCOPING PERIOD

4.1. Dorothy met her husband when she was 16 and they had three children. The family emigrated to North America due to Dorothy's husband's job. Dorothy worked all of her adult life, whilst caring for her family. Dorothy's husband had a stroke and suffered from dementia which included significantly difficult behaviours. Dorothy cared for him until an incident that resulted him being sectioned under the Mental Health Act and detained in hospital. He was subsequently admitted to a care home due to his ongoing care needs. At this point Dorothy herself was developing dementia but the routine of visiting her husband was positive and gave her focus. Dorothy's daughter was concerned regarding the care that her father was receiving at the care home. Ultimately Dorothy's husband was admitted to hospital with significant pressure ulcers and died a few days later from sepsis. Dorothy's dementia continued to be of concern to her daughter and she cared for Dorothy at home for as long as she could. Following an admission to hospital two months before the review period a robust discharge planning

[1] Karen Rees is an Independent Safeguarding Consultant with a nursing background. Karen worked in safeguarding roles in the NHS for a number of years. Karen is completely independent of WSAB and its partner agencies.

meeting agreed that Dorothy could be currently managed at home being cared for by her daughter with replacement care and day centre recommended. These would be privately accessed and funded.

4.2. Dorothy's daughter contacted Adult Social Care in Area 1 (see table below) the next month as she was struggling to manage. This did not result in any assessment; the plans remained the same but with a view to seeking a Continuing Health Care Assessment (CHC)[2].

4.3. Leonard and his wife had been married for 43 years at the time of this review, enjoyed travelling having travelled all over the world. They were a very private family and had one daughter who did not live locally. Leonard was described by his wife as a very mild-mannered gentleman who is a loving and proud father. Leonard was diagnosed with vascular dementia when he was 62 years old; he continued to work until he was 66. As Leonard's dementia progressed more difficulties were arising. Leonard's wife was working whilst Leonard remined at home. Leonard was seen by the GP and referred to mental health services for assessment and support. Three months before the review period Leonard's wife contacted Adult Social Care as she was finding it increasingly difficult to cope with Leonard's aggressive behaviours. Leonard was referred back to Mental Health Services for further assessment and support. He remained open to those services into the review period

5. HOW DOROTHY AND LEONARD WERE PLACED IN THE CARE HOME

5.1. The scoping period will be divided into the journeys of Dorothy and Leonard into the care home. This will provide the relevant information for in depth analysis of where learning has occurred.

Leonard

5.2. Leonard went to live in the care home in advance of Dorothy, so his journey is recorded first. Five weeks prior to the start of the review period, Leonard had been seen by the older adult mental health team who had undertaken a GRiST[3] risk assessment. Leonard was assessed as low risk from the information gathered from Leonard and his wife at a home visit. Leonard was also seen by an occupational therapist who identified that Leonard was less capable of managing tasks than his wife believed. The assessment also indicated that Leonard was being affected by being at home on his own and a lack of stimulation when his wife was at work. Adult social care and older adult mental health services signposted Leonard's wife to sources of help and support.

5.3. Three weeks into the review period on a Sunday afternoon, Leonard became suddenly aggressive and carried out a significant physical assault on his wife who was recovering from major surgery. Leonard then called his daughter to tell her that he had hurt her mother. The daughter, who lived some miles away arrived later and on arrival, called Adult Social Care emergency duty team (EDT). EDT asked Leonard's daughter to stay overnight for protection and to phone the police if they felt in immediate

[2] **The Continuing Healthcare Checklist and the Decision Support Tool** form part of the National framework for NHS continuing healthcare and NHS funded nursing care https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

[3] **The Galatean Risk and Safety Tool (GRiST)** is a web based clinical decision support system for assessing and managing the risks of suicide, self-harm, harm to others, self-neglect, and vulnerability. GRiST is a mental-health risk-assessment approach that explicitly combines clinical judgements with empirical evidence

danger. The plan was for EDT to refer to the locality team on the Monday morning.

5.4. On Monday morning the locality team contacted Leonard's wife and it was agreed that she could no longer care for Leonard and that he would need to move to a care home. The social worker contacted the GP who shared information regarding the previous mental health referral and the diagnosis of vascular dementia. It was confirmed between the social worker and Leonard's wife that Leonard would be self-funding. A request was sent to Brokerage[4] to identify a suitable care home. A care home was identified, and a care plan was drawn up by the social worker to send to the identified placement. Leonard's wife took Leonard to the care home later the same day.

Dorothy

5.5. Six days into the review period. Dorothy's daughter contacted NHS 111 with several concerns for her mother. An ambulance was sent with paramedics assessing that Dorothy needed assessment in hospital. Dorothy was admitted to hospital from the Accident and Emergency department. All physical healthcare screening ruled out physical causes for change in behaviour. Dorothy was treated as a person with worsening dementia; a request for an assessment by a social worker was sent. It was noted that Dorothy had an ongoing physical healthcare condition whereby her drinking more than one and a half litres of fluid day could be dangerous. This needed careful observation as Dorothy would often not remember that she needed a restricted fluid intake.

5.6. Six days later Dorothy was deemed to be medically fit for discharge. It was noted that her daughter had requested, a CHC assessment to be undertaken. Dorothy was discharged on the 'discharge to assess' pathway to the community hospital to enable her to be assessed in an environment away from an acute hospital. (See further discussion in 7.35).

5.7. The CHC checklist was undertaken but this was contested by Dorothy's daughter who was not present at the time of the checklist being completed. The complex discharge team at the hospital were identifying suitable care home placements for Dorothy. At this point there were complexities due to rising concerns and restrictions related to the COVID-19 pandemic. It was just under two weeks before a care home was identified that would be suitable for Dorothy. Dorothy was admitted to the care home two days later and settled well. Following some confusion regarding where the care plan was and who had completed it, a care plan was sent to the care home in respect of Dorothy's needs. Dorothy was initially anxious but settled well.

6. THE INCIDENT

6.1. 11 days after Dorothy was admitted to the care home an incident occurred between Dorothy and Leonard. Leonard was holding a cushion in his hand as he walked past the lounge where Dorothy had previously entered. Dorothy came out of the lounge, approached Leonard and challenged him for the cushion which resulted in an altercation and subsequent pushing by Leonard. Dorothy fell backwards to the floor hitting her head on the door frame. Dorothy remained conscious and was transferred into a

[4] **The Local Authority Brokerage Team** in this instance have the responsibility for sourcing appropriate emergency placements. The selected care home indicates if they can meet the needs of the person. A detailed support plan is then sent to the home.

wheelchair and taken to the office. An ambulance was called, and Dorothy was conveyed to hospital. During the transfer, Dorothy suddenly deteriorated, she was assessed in hospital as having a large bleed on the brain. Dorothy died ten days later.

7. ANALYSIS AND LEARNING

7.1. The analysis section takes a strengths-based approach identifying what went well and then building a picture of areas where learning has been identified, as well as further steps that should be taken to achieve stronger systems. Systems and services that worked with Leonard and Dorothy have been updated and improved since this case. This is due to natural ongoing improvement, service changes, and elements that have been changed already due to early learning from this review.

7.2. The following table is presented to support understanding of which services were involved with each person during the review period.

Agency/Service	Leonard	Dorothy
The Care Home	✓	✓
Area 1 Council • Locality Team • Trusted Assessor Service		✓ ✓
Area 2 Council • Area Social Work Team A, • Area Social Work Team B • Emergency Duty Team • Brokerage	 ✓ ✓ ✓ ✓	
Area 1 and 2 Health and Care NHS Trust ○ Community and Assessment Recovery Services Older Adult Mental Health Team ○ Neighbourhood Team Advanced Nurse Practitioner	 ✓ ✓	 ✓
Area 1 and 2 CCG: ○ GP ○ CHC Team	 ✓	 ✓ ✓
Area 1 NHS Trust ○ County Hospital ○ Community Hospital		 ✓ ✓
Ambulance Service		✓
Police	✓ Post incident only	

Assessment and Placement of Leonard

7.3. Leonard had been referred to older adult mental health services prior to the review period and was still open to services at the start of the review period. The older adult mental health team had assessed and signposted Leonard's wife to services to support Leonard to remain at home and his wife as carer. The assessment had shown that Leonard's wife thought that Leonard could undertake more tasks than he could. Leonard's wife worked full time and told the author that she was not able to investigate or access the support services such as carers support or replacement care as those services were only available during working hours. Some of this will be picked up in a later part of this report.

7.4. The risk assessment was scored as low on the basis that there had been 2 isolated incidents of physically 'challenging behaviour' that had a clearly identifiable trigger. There was no indication of agitation, irritability, hostility, paranoia that may have indicated a higher risk at that time. As part of Leonard's presentation of advanced dementia, he had expressive dysphasia[5] which caused frustration for both Leonard and his wife. It was believed by the older adult mental health team that this was a contributing factor to the individual aggressive episodes. Leonard's wife told the author that it was when Leonard was looking for his father who had died years before, that he got most upset and agitated; agency reports for the review support this.

7.5. The assessment, intervention and support by the older adults mental health team was strong practice and in line what would be expected. They had identified that being at home all day on his own was difficult for Leonard and that stimulation from somewhere like a day centre would be helpful for him as well as some replacement care and carer support for his wife.

7.6. On the day of the most significant attack, Leonard's wife told the author that she was no longer safe to be in the house with Leonard and had considered leaving the house to go to safety. Leonard's daughter telephoned Leonard's wife stating that she had had a call from her dad to tell her that he had hurt her mother. The situation had reached a critical point. The daughter's action to drive to support her parents prevented Leonard's wife leaving the house. They called the Emergency Duty Team which was an appropriate decision.

7.7. The action from the emergency duty team considered the safety of Leonard's wife. The request to the daughter to stay overnight to ensure that the parents were supported with advice to call the police if any other violence occurred was on the face of it seemingly a safety plan overnight until the locality team could get involved the next day. No medical opinion was sought regarding the dementia to see if a mental health response was required; there was no evidence on record systems visible to social care that Leonard was known to mental health services. Had this been available it may have supported the considerations to involve MH services at this time.

7.8. This decision was discussed at length in the workshops to understand if practice could have been stronger in this area. There were several elements that were missed. Leonard had carried out a serious attack on his wife that had caused her injuries and leaving her scared to be alone with her husband. The motivation behind the attack was not in the control of Leonard due to his diminished ability to observe

[5] **Expressive dysphasia** is a difficulty in expressing what you want to say. This may be in the form of speech but may also affect their writing and reading aloud abilities. Speech may be non-fluent, and a person may find it difficult to find the right word for something. For example, when describing the television remote, someone may point to the television and stutter and hesitate whilst trying to find the correct word. This can be incredibly frustrating for both the person affected and their family and friends. https://www.slt.co.uk/conditions/neurological-problems/expressive-dysphasia/#:~:text=Expressive%20dysphasia%20is%20a%20difficulty,the%20right%20word%20for%20something

reality and control his frustration. The incident and outcome for Leonard's wife, however, was the same as in any domestic abuse incident.

7.9. The incident was not recognised as domestic abuse or that this was a safeguarding incident that required a specific response. The emergency duty team should have involved the police as a domestic abuse incident. This would then have triggered a response to visit the family and risk assess the situation using a DASH risk checklist[6]. A more thorough safety plan may have then been put in place.

7.10. A safeguarding concern should have been raised and a decision made relating to whether the concern met the criteria for a Care Act section 42[7] enquiry or other response. It is not clear that the outcome of the decision to admit to care home would have been any different, but the rationale, process and decision making would have been clearly recorded on the social care system.

7.11. In trying to understand why this incident did not receive the expected response, it was identified that there was a gap in the emergency duty team system. The system predominantly deals with child safeguarding and other issues out of hours but also covers adult emergency cases out of hours. The gaps that were identified were multi-facetted and have been analysed in the Area 2 Adult Social Care report with recommendations made to strengthen practice.

7.12. Stronger practice needs have been identified related to the following:

- Clarity on raising an adult safeguarding concern
- Ensuring on call manager is contacted for advice regarding complex adult care cases (the only Adult Social Worker had gone home at 5pm)
- Recognition of domestic abuse in older people in a case where behaviour challenges, specifically in dementia
- Seeking GP support out of hours for adults
- Recognition that adult carers are afforded the same protection as people with care and support needs under the Care Act (the 'victim' was not seen as the person with care and support needs).
- Identifying appropriate access for social care staff to health recording systems.

7.13. The emergency duty team on call manager was previously available 24 hours a day. This has been reduced until 10pm. The impact of this has been assessed as a safe option as there is availability of a children's social care on call manager and the fact that audit identifies very few adult calls received after 10pm.

7.14. It is of note that the weekend of the incident was the start of the national lockdown due to the Covid pandemic and therefore no face-to-face social work visits were taking place; this may also have been a

[6] The purpose of the domestic abuse, stalking and honour-based violence **Dash risk checklist** is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify those who are at high risk of harm. https://safelives.org.uk/practice-support/resources-identifying-risk-victims-face

[7] **The Care Act 2014 (Section 42)** requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom. 2014 HM Government The Care Act 2014; https://www.legislation.gov.uk/ukpga/2014/23/resources

barrier to a thorough assessment of risk at that point. The police, however, had not changed their process and would still have undertaken a DASH risk assessment face to face, had they been notified of this incident.

7.15. There was evidence of strong practice when the case was handed over to the locality team the next morning. The social worker contacted Leonard's wife and gathered the recent history. The severity and frequency of recent incidents was shared by Leonard's wife. It was ascertained from Leonard's wife that Leonard would not accept carers and that they would be self-funding. The social worker discussed Leonard's mental capacity to decide on his living arrangements. Leonard refused to speak to the social worker on the phone; Leonard's wife said that she doubted that he had capacity. The social worker recorded that Leonard's wife and daughter were the decision makers and that Leonard needed to go into care. Following a discussion with the manager it was agreed that the social worker would contact the Brokerage Team to identify a suitable care home and then let Leonard's wife have the required information to decide on which home he would go to.

7.16. Further stronger practice was evidenced when the social worker then contacted the GP. The GP confirmed Leonard's diagnosis. The GP shared that Leonard had been seen by older adult mental health services three months previously. The GP also stated that from the records they did not think that Leonard would have capacity. With this information and the information from Leonard's wife it was agreed and recorded that Leonard did not have the mental capacity to decide on his living arrangements and that his daughter and wife were the decision makers. This was done because of the urgent nature of the situation. It is of note that Mental Capacity Assessments face to face could not take place by social workers at that time due to the pandemic and lockdown.

7.17. There is a debate here regarding whether this was the right approach given the level of violence and difficulties that Leonard had perpetrated against his wife. There were other options available. It would have been more in line with the Mental Capacity Act that, having recorded the assessment of capacity, that a Best Interest decision was made based on the assessment outcome. The social worker could have been the decision maker in these circumstances or could have supported Leonard's wife and daughter in their decision-making.

7.18. Legal advice to the review has indicated that the social worker is the decision maker in terms of how a person's eligible needs are to be met – i.e., the social worker decides how to meet the needs and what the care plan should be usually in discussion with the person. This is then offered to the person or their Attorney, who can either accept or reject the care plan. If the Attorney rejects the care plan and that is thought not to be acting in the person's best interests, then there could be an application to the Court of Protection to either revoke the Lasting Power of Attorney or make Best Interest declarations on the person's behalf. In this case, Leonard's wife did not have a Lasting Power of Attorney for Health and Welfare, only for property and finance therefore, although Leonard's wife could be the decision maker related to the self-funding element, she could not be decision maker in terms of Leonard's care and support needs. There was no disagreement from Leonard's wife, however the recording should have shown that the social worker was the decision maker and that there was a Best Interest decision made.

7.19. Mental health services could have been contacted to undertake a mental health assessment, this may have led to a face-to-face mental capacity assessment and admission to hospital if that was deemed

appropriate or further information for a Best Interest decision.

7.20. The social worker completed an assessment document and support plan. This was sent to the brokerage team to enable them to have the required information to enable an appropriate placement to be found. The support plan identified the behaviour that challenges that Leonard had presented with.

7.21. A placement was found the same day and the home identified that they could meet Leonard's needs; the social worker sent the assessment before Leonard moved to the home. Leonard's wife and daughter took him there later that day.

7.22. There are several areas that were discussed in the practitioner workshops where areas for stronger have been found.

7.23. Following the conversation with the GP there was no check with mental health services regarding the previous involvement. No one working with Leonard at that time knew that he was still open to the older adult mental health team. The older adult mental health team did not know that Leonard had moved to a care home until they were contacted after the incident. This information would have been known if the social worker had contacted the Health and Care Trust to check records of who else was involved. The advanced nurse practitioner who visited the care home to see Leonard soon after admission could also have checked records to see if there were any other professionals involved. Area 1 and 2 Health and Care NHS Trust have included this in their single agency recommendations for this review.

7.24. There was no consideration of a safeguarding concern being raised in respect of Leonard's wife or any signposting for support services that could help her in the circumstances that she had found herself in i.e., as a victim of abuse from her partner.

7.25. There was a further complication with the care home in that it had been previously deemed inadequate by CQC and was operating under contractual restrictions agreed between the local authority and the home at the time that Leonard was admitted. Although admissions had been recommenced due to improvements being made, there was still a condition that no one with 'challenging behaviour' should be admitted.

7.26. The usual process through the brokerage route would be to ensure that the needs of the person fitted the care home and that any restrictions would be understood. This did not happen. The system of checking for restrictions relies on a manual check on a spreadsheet that is updated regularly. There is no evidence as to whether this document was checked. The brokerage team have not been able to verify what was contained in the support plan to understand why the home was found to be suitable despite restrictions and Leonard's behaviour, as it was deleted from the system. This error was due to an early issue with a new recording system, whereby, in order to prevent self-funders being charged, support plans and documentation were deleted before the next stage in the process that would be to fund the placement.

7.27. The learning from this for the brokerage team had been recognised prior to the review commencing, when initial information was gathered post incident; changes that will prevent future errors of this nature occurring have been put in place and further system improvements are planned.

7.28. The next question was then why did the care home admit Leonard, when they knew of the restrictions that were in place? This has remained unanswered as the whole management team has been replaced to make the significant improvements that were required. The current team have assured the review that they would not have admitted Leonard given the assessment that they had seen.

7.29. The attendees at the workshops questioned what the term 'challenging behaviour' means; there is further learning here. Safeguarding Reviews can often highlight issues of recording. The author considers that the use of labels can also be recognised as a recording issue; 'challenging behaviour' is one of those labels. It does not tell you exactly what that means, is subjective, and therefore can make risk assessment more difficult. This 'label' could include anything from slight agitation to behaviour that identifies significant risk to carers, professionals, and others. Labels need to be qualified by clarifying what is meant so that the risk level can be understood and assessed appropriately.

7.30. It is of note that despite all these difficulties Leonard responded well to the activities and stimulation of being around others; his aggression was not seen, and any early signs of agitation were resolved by distraction techniques. Leonard's observed behaviour was no different to other residents that would be usual in a care home of that nature. It is always a risk, however, that with significant and complex cognitive loss, there is always the potential for a thought or incident to trigger an event of behaviour that challenges with this often being unpredictable. (See later section).

Points for strengthening practice:

- Ensuring a skilled workforce within EDT related to adults with Care and Support needs, with early access to on call managers will lead to better outcomes for those in crisis.
- Auditing the use of on call managers may provide further learning.
- Recognition of domestic abuse incidents between older couples may widen the network of assessment and support services. e.g. DASH risk assessments.
- Professionals involved in supporting or arranging admission to a care home being aware of and adhering to any restrictive agreements is important to ensure people have access to safe and effective care.
- Professionals being encouraged to explain 'labels' in their assessments and recording can provide for improved risk assessments.
- Gathering information from all available sources as well as seeking to improve systems sharing, will ensure that history of other services' involvement is included in current assessments.

Assessment and Placement of Dorothy

7.31. It was agreed within the workshops that the extensive family history gathered by the reviewer was not known to those that were assessing Dorothy in the time frame of the review. Whilst this did not impact on the assessments that were undertaken, it could have been helpful to those who were trying to understand Dorothy's daughter's actions and the ongoing disputes (see later in the report) regarding

assessments.

7.32. The hospital admission discussed in 4.1 sets the context for the review period.

7.33. When Dorothy was readmitted within the review period there was evidence of increased confusion, paranoia, and a concern regarding her physical health. The extent of this was such that Dorothy's daughter stated that she could no longer care for her mother at home.

7.34. Seven days later, Dorothy was physically fit for discharge. Dorothy's daughter had requested that her mother be assessed for CHC funding. This had previously been discussed with the social worker allocated to Dorothy just prior to the review period. It appears that there were conversations between the social worker and Dorothy's daughter that related to inaccurate information being given regarding the CHC assessment process. The Area 1 council report addresses this issue stating that this would not have been helpful as the process progressed. The reasons this occurred cannot be identified as there is little recording; the social worker was from an agency and is longer working with the council.

7.35. Dorothy was transferred to a community hospital to allow for further assessments of needs and so that the CHC assessment could be undertaken. It is noted as preferred practice[8] that the CHC checklist (the start of the process for assessing for CHC eligibility) should be commenced following acute hospital discharge to ensure that longer term needs can be assessed more accurately, and that acute hospital discharge is not delayed whilst awaiting the checklist to be completed. The community hospital was therefore the most appropriate environment for this to be undertaken.

7.36. Dorothy's daughter had contacted the ward to make it clear that she did not want her mother's CHC checklist undertaken without her present. The CHC checklist was completed which resulted in a score that did not indicate that Dorothy was eligible for CHC funding; Dorothy's daughter had not been involved in the completion of the checklist. In the workshops for the review, professionals told the author that this was an inadvertent mistake as there had been an intention to include Dorothy's daughter. Albeit that all visiting had been suspended due to the covid pandemic, Dorothy's daughter could have been included over the telephone.

7.37. Dorothy's daughter had a firm belief that her mother did meet the criteria for CHC funding, and this resulted in a dispute between Dorothy's daughter and the hospital that was not resolved. A CHC checklist cannot be changed as the assessor assesses the needs of the person at the time. The CHC checklist was revisited during the workshops and discussed with those that had known and cared for Dorothy. All agreed with the outcome of the assessment.

7.38. It was agreed within the workshops that to not involve Dorothy's daughter was a likely trigger point to a breakdown in any relationship and caused friction. Dorothy's daughter then focussed on the CHC checklist, which added delay to the discharge. Discussion at the workshops also related that that professionals may not have a full understanding of what life can be like for carers who are struggling with understanding dementia (picked up in next section). It was identified that better communication

[8] See para 109
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/746063/20181001_National_Framework_for_CHC_and_FNC_-_October_2018_Revised.pdf

with families is important. There was also some learning for the CHC team as the form that was submitted did not have the right consents on it and should have been returned. Due to improvements from the merger of Area 1 and Areas 2 CHC teams, the electronic system would now prevent this from happening.

7.39. Once the CHC checklist had indicated that nursing needs had not been identified the search for a suitable placement for a person with dementia commenced. At the time in Area 1, there was a trusted assessor process in place. This process was a scheme whereby care homes could sign up and have the assessment of the person's needs undertaken by an independent assessor. This would be shared with the care home who had been approached to offer care to a person but was not shared with anyone else. This process was undertaken for Dorothy.

7.40. The allocated social worker visited Dorothy in hospital and carried out a Mental Capacity assessment and evidenced that Dorothy did not have capacity to decide on her living arrangements; the trusted assessor then went on to undertake the assessment.

7.41. The situation regarding funding hospital discharges then changed following the government's response to the pandemic. To expedite discharges and relieve the bed crisis situation, funding would be available for all those needing care home or ongoing care packages. The CHC nurses moved to be part of the discharge team at the hospital in Area 1. Therefore, although Dorothy had not reached the criteria of CHC funding, her care home placement was to be funded via the COVID-19 Hospital Discharge Service Requirements at least for a while (the system remained the same for six months).

7.42. The way that services were able to adapt to the new process, switch roles and undertake new ways of working practically overnight was one of the positive elements of working through the pandemic crisis. This evidences extremely strong practice and should be applauded. It also provides for evidence that change can happen swiftly and can be of benefit to those in receipt of services.

7.43. The impact of the Covid pandemic on finding a care home who would accept Dorothy though, was significant. The discharge team described several issues that they faced:

- some care homes, including the one that the trusted assessor had been asked to assess for, would not accept Dorothy without a negative Covid test particularly as there had been an outbreak on the ward; Covid tests within the NHS were not available to non-symptomatic people at that point.

- Some care homes were concerned that as Dorothy walked about and this was particularly of concern as she suffered from sundowning[9], they stated that they could not accept residents who were unable to be isolated for 14 days post admission.

[9] **Sundowning i**s a term used for the changes in behaviour that occur in the evening, around dusk. Some people who have been diagnosed with dementia experience a growing sense of agitation or anxiety at this time. Sundowning symptoms might include a compelling sense that they are in the wrong place. The person with dementia might say they need to go home, even if they are home; or that they need to pick the children up, even if that is not the case. Other symptoms might include shouting or arguing, pacing, or becoming confused about who people are or what's going on.https://www.dementiauk.org/get-support/understanding-changes-in-behaviour/sundowning/

7.44. Although there is clear learning here, it is important to note that at that stage the pandemic response was new and unprecedented. Rules were changing daily and there was a lot of fear and confusion. Later in the pandemic much of these issues were resolved as people settled into what was quoted as being the 'new normal'.

7.45. It was suggested, due to these difficulties, that the search area was widened, and a placement was found at the care home in Area 2. The trusted assessment was not available then as Area 2 homes were not signed up to the process. The assessment that was undertaken by the discharge team was emailed to the home the day before admission. Dorothy's daughter was informed that a care home had been located and that transfer arrangements had been made. During the workshops it was discussed that the care home was very used to supporting residents with sundowning and who walked with purpose.

7.46. Dorothy's daughter was not happy that she not been involved in choosing a care home and that her mother had been transferred at short notice on a Sunday afternoon. Due to the pandemic, the process for finding care homes for people who were in hospital, at this point was that it would be the first available and suitable placement and there would be no choice. This was hard for families put in this position. Dorothy's daughter was also concerned how long the agreed funding would last for and the fact that the care home was still rated by CQC as 'requiring improvement'. The care home could admit one resident per week, so this was in line with agreements in place at the time.

7.47. In considering the learning here it was agreed in the workshops that this admission was very rushed. It must be noted again that this was in the context of the rising concerns regarding the pandemic and the need to move those patients who were fit for discharge out of hospital as soon as possible.

7.48. There is no clarity as to whether Area 1 local authority contacted the host authority to undertake the usual quality assurance checks or that the discharge team did this prior to the placement. It appears in the rush to place Dorothy after a delay of many days with care homes not accepting her, and the knowledge that there was a positive covid case identified at the community hospital, that this important element was missed. It is of note that the usual process in place in line with The Association of Directors of Adult Social Services (ADASS) Advice Note for Commissioning Out of Area Care and Support Services[10] was for these checks to be undertaken and there is no evidence that this would generally be missed. The CHC team now have a clear policy in place for out of county placements.

7.49. All the evidence at the time suggested that the care home could meet the needs of Dorothy. There is one element that should have been clarified. The assessment by the discharge team had indicated that Dorothy did have a history of presenting with behaviour that challenges and could become agitated and show aggression particularly due to the sundowning effect. There was no evidence of physical or verbal aggression identified in that assessment. It came to light during the safeguarding enquiry following the death of Dorothy, that the Trusted Assessor assessment did have more evidence of the challenges that Dorothy could present. It appears that the trusted assessor had contact with Dorothy's daughter to complete the assessment and that the discharge team spoke to the community hospital staff who were

[10] Advice Note for The Association of Directors of Adult Social Services (ADASS: Commissioning Out of Area Care and Support Services) Advice_Note_commissioning_out_of_area_care_and_support_services.pdf

caring for Dorothy. Both had contact with those who had or were caring for Dorothy, but the history of presenting behaviour was missed in the later assessment.

7.50. It is not clear if the two elements above are linked and that it was urgent nature of the placement in respect of the very fluid and changing nature of practice at the time being impacted on by the pandemic. It should be noted that the assessment did provide clarity that Dorothy could present with behaviour that challenges which was in contravention to the agreements in place as discussed previously.

7.51. Once admitted to the care home, contact was made with Dorothy's daughter over a few days to glean information to inform the care plans. This was strong practice and evidenced that it was important to keep family involved even though there could be no visits.

7.52. The same analysis and learning therefore also apply here as in the previous section regarding Leonard.

Points for strengthening practice:

- Keeping families up to date with rationale for decision making, plans and transfers may help families feel more involved even if there are other constraints placed on usual practice.
- Involving families and carers in assessments ensures all information necessary is used to assess needs.
- Out of county placements that are pre checked with host authorities in line with national guidance keeps people safer.
- Supervision of staff can add checks and balances into practice and ensure practice standards are maintained especially where families are demonstrating concerns.

Resident on Resident Abuse or Harm

7.53. The incident that occurred was an altercation over a minor issue (see para 6.1) but the impact of the way that Dorothy fell caused the tragic circumstances that led to this review. Whilst some resident-on-resident abuse is of a very serious nature, this incident was minor in comparison. It is of note therefore for learning, that all resident-on-resident incidents could result in trauma and tragedy, mostly of an accidental nature where cognitive impairment is a specific issue. This means that there should be action taken to minimise the risk of these incidents occurring.

7.54. A very recent publication[11] identified that research in the UK was limited in the area of resident-on-resident abuse and harm, but by reviewing wider research, there were some key findings that would offer elements that need to be in place. This would enable recognition of possibly normalised incidents as abuse or harm and to ensure a consistent reporting and response in recording and preventing incidents wherever possible. Post incident actions to understand risks and trigger points would need to follow. The report identifies various strands of reduction strategies including, robust assessment of histories, staff training, person centred care plans identifying what might trigger agitation, ensuring adequate resources and staffing to enable residents to be occupied and supervised so that altercations

[11] Mitchell, D. Sheikh, S. & Luff, R. (2021) **Resident-to-resident harm in care homes and other residential settings: a scoping review** by the Social Care Institute for Excellencehttps://www.scie.org.uk/safeguarding/evidence/resident-to-resident-harm

can be deescalated quickly.

7.55. Whilst some care homes may have good strategies in place there is learning for those that do not that may prevent and reduce incidences of resident-on-resident abuse. It is noted that there had not been any previous incidents involving Leonard or Dorothy in the home; this learning though is important in possible future prevention and monitoring levels of incidents.

Points for strengthening practice:

- Use of current advice from research may help in the reduction of resident-on-resident harm in care homes

Caring for the carers

7.56. The histories that both families told the author had similar themes and therefore it is important to identify learning when working with family carers who are under enormous stress.

7.57. Leonard's wife had been attacked and injured by the person that she had loved and been married to for many years; he had never been violent or abusive during their life together. Leonard's wife worked full time, was recovering from significant surgery and had no family close by to support her.

7.58. With Dorothy's daughter she had many years of caring for her father with advanced dementia who displayed very difficult behaviours often in public places. As mentioned previously, Dorothy's husband was eventually admitted to a residential placement where it was reported that he received poor care, was admitted to hospital with grade four pressure ulcers and died of sepsis. Dorothy's daughter also had her own significant health concerns.

7.59. These were the contexts with which these carers came to the attention of services in the review period. At the workshop it was discussed whether professionals that work with dementia daily can really understand this and put themselves in the shoes of family carers.

7.60. The Care Act recognised the excellent job that family carers undertake, with the knowledge that the pressures of caring can have a significant impact on the carer. The Care Act made it statutory that those providing care are offered a carer's assessment which considers eligibility for support.

7.61. This review recognises that the carers in this case offered carers assessments and signposted to appropriate carer support networks, day centres and replacement care that may help. This was strong practice and meant that the professionals working with the families understood the pressures that carers can be under; neither carer took up these offers.

7.62. The carers identified that they had reached the realisation they were no longer in a position to where they could manage to look after their family member. Leonard's wife told the author that she was a private person and no one they knew had any idea that Leonard had advanced dementia. This meant that she was managing without support of friends and being able to talk about how she was feeling.

7.63. The lifestyle changes that must be made as dementia progresses can also be significant for family carers e.g., Leonard and his wife had travelled all over the world and this had now ceased sooner than they had planned.

7.64. It was discussed in the workshops that in general, families know very little about dementia. Even if they have some knowledge, knowing the best way to manage the manifestations of different types of dementia, e.g., looking for a deceased loved one, agitated regarding a certain situation, are not understood. This may then lead to a worsening situation. One professional at the workshop stated that the media does not help this situation with representations of living with dementia displaying a 'quietly muddled' person often not communicating and sitting in a corner. Very rarely does the media portray the reality of frustration and confusion leading to displays of aggression and sometimes physical violence.

7.65. Advancing dementia is difficult to come to terms with for carers. Their loved one is no longer the person that they have known and with that comes denial but also no knowledge of how to manage that emotionally. Those that specialise in dementia care point out that it can take several years for families to learn to understand and be able to grieve for the person that they have lost whilst celebrating the person that they were. There are different types of dementia, and each person is different, therefore caring for carers also needs to be different i.e. person centred as opposed to service centred. e.g., Leonard's wife worked and could not access day services or make calls during working hours. Working out what will help for each person may achieve greater acceptance of help and support.

7.66. If carers are not supported to understand dementia type and specific prognosis, it may be difficult for them to know how to manage the challenges of caring for a person with dementia. Understanding how carers may feel about possible guilt, shame and privacy may be an indicator of why Dorothy's daughter and Leonard's wife declined help and support.

7.67. If professionals were able to enquire further why support services were declined, or not actively sought out, a better understanding may lead to resolution and acceptance of support. This was discussed in depth at the workshops with learning identified.

7.68. The author would suggest that in cases where the support has been refused it may be because they do not see the benefit and may think it is an indication that they are unable to manage alone. The older adult mental health team informed the review that, all patients who are diagnosed with dementia by mental health services are offered post-diagnostic counselling which includes education about the illness if needed. They are also offered the opportunity to attend "Living Well with Dementia" and/or Carer Support Groups. There are also options to be supported by the Admiral Nursing Service. Leonard's wife was offered these services but declined due to work commitments.

7.69. Carers could also be better understood and supported if their back story is known in relation to previous lifestyle, working commitments being a respite for carers, as well as previous experiences of the care and support sector. These things can have a significant impact on how the care and support

sector is seen and how carers might respond.

7.70. Other learning relates to the fact that both the people with dementia in this case would be self-funding for the services that were on offer. Both carers reported having been given information regarding what replacement care services were available and left to go away and think about what would be suitable and make approaches and source the services by themselves. Both carers told the author independently that they had never had experience of such services and did not know what they were looking for. In the case of Leonard's wife, as explained before, working full time made this more difficult. As a result, neither carer made any enquiries and day centre, and replacement care services were not accessed.

7.71. Day services and replacement care not only support carers to have a break but are also of huge benefit to the person with dementia through the stimulation, routines and mixing with others. This is known to often slow the progress of dementia and should be routine sources for dementia care whether self-funding or funded.

7.72. The author would suggest that if Dorothy and Leonard had been funded by adult social care or health funded, the families would have had more support and it would have been a more collaborative approach in identifying and accessing the right support.

7.73. This view is backed up from recent research[12] that suggests as the threshold for care funding increases and the need for care increases, that the estimated number of between 170,000 and 290,00 people in England are thought to be self-funders and pay for their own social care. This number is an estimate because these figures ae not recorded even if there has been an approach to social care in the first place. The research findings show that older people in England who pay for social care from their own funds receive little help in seeking and arranging care compared to older people funded by their local council or health. This suggests an implicit assumption that people funded by local councils need help to manage their care whereas self-funders do not.

7.74. It is of note that a carers network/support service could very well be a supportive in this element, but where it is absent then support should be offered by those professionals involved. The local association of carers is open to self-funders; this support was offered both during the timeframe of the review and post review.

7.75. The research also evidences there are some key skills required in order to arrange social care. the relevant ones from the list are included below:

- the ability to search for and manage information about their options
- objective decision-making between options
- the ability to manage money and budgets
- administrative skills to manage paperwork

[12] Baxter, K. Wilberforce, M. & Birks Y, (2020) What Skills Do Older Self-Funders in England Need to Arrange and Manage Social Care? Findings from a Scoping Review of the Literature, **The British Journal of Social Work,** bcaa102, https://doi.org/10.1093/bjsw/bcaa102

7.76. Whilst some people may have the support of family and friends that may help, some do not; the carers in this case did not. The research points out that these are the skills usually akin to senior managers in social care rather than older people or their families.

7.77. It appears that this is a national issue and a local one that should be addressed, possibly because there is a lack of understanding amongst professionals regarding the issue. There should be no difference in the service offered as there is no distinction in the Care Act that the level of support is different if a person is a self-funding client. The Adult Social Care agency review has identified this as learning. Social workers have indicated that it is the rarity of the situation that has led to the issue arising. Procedures are now being written to provide clarity.

7.78. In this case, the urgent nature of the need in respect of Leonard, and the Covid pandemic in the case of Dorothy, took over and homes were found, but that meant placements were made with limited involvement from carers. The author would suggest that this was largely unavoidable.

7.79. In this case the impact of the limited earlier support available to the carers led to missed opportunities for stimulation for persons with dementia and replacement care for family carers under stress. The situation also led to increasing frustration and disputes with professionals in the case of Dorothy's daughter.

Points for strengthening practice:

- Understanding family history can be important in having a more in depth understanding of carer stress
- Wherever carers refuse assessments and support there should be a revisiting and further explanation of what support could be available and trying to understand the rationale for refusal.
- Offering carers more support to understand dementia and the likely challenges may offer more information that would help and support the person with dementia and their family.
- The service offered should be the same whether a person is self-funding or not.

8. SUMMARY AND CONCLUSION

8.1. At the time of writing this report there was an ongoing coroner's inquest and as such the author is not able to comment on the incident more fully. What this review can say is that Dorothy and Leonard had an altercation that led to a fall in which Dorothy received a head injury and subsequently died.

8.2. This review gave an opportunity to assess the processes that were undertaken to understand whether assessments identified that the chosen care home could meet the needs of each person.

8.3. Throughout this review strong practice in various services has been identified as well as systems and processes adapting quickly when the Covid 19 pandemic was taking hold.

8.4. Practice needs strengthening in out of hours support for adults with care and support needs and their carers at the point where they are in crisis. Safeguarding risks and ongoing safety concerns need to have robust risk assessments that lead to ensuring the safety of all concerned.

8.5. The labels and language regarding the use of 'challenging behaviour' need to be clarified so that the appropriate services can be sought based on fact and not assumptions. The term challenging behaviour should be referred to as 'behaviour that challenges'. This label should give some indication of exactly what is meant as a guide to all those who are assessing people who may have a level of agitation.

8.6. Ensuring that any local agreements on restrictions that are in place regarding placement in care homes is the responsibility of not only the placing authority and hosting authority (where they are different) but also the care home. Systems must be able to ensure that such agreements are observed. Despite the system error, Leonard did not display aggression to the level he had at home.

8.7. Dorothy's CHC assessment was appropriate albeit that there were many questions posed along the way by her daughter who was concerned to find the right care and appeared to be doing this with little support. The assessment prior to placement had not picked up the level of challenge that Dorothy sometimes presented that the Trusted Assessor assessment had done, and she too was admitted to the care home against the agreements in place. Ultimately when it came to the actual placement, the covid risk took over and Dorothy was placed without her daughter's input and without the Trusted Assessor assessment that had been undertaken. Dorothy's daughter would not have chosen a home that was in 'special measures' with mutually agreed suspension, after the experience she had with her father.

8.8. This review evidences a considerable amount of learning regarding support for carers and really understanding their needs. There is also learning relating to ensuring that people who self-fund and their carers, do not receive a different service when trying to find the right care and support, than someone who is funded.

8.9. Ultimately, although there have been some notable areas for strengthening practice, the incident may well not have been preventable. The type of issue that led to the altercation would not be unusual in a care home for people who are in the advanced stages of dementia who, at times may struggle with confusion and agitation. It is noted that Leonard should not have been in the home because the nature of his behaviour was against the agreements set for admissions to the care home at that time, however it was not this type of behaviour that was displayed in the incident. Dorothy, albeit she had not displayed the level of violence that had been triggered in Leonard previously, may also have been considered as having behaviour that challenges that met the suspension agreements. The type of behaviour that she displayed during the incident had been previously identified in assessment. A new scoping of research regarding resident-on-resident harm may provide strategies to ensure a reduction in incidents of this nature and recommendations for improvements are made as a result.

8.10. Albeit that the incident happened in a care home who had agreed to two admissions that were against the agreements in place at the time, if all agencies ensure that their systems for assessments and placements are robust then residents should be in appropriate placements that can meet their needs safely.

8.11. The learning points for strengthening practice throughout this review lead to recommendations.

9. RECOMMENDATIONS

9.1. Many of the issues that occurred in this case related to single agency learning; where this is the case those agencies have made relevant recommendations to address these. WSAB must seek assurance that those recommendations are underway and that they have been impactful.

1. Domestic Abuse in Older couples

- WSAB should share the learning from this SAR with the newly formed Worcestershire Domestic Abuse Partnership Board. This should include a precis of the issues and nuances of the case to be included within an upcoming conference.
- WSAB request that all domestic abuse and safeguarding adult training includes at least reference to domestic abuse in older couples especially where the abuse is happening as part of dementia where no previous abuse existed.

2. Placement Safety

- Agencies across Hereford and Worcester who may be involved in managing, receiving and supporting placements will be reminded of the Association of Directors of Adult Social Services (ADASS) Advice Note for Commissioning Out of Area Care and Support Services[13] via the briefing for this SAR.
- WSAB and HSAB must undertake a joint audit of recent self-funded and other placements that have involved brokerage and/or Care Act and CHC assessment to test out the safety of the placement system.
- WSAB should assess via a sub group or other identified relevant resource the Mitchell, D. Sheikh, S. & Luff, R. (2021) **Resident-to-resident harm in care homes and other residential settings: a scoping review** by the Social Care Institute for Excellence https://www.scie.org.uk/safeguarding/evidence/resident-to-resident-harm and identify if there is any further work for the Board.
- WSAB should seek assurance that commissioned contracts with placement providers and CHC funded placements are working towards ensuring systems in place to manage resident on resident harm are robust.

3. Labels in recording

- WSAB should establish what work agencies are undertaking regarding the use of labels such as 'challenging behaviour' (in this case), disguised compliance, etc. to ensure that there are accurate descriptions of the behaviour/issue/problem. Ceasing use of such labels from records should be set as gold standards for record keeping.

4. History informing assessment

- WSAB should support a case study approach, based on this review, to understanding how important history is to ensure robust assessment and care delivery.

[13] Advice Note for The Association of Directors of Adult Social Services (ADASS: Commissioning Out of Area Care and Support Services) Advice_Note_commissioning_out_of_area_care_and_support_services.pdf

5. Carers Support

- In an audit of placement cases (see previous recommendation) WSAB should ensure that there is evidence of family involvement in assessments and placement decisions where appropriate.
- WSAB should ensure that the case study (see previous) includes consideration of the needs of carers in this case in choosing services and ongoing support to recognise the changes and needs of a person with dementia.
- WSAB should be assured by all relevant agencies that their websites have clear easy to find links to information regarding choosing day services, care homes, carers support and dementia support for families.
- WSAB must ensure that the WSAB Carers Reference Group are aware of the learning from this review.

6. General Learning Briefing:

- WSAB should consider various methods of sharing the learning from this review e.g. podcast, video, as well as the traditional learning briefing.
- A case study should be developed to support individual and team reflection and for use in single and multi-agency training.

Appendix One: Appendix One: Terms of Reference and Project Plan (Redacted)

Safeguarding Adults Review
Case 48Dorothy.
(to include 49Leonard)
Terms of Reference and Scope

1. Introduction

A SAB must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

The Care Act Statutory Guidance 2014 states that in the context of SAR's "something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect".

All Safeguarding Adults Reviews will reflect the 6 safeguarding principles as set out in the Care Act and SAB multi-agency procedures. In addition, SARs will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and

empowerment of adults, identifying opportunities to draw on what works and promote good practice;

- Be proportionate according to the scale and level of complexity of the issues being examined;
- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;
- Develop an understanding of who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;
- Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to panels;
- Make use of relevant research and case evidence to inform the findings of the review;
- Identify what actions are required to develop practice;
- Include the publication of a SAR Report (or executive summary);
- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

2. Case Summary

2.1. Dorothy was a 77-year-old lady who died following a fall during an altercation with another resident (Leonard) in a care home. Dorothy had severe dementia and her daughter had found it increasingly difficult to care for her at home. After a period of 5 weeks in hospital during which she was assessed for her care needs, Dorothy was placed in the Care Home. Following the incident Dorothy was taken to Hospital. During the journey to hospital Dorothy deteriorated. Dorothy died 10 days later in hospital.

2.2. A safeguarding alert was raised regarding the incident; the safeguarding investigation highlighted concerns regarding the suitability of the care home to manage residents with the challenging behaviours of both Dorothy and Leonard. Dorothy was CHC funded and Leonard was self-funded. Both had only recently moved to the care home following completed assessments.

3. Decision to hold a Safeguarding Adults Review

3.1. A SAR referral was received in May 2020. Initial scoping information was gathered, and the Case Review Subgroup of the Safeguarding Adults Board met in July. It was agreed that the criteria for a Safeguarding Adults Review were met. It was agreed that the SAR would relate to Dorothy, but that information related to Leonard would also be required to respond to the concerns regarding suitability of the care home for both residents. The WSAB Independent Chair endorsed that decision.

3.2. As this review includes several services from Hereford Safeguarding Adults Board area where Dorothy was ordinarily resident, contact will be made with HSAB to ensure that they are fully aware of the review and seek from them how they would wish to be involved.

4. Scope

The review will cover the period from **two months before the incident.** Key background information will also form part of the review that will inform the more contemporary elements of Dorothy's life.

5. Method

5.1. The Care Act 2014 Statutory Guidance states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

5.2. WSAB chose to use a methodology that engages frontline practitioners and their line managers. Agencies are asked to review their own involvement and provide a report of their findings and learning. Those who were involved, alongside the authors of the reviews will then be invited to engage in a series of workshops undertaken using virtual meeting technology (Due to pandemic restrictions). Each workshop will focus on one or two themes or periods of time and be set the task of exploring the themes/episodes of care and answering questions. The themes will be identified from the chronologies and reports that have been undertaken by agencies. This will lead to identification of areas for learning and improvement.

6. Key Lines of Enquiry to be addressed

As well as broader analysis provided within the Agency Review Reports the following case specific key lines of enquiry will be addressed.

These key lines of enquiry relate to both Dorothy and Leonard.

6.1. Assessment

- What assessment (to include **all** types of assessment e.g., risk assessment, care and support assessment etc.) did your agency undertake of Dorothy.'s/Leonard's holistic care needs, inclusive of physical and mental health?
- How robust was this?
- How did this inform care planning, interventions and care delivery?
- Please provide analysis of what assessment policies and frameworks were in use and identify any gaps in policy and/or practice.

6.2. Placement

- How did these assessments inform placement planning?
- How was the care home chosen?
- How were the family involved in reviewing and choosing the care home?
- What information was shared with the care home regarding needs and assessments that had been undertaken?
- What assessments did the Care Home undertake before accepting Dorothy/Leonard? How did those assessments inform acceptance and care planning in the Care Home?

6.3. Mental Capacity

- How did your agency apply the Mental Capacity Act at times where significant decisions were made?
- What evidence is there regarding any best interest decisions that were made?
- How were family/advocates engaged indecision making?
- Please provide thorough analysis of application of the Mental Capacity Act.

6.4. Pandemic Impact

Following the national response to the Covid- 19 pandemic, please analyse the impact on Dorothy/Leonard of any changes to services and/or practice.

6.5. Management of conflict and disputes

- Was your agency involved in any disputes regarding this case in the timeframe of the review?
- How were these managed?
- How were disputes/conflict resolved?

6.6. Regulation

- What did your agency understand of the regulatory sanctions in place regarding the Care Home?
- How does you agency ensure that regulatory regimes and inspections are considered as part of assessment and decision making regarding choosing a care home to meet the needs of patients/service users?

6.7. Family Involvement

How did your agency engage with Dorothy/Leonards family? How were they included in plans and assessments?

6.8. Documentation

Please identify if documentation was in line with agency requirements. If not, please analyse why this might be.

6.9. Good Practice

Please identify examples of good practice from your agency and others throughout your report and more specifically in this section.

7. Independent Reviewer and Chair

The named independent reviewer commissioned for this Review is **Karen Rees.**

8. Organisations to be involved with the review:

- The Care Home
- Area 1 Council; The Council services related to Dorothy:
    - Adult Social Care, Locality Team
    - Trusted Assessor Service
- Police
- Ambulance Service
- Area 2 Council; services related to Leonard
    - Adult Social Care:
        - Area Social Work Team A,
        - Area Social Work Team B
    - Brokerage
    - Quality Assurance Team
- Area 2Health and Care NHS Trust:
    - Community and Assessment Recovery Services
- CCG:
    - GP
    - CHC Team
- Area 1 NHS Trust
    - County Hospital

- Community Hospital

9. Family Involvement

A key part of undertaking a Safeguarding Adults Review is to gather the views of the family and share findings with them prior to finalisation of the report. Dorothy and Leonard's family will be contacted by the author and arrangements made to include them in the review.

10. Project Plan dates:

The timeline of this review is extended in order to allow full participation of all agencies during the current pandemic crisis.

	Key Dates	**Date**
1.	Scoping Meeting	21/01/2021
2.	Terms of Reference updated	28/01/2021
3.	Agency Authors' Briefing	24/02/2021
4.	Agency Review Reports submitted	26/04/2021
5.	Review of Reports by Independent Author	28th-30th April
6.	Distribution of Reports to all Learning & Reflection Workshop attendees	03/05/2021
7.	Virtual Learning and Reflection Workshops x4	W/C 17 & 24 May
8.	First Draft Overview Report to all attendees	16/07/2021
9.	Feedback from workshop attendees	13/08/2021
10.	V2 Overview report circulated to workshop attendees & panel	27/08/2021
11.	1st panel/subgroup	W/C 06/09/2021
12	V3 to panel/subgroup	TBC
13	SAR Case Review Group meeting to agree workable achievable recommendations and agree report prior to presentation at Board.	TBC
14	Presentation to WSAB Meeting	NOV/DEC 2021

11. Media Reporting

WSAB will prepare a media statement which must not be varied from without the specific authorisation of the Chair of WSAB's approval. During the SAR process any enquiries from the press in relation to the SAR are to be passed to the WSAB Coordinator.

12. Publishing

It should be noted by all agencies that the SAR report will be published once complete unless it would adversely impact on the adult or the family.

Reference to the adult in the report may be anonymised further prior to publishing. This will be following consultation with the adult/family and time allowed to reflect on how they would like the adult to be referred to.

The media strategy around publishing will be managed by the Community Awareness and Prevention subgroup of the WSAB and communicated to all relevant parties as appropriate

Consideration should be given by all agencies involved in regard to the potential impact publishing may have on their staff and ensure that suitable support is offered, and that staff are aware in advance of the intended publishing date

Whenever appropriate an 'Easy Read' version of the report will be published.

13. Administration

It is essential that all correspondence with identifiable information is sent via secure methods only. This would be via a secure e-mail account. Failure to do so will result in data breach.

The Board Co-ordinator will act as a conduit for all information moving between the Chair, IMR authors, Author and the Case Review subgroup

14. Confidentiality

All reports and documentation relating to the SAR are confidential and must be treated as such by all parties. No items should be shared without prior consent from the SAR Independent Author or the Case Review Chair.