WSAB
Worcestershire Safeguarding Adults Board

Learning Briefing

Regarding the learning from the death of Dorothy

What were the circumstances that led to this SAR?

- Dorothy was a 77-year-old lady diagnosed with progressive dementia.
- Her daughter had found it increasingly difficult to ensure Dorothy had the support she required to continue living at home.
- After 5 weeks in hospital, Dorothy was placed in the care home.
- Following an altercation with another resident, Leonard, who was also living with dementia, Dorothy fell and was taken to hospital.
- During the journey to hospital Dorothy deteriorated and died 10 days later in hospital.
- The male resident had recently been admitted to the care home following a violent incident against his wife at their home. There had been no previous indications of domestic abuse prior to his dementia.
- Due to covid there were no face-to-face social work visits. Leonard refused to speak to a social worker on the phone.
- Following the incident in the care home a safeguarding alert was raised.
- Dorothy was CHC funded (under Covid discharge scheme), and the other resident was self-funded.
- Both had only recently moved to the care home following completed assessments.
- Concerns had previously been raised regarding the suitability of the care home to manage residents with challenging behaviours, however there was no indication of this on the social care system.

Key Learning Points in relation to this situation

- The Social Work team should have contacted the police to report the attack that Leonard made on his wife as categorised as domestic abuse.
- A safeguarding concern should also have been raised and a decision made relating to whether the concern met the section.42 criteria of the Care Act.
- When placing someone in a residential setting the care plan should assess all the possible risks to the person and others. It should be recognised that where there is cognitive decline or dementia that these may present new risks previously unknown.

Learning identified	What will help?
Assessment and Placement	Ensure that if you refer to the Emergency Duty Team that you are aware of actions expected and risks of wating until next working day. Ensure that you are clear on the risks of domestic abuse in older people whatever the triggers for violence may be. Assess the here and now risks. Check agreed admission restrictions if you are involved in finding a care home for a person. Challenge your use of labels in recording - are you clearly identifying what you mean by the label e.g., challenging behaviour? Are you evidencing how history informs your current assessment? Have you checked who else is, or has worked with the person? Keep the family up to date and involved with your assessment and progress on finding a suitable care home and how this will be funded. If you are placing out of county check placement with host authority. Ensure you access regular supervision inline with your organisation's policy.
Resident on Resident Abuse and Harm	In your work with care homes, understand and support if appropriate the check the system for recording and managing resident on resident harm. See 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
Caring for Carers	Seek to understand family history in order to offer the best support for carers. Offer in depth explanations of available support especially when carers refuse an assessment. Revisit carer support at every opportunity and consider rationale for refusal of support. Link to Worcestershire Association of Carers Website Challenge yourself and put yourself in the shoes of the carer as a way of understanding needs. Challenge yourself to support self-funding people in the same way as you would those who are partially or fully funded in all aspects of care and support.
Case Study	Reflect on this case within team meetings and reflective sessions. Use in Training where appropriate. Consider what good practice looks like? What works? What were the barriers? What can you do? Add your reflections and learning to your CPD log or journal

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