West Berkshire Council conducted an internal review following the death of a 70 year old lady. RB died in hospital with pressure wounds acquired at home. Multiple care calls had been cancelled over a period of time. The review identified a number of recommendations for practitioners that are summarised here.

Historic information is important, particularly in relation to safeguarding concerns/enquiries. Has the client been referred for the same, or similar reason? Whilst it is important to view each incident referred on its own merit, considering an incident in the context of historic safeguarding or care management issues is equally necessary to establish the circumstance in the round.

A DASH risk assessment tool should be completed where there are any concerns relating to domestic abuse. A DASH form can often give insight into a relationship that an ordinary assessment may not elicit. In this case there was no DASH completed. The S42 form has a prompt for a DASH. Any decision not to complete a DASH should be clearly documented.

Repeated safeguarding concerns should trigger a review of patterns of behaviour in a case. In this instance there were 8 safeguarding concerns raised in a short period and all of a similar nature. Consideration of safety, evaluation of risk, capacity, individual wishes and risk management within the context of previous concerns and indicators of patterns of behaviour would have been helpful.

A reluctance to engage and decline or cancel services are not unusual responses. In this case 3 packages of care were cancelled very shortly after they had started. Where care has been cancelled prematurely this should trigger the need to explore further and identify the reason for cancellation – documenting capacity is critical and gathering the views of other professionals involved may be very pertinent.

Strategy meetings are useful in formulating an holistic view of risk, by gathering the views of all professionals involved. In this instance there were a number of occasions in which a strategy meeting may have been helpful. Strategy meetings can be conducted in a variety of ways, dependent upon urgency, including over the phone. WBC has a template for strategy meetings which acts as a useful guide.

MCA assessments are critical where capacity is in doubt. In this instance there were conflicting views about capacity for the same decision but only one assessment formally completed. Documenting on record information you have considered when you view a person to have capacity is just as important, particularly where capacity has previously been assessed as lacking for the same decision. Might it indicate fluctuating capacity or recovery from illness if so, some commentary on that shift is helpful.

BACKGROUND

RB was a 70 year old lady living at home with her husband who was her primary carer. She was a high falls risk with a number of significant health conditions including some cognitive decline. RB was admitted to hospital in Feb 2022 unconscious with substantive pressure wounds. RB died the following day.
RB only came to the attention of ASC in 2019 following a hospital admission. Between 2019 and 2022 when she died RB was subject to 4 hospital admissions, 8 safeguarding concerns and had cancelled 3 packages of care.
Many of the 8 safeguarding referrals, which resulted in a number of S42 enquiries, had, at their core, a concern about the perceived controlling relationship between RB and her husband, his treatment of her on occasions and the impact on her care.