Safeguarding Adult Review Learning Brief – Adult L

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Case Summary

Adult L had a diagnosis of Alzheimer's and lived in a Lancashire Care Home; she was injured after an incident at her Care Home. During the incident Adult L was pulled from her bed in the night and physically assaulted by a male Care Home resident (second adult), resulting in her sustained a fractured hip and fractured shoulder which required hospitalisation. Adult L died 2 months after this incident at the age of 91, her cause of death was established to be a subdural bleed. The second adult had dementia and had a history of violence when agitated.

The focus of the Safeguarding Adult Review were the circumstances surrounding the physical assault against Adult L, including placement planning and the care and support provided to both Adult L and the second adult by all agencies in the year prior to the incident. Although the Safeguarding Adult Referral was received in respect of Adult L, the second adult was vulnerable by virtue of his dementia diagnosis, it is therefore the case that many of the learning themes arising from the review relate to the care and support provided to the second adult.

The review highlighted several key themes and areas of learning which are explained below. It is anticipated that a copy of the SAR report will be made available on the LSAB website once the Coronial process concludes.

Key themes and learning points

Pre-Admission Assessment and Information Sharing:

The risks that the second adult presented to others were not adequately described in the care plan and in documentation shared with the Care Home. Pre-admission assessments and sharing of information by those agencies already providing support to an individual help to ensure that they receive appropriate care and ensure that any risks have been effectively assessed.

Domestic Violence and Abuse:

The second adult's wife suffered domestic violence and abuse from her husband when he was agitated prior to his placement in the care home. She was not recognised as a victim of domestic violence and abuse. There appeared to be a tolerance of domestic violence and abuse from a partner who is elderly, has a diagnosis of dementia and presents as aggressive when agitated.

Risk Management:

The risk of violence to female residents who the second adult misidentified as his wife was never articulated as a trigger for agitation and violence or the threat of violence. Threats or use of violence after entering a female's bedroom were a factor to which insufficient attention was paid. Care Homes and those agencies that support them need to ensure that risk management plans are of high quality and enable them to manage the risks presented by some care home residents.

Monitoring of Second Adult's placement:

The risks that the second adult presented to other residents was minimised by agencies. The 'rule of optimism' was present on many occasions. Although there was evidence that not all incidents had been shared by the Care Home with those agencies who were supporting the second adult. Accurate information about incidents needs to be recorded and made available to supporting agencies to help ensure informed decision making.

Lack of multi-agency discussion:

When the second adults' behaviour was known to have deteriorated, opportunities were missed to undertake multi-agency discussions and the opportunity to find the second adult a placement that better met his needs was not taken.

Needs of other care home residents:

When key decisions were taken about the second adult, insufficient attention was paid the impact of these decisions on the safety and wellbeing of other residents. Violence, threats of violence, verbal abuse and invasions of privacy were accepted. Such behaviour and any associated incidents should be appropriately reported and should not be tolerated.

Violence against staff and other residents:

The response of the provider to assaults against care home staff by the second adult were inadequate and there was a lack of oversight of this issue. Violence by the second adult towards his wife, care home residents and care home staff was tolerated, minimised and often not properly recorded.

Whistle-Blowing:

The response of key agencies to whistle blower disclosures was inadequate. Whistle blower disclosures should be viewed as a valuable early warning system highlighting managers to problems that they may be unaware of. Lancashire Safeguarding Adults Board promotes the value of encouraging and listening to whistle-blowers from all relevant stakeholders as a key element of the whole system for safeguarding adults.

Deprivation of Liberty Safeguards (DoLS):

Although an initial DoLS application was submitted, this wasn't updated when the risks that the second adult posed increased and he became subject to further restrictions. Care Home providers should have clear advice of when to submit updated DoLS applications and must comply with this advice.