WOLVERHAMPTON SAFEGUARDING TOGETHER

Board publishes review into death of woman following assault

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The Wolverhampton Safeguarding Together Board has today (Wednesday 15th December, 2021) published the findings of a Safeguarding Adult Review into the death of an elderly woman.

The woman, referred to in the review as Edna, was living in a short stay residential home when she was physically assaulted by another resident, known as JC in the report, and consequently died 12 days later. She was 83.

Prior to this, Edna had been living at home with her husband and received domiciliary care support, until she was admitted to hospital due to a stroke.

Wolverhampton Safeguarding Together Board commissioned the Safeguarding Adult Review to ascertain the involvement of agencies from May 2019 to November 2019, the time of the incident, and to determine if anything could be learned which may improve frontline practice in the future.

The review found that JC, who had vascular dementia, was on occasions a risk to herself, her husband and staff and residents in the care home. However, the absence of an assessment prior to her admission meant care home staff did not have a clear understanding of her needs and behaviours and how these may impact upon others.

Furthermore, Edna's family had reported to the care home that JC had been into her room on a number of occasions and had previously assaulted her, but checks were not undertaken and, as a result, staff potentially missed the chance to intervene before the incident which led to Edna's death.

Independent Lead Reviewer Jenny Butlin-Moran’s final report identifies a number of learning points and makes seven recommendations to Wolverhampton Safeguarding Together Board.

These are focused on the assessment and safeguarding processes, inter-agency and intra-agency communication and how agencies hear the voices of service users.

The recommendations have been accepted by the board, which is overseeing their implementation.

Sally Roberts, the Independent Chair of Wolverhampton Safeguarding Together Board, said: "This was a very sad case in which an elderly woman was physically assaulted by a fellow resident in the care home where she was temporarily living, and subsequently passed away.

"The report paints a picture of Edna as a very proud and caring lady who loved her family and liked to wear nice clothes and doing crossword puzzles. She is much missed by everyone who knew her and, on behalf of the Board, I pass on our sincere condolences to them.

"The review looked in detail at the involvement of a range of agencies with Edna in the last few months of her life. It identified some good and conscientious practice from professionals that was focused on Edna's needs, with practitioners that contributed to the review showing themselves to be dedicated individuals who worked hard to provide a good service.

“It also identified a number of learning points, and seven actions which are being implemented by Wolverhampton Safeguarding Together Board and the individual agencies concerned which will believe will help ensure, as far as possible, that happened to Edna does not happen to anyone else in the future."

The Safeguarding Adult Review report has been published on the Wolverhampton Safeguarding Adults Board website. For more information, please visit www.wolverhamptonsafeguarding.org.uk.

Agencies involved in the review included the City of Wolverhampton Council, the Black Country and West Birmingham Clinical Commissioning Group, the Black Country Partnership Foundation NHS Trust, The Royal Wolverhampton NHS Trust and West Midlands Ambulance Service.

ENDS

Note to editors:

1/ A Safeguarding Adult Review is a multi-agency review process which seeks to establish the circumstances around an individual's death and determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place. The purpose of a SAR is not to apportion blame; it is to promote effective learning and improvement to prevent future deaths or serious harm occurring again.

2/ Section 44 of the Care Act 2014 requires a SAR to be carried out “where an adult with care and support needs (whether or not those needs are met by the local authority) in the Safeguarding Adult Board’s area has died as a result of abuse or

neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult".

3/ Wolverhampton Safeguarding Together Board provides strategic leadership for safeguarding work to ensure there is a consistently high standard of professional response to situations where there is actual or suspected harm. For more information, please visit www.wolverhamptonsafeguarding.org.uk.