

# Lessons Learned



## Dorothy's story....

Dorothy was an 87 year old lady who lived alone and was not in receipt of any support. She became known to services initially because she had been targeted by Rouge Traders. Whilst being supported to protect her from the rogue traders her appearance was described as unkempt and her property was cluttered. Over the next 18 months she was admitted to hospital 5 times, having experienced falls and abdominal pain; on three occasions the ambulance crew raised a safeguarding referral due to concerns about Dorothy's living conditions and her ability to cope at home. Following one discharge Dorothy was offered support however, as she chose to decline this the support was not offered again. In the months leading up to her death concerns increased in respect of Dorothy's living conditions and ability to cope independently at home. Concerns were being reported in respect of Dorothy, however these were raised with an individual social worker that had previously been involved, rather than referring to the appropriate team. She was seen by an Office Cover Worker on two occasions. The second visit identified concerns that Dorothy was self-neglecting. Her home was described as very cold, the environment cluttered, and it was unclear how she was managing to purchase and prepare food. The Office Cover Worker recommended that an urgent allocation for assessment was required. Sadly, Dorothy died before this assessment was completed.

## What we have learned ....

- Dorothy had been targeted by Rogue Traders on more than one occasion. Whilst she was supported well the police were not advised of the situation which resulted in a missed opportunity for Dorothy to receive additional support and advice. **Learning for Practice:** Where there are concerns that someone is being targeted by rogue traders, ensure the police are made aware at the earliest opportunity as they can offer a range of support and advice
- Concerns were being raised about Dorothy's living conditions and ability to cope, however these concerns were being raised to a specific social worker via email and not through the appropriate route thus causing delay and a potential for the referral to become lost. **Learning for Practice:** When referring to Adult Care Services ensure that the correct pathway is used
- Dorothy had 5 admissions to hospital and concerns were raised about how she was managing at home. She declined support on one occasion which resulted in support not being offered again in the future. There is no evidence that agencies came together to discuss the multiple referrals and admissions to determine how to best support Dorothy. **Learning for Practice:** Where there are multiple referrals, or admissions to hospital, ensure that a multi-agency exploration is completed

# Lessons Learned (cont.)



## What do I need to do?

1. Find out more about the support and advice [Warwickshire Police](#) can provide
2. Familiarise yourself with the appropriate ways to make a referral to [Social Care and Support](#)
3. Read the [Care Act 2014 Section; 15. Integration, cooperation and partnerships guidance](#) and evidence multi-agency working in future case files
4. Reflect on multi-agency working within team meetings and supervision, and consider Multi-Agency and Interdisciplinary training
5. Read and share in your team meeting the information from the Warwickshire Safeguarding website on [Self Neglect](#)
6. Read the Warwickshire Safeguarding [7 Minute Briefing on self-neglect](#)

### Contact us

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