Keeping Adults Safe in Shropshire Board

Keeping Adults Safe in Shropshire Board

Executive Summary under Section 44 the Care Act 2014

Report into the cause of injuries to Mrs V.

Case No. SAR 1

Keeping Adults Safe in Shropshire Board

Introduction

For the purposes of this report to protect the identity of those involved and having been agreed with the family the following key will be used throughout:

- Person subject of this review – Mrs V
- Her daughter and person engaged with the review - Miss V

Mrs V sadly passed away on 21st April 2015 of natural causes.

This review is concerned with matters prior to and not associated with Mrs V's death.

Mrs V was in receipt of a direct payment for her care and support needs, her care package being arranged by her family. She was also under the care of the district nursing service for management of her leg ulcers.

On 10th February 2015, Mrs V was admitted to Oldbury Grange Nursing Home, Bridgnorth for respite care. During the respite period she developed a urinary tract infection as a consequence of which her period of respite was extended.

On the evening of 25th February 2015 staff at the home noted Mrs V had sustained some bruising to her upper body, which developed over the following days. Miss V was so concerned that no reasonable account could be given as to how the bruising had occurred that she chose to remove her mother from the home on 2nd March 2015.

During the days that followed Shropshire Council commenced the safeguarding process, Oldbury Grange conducted an internal investigation and Miss V informed West Mercia Police.

The review was concerned with the possible cause and timing of the bruising but was conducted after a full police investigation had occurred. This investigation had been delayed by internal Police decision making and procedural matters, which were subject of the review.

The report author made it clear to Miss V that in view of the fact a Police investigation had taken place it was unlikely that the review would provide any additional clarity as to the cause of the bruising.

The review was also particularly concerned on the communication and co-ordination of the differing enquiries between the agencies involved, and the communication between them and Miss V.

Professionals associated with the review

The professionals' designations of those who contributed to the review process were:

- Detective Inspector, West Mercia Police
- Dedicated Adult Safeguarding Manager, Shropshire Council, Adult Social Care
- Local Authority Designated Officer, Shropshire Council, Children's Services
- Social Worker, Telford and Wrekin Council, Adult Social Care
- Adult Safeguarding Lead Nurse, Shrewsbury and Telford Hospitals NHS Trust (SaTH)
- Chief Operating Officer, Morris Care (Oldbury Grange).

Process of the review

The issue of communication between the agencies involved with the family and in particular, Miss V was specifically dealt with within the review, however it is an important factor to consider to understand how this review evolved.

During the summer of 2015, Miss V was feeling frustrated at the lack of update and consequently sought the support of an advocate who had significant experience of navigating elements of the public sector.

On 24th November 2015 a meeting was held between Miss V and her husband, their advocate, the Director of Adult Social Care for Shropshire Council and the Independent Chair of the Keeping Adults Safe in Shropshire Board. The purpose of this meeting was to secure clarity on the issues for resolution from the family's perspective and to agree an appropriate mechanism by which to do so.

Formal complaints procedures were explored but dismissed given that responses were likely to be one dimensional on the part of each agency involved.

This incident and tripartite of investigation processes occurred shortly before the enactment of the Care Act 2014, and importantly before Shropshire had produced its revised and now current Safeguarding Adult Review (SAR) procedure. SAR methodology was however fully explored as an option with the family, but it was not accepted as robust enough by the advocate on behalf of the family and so declined.

A pragmatic solution was sought and reached and it was therefore agreed that the appropriate methodology would be to ask for single agency review reports against specific terms of reference, and then a drawing together of both single and across agency issues by the Independent Chair. This was with a view to be able to explain what happened and why, and to enable agency learning so that other families should not endure the same experiences.

It has been identified as learning for the board that this was in fact SAR methodology.

Terms of reference for the review

The purpose of conducting a Safeguarding Adult Review is to:

- Establish what lessons can be learned from the particular circumstances of a case in which professionals and agencies work together to safeguard adults
- Identify what those lessons are, how they should be acted upon and what is expected to change as a result
- Review the effectiveness of procedures both of individual organisations and multi-agency arrangements
- Improve practice by acting on the findings (developing best practice across the organisations)
- Improve inter-agency working to better safeguard adults
- Make a difference for adults at risk of abuse or neglect

Family involvement

Miss V was the key contact for the family during the review process. The report author also met with Miss V and her daughter on two occasions to discuss the draft report document and to take their views into account.

Summary of events

10th February 2015 Mrs V was admitted to Oldbury Grange Nursing Home.

25th February 2015 Mrs V received personal care in the morning and had a shower with support from staff.

At 21:00 hours, that evening, bruising was noticed by staff to Mrs V's left underarm and four or five smaller bruises to left upper arm.

26th February 2015 the above bruising was noted on Mrs V's care plan at the home.

1st March 2015 at 16:00 hour's carers helping Mrs V into her nightwear noted extensive bruising to her left arm, breast, axilla and her left side below her breast.

2nd March 2015 Mrs V was removed from the home by Miss V and taken home.

2nd March 2015 Miss V contacted SW1 from Telford and Wrekin, Adults Social Care and informed her of the circumstances.

2nd March 2015 SW1 informed Oldbury Grange that she was making an adult safeguarding referral.

3rd March 2015 SW1 made the safeguarding referral to Shropshire Safeguarding Team via secure Email.

3rd March 2015 Oldbury Grange commenced their internal investigation.

4th March 2015 CHM the Oldbury Grange, Care Home Manager made a safeguarding referral to Shropshire Safeguarding Team.

6th March 2015 Miss V reported the matter by telephone to West Mercia Police.

7th March 2015 PC1 from West Mercia Police attended and spoke to Mrs V in the presence of her daughter Miss V. The officer did not record a crime or commence an investigation.

8th March 2015 Mrs V was admitted to the Princess Royal Hospital in Telford.

9th March 2015 Miss V informed PC1 by e-mail of the fact that Mrs V had been diagnosed with a dislocated shoulder.

16th March 2015 West Mercia Police were involved in a strategy decision with Shropshire Safeguarding Team. It was confirmed that that the Police were not conducting an investigation and that therefore the safeguarding process should continue.

17th March 2015 it was confirmed with Oldbury Grange that West Mercia Police were not conducting a criminal investigation.

1st April 2015 Mrs V was discharged from hospital to Cottage Christian Nursing Home, Telford.

13th April 2015 Mrs V was readmitted to the Princess Royal Hospital on referral from the GP.

21st April 2015 Mrs V sadly passed away.

27th April 2015 SW2 from Telford and Wrekin Council adult social care team contacted West Mercia Police to obtain an update on the status of the police investigation.

28th April 2015 DS1 was made aware of the incident, reviewed previous police actions and instigated a formal police investigation.

8th May 2015 joint visit occurred to Miss V by DS1 and SSP1 from Shropshire Safeguarding Team.

21st August 2015 SSP1 met with Miss V in order to gather further information following being made aware of Police closure. The complaints procedure was given to Miss V including Local Government Ombudsman information via email. Miss V did not wish to make a complaint at that stage.

9th November 2015 Miss V and Mrs Bailey met with Sarah Hollinshead-Bland, Designated Adult Safeguarding Manager, Shropshire Adult Social Care.

24th November 2015 Miss V, her husband and Mrs Bailey met with Director of Shropshire Adults Social Care Mr Andy Begley and the Independent Chair of the Keeping Adults Safe in Shropshire Board Mr Ivan Powell.

Analysis and recommendations.

The review identified that the aspect of communication and understanding between the agencies involved and Mrs V and her family was both considerably below the standard expected, and also contributed significantly to delays in investigative processes. This doubtless hampered any opportunities which may have existed earlier in the investigative journey to discover how Mrs V's bruising had been caused.

In particular, between the time when Mrs V was removed from Oldbury Grange on the 2nd March and readmitted on the 8th March to the Princess Royal Hospital no agency was involved in actively monitoring the development of Mrs V's bruising. Again, this further exacerbated the system's ability to provide a reasonable explanation for the cause of the injuries.

In this case, the placing authority were Telford & Wrekin Council, whereas the safeguarding process was the responsibility of Shropshire Council given the location of the care home being in Shropshire.

In June 2015, Shropshire Council appointed a new Designated Adult Safeguarding Manager who has since conducted a wholesale review of adult safeguarding policy, procedure and practice and implemented significant changes, much of which takes account of the recommendations arising from this review.

The review established that the safeguarding response from Shropshire Council was not as timely as it should have been and there was a failure to communicate with the family in a timely manner. Similarly, their contact with colleagues in both Telford & Wrekin Council and West Mercia Police was also not as timely as it should have been. This led to misunderstanding of the status of any investigation, which in turn caused confusion on the part of staff at Oldbury Grange, charged with conducting their own internal investigation.

Shropshire Council should have taken the lead in co-ordinating the communication with the family concerned.

West Mercia Police only have a small number of specialist detectives with experience of adult safeguarding and as a consequence, most often as in this case, the matter will be responded to and investigated by frontline uniformed officers.

The review identified that the officer in this case had not previously experienced any incident of adult safeguarding, and whilst he had received the training modules provided by his force, his response fell short of compliance with the force policies which applied.

It was further identified that the police service nationally is still awaiting publication of Approved Professional Practice from the College of Policing on Adult Safeguarding.

The officer also did not understand that he should have also informed Shropshire Council Adult Safeguarding Team of his findings and decision-making.

Later in the process because of the nature of the officer's closing comments on the police log following the call from Miss V, the Police Officer (for the Adults at Risk Unit) who was contributing to the local authority led telephone strategy discussion reported that no police investigation was required and the matter should proceed as a safeguarding investigation.

The review established that prior to the start of the review the first responding officer had been subject of intervention by a supervisor by way of management advice.

On 28th April 2015, a specialist supervisor had cause to review the initial response and finding it lacking, formally opened a criminal investigation. Although by this time Mrs V had passed away, the supervising officer felt that there was a strong over-riding public interest to attempt to establish how the injuries had occurred.

Despite an extensive investigation, no cause for the injuries was formally established and the matter was filed 'undetected'. The police however, identified four areas of action required (please see below), which they passed as recommendations to Morris Care, the operators of Oldbury Grange.

During the review, Miss V raised a number of factual inaccuracies from her perspective with the report author. These were all individually addressed within the review and clarification was given to Miss V.

The learning from this was that given Miss V's concern about the professionalism of those involved in the varying enquiries, her trust was further eroded in the safeguarding process because of the poor quality of the related record keeping in particular on Shropshire Council's safeguarding system. Additionally, there was a single page overview report from

West Mercia Police which Miss V, understandably but incorrectly had assumed was the whole police investigation.

Morris Care during their internal investigation had cause to take disciplinary action against two staff members for failing to keep records to the standard expected by the Nursing and Midwifery Council. These in particular were concerned with record keeping to 'keep track' of the emerging bruising on Mrs V.

Interpretation of injuries

In this case, West Mercia Police did consider securing a medical opinion concerning Mrs V's injuries; however, they did not do so as they felt it unlikely such an opinion would add value to the criminal investigation.

Shropshire Council in the absence of police securing a medical opinion did so themselves, however the review established there is no current mechanism for doing so and has resulted in an action for the Board to consider.

The medical opinion offered was ''the distribution of the bruising and it's near symmetrical nature does not suggest an assaultive causation. In my opinion, the most likely cause of the various bruises would be related to lifting this lady to the erect position from either lying or from sitting''.

Conclusion

Mrs V had sustained some bruising, by means unknown, whilst in Oldbury Grange.

Miss V and Oldbury Grange took photographs of Mrs V's bruising on the 2nd March 2015. These were used in consideration of the civil action settlement between Miss V and Morris Care.

Miss V recorded further photographs on 6th March 2015, and staff at the Princess Royal Hospital recorded further photographs on the event of Mrs V's admission to the hospital on 8th March 2015.

It is clear from the photographs that the bruising continued to develop between 2nd and 8th March 2015.

None of the investigating agencies had properly established contact between themselves and Miss V by this time and as a consequence, the emerging bruising was not known by the agencies until much later in the investigative process.

The expert opinions offered suggest the most likely cause of the injuries was by so called 'drag and lift' activity, but given the time lapse identified concerning the monitoring of the development of those injuries coupled with the lack of explanation as to when they occurred, no clarity could be established.

Morris Care suspended a staff member identified during investigations to have 'bumped Mrs V's wheelchair into a lift', on the basis that this may have been the incident at the root cause of Mrs V's bruising. Subsequent investigation revealed that this was categorically not the case.

It is not for the review to comment upon that action by Morris Care, but given that staff will have seen a staff member suspended for an action they were later have found not to have committed, it is offered as a possibility that this may have caused other staff in possession of relevant information not to come forward. Morris Care do operate a policy of openness and transparency, have in place a 'whistle blowing' policy, and during the action planning stage of the review were able to offer an example of where a staff member had recently come forward with concerns.

There are occasions when even the most efficient of safeguarding enquiries do not reach definitive conclusions. There is no doubt in this case that the poor co-ordination between the agencies involved hampered this enquiry and has contributed to the position where there is no clarity of the facts.

During the first meeting with Miss V, the report author was struck by the particularly emotive phrase she used, stating 'I feel like I got mum battered to death'. Whilst the review has been unable to provide any more clarity on the likely cause of the injuries to Mrs V it is hoped that the expert opinions offered that the injuries were not of 'assaultive causation', were most likely indicative of 'drag and lift' activity and in consideration of Mrs V's high Waterlow score and associated skin frailty go some way to alleviate Miss V's concerns.

The findings of the review have been shared in full with Miss V and her family. They have also been given the opportunity to consider draft versions of the final report and offer comment.

The learning and recommendations have been formalised in an action plan. Delivery of this is managed by the Executive Group of the Board. These actions will make a difference to people's experience of the adult safeguarding process in the future.

Recommendations

Recommendation 1 West Mercia Police

West Mercia Police to review its crime management systems to identify a mechanism by which supervisors can readily identify and scrutinise the adult safeguarding caseload.

Recommendation 2 West Mercia Police

West Mercia Police should undertake an adult safeguarding training (including awareness of the Mental Capacity Act) needs analysis (to include West Mercia Police's crime audit staff and function) which include an implementation plan, which will be reviewed by the Safeguarding Board's Executive group who should receive regular progress reports.

Recommendation 3 West Mercia Police.

It is acknowledged that the College of Policing on behalf of the police service nationally has still not produced the policy on approved professional practice with regard to Safeguarding Adults. Given the Care Act was implemented on 1st April 2015, this position is unacceptable.

In the interim, Warwickshire and West Mercia Police should develop a local force level policy and procedure for officers responding to incidents of adult safeguarding. This should include guidance on what it means to be an 'adult with care and support needs' (as defined by The Care Act 2014).
This should include how officers investigating matters in care homes are supported to understand care home procedures e.g. care plans and medicines management records.

Recommendation 4 Morris Care

Morris Care to ensure that staffing rotas easily and clearly identify which members of staff are on duty at any particular time and date.

Recommendation 5 West Mercia Police

Staff conducting criminal investigations in parallel with the safeguarding process must ensure that all agencies are informed of the findings of the police investigation at case closure stage.

Recommendation 6 West Mercia Police

West Mercia Police to consider removing the process whereby investigating officers produce investigation closure summary reports as a stand-alone document. This information should quite properly be recorded on the case management system (CRIMES).

Recommendation 7 Shropshire Council

That all safeguarding staff are reminded of the need to clarify who will engage with the adult (or their representative) concerned at the start of the safeguarding process to establish what is to be achieved through the process. This accords fully with 'Making Safeguarding Personal'.

Recommendation 8 Shropshire Council

That Senior Safeguarding Practitioners provide timely and accurate updates of progress to adults and their family/or advocates. In the case of multi-agency investigation, the safeguarding team should also take the lead on the coordination of updates between agencies to ensure the adult is kept fully informed.

Recommendation 9 Shropshire Council

That staff understand the importance of recording information accurately first time, and that the recognised case management system is used properly for this purpose.

Recommendation 10 Shropshire Council

Safeguarding practitioners need to understand the importance of avoiding using subjective information to inform risk assessments.

Recommendation 11 Shropshire Council.

That 'CareFirst' case records are fully updated and contemporaneously recorded with ongoing progress of enquiries and decisions to avoid the duplication of effort required by the staff member here on her return to the office.

Recommendation 12 Shropshire Council

That in setting timescales for provider enquiries anticipated reporting dates are accurately recorded and actively monitored by the safeguarding team.

Recommendation 13 keeping Adults Safe in Shropshire Board

The Board should satisfy itself that copies of enquiries are offered and shared (where they are wanted), to adults with care and support needs or their representatives at the end of safeguarding enquiries.

Recommendation 14 Shropshire Council

That Shropshire Council senior management team introduce a process whereby safeguarding caseload is monitored together with consideration of other factors including demand and team resilience.

Recommendation 15 Telford & Wrekin Council

Telford & Wrekin Council should establish and promote escalation procedures making sure all adult social care staff are aware of their responsibility to escalate concerns when they are concerned about the performance of other teams and organisations.

Recommendation 16 Shrewsbury and Telford Hospitals Trust

It is recommended that staff when making a safeguarding referral are objectively accurate in the way in which information is recorded. It is perfectly acceptable to record comments from family members and those accompanying a patient, however the record should be made clear where narrative is that and not necessarily fact, (unless a direct witness). It is for an enquiry or investigation to establish a cause.

Recommendation 17 Shropshire Council

As part of developing the initial enquiry plan, Shropshire Council safeguarding team provide absolute clarity to a provider on the status of any police activity.

Recommendation 18 Shropshire Council

At the conclusion of the safeguarding process in discharging their responsibility to ensure there is no further safeguarding activity required, the local authority should ensure they triangulate information available from all agencies involved in the process. On the occasion where there is a difference between what the adult at the centre of the safeguarding process wishes to happen and what an enquiring officer feels should happen, then those differing views should be formally recorded.

Recommendation 19 Keeping Adults Safe in Shropshire Board

The Safeguarding Board should establish a clear process for the commissioning of medical opinion when required including which organisation is responsible for paying for such an opinion.

Recommendation 20 Morris Care

For all staff to be retrained or reminded of the importance of completing or noting incidents when incidents have occurred, and where to note such incidents for recording purposes and appropriate action.

Recommendation 21 Morris Care

A positive culture for staff to be able to report any incidents to management in confidence.

Recommendation 22 Morris Care

A review of all chairs throughout the home throughout the home to ensure adequate padding on the arms of chairs to prevent injury, should residents "slump down" or "flop down"

Recommendation 23 Morris Care

A review of the passenger lift to correct an identified gap between the lift and the floor.