Safeguarding Adult Review

Jenny

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Name:	Jenny
Date of Referral:	12 December 2021
Date of Case Discussion:	02 February 2022
Date of Practitioner event	02 November 2023

Professionals Present:		
Name	**Agency**	

- Independent Reviewer
- Greater Manchester Police
- Head of Safeguarding Tameside and Glossop Integrated Foundation NHS Trust
- Adult Social Care
- Designated Nurse Safeguarding Adults Greater Manchester Integrated Care Board
- Tameside Adult Social Care
- Northwest Ambulance Service
- Greatwood House
- Digital Health Services – Tameside
- GP
- TASPB Business Administrator (minutes)

1. Background

Jenny sadly died on 12 December 2021. Coronial inquest has been arranged for 2024. A postmortem has identified that Jenny was found to have sustained a intercranial bleed to her brain and a fracture to her left femur. A criminal investigation was initiated due to the unexplained nature of the injuries. This has now concluded.

Jenny had lived at a residential care home since 2016. She had been admitted to residential care after she was having an increasing number of falls and developed dementia. She was assessed as not having mental capacity to make decisions about her health. A Deprivation of Liberty safeguard was in place so that Jenny could access care that she required others to provide.

In November 2021 night staff at the care home identified that Jenny had significant bruising to her left eye. There was no information documented to identify the cause of the bruising. Later, on the same shift, an explanation was given, by the allocated carer to Jenny for that shift, that Jenny had been hit in the face with a hoist when she was being moved. The home initiated a safeguarding alert. The staff at the home contacted 111 to seek further medical advice as to whether Jenny's injury warranted further investigation in hospital. The 111 service were aware that a safeguarding alert had been initiated and advised the home to seek further medical advice via the GP and Digital health.
Digital health services were then contacted by the home. No further advice was given about the incident. Practitioners said that this was because Jenny was reported to not be in pain and was eating and drinking normally. At the practitioner event the review was informed that the decision made by staff i.e. that Jenny did not need to attend the accident

and emergency department, was in line with NICE national guidelines on the management of head injuries which were in place at that time. Jenny was also booked with her GP for telephone consultation that day. This occurred later that afternoon. The GP requested that a photograph of the bruise was sent digitally. Although this occurred, the GP did not view the image until a few weeks later. No further advice was offered after a picture of the injuries were sent to the GP.

The care home conducted their own internal investigation at the time of the incident with the hoist on 24th November 2021. Jenny's daughter was informed about the injury to Jenny's face and was told that it had been caused by the hoist. She was not given any more details about this at that time.

On 25 November 2021 a member of staff at the care home documented that Jenny was in pain when moving her left leg. Jenny's pain to her leg is also documented on both the 26th and 27th November 2021. No action appears to have been taken to review the cause for Jenny's pain.

On 25 November 2021 it is also noted that Jenny has a red mark on her arm and the skin is off.

On 29 November 2021 staff documented that Jenny had bruises on her shoulder. This is described as the home manager as old and looks to be the same as her forehead. It says on the 29th there are no other markings or pain. There are 3 entries from different staff members, and one notes she has a lump on her left leg.

It does not appear any medical advice is sought about these other bruises and markings.

A safeguarding strategy meeting was held on 06 December 2021, two weeks after the injury to Jenny had occurred. Greater Manchester Police were not invited to attend.

The outcome of the meeting was that the accident had been caused by compromised clinical practice, however, all required interventions were in place to reduce risk of an incident occurring later. This included training of the use of hoists by carers at the home.

At the practitioner event the home reported that the member of staff had complied with the training programme. It was documented that the family were happy with this outcome. The possibility of intentional physical abuse of Jenny was considered at the strategy meeting but there was insufficient evidence to suggest such .

On 07 December 2021 the care home contacted Digital health again. Jenny was described as being much more lethargic than usual, not eating and drinking. Observations of blood pressure, pulse and temperature were within normal limits. No further action was taken. There is no documentation available as to whether Jenny's symptoms were linked to any potential worsening of her head injury. There appears to have been no information shared about Jenny's pain to her leg or other injuries. Jenny was not offered physical examination. The deterioration in Jenny's health appeared to have been regarded as a general deterioration in her condition.

On 12 December 2021 Jenny's condition deteriorated further and she was taken by ambulance to hospital where she later died.

The hospital contacted Her Majesty's Coroner and a postmortem was carried out. An intra cranial bleed and a fractured femur were identified. Greater Manchester Police were contacted to undertake potential criminal investigation.

2. About the person

Jenny was a 78 was a year-old lady. Jenny lived independently until she suffered a stroke in 2015. She continued to live in her own home at the time with her daughter being her main carer. She appeared to be having symptoms of dementia. A care package from the local authority supported her daughter. After some major repairs were required to the home Jenny went to residential care where she remained until her death.

Jenny was retired. Prior to her retirement she had worked for many years at a local food factory. Jenny was a widow. Her son had died previously as a result of a motorcycle accident. Jenny's daughter described the family as close. Jenny had previously helped her daughter with the care of her grandchildren. Jenny was also close to her granddaughter.

A Deprivation of Liberty safeguard had been in place since 2020 as Jenny was considered to lack capacity to make decisions.

From July 2021 it was recorded that Jenny was having increasing problems with her mobility and now required help to mobilise and other tasks such as eating. The family informed the reviewer that they had noted a deterioration in Jenny's health when they were able to visit her during the time of the Covid lockdown. Jenny was no longer able to hold a conversation with her family.

At the time of the incident occurring Jenny was bed bound, had little verbal communication and required feeding.

3. Immediate Thoughts

The Panel were concerned that there had been a failure to consider physical abuse as a "differential diagnosis" for the cause of injuries to Jenny.

Of considerable concern to the Panel was that if the incident with the hoist was accidental, there was an initial failure of the night duty staff caring for Jenny to record the incident, failure to seek immediate medical advice and failure to pass information to other practitioners. At the practitioner event it became clear that although initial reporting and response to the incident had not occurred this was rectified within a few hours. These issues were identified by the care home and the Panel believed that further training had taken place and learning had been identified. Disciplinary action of staff would not be within the remit of a safeguarding adult review but there is a need for assurance to be gained that practitioners working with the care home have undertaken sufficient training in the recognition and response of accidents which have occurred and ensure that the criteria for seeking immediate medical help is embedded within their practice. The need to consider the possibility of abuse of a vulnerable person also needs to be considered. Safeguarding needs to be included within all assessments made.

When practitioners at the home did identify, that Jenny had bruising to her face, they sought correct advice from the 111 service, Digital health and later the GP. The NICE guidelines, in place at the time of the incident, were followed for the management of head injury. This meant that Jenny did not attend the accident and emergency department for full physical assessment. There was then no opportunity, therefore, for other potential injuries, which may have been sustained during the incident to be identified.

Jenny was unable to vocalise any pain, was immobile and lacked mental capacity to communicate any potential pain or discomfort. Her condition after the incident, had, therefore, been assessed using nonverbal means and did not appear to have changed after the incident., However, the Panel has since learnt that staff recorded that Jenny appeared to have been having leg pain and bruising in other areas of her body in the days immediately after Jenny's head injury was identified. There is no rationale given as to why this was not investigated further by the home.

On reflection if Jenny had been referred to Emergency Department there is a likelihood that injuries may have been identified and treatment commenced. In the updated NICE guidelines for management of head injuries (May 2023) there is clarity as to the procedures to be undertaken in the management of head injury, when a person lacks capacity. This includes guidance on attendance to accident and emergency departments for further assessment.

A photograph of Jenny's injury to her face was sent by the home to the GP practice, as requested by the GP service. At the practitioner event it became evident that the photograph was not viewed by the service until some weeks after the incident. This incident must be addressed by the GP surgery.

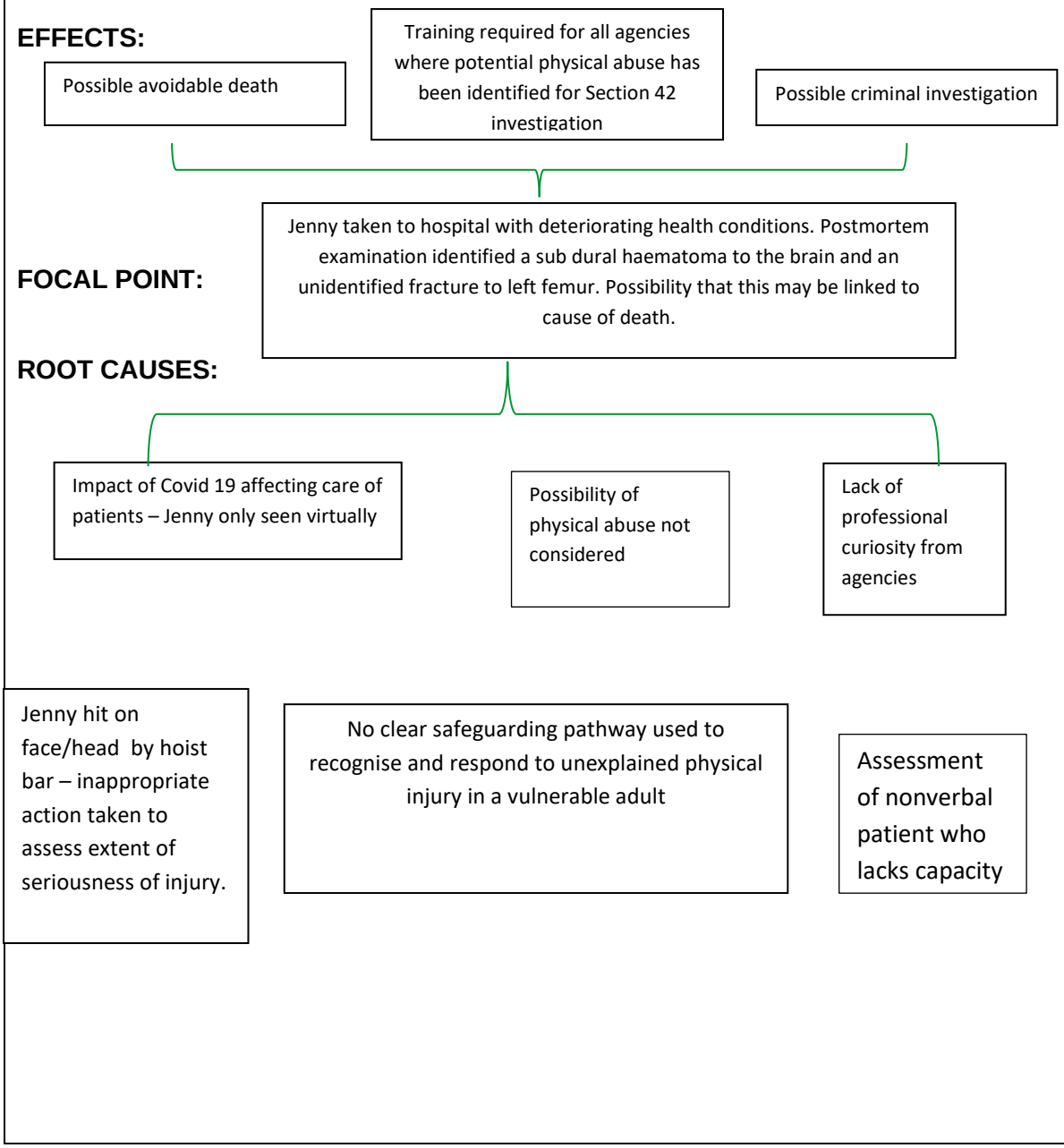
There also appears to have been a delayed response by other agencies to assess the injuries which Jenny had incurred. Adult Social Care did not make direct contact with Jenny and although district nursing services delivered direct patient care, through treatment of a wound elsewhere on Jenny's body, they did not assess extent of bruising to Jenny's face and no comment is made in records. It is unclear whether other agencies knew about the other signs of injury which had been identified by the care home staff in the immediate time after the initial injury.

Practitioners appeared to have been "task focused" rather than consideration of further health need which may have been required. This is understandable given that it was being reported that there was no change in Jenny's overall behaviour.

In line with the Tameside Safeguarding procedures for safeguarding strategy meetings the Police ought to have been invited as a core member to such meetings. It is understood that these procedures have since been updated to reflect attendance of key safeguarding agencies to strategy meetings.

The safeguarding strategy meeting was held some two weeks after Jenny's injuries had occurred. Because of the failure for Jenny to have a thorough medical examination the extent of her injuries were not known and decisions made were based on the information available to practitioners at the time.

4. Analysis Tree



5. What are we worried about?

The Panel was concerned that a partially unexplained injury in an adult with limited mobility, who lacks capacity to verbally communicate, does not appear to invoke the same response from practitioners working with vulnerable adults as it would for those working with children. Mainly this was believed to be because procedures for responding to concerns about unexplained injuries for children are embedded in legislation (Section 47: Children Act 1989).

At the practitioner event it was argued that there was an explanation for the head injury incurred by Jenny, but the panel remained concerned. This is because there is still no explanation for the fracture of Jenny's femur which appears to have occurred at a similar time to the head injury. The history given for the incident was that Jenny had been hit in the face by the hoist. It has since been identified that some staff at the care home had noted that Jenny appeared to have been having pain in her leg there is no evidence, however, that this was considered as a potential further injury which may have been linked from an incident with the hoist.

The panel concluded that vulnerable people, who lack capacity to communicate, require face to face examination of the person by medical staff when such injuries occur. This is in line with updated NICE guidelines. This procedure needs also to be included for consideration in the management of all injuries of vulnerable people.

Recommendation1: When a vulnerable adult sustains an unexplained injury a face-to-face medical examination must be made to ensure that the full extent of injuries incurred have been identified. This requirement needs to be jointly led between Adult Social Care, Police and Health.

Failure to recognise the possibility, however small, that Jenny had possibly suffered physical abuse was not considered. Although a safeguarding meeting was initiated within 24 hours of the incident, it took a further 2 weeks for a strategy meeting to have occurred. Assessment of Jenny of any immediate risk of harm had not been considered in that time. In addition, there had still been no assessment of the extent of her injuries and Jenny was unable to tell practitioners about whether she was having symptoms of deteriorating health.

When the strategy meeting did occur, it appeared that discussion focussed on why practitioners had failed to report the incident and appeared to focus on the inappropriate use of a hoist rather than consideration of whether the nature of the injury should have prompted further safeguarding investigation. A conclusion was made by individual practitioners that the injury was accidental but they may not necessarily have the clinical skills to make this judgement.

In addition, a safeguarding alert was raised by the care home, who are then required to undertake the strategy meeting. This was practice in Tameside during this time period, This means that there is a potential risk of compromise to any investigation. This policy has now been updated so no recommendation will be made with respect to responsibility for initiating safeguarding alerts. However, a recommendation will be made for the timeliness of strategy meetings being held is made.

Recommendation 2: When a safeguarding alert is raised about a vulnerable adult a strategy meeting between 3 agencies of Adult Social Care, Police and Health must be undertaken within 48 hours of the incident being reported.

Recommendation 3: the agency responsible for the care of the vulnerable adult must ensure that an immediate full risk assessment is carried out, including medical examination of the person so that the risk of any immediate harm is effectively assessed and strategies to reduce risk can be minimised.

A number of agencies cited that face-to-face examination of Jenny could not be carried out due to restrictions imposed by Covid 19 pandemic. This is not wholly accurate, however. The Panel discussed that although policies in one agency may have restricted direct contact with a patient, there were alternative routes which could have been taken to ensure that Jenny received a thorough physical medical examination of her body. Staff at the home had reported some very concerning facial injuries and this ought to have prompted such examination. In the event no examination was made and inappropriate advice was given. The reluctance to ensure that Jenny could access appropriate medical care was denied to her.

Despite the pandemic, there were procedures in place, especially in health, which ensured that any immediate health needs could be met. In ordinary circumstances, the significance of the head injury of Jenny could only have been ascertained by direct referral to the Emergency Department in an acute trust. There was no reason for this not to have occurred within the pandemic restrictive period. It was a missed opportunity to fully identify the severity of injuries which Jenny had sustained, failed to provide necessary medical care to help her manage her injuries such as pain relief and failure of Jenny to receive treatment of the injuries which she had sustained.

6. What worked well?

There appeared to be good communication between agencies and much discussion took place. However, these were focused on viewing Jenny's injury as a clinical incident rather than considering the possibility of safeguarding concerns being addressed.

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7. Action

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Addendum

This review began in 2021 and was concluded in 2023. The delay to complete the report was to ensure that the Safeguarding Adult Review did not impact on the ongoing criminal investigation. Consequently, following the completion of the initial report prior to sign off from the Tameside Adult Safeguarding Partnership Board (TASPB) additional information is available to inform the Safeguarding Adult Review. This information does not impact on the SAR Recommendations. However, the Board have requested an Addendum to the report is included:-

- During the initial GP consultation, pain medication was prescribed.
- GMP have confirmed that Jenny's death was reported by the hospital to HM Coroner. HMC authorised a Postmortem on 21.12.21. GMP were contacted by HM Coroner following the Postmortem.
- Signed first accounts of the incident were provided on the morning of the incident to the Care Home by the staff members using the hoist and supporting and assisting with care.