

Safeguarding Adult Review: Kannu

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Prepared for Salford Safeguarding Adults Board

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Salford
**Safeguarding
Adults Board**

Contents

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|--|----|
| 1. Introduction | 2 |
| 2. Safeguarding Adult Reviews | 4 |
| 3. Review Focus..... | 6 |
| 4. Case Chronology and Commentary | 8 |
| 5. Analysis | 29 |
| 6. Revisiting the Terms of Reference and Key Lines of Enquiry..... | 42 |
| 7. Recommendations | 46 |

1. Introduction

- 1.1. Kannu¹ died on 20th November 2020 in hospital at the age of 91. Her nationality was British and her ethnic background Sri Lankan. Cause of death was given as old age and frailty, congestive cardiac failure, ischaemic heart disease, hypertension and type 2 diabetes.
- 1.2. From a pen picture provided by her son and daughter-in-law, it is known that Kannu completed her medical training in the UK in the 1960s, becoming a permanent resident in 1974. She worked as a radiologist. Her husband remained in Sri Lanka and she was widowed in 2009. Tamil was her first language; her English was good. She was very proud of her first language, being one of the most ancient languages still being spoken. She was primarily a Hindu but had an interest in other faiths such as Christianity and Buddhism. She had a deep affinity towards Hindu customs practised in Tamil Nadu, India.
- 1.3. Kannu had two children. Her son lives in the UK and her daughter lives abroad. They have reported that their mother had a tendency to collect belongings and memories, which became more noticeable in the early 2000s after her retirement. She lived in what has been described as a “busy home.” She lived alone and has been described as “very independent.” Concerns about her wellbeing increased from 2017, with memory decline observed and an increasing tendency to refuse to take medications and/or to cancel support visits.
- 1.4. She was a spiritual/religious person, becoming more so after her retirement. She enjoyed attending meditation meetings and appeared calmer afterwards. She missed attending these meetings, where she had built up close friendships. Not being able to see her friends made her feel “very low”, like “withdrawal symptoms.” She had lots of books, videos and CDs, together with many souvenirs of her travels. Her house was not “unliveable” and she kept her possessions because they helped her to feel “at home.” She had a history of complaining about the side-effects of her medication².
- 1.5. Kannu had been known to Adult Social Care (ASC) for some time and received commissioned services from the local authority or through Salford CCG Continuing Health Care until 26th September 2019, after which a private care provider arrangement commenced, commissioned by Adult Social Care. This arrangement continued, interspersed with concerns about her physical health, not eating/drinking and refusal of support from her carers, until the end of March 2020, when she was admitted to a nursing home.
- 1.6. The day after admission Kannu expressed a wish to return home, a position which she consistently maintained. However, this did not happen, partly because of repairs being

¹ This name has been chosen by family members.

² This information has been given to the independent reviewer by her family.

needed in her home, and she remained in the nursing home until shortly before her death. Concerns were periodically expressed about self-neglect, her physical health, not eating/drinking, refusal of medication and low mood. Some mental capacity assessments were delayed as a result of responses to the Covid-19 pandemic. The first of three adult safeguarding strategy meetings was only held on 17th November. She was admitted to hospital the day before she died in her best interests after it had been decided that her advance care plan was not legally applicable to her situation, that there was at least a possibility that her ill-health might be reversible and that giving IV fluids to Kannu in the nursing home was not an option.

- 1.7. There are, therefore, two episodes to review, namely the care and support Kannu received in the months before her admission to the nursing home, and how services worked together after that admission.

2. Safeguarding Adult Reviews

- 2.1. Salford Safeguarding Adults Board (SSAB) received a referral on 26th November 2020 from Adult Social Care. A decision was reached on 15th December 2020 to commission a mandatory safeguarding adult review (SAR). **Commentary:** both the referral and the commissioning decision were timely, which is good practice.
- 2.2. SSAB has a statutory duty³ to arrange a Safeguarding Adults Review (SAR) where:
 - An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and
 - There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.
- 2.3. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future⁴. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.
- 2.4. In reaching its decision to commission a mandatory review, SSAB concluded that there appeared to have been missed opportunities to ensure a fully integrated approach to meeting Kannu's care and support needs, and that there were delays in recognising concerns. There appeared to have been missed opportunities to complete mental capacity assessments, as a result of which she had remained in the nursing home against her expressed wishes, raising questions about deprivation of liberty. SSAB concluded that there were concerns about neglect/omission, about self-neglect, and possibly organisational abuse/neglect to be explored. The importance of reflecting on the impact of the Covid-19 pandemic on how agencies worked, singly and in partnership, was also recognised.
- 2.5. The following services contributed to the combined chronology for the review, namely:
 - 2.5.1. Salford Royal Foundation Trust (SRFT) – Hospital for Acute Care/Community Services including District Nurses
 - 2.5.2. SRFT – Adult Social Care (ASC)
 - 2.5.3. SRFT – Nursing home Practice (GP Service)

³ Sections 44(1)-(3), Care Act 2014

⁴ Section 44(5), Care Act 2014

- 2.5.4. SRFT – Palliative Care/End of Life Team
 - 2.5.5. Salford City Council – DoLS Team
 - 2.5.6. Greater Manchester Mental Health (GMMH)
 - 2.5.7. Clinical Commissioning Group (CCG) – NHS Funded Care Team
 - 2.5.8. Nursing home
 - 2.5.9. Private Sector Home Care Provider.
- 2.6. The review was overseen by the SSAB’s SAR Review Group. Owing to potential conflicts of interest, the composition of the Review Group for this SAR comprised senior managers from the services involved. This had the added advantage of enabling safeguarding specialists who would normally attend Review Group meetings but who had been involved in decision-making towards the end of Kannu’s life to contribute fully to reflection sessions. **Commentary:** discussions surrounding declaration of interest and Review Group membership for this particular SAR were robust but always mindful of the importance of transparency and accountability, and the integrity of the SAR process. SSAB’s Independent Chair and Executive were briefed and appropriately involved.

3. Review Focus

- 3.1. The case has been analysed through the lens of evidence-based learning from research and the findings of other published SARs on adults who self-neglect⁵. In particular SSAB expressed the intention that this SAR should build on two previously published SARs⁶. Learning from good practice was also to be included. By using that evidence-base, the focus for this review has been on identifying the facilitators and barriers with respect to implementing what has been codified as good practice. The focus has also been on enquiry into whether or not there are systemic issues still to be fully understood and addressed in Salford, and on what difference recommendations from the two previous SSAB SARs have made to practice and the management of practice locally.
- 3.2. Specific lines of enquiry, or terms of reference were agreed. Those seen as arising from how practitioners and services worked with Kannu were as follows:
 - 3.2.1. Making Safeguarding Personal and use of advocacy
 - 3.2.2. Family relationships and consultation with family members
 - 3.2.3. Consideration of Kannu's ethnicity, religion, culture and heritage, including communication needs
 - 3.2.4. Use of Deprivation of Liberty Safeguards
 - 3.2.5. The accessibility of the pathway into Adult Social Care
 - 3.2.6. The impact of the Covid-19 pandemic
 - 3.2.7. Advance Care Planning
 - 3.2.8. Management of the review process in terms of declaration of interests.
- 3.3. Additional key lines of inquiry were agreed as spanning not just the review of how practitioners and services worked with Kannu but also the findings and recommendations arising from the previous two SARs, Andy and Eric. Thus:
 - 3.3.1. Assessment and risk management
 - 3.3.2. Working together – roles and responsibilities
 - 3.3.3. Use of escalation

⁵ Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

⁶ Preston-Shoot, M. (2019) Safeguarding Adults Review – Andy. Salford Safeguarding Adults Board.
Preston-Shoot, M. (2020) Safeguarding Adults Review – Eric. Salford Safeguarding Adults Board.

- 3.3.4. Legal literacy
 - 3.3.5. Use of section 42 Care Act 2014
 - 3.3.6. Use of self-neglect policy and procedures
 - 3.3.7. Interface between mental capacity and mental health legislation
 - 3.3.8. Awareness of mental wellbeing and how it can impact on a person's behaviour
 - 3.3.9. Application of Mental Capacity Act 2005.
- 3.4. It was agreed that the review would cover the period from 1st June 2019 to the date of Kannu's death. Agencies were requested to provide a chronology and reflective review of their involvement with Kannu within the agreed timeframe. The individual chronologies were combined. The independent reviewer and the SAR panel then identified specific issues and questions for further exploration by the agencies involved.
- 3.5. Given apparent similarities with two previous SARs published by SSAB, it was decided to hold two reflection events. The purpose was to explore learning from how services worked with Kannu and together, but also to consider whether the three reviews combined were highlighting systemic issues that had not yet been effectively addressed. The first reflection event, held virtually, was for senior leaders and the second for practitioners. Contributions from these reflection events have been integrated into the analysis in section 5.
- 3.6. Additionally, fifteen managers and practitioners with involvement with Kannu's situation answered questions asked by the independent reviewer in terms of what they felt worked well, what might have been done differently, and the lessons and training needs arising from consideration of the case. The feedback obtained has been integrated into the analysis.
- 3.7. Both Kannu's son and daughter expressed a wish to participate in this review. The independent reviewer and the SSAB Business Manager met with them and her daughter-in-law virtually, using Microsoft Teams, owing to the Covid-19 pandemic. Their reflections and observations have been integrated into the analysis that follows in section 5.
- 3.8. A learning event is planned to disseminate the findings of the review once SSAB has accepted the report and agreed the action plan to implement its recommendations.

4. Case Chronology and Commentary

Kannu at home

- 4.1. Between June 2019 and 31st March 2020 Kannu lived at home, interspersed with several hospital admissions. Kannu had been admitted to SRFT on 4th May 2019 with chest pains. This was to become a feature of the case whilst she was living at home. She was discharged on 5th June with care and support to be provided by a care provider, with assessment in her own environment where she lived alone. District nurses and occupational therapists visited the following day. A replacement shower stool was ordered. Kannu had to self-administer her insulin as the paperwork was not available for the district nurses.

Commentary: there was a short delay in discharge due to capacity issues with the care provider. Immediate home visits by occupational therapy and district nursing was good practice to ensure a safe discharge but not all the relevant paperwork was available for the district nurses to be able to treat Kannu.

- 4.2. On the evening of 6th June an advanced practitioner visited to administer medication. Kannu was difficult to rouse and appeared slightly confused and disorientated. An ambulance was called and Kannu was readmitted to SRFT. No safeguarding concerns or doubts about her mental capacity were recorded. She presented as able to manage activities of daily living and to maintain pressure areas. Nonetheless, hospital records observe deterioration over recent months and concern that Kannu returning home might not be in her best interests.

Commentary: the question of whether Kannu could and should return home was to become a significant feature of the case. Indeed, on 10th June Kannu requested to return home during a ward round. Such requests, and how practitioners responded to them, were also to become a significant feature of the case.

- 4.3. SRFT notes record Kannu as experiencing heart failure with fluid overload, frailty with recurrent admissions, Bradycardia, and concerns about managing at home with the current level of care. Cardiac review indicated that there were not many therapeutic options for Kannu, suggestive that moving toward palliative care was appropriate.

Commentary: SRFT records note that Kannu was advised that a discharge plan would be necessary before she could return home. At a subsequent meeting with Kannu's son it was recognised that she had mental capacity to decide where she was discharged to; she did not wish to enter a nursing home. Her son is recorded as not objecting to her return home. Planning appears to have been person-centred at this point, with appropriate family involvement in discharge planning.

- 4.4. On 11th June Kannu was referred to the NHS Funded Care Team via a Fast Track application for NHS Continuing Healthcare. An assessment was completed and authorisation given the same day. A package of care was to be commenced with district nurses delivering personal care, and a care agency assisting with meal preparation (this

element of the package arranged by the hospital social worker). Kannu and her son were involved in discharge planning, including agreement for a hospital bed to be provided and located in the downstairs dining room, provision of a key safe to enable district nurses to gain access, and the family arranging for some furniture removal.

Commentary: discharge planning was timely and person-centred.

- 4.5. Kannu was discharged on 17th June, with a district nurse that evening that recorded no concerns. The following day a referral was sent for night sits and hospice at home. The referral appears to have resulted in a palliative care multi-disciplinary team meeting on 26th June, involving SRFT, palliative care team, a hospice and district nurses, which resulted in a decision to continue with support in the community. **Commentary:** multi-disciplinary team meetings, to share information and agree treatment and risk mitigation plans are good practice. It might have been appropriate to include adult social care.
- 4.6. On 19th June, when a district nurse arrived, Kannu was in bed upstairs. She requested that the hospital bed be sent back so that she could have her dining furniture back. Kannu reported that she would be happy with upstairs living if unable to get downstairs. All benefits and risks of not having the hospital bed were discussed. **Commentary:** her decision was to have a consequence on 26th June when she was sleeping upstairs and experienced chest pains for which her medication was downstairs. Her daughter-in-law called an ambulance and Kannu was readmitted to hospital.
- 4.7. In hospital a mental capacity assessment concluded that there was no reason to doubt her decisional capacity. Discharge planning commenced with a change in the care provider to assist with meal preparation (three times daily) owing to the workload of the previous agency. Fast Track funding remained in place. Kannu was involved in decisions about medication, with options explained. She is recorded as having accepted the risks of the option she chose. Kannu was discharged on 4th July, with the family and district nurses informed. The electronic patient record lists diagnoses as myocardial infarction, hypertension, heart failure, previous heart attack and diabetes. A social care assessment describes Kannu as independent in terms of activities of daily living, with a stair lift installed at home. No concerns about her cognition are recorded. **Commentary:** again, discharge planning was person-centred. A social care assessment records risks as including medication non-compliance and inability to maintain her home environment. Both risks feature later on.
- 4.8. A diabetic nurse review occurred on 23rd July. At this time the Adult Community District Nursing Team visited for daily blood glucose monitoring and administration of Lantus [Insulin]. When necessary the frequency of visits was increased. This continued until 30th March 2020 when Kannu entered 24 hour care and alternative arrangements were made for her diabetes care. In addition to these daily visits, Kannu received a separate visit each day from a support worker within the same service. The support worker offered assistance with personal care and provision of a meal/drink as required by Kannu. It appears that depending on how she felt on any particular day would determine whether or not she accepted this support. This continued until 26th September 2019 when a private care provider commenced. On average Kannu would accept support with a

shower every 2-3 days from this service. She was able to make meals/drinks for herself at this time; however, there was evidence to suggest she was not always compliant with her recommended dietary requirements.

Commentary: the risks foregrounded in an earlier social care assessment are emerging here.

- 4.9. A review of the home care package on 15th August identified a discrepancy between records held at the care provider's agency base and those at Kannu's home, as a result of some visits having been cancelled by the family and not fully recorded. The other outcome of the review was that Kannu's condition had stabilised and she was no longer thought to be in a terminal phase of her condition; therefore the process was begun of NHS Salford CCG assessing her ongoing eligibility for NHS Continuing Healthcare⁷.

Commentary: a very detailed assessment by the nurse commissioner was completed on 15th August. It recorded that a "do not attempt resuscitation" notice was in place. It recorded variable acceptance by Kannu of support with managing personal hygiene and that she was not always compliant with recommended nutrition and fluid intake. It is recorded that she needed psychological and emotional support due to the nature of her medical history and the effects on her current health status. It is not clear whether this was further discussed with Kannu and provided.

Commentary: a referral was received on 16th August by Adult Social Care requesting their involvement in this process but there was a delay until 2nd September in allocating a social worker due to workload demands.

- 4.10. On 5th September a diabetes specialist nurse met with community nurses. Pre-breakfast readings were noted to all be above her target range. It was agreed to commence measurement of blood glucose levels pre-evening meal as well as pre-breakfast. Any concerns regarding diabetes control, the community nurses could liaise with the Community Diabetes Team.

Commentary: such reviews are good practice. They took place on a regular basis ranging from twice to six times per month depending on Kannu's clinical condition. There is evidence of regular liaison with the diabetic specialist nurse prescriber and GP as part of these reviews.

- 4.11. A nurse commissioner spoke with Kannu and her daughter-in-law about the multi-disciplinary meeting that would review her eligibility for CHC funding. Kannu did not wish to be involved. Her daughter-in-law was unable to attend but was happy for the meeting to proceed.

Commentary: involvement of Kannu and her family was good practice.

⁷ The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, October 2018 (revised).

- 4.12. On 11th September the multi-disciplinary meeting, comprising a nurse commissioner, district nurse and social worker, with reports from the GP and a second nurse commissioner, determined that Kannu was no longer eligible for CHC funding. She was assessed to be no longer rapidly deteriorating in health and her care needs at this time were stable. She was assessed to have a low level of care need at this time which no longer met the criteria for NHS Continuing Healthcare funding. Assessments completed by Adult Social Care identified risks of self-neglect if Kannu did not receive daily visits, mainly because of the impact of breathlessness on motivation. 4 carer calls daily were recommended to support her with personal care and activities of daily living.
- 4.13. The final visit by the support worker for the purposes of personal care and meal/drink preparation from the Adult Community District Nursing Team occurred on 26th September. From this date until Kannu's admission to a nursing home, such provision was offered by a private care provider, commissioned through Adult Social Care. The support plan comprised a 30-minute call at breakfast time to support and encourage personal care and meal preparation. 15-minute calls at lunchtime, teatime and mid-evening were also designed to support meal preparation. Encouraging Kannu to take medication featured on all four visits. Blood glucose monitoring continued from the Adult Community Nursing Team.
- 4.14. Thereafter a period of some stability appears to have ensued. The combined chronology reports an electrical malfunction at Kannu's home at the end of November, which required repair. A diabetes specialist nurse in mid-December requested Kannu's GP to alter her medication due to her experiencing hypos in the morning, yet elevated blood glucose levels in the evening. In mid-January there were reports of Kannu declining to take her medication⁸. On 23rd January 2020 during an Adult Community District Nursing practitioner's home visit undertaken for diabetes care, Kannu complained of chest pains radiating down her left arm, stating that she felt she was having a heart attack. An ambulance was called, Insulin administered and the carers made breakfast. When the ambulance arrived Kannu stated that she felt much better; pain in her chest had gone leaving only slight pain in an arm. ECG was inconclusive so she was taken to hospital. At hospital Kannu underwent a CT scan of the Aorta which revealed no obvious cause of the pain. The plan was for discharge home as soon as possible and cardiology review for optimisation of medication for angina. She was discharged home on 25th January, with district nurse visits and the care package recommencing.
- 4.15. The pattern repeated on 7th February. A nurse attending for diabetes care found Kannu complaining of chest pain, stating also that her medication had run out⁹. The nurse

⁸ **Commentary:** care providers passed this information to their coordinator but no action has been recorded by the coordinator. The care provider's policy is to report such information to a person's GP if medication has been refused on three successive days. The risks associated with medication refusal should determine when the GP is informed.

⁹ Kannu's daughter has commented that one medication, possibly for angina pain, had not been supplied by the hospital due to a new regime. It was later re-prescribed.

declined to administer morphine, requested by Kannu, as this was not authorised. Kannu refused to allow an ambulance to be called, with the combined chronology recording that there was no reasons to doubt her capacity. Kannu was given advice and her GP was contacted who agreed to speak with Kannu. A message was left for her next of kin.

Commentary: it is concerning that it appeared her medication had run out. She had recently been discharged from hospital with a two-week supply of medication.

- 4.16. The GP referred Kannu to A&E later that day. A chest x-ray showed possible 'pulmonary oedema'. However, as there were no further symptoms she was discharged.

Commentary: there is no clear follow-up plan from this admission. Subsequent events highlight the need for a care and risk mitigation plan at this point.

- 4.17. The pattern repeated on 9th February. By the time a nurse arrived to undertake diabetic care an ambulance crew had visited due to Kannu experiencing chest pain but had concluded that she could be left at home. Because of this and also Kannu's reduced mobility, the nurse referred her to the Rapid Response Team. The same day an occupational therapist attended but could discern no issues with mobility or transfers. Accordingly, Kannu was discharged by the Rapid Response Team. **Commentary:** it is unclear how widely known this discharge was.

- 4.18. The pattern repeated again the following day. When the nurse arrived to administer diabetic care, Kannu complained of not having slept all night and feeling very weak and dizzy upon sitting up. Observations were taken and her GP informed who stated they would visit later that day. Subsequently the GP called an ambulance. At A&E Kannu presented with 'shortness of breath.' She appeared not to be experiencing pain and observations were normal. The combined chronology records working diagnoses as sudden onset short of breath - likely heart failure and possible cognitive impairment.

Commentary: it is unclear how possible cognitive impairment was followed-up. It is also unclear from the combined chronology how compliance with medication was being monitored by care providers.

- 4.19. Kannu remained in hospital until 28th February, during which time she was reviewed by palliative care and cardiology teams. Diabetes care and the care package recommenced when she was discharged. A palliative care support plan was introduced. On 3rd March a pressure relieving cushion was ordered following an occupational therapy assessment.

Commentary: no multi-agency or multi-disciplinary meeting appears to have taken place prior to hospital discharge. Such a meeting would have been best practice.

- 4.20. Concerns began to escalate from 10th March. On that date it appeared that Kannu had not taken her morning medication. Care provider staff were advised to watch Kannu take her medication. Kannu's daughter was staying at this time, having arrived from abroad on 8th March. Her view is that her mother wanted to rest and knew her body. She was reluctant to accept her heart medication because she experienced side-effects. Her daughter, however, felt that she was consistent in accepting medication for her

diabetes¹⁰. On 16th March, when a nurse arrived to administer diabetes care, Kannu was still in bed. She had refused support from carers that morning and had therefore not had breakfast or her medication. The nurse attempted to administer missed medication but Kannu refused.

Commentary: there is no evidence in the records that this was escalated. There is no evidence that SSAB's self-neglect policy was considered at this time. Kannu's daughter has said that she had to return to her home abroad on 16th March and looking back feels that her mother may have been "a little depressed" because of this. It is not clear from any records that this was considered by practitioners involved at the time. This highlights the importance of "thinking family."

- 4.21. The same was reported by care provider staff on 19th and 23rd March; on the former occasion Kannu's daughter-in-law was informed.

Commentary: there is no reference in the combined chronology to consideration of Kannu's mental capacity at this point or of exploration with her of the risks involved and the reasoning behind her refusals. This pattern was to reappear later in the nursing home.

- 4.22. A review of her support plan by Adult Social Care resulted in no change to the pattern of 4 visits daily by care provider staff.

Commentary: there is no mention in the review of her support plan of the concerns regarding non-compliance with medication; care provider staff were meant to support and oversee this aspect of Kannu's care. Indeed, it is recorded that no concerns were raised by Kannu, her family, district nurses or formal carers, with all agreed that the care package was working well.

- 4.23. On 24th March, as a result of Kannu's ongoing refusal to take her medication, the care provider contacted Adult Social Care. The contact record states that the family were aware of Kannu's non-compliance since 19th March. Kannu was apparently reporting problems with swallowing but liaison with a district nurse and nurse practitioner found no evidence of difficulties with swallowing or with eating/drinking.

- 4.24. **Commentary:** there is no record of further engagement with Kannu about reasons for her non-compliance (medication and eating/drinking) given that there was no evidence of swallowing difficulties. These concerns were to resurface after she was admitted to the nursing home.

¹⁰ Kannu's daughter has told the independent reviewer that she felt the carers were being "somewhat forceful" although she did not say so at the time. She was able to watch television, cut vegetables and put clothes in the washing machine. She did say that she was too tired to do anything, which her daughter feels was understandable due to her health problems. She enjoyed receiving visitors from her meditation group.

- 4.25. Contact assessment records in Adult Social Care for 24th and 26th March report contact from Kannu's daughter-in-law. A fall is mentioned, Kannu having been found on the floor by a district nurse, and the view of an ambulance crew that Kannu was not safe at home and required 24-hour care. The contact record notes that Kannu had fallen off her stair lift and her blood sugars were low. An ambulance crew had decided not to transport Kannu to hospital because of the Covid-19 virus outbreak and were reported to be making a safeguarding referral as the crew did not believe she had decisional capacity regarding care and treatment, and needed 24-hour care. The contact record notes that the district nurse believed that Kannu did have mental capacity regarding care and treatment. Adult Social Care updated the care provider who intended to liaise with district nurses and to ensure that formal carers encouraged Kannu to eat/drink. A medication review by the GP would be requested.

Commentary: there is no reference in the combined chronology of a review of Kannu's mental capacity as a result of an apparent divergence of views. The anticipated safeguarding referral from the ambulance crew appears in fact to have been an adult welfare notice rather than an adult safeguarding concern, received by Adult Social Care on 26th March.

- 4.26. The daughter-in-law is recorded by Adult Social Care as commenting that the family would need to apply for power of attorney for health and welfare, and were requesting reassessment of the level of care being provided. Although Kannu had 'care on call', she had not been wearing the bracelet when she fell. The family are recorded as saying that she needed 24-hour care but Kannu did not want to enter a nursing home and family members felt that she had decisional capacity. Indeed, Kannu's view appears to have been that she could stay in her home since carers were visiting four times daily, she was supported by district nurses, and further care support was being considered by the family.
- 4.27. The daughter-in-law reported that Kannu was experiencing frequent hypoglycaemic episodes, was not eating/drinking well and was refusing medication. Her daughter-in-law reported that Kannu was confused during a hypo, which affected her cognitions and capacity to consent to treatment. The family were considering commissioning night-time carers. The contact record concludes with referral to the area team for review and reassessment, and for multi-disciplinary working. Discussion with Kannu and review of her mental capacity regarding care and treatment was recommended, including her wishes regarding treatment when experiencing a hypo. District nurses were to undertake a screening for Continuing Healthcare funding and the GP to be requested to complete a medication review. It is recorded¹¹ that Kannu's next pf kin had been informed that a multi-disciplinary team meeting had been suggested.
- 4.28. Community health care records additionally refer to discussion with Kannu about her home possibly not being the safest place for her given increasingly frequent falls and hypoglycaemic episodes. It is not recorded in the combined chronology what her

¹¹ Information from Adult Community Nursing.

response was. The records also refer to discussion with family members that a multi-disciplinary team meeting was required and possibly a best interests meeting to consider options.

- 4.29. On the same day, 26th March, the care provider is reported as noting that Kannu had not eaten since the previous afternoon and was refusing all offers. Community health care records note that home-based triage for an intermediate care bed was conducted. The triage record observed that Kannu was “at risk but has capacity currently.”

Commentary: there was no change in the care package, which seems surprising in light of the risks and Kannu at this stage remaining at home.

- 4.30. **Commentary:** North West Ambulance Trust submitted an adult safeguarding referral dated 26th March. This is good practice. It names self-neglect and records in full the information about her diabetes, hypoglycaemic episodes, non-compliance with medication and extreme risk. The referral observes that Kannu had capacity and did not believe that she was at risk of harm. It is, however, questionable as to whether Kannu did have mental capacity if she could not understand concerns being raised with her in order to use or weigh these observations. This was an opportunity that appears to have been missed to complete a mental capacity assessment. There were also missed opportunities to convene a multi-agency, multi-disciplinary risk management meeting to agree a plan for meeting her care, support and treatment needs, alongside her known wishes and feelings, and to consider legal options with respect to self-neglect and decision-making about care and treatment, especially when she was experiencing hypoglycaemic episodes. There is no reference at this point to referral to a dietician or to assessment of her low mood and its impact on her decision-making.

- 4.31. On 28th March the Care on Call service recorded a home visit. This is a 24-hour service to enable people living in their own homes to seek assistance. She had requested assistance to use the toilet and reported feeling unwell with a sore throat and dry cough. She was reported as alert and able to access the toilet using her Zimmer frame. The warden contacted her son and daughter-in-law to report the assistance given and to note that the house was cold, with a note attached to the boiler indicating that it was dangerous and should not be used.

Commentary: the chronology does not indicate who wrote the note about the boiler but it was observed and recorded by Care on Call staff.

- 4.32. A specialist health needs assessment, completed by a district nurse on 30th March, recorded that Kannu was non-compliant with medication and with her diet, and at risk of pressure ulcers and falls. No evidence of impairment, confusion or disorientation was observed. She was breathless and required support with some activities of daily living. She was “hard of hearing” but not using hearing aids. 24-hour care was recommended to ensure her safety and compliance with care and treatment. An independence-led re-assessment was completed on the same day by Adult Social Care. It recorded that Kannu was struggling at home even with the support provided. It too recommended 24-hour care urgently due to the impact of her ill-health on her safety and independence at home.

- 4.33. **Commentary:** there is no record of consideration of whether the care package could be increased to mitigate the risks of remaining at home. There is no record of discussion with Kannu regarding her non-compliance with recommended medication and diet. The Adult Social Care assessment records that Kannu had stated that she had not fallen recently and had a good appetite. This self-reporting appears to have gone unchallenged. No concerns are recorded in the Adult Social Care re-assessment about her ability to understand and make decisions. It also appears that she refused to discuss advance care planning. The section to record her wishes and preference is blank, raising a question as to whether her desired outcomes were explored in line with the principle of making safeguarding personal. The interim plan is recorded as being an emergency short-stay, commencing 31st March, as no intermediate care beds were available. There is no sense in the re-assessment of what the longer-term plan might be.
- 4.34. **Commentary:** Kannu is recorded as verbally consenting to assessment for Continuing Healthcare Funding, which was approved the same day in line with protocol, and to admission to nursing care for a short-stay. Although Continuing Healthcare assessment processes had been suspended at this time due to the Covid-19 pandemic, reassurance was sought by the CCG that Kannu had, indeed, consented to the assessment and further that she was consenting to admission to nursing care. This was good practice. It was also noted that the consent form needed amendment to include a witness signature and date. District nursing records note that in discussion, Kannu had agreed to admission to 24-hour nursing care “for a period of assessment” and that her family were in agreement with this move. This record also observes that her home was very cold as the boiler was not working. It appears that Kannu may not have told anyone about this. Although it is recorded that discussion about admission with Kannu included reference to her falls and the risks of remaining in her home environment and of continuing to refuse medication and diet, other than recording her decisional capacity it is not clear what her responses were to the expressed concerns. This is a missed opportunity to demonstrate making safeguarding personal in action.
- 4.35. On 31st March Kannu was admitted to a nursing home.

Kannu in the nursing home

- 4.36. On 1st April the nursing home contacted Kannu’s son as she was expressing a wish to go home. She agreed to stay for a period after speaking with her son who is recorded as explaining that she would not be safe at home if she returned there.
- Commentary:** it is unclear what the longer-term plan was.
- 4.37. Kannu was registered with the GP attached to the nursing home who was aware of her medical history. This included noting that in July 2017 she had an advance care plan with preferred place of care in her home and not in hospital; her home was her preferred place of death also. A medicine reconciliation with a pharmacist occurred on 2nd April.
- Commentary:** this was good practice.

- 4.38. On 4th and 12th April, Kannu's daughter telephoned the nursing home to enquire about how she was.
- 4.39. On 20th April Adult Social Care allocated Kannu's case to complete a review of placement. The worker spoke to her daughter in law who felt that Kannu should remain in the nursing home as she was self-neglecting at home and was not looking after herself, eating little, with no hot water as the boiler broken and she was not taking any active steps to get it fixed. The worker spoke to a nurse at the nursing home who felt that Kannu had capacity. It is recorded that, although Kannu wanted to return home, she accepted to stay in the nursing home until a worker could visit her and assess her face to face. The entry from Adult Social Care does not state whether the worker spoke with Kannu herself.
- 4.40. **Commentary:** since admission was initially envisaged as an interim care plan by Adult Social Care, it is questionable whether the case should have been allocated immediately after her admission to the nursing home. Due to the concerns about risks, enhanced by Kannu requesting to return home, a multi-agency meeting should have been arranged. Adult Social Care funded and commissioned the placement but NHS Funded Care authorised payment for the nursing element of the placement. If the usual process had been followed, it would have been a joint review led by Adult Social Care. On this occasion, however, there was confusion regarding which agency should take the lead. To inform that care planning and consideration of options, an assessment of the home environment was indicated and also a mental capacity assessment. Guiding these discussions and actions should have been SSAB's self-neglect procedures. It is clear that Kannu was low in mood; she had stated she was '*sad*'. If a formal mental capacity assessment had been undertaken, and an adult safeguarding assessment or enquiry guided by the principle of making safeguarding personal, Kannu's choices and (capacity relating to) decisions could have been clearly documented, for example concerning her not eating and drinking, non-compliance with medication, and understanding and ability to use or weigh information about the risks as perceived by practitioners and her family.
- 4.41. On 25th April Kannu was seen by a chiropodist. On 19th May, the GP for the nursing home used a video link to meet with Kannu. The GP had been told by nursing home staff that Kannu was declining to take her medication on occasions. The GP reviewed the medication charts. The GP assessed her as having decisional capacity, recording that, owing to her medical background, she knew what the medication was for, why it was important and what might happen if not taken. The GP knew that this was a repeating pattern from when she had been living at home and planned to re-assess in one week if the pattern was continuing.
- Commentary:** the review by the GP of her mental capacity and decision-making regarding medication was good practice but there is no record in the combined chronology that this was followed-up subsequently. Noteworthy, too, is that some practitioners were visiting the nursing home, notwithstanding the Covid-19 pandemic.
- 4.42. **Commentary:** the combined chronology then falls silent. Between 19th May and 9th August, no agency has provided any information about work with Kannu. The nursing home has confirmed that there was no contact with, or visits from practitioners during

this time. Kannu's family have expressed "shock" at this absence of contact but did question whether she had become "caught up" in the responses to the pandemic. This gap falls far short of standards of acceptable and lawful practice. Kannu had expressed a wish to return home and appears to have understood that the admission to the nursing home would be short-term. Where mental capacity had been assessed formally, with respect to decisions about care and treatment, Kannu had been assessed as having decisional capacity. There does not appear to have been any consideration about a long-term plan for meeting Kannu's care and support needs, including whether a care package could be arranged that would enable her to return home with risks mitigated. If multi-agency care planning had concluded that this would not have been possible, and if Kannu was still saying that she wished to return home, a mental capacity assessment and consideration of legal options regarding her liberty should have been initiated at this point. As it was, it would appear that Kannu had simply been forgotten.

- 4.43. On 9th August the nursing home has recorded that Kannu was refusing to eat and had expressed a wish to return home. Contact was made with her son. The following day she again expressed a wish to return home to nursing home staff and felt that her son had left her in the nursing home. On 16th August she again expressed a wish to return home and felt that her son was not visiting her because he did not wish her to leave the nursing home.

Commentary: the law relating to mental capacity and deprivation of liberty safeguards is clearly engaged here, as it was from the first occasion in April when she expressed a desire to return home. However, the care provider does not appear to have notified Adult Social Care as soon as Kannu was expressing her wish to leave the nursing home. By this time, and arguably earlier, Adult Social Care should have arranged and led on a formal review of the placement.

- 4.44. On 17th August a nurse at the nursing home did contact Adult Social Care, expressing concerns that Kannu was eating little, was low in mood and wanting to go home. There was no allocated social worker at that time, according to the nursing home's entry in the combined chronology. Adult Social Care's entry for the same date has recorded the conversation with the nurse but observes that there was conflicting information and that it was difficult to tell if it was due to Kannu's capacity and level of understanding or whether the professionals involved were not understanding the situation. Funded Nursing Care were asked to review the placement and feedback to Adult Social Care.

Commentary: an entry from Adult Social Care on the combined chronology reflects that an urgent multi-agency, multi-disciplinary professional meeting could have been considered given the conflicting information and the delay (from April 2020) in resolving when, if at all, Kannu could return home. A mental health referral could have been made and a thorough mental capacity assessment completed.

- 4.45. The following day a nurse spoke with Kannu who said that she was unhappy because her son was not visiting and wanted her to stay at the nursing home when she really wanted to return home. The nursing home record of this conversation appears to link Kannu wanting to return home with her not wanting to eat and drink. Also on 18th August the

nursing home was informed by a social worker that a nurse from the Funded Care Team would complete an assessment.

- 4.46. This assessment by telephone was conducted on 19th August with a registered nurse. The record of the assessment observes that she required some assistance with activities of daily living (shower, meal preparation), and was able to express her wishes and needs reliably and consistently. She engaged in care planning. Her mobility was minimal but she did not require assistance or supervision. She needed prompts about medication but was assessed as being compliant. No assessed need for dietetic involvement was recorded. However, a diabetes management plan was required.
- 4.47. Crucially the assessment records that Kannu “does not appear to be low in mood, she engages well with care staff. Her appetite can become reduced when she is asking to go home. Kannu appears to understand the concerns raised by the nursing staff in relation to how she will manage if she is to return home. Kannu states that she thought that her current placement was a respite placement and not a permanent placement and wishes to go home. She has stated that she would like to try and manage. There is no reason for the nurses to doubt Kannu's mental capacity in relation to decision making and this was confirmed throughout the review process.” The assessment later concludes that Kannu was “fully orientated to time, place and person. Nursing staff report that Kannu appears to be aware of her care needs, her own limitations and risks in her environment.”
- 4.48. This assessment was passed by the CCG to the local authority (SRFT Adult Social Care) as the “lead commissioner”, with a request to be informed if Kannu was returning home. On 21st August a diabetes specialist nurse advised nursing home staff on management of Kannu’s diabetes and hypoglycaemic episodes. Her insulin dose was adjusted.
- 4.49. On 22nd August the nursing home asked the social worker to urgently review the situation as Kannu was requesting to return home and had decisional capacity. Two days later the case was allocated to a different social worker due to a capacity assessment being required and “conflicting information being needed to be looked into.” By this time the nursing home had recorded the first positive test for a resident with Covid-19.

Commentary: it would seem that Adult Social Care did not accept that Kannu had decisional capacity regarding her place of residence. It is unclear from the chronology whether this is what was meant by conflicting information or whether there were other discrepancies that Adult Social Care wished to investigate.

- 4.50. The GP for the nursing home conducted a video call with Kannu on 25th August. An ECG showed old changes and nothing acute, which seemed to reassure her. On 26th August Adult Social Care records note that Kannu agreed to remain in the nursing home whilst work in her own home could be completed and until a social worker could visit her in the nursing home. There was an update exchange of information between Adult Social Care and both the nursing home and the CCG.

Commentary: it appears that there was no concern about her mental capacity to make this decision to remain in the nursing home for the time being.

- 4.51. An entry on the combined chronology from Adult Social Care for 28th August notes that the nursing home was not allowing social workers to visit due to Covid-19, with a decision therefore to monitor the case alongside the Funded Care Team until a face-to-face assessment could be safely completed.

Commentary: a reflection entered on the chronology at this juncture questions why, with full PPE, a face-to-face assessment was not attempted given the history and concerns. It also questions why a meeting of professionals was not arranged.

- 4.52. On 1st September Adult Social Care recorded a conversation with Kannu's son and daughter-in-law. They are recorded as saying that, in their view, Kannu should not return home and that they would find it difficult to support her if she did. It is also recorded that the social worker began to pull information together for an assessment but that it was difficult to gain a clear picture of Kannu's needs by telephone due to limited communication.

Commentary: presumably this is a reference to her hearing disability. However, could not a video link have been tried as there is a clear acknowledgement of her wish to return home?¹² With divergent views already apparent as to whether or not Kannu had decisional capacity regarding her place of residence, it might have been prudent to have sought legal advice at this stage and to have considered referral to the Court of Protection.

- 4.53. On 2nd September the nursing home recorded a staff member as Covid-19 positive. The last recorded positive test of a staff member was 15th September. During this time period, on 9th September Kannu told care staff that she wished to go home and on 11th September she refused to take all her medication. Her daughter telephoned and spoke with her about this. On 12th September she was seen by an advanced nurse practitioner via video link because of suspicion that she had contracted Covid-19. This was confirmed several days later, with Kannu being asymptomatic and advised to isolate for 14 days. She is recorded as having told the GP via video link that she wished to go home. The GP undertook to speak with her son.

- 4.54. On 16th September the GP, with a palliative care nurse, completed by telephone an advance care plan with Kannu, her son being present also. The plan clearly records that Kannu had mental capacity to make a medical advance care plan and that a DNA-CPR was in place. Her medical conditions were recorded as "Frailty, Cardiac Problems, Ischaemic Heart Disease, Aortic Stenosis, and Heart Failure. " Under management of anticipated potential symptoms is recorded: "Where possible please treat any health deterioration within the nursing home setting following review and assessment from GP. In the event of Heart Attack or Stroke please focus care on symptom control and avoid hospital admission as per families' wishes. For End of life care at the Nursing home with support from GP and Palliative care team." On fall management the following was

¹² The reviewer understands that the nursing home had been provided with tablets and IT resources to facilitate video/facetime reviews.

recorded: "If Kannu has a fall please seek medical review and advice. If signs of obvious fracture, head injury or uncontrolled bleeding please dial 999 and arrange transfer to hospital for treatment there."

- 4.55. 19th September is the date for the last recorded Covid-19 positive test result for a resident in the nursing home.
- 4.56. On 24th September the nursing home referred Kannu to the Community Dietetic Service. The referral was rejected on the basis of insufficient weight history and inaccurate MUST¹³ score. The Funded Care Team completed a further review on 28th September.

Commentary: a reflection entered on the combined chronology questions why a joint review was not undertaken at this juncture, in order to fully address any concerns arising from this case, and what actions were being taken, if any, to facilitate Kannu's return home in line with her expressed wishes.

- 4.57. On 29th September the nursing home made a second referral for dietician involvement as Kannu had not eaten for several days and was losing weight. She is recorded as having said that she wanted to die. On the same day Kannu was seen by the GP via video link. The referral to the dietician was one outcome. Medication was discussed and some was stopped to reduce the medication burden. A blood test was to be arranged. Kannu, drawing on her medical background, was able to communicate what medications she felt she did not need. The following day the nursing home sought advice from the Diabetes Service as Kannu had not been refusing food and medication, and insulin had been omitted twice. The home recorded the advice given as: (1) Omit insulin and continue to monitor blood glucose level pre-breakfast and pre-evening meal, with the acceptable range noted; (2) Metformin can be crushed and mixed with cold foods if necessary.

Commentary: as an entry on the combined chronology rightly questions, was the advice suggesting that medication could be given covertly and, if so, was this lawful? That meant, had Kannu been assessed as lacking decisional capacity regarding treatment for diabetes, with this clearly recorded?

- 4.58. On 2nd October the nursing home recorded that Kannu had been expecting to go home and felt sad. She expressed a wish to die if she could not return home. The following day the nursing home recorded that she was "quite lethargic" and that her son had been expected to visit but did not arrive. Kannu's son has clarified, however, that he had been asked to visit but was aware of "strong guidance" from the local authority not to visit, so he had spoken to his mother by telephone instead. Also on 3rd October GP records note that Kannu was reviewed by an advanced nurse practitioner and still had Covid-19 but

¹³ Malnutrition Universal Screening Tool. Adult Community Nursing records indicate that a nutritional care plan was provided, together with contact details for the service.

remained asymptomatic. On 5th October a further routine review was completed by a nurse commissioner and subsequently discussed with a social worker.

Commentary: Kannu's wish to go home was clearly understood but the combined chronology is silent about how this was being addressed. It is recorded on the chronology that "everything was alright." It is unclear how such a judgement could be sustained.

- 4.59. On 6th October Kannu's medication was again reviewed and her insulin dose reduced. Advice from a diabetes specialist nurse again included crushing medication in cold food.

Commentary: the commentary in section 4.56 is relevant here also. There does not appear to have been a policy and/or procedure with respect to covert medication. There does not appear to have been a formal mental capacity assessment with respect to Kannu's decisional capacity regarding acceptance or otherwise of medication.

- 4.60. Between 7th and 14th October there was communication between a social worker and the Funded Care Team that concluded a mental capacity assessment was required. A social work review was completed on 16th October, the combined chronology containing an entry from the nursing home that a best interest review would be done to establish if Kannu had decisional capacity about returning home. The equivalent entry from Adult Social Care records that nursing home staff were doubtful about whether Kannu understood the risks of returning home due to Covid-19 and her home environment. During this time (12th October) Kannu remained asymptomatic.

Commentary: as a reflection entered on the combined chronology observes, Kannu had been asking to return home since April, exhibited low mood and was eating little. The apparent delay in resolving the issue of mental capacity with respect to returning home is unacceptable. It is not clear from the chronology why a face-to-face assessment of care and support needs and of mental capacity was not undertaken, as allowed for by local and national guidance with respect to the pandemic. No-one appears to have escalated concerns, referred an adult safeguarding concern or convened a multi-agency risk management meeting up to this point.

- 4.61. On 19th October a review was completed by a social worker. Those involved appear to have been her son, a nursing home worker and nurse assessor. The review form records the history from the point of her admission to the nursing home. It notes nursing home staff as reporting that, in their view, Kannu would not be able to be supported safely at home, and that she had some understanding of the current situation but did not seem to have an awareness of her support needs. Her mental capacity was recorded as variable, with nursing home staff feeling unable to assess the risks in terms of a decision to enable Kannu to return home. Her son is recorded as being of the view that his mother would not be safe at home and as reporting that he and his wife found it very stressful when she had been at home. He reported that the heating was now working at her home.

Commentary: Kannu does not appear to have been involved in the review, contrary to the principle of making safeguarding personal. The review observes that a formal mental capacity assessment was required with respect to the decision about place of residence

and attributes the delay in its completion as due to the restrictions imposed because of the pandemic.

- 4.62. On 20th October GP records noted that “all bloods were normal including full bloods count, renal function, liver function test, bloods sugar stable level for diabetics’ patient. No signs of infection, biochemically well hydrated and no signs of malnutrition in the bloods.” The following day a dietician called and instituted a plan to address Kannu’s weight loss. Advice was given to the nursing home about her dietary intake and monitoring her diabetes.

Commentary: an entry in the combined chronology questions whether this intervention should have occurred earlier. GP records concerning the dietician assessment note that Kannu was “likely within a malnourished state given significant weight loss and poor dietary intake.” The record also observes that the weight loss was probably driven by low mood and possibly also Covid-19, and that Kannu was reported as having “full capacity.”

- 4.63. On 27th October a different social worker was allocated the case in order to complete a face-to-face mental capacity assessment. The following day a GP completed an assessment after discussion about the risks and benefits of visiting with nursing home staff. The records note that there were “no new firm signs or symptoms of infection; clinical picture is one of gradual decline and worsening oral intake.” Kannu was not thought to require end of life care at this point.

- 4.64. On 29th October Adult Social Care received a request for standard authorisation to deprive Kannu of her liberty. An urgent authorisation was signed by the nursing home for seven days, beginning on 29th October. On 2nd November Adult Social Care records note that the nursing home had stated that no practitioners could visit and, accordingly, a mental capacity assessment was to be attempted by video link.

Commentary: no-one appears to have challenged this decision by the nursing home.

- 4.65. Also on 2nd November receipt of the deprivation of liberty has been recorded by the DoLs team and the case added to the list for allocation.

Commentary: the application is dated 29th October but does not appear to have been received before 2nd November. There is no sense given on the application of urgency, the form stating that she was a significant fall risk if she returned home, was semi-dependent on nursing home staff for activities of daily living, and appeared confused with some signs of cognitive impairment.

- 4.66. On 3rd November Kannu was seen by a GP with the record noting that she had mental capacity. It was recorded that her son had not visited and she was feeling “down.”

Commentary: the combined chronology does not indicate whether there was a formal mental capacity assessment or the decision that was the focus of any assessment.

- 4.67. Adult Social Care records contain an entry for 4th November that an attempted mental capacity assessment did not take place. On the same day the social worker requested that the Deprivation of Liberty application be prioritised. The next allocation meeting was scheduled for 10th November.

Commentary: given that Kannu had been requesting to return home for some time, completion of mental capacity and associated assessments were already long-delayed. Waiting for case allocation until 10th November, and for a mental capacity assessment that had been rescheduled for 11th November, does not represent timely decision-making.

- 4.68. On 5th November the GP and nursing home staff discussed Kannu who was refusing medications and declining to eat/drink. The GP contacted Kannu's daughter-in law. The nursing home is recorded as having requested an urgent deprivation of liberty assessment. The same picture was repeated on 10th November, with nursing home staff frustrated at the lack of response from Adult Social Care when they attributed Kannu's not eating/drinking to wanting to return home. The GP recorded that Kannu had mental capacity to refuse medications and referral to a community mental health team. Kannu was recorded as being "down" as her son had not visited.
- 4.69. Also on 10th November Kannu's case was reviewed for allocation for deprivation of liberty assessment. The combined chronology contains the following entry: "The request for priority DOLS allocation had to be balanced against the ongoing uncertainty over Kannu's mental capacity, and the workload of the DOLS team due to current complex cases and staff shortage due to illness ... therefore decided to re-consider allocation after [the social worker had] completed her capacity assessment on 16th November."
- 4.70. On 11th November nursing home staff spoke to the GP and requested end of life nurses to review the situation. The same day the social worker began a mental capacity assessment by video link, with Kannu supported by a member of nursing home staff. It is recorded that: "she lacked mental capacity to decide on her long term care needs and accommodation, but further assessment will be required in order to make conclusion. [Social] worker asked again whether she can have a face to face mental capacity assessment, [nurse] advised that no visits are currently allowed. The nurse who was present advised that Kannu was not accepting food and medications consistently and saying she is on 'strike' until she goes home. GP was aware and felt that Kannu had mental capacity to refuse medications because she knows her medications and what they are for."
- 4.71. Also on 11th November Adult Social Care made an urgent referral for allocation of an Independent Mental Capacity Advocate (IMCA). Internal discussions with managers resulted in discussion with nursing home staff that led to an agreement for a face-to-face assessment planned for 16th November. It was also agreed that the GP would need to complete a formal mental capacity assessment. When the social worker contacted and updated the Deprivation of Liberty Safeguards Team it was agreed that allocation would be expedited.

Commentary: referral for advocacy arguably happened too late, especially given the position of the son and daughter-in-law. Further delaying the face-to-face assessment reflects a lack of timeliness also.

- 4.72. On 12th November Kannu was seen by palliative care team staff. Nursing home staff felt that she had maintained decisional capacity and was oriented in time and place. She was continuing to refuse medications and declining food/drink. An assessment conducted on 13th November by a member of the deprivation of liberty safeguards team concluded that her mental health and wellbeing were being adversely affected by her wanting but being unable to return home, effectively a deprivation of liberty, and that there was evidence of cognitive impairment and probable depression. The assessment clearly records that she had a mental disorder within the meaning of the Mental Health Act 1983.
- 4.73. On 15th November the GP completed a statement of intent – to issue a medical certificate of cause of death. Old age and frailty are listed as the advanced and irreversible illness anticipated to lead to her death. This followed a telephone consultation involving an advanced nurse practitioner and consultant nurse practitioner, and a video consultation by the GP with Kannu. The combined chronology records that Kannu was not eating, was not in pain, and had tried taking medication but vomited. She was conscious, peripherally blue, agitated and refusing oral medication. The GP reported a decline in her condition, she was cold and mottled on extremities, confused but not in pain. She lacked capacity following a completed assessment. Kannu's son is recorded by the GP as being happy with the approach being taken.
- 4.74. On 16th November the social worker completed a mental capacity assessment with respect to Kannu's long-term care needs and accommodation. It concluded that she did not have decisional capacity, being unaware of her needs, and unable to recall and retain information. The social worker made an urgent referral to the community mental health team, which was rejected because Kannu had been assessed as lacking decisional capacity regarding her needs and accommodation, and was also end of life. The social worker ascertained from a palliative care nurse that the statement of intent had been issued due to Kannu's underlying health conditions, poor oral intake and non-compliance with medications. It is recorded that an advance care plan had recorded Kannu's wish to remain in the nursing home if she required palliative care. Finally, the social worker raised a safeguarding adult concern for self-neglect and discussed the situation with specialist advisers, which resulted in a strategy meeting being convened and a recommendation for urgent mental health assessment/support as Kannu was becoming end of life as she was refusing to eat as she wanted to return home. As noted above, that referral was rejected.
- 4.75. **Commentary:** seeking specialist advice is good practice but was happening too late. The community mental health team did not see much of a mental health component in the referral, perhaps because historical information about Kannu not eating/drinking was not included in the referral. Further complexity arose due to perceived divergent assessments of mental capacity regarding medications on the one side and care needs and accommodation on the other. However, the GP had completed a mental capacity

assessment concerning her refusals of medication and concluded that, on that day, she did not have decisional capacity. Referral of an adult safeguarding concern was appropriate but, again, too late. The decision to convene a strategy meeting was happening at the point of crisis and, again, was taking place too late.

- 4.76. An emergency strategy meeting was held on 17th November. The meeting reviewed available information, including whether her health deterioration was reversible since she was not currently receiving end of life care. The meeting reached the following decisions: (1) a section 42 Care Act 2014 would be completed to understand the reasons why earlier concerns had not been raised; (2) Adult Social Care and the CCG would work together to understand the root cause of the current situation; (3) the community mental health team would be asked to reconsider the referral for a Mental Health Act 1983 assessment; (4) the nursing home would be reassured that all viable options were being explored; (5) Legal Advice to be sought.

Commentary: neither the nursing home nor the social worker were present at the meeting. Legal advice was not sought and a lawyer was not present at the meeting to advise. The GP was keeping the son informed, which was good practice. The community mental health team could not undertake an assessment that day as the consultant best placed to conduct an assessment was not available. Her case was allocated at a deprivation of liberty safeguards team meeting for a best interest assessment, reflecting the urgency of the situation. Adult Social Care was advised by the community mental health team that, if the criteria to detain Kannu under the Mental Health Act 1983 were not met and she was refusing admission to hospital, an urgent referral to the Court of Protection would be necessary. Legal advice had not been sought at this point.

- 4.77. On 18th November Kannu was seen by a community mental health consultant. The conclusion was that Kannu should be managed in the nursing home with support of a carer to prompt with food and fluids. This would be the same care she would receive in a mental health hospital particularly given her advance care plan about not wanting treatment in hospital. A deprivation of liberty assessment was to be completed. The GP had some blood test results that were of concern. A second strategy meeting was held at which the mental health consultant reported that Kannu could not be detained under the Mental Health Act 1983. Agreed actions were: (1) to follow up concerns about food and fluid charts at the nursing home; (2) to complete a Funded Nursing Care review; (3) to seek legal advice; (4) to reconvene the strategy meeting and to hold a best interest meeting; (5) the GP to make a clinical decision about the necessary response to the blood test results; (6) one-to-one support to be provided by the nursing home with respect to food and fluid intake. The social worker update the care plan.

Commentary: neither the nursing home nor the social worker attended this second strategy meeting. A lawyer was not present to provide legal advice.

- 4.78. A member of the deprivation of liberty safeguards team began a best interest assessment on 18th November which, due to Covid-19, was a documentary analysis and interviews with care staff and Kannu's son and daughter. The assessment refers to the mental health assessment completed on 13th November. It clearly states that there was no advance decision. It clearly records that her son agreed with 24-hour care in the

nursing home and to her daughter being the relevant person's representative if deprivation of liberty safeguards were being considered. The daughter agreed with Kannu remaining in the nursing home. The assessment could not be completed as Kannu was admitted to hospital before the assessor could see her.

- 4.79. The GP understood the outcome of recent assessments to be that Kannu did not have decisional capacity regarding medication and that one-to-one arrangements were being instituted regarding food/fluid intake and medication compliance. Her medications were being rationalised.
- 4.80. On 19th November a third strategy meeting was convened. The legal advice obtained by SRFT and Adult Social Care was reviewed; the legal advice from SRFT expressed concern about whether the advance care plan covered the current circumstances. In relation to her best interests, although blood test results indicated renal failure and dehydration, with the GP advising that most likely the hospital would not do any active treatment, it was concluded that these health concerns might be reversible and, therefore, hospital admission should be arranged. It was also agreed that a section 42 enquiry was still needed and that further legal advice about the best interest decision for admission would be sought. Mental health input would also be sought if and when her health improved. The request for legal advice provided a summary of the chronology. The advice received amounted to ensuring that the GP had completed a formal mental capacity assessment and, if Kannu lacked capacity and was deprived of her liberty, ensuring that the deprivation of liberty safeguard process was completed. Any safeguarding concerns should be explored and her mental health reviewed if there were signs of deterioration.

Commentary: neither the nursing home nor a lawyer were present at the meeting. No palliative care consultant was present. No legal opinion was expressed about the advance care plan by the lawyer whom Adult Social Care consulted because a specific question was not asked although it was referred to in the chronology. It was suggested that the SRFT and Adult Social Care should seek further legal advice because of her consistently held objections to being helped in relation to eating/drink, including checking whether referral to the Court of Protection should be considered since Kannu's Article 8 right to private and family life appeared to be engaged. It was also noted that section 63, Mental Health Act 1983 could be used if not eating/drinking was a manifestation of depression.

- 4.81. The same day the GP received advice from a dietician who did not recommend active treatment for refeeding syndrome; nutrition was to be for support and comfort. The GP saw Kannu. She was sleepy and unresponsive. She had not taken any fluid or food. The paramedics are recorded as questioning the rationale for admission to hospital in the GP records as Kannu was "shutdown." However, Kannu was conveyed to hospital, this being a decision under section 5, Mental Capacity Act 2005. The deprivation of liberty safeguards process was halted. On admission the GP spoke with a consultant who confirmed that Kannu was end of life. Kannu died on 20th November in hospital.
- 4.82. Meanwhile CCG records note that the nursing home records had been checked. There were no significant concerns over staffing levels for the previous weeks; on reviewing

food and fluid charts, Kannu had been offered diet and regular snacks each day but frequently refused. A new body weight was taken on 18th November which reflected a further significant drop in body weight. This information was given at the third strategy meeting.

5. Analysis

- 5.1. The same framework for analysis is used as for SAR – Eric (2020) and SAR – Andy (2019), earlier reviews completed by SSAB. This provides a structure for analysis and also enables cross-case comparison.

Direct work with Kannu

- 5.2. The first key component relevant to this case is *Making Safeguarding Personal* (MSP). This comprises a person-centred approach that includes proactive rather than reactive engagement and a detailed exploration of a person's wishes, feelings, needs and desired outcomes. It involves concerned and authoritative curiosity characterised by gentle persistence and skilled questioning. What might lie behind a refusal to eat/drink, or to accept medications, is a key line of enquiry.
- 5.3. The early part of the chronology includes several hospital admissions. Discharge planning was generally timely and person-centred. Kannu and her relatives were clearly involved in planning. When at home, and with declining health and periodic refusals to take medications, it is less clear whether the implications were fully explored with Kannu. Following the welfare concerns expressed by the ambulance crew, an assessment was completed. Care providers were to encourage Kannu to eat and drink and to report concerns to district nurses, with whom they were expected to work closely and seek their advice and guidance. The GP was to be informed that Kannu was non-concordant regarding her medications and to be asked to complete a medication review. It is less clear how Kannu was involved in these decisions and whether any increase in the package of care was considered and discussed with her.
- 5.4. From the point of admission into the nursing home Kannu was consistent in her expressed wishes and feelings. Her voice can be clearly heard in advance care planning and in her desire to return home. Kannu expressed this wish to return home immediately after her admission. She apparently accepted the need to remain in the nursing home during the first lockdown, which has been put forward as the main reason for the gap in the combined chronology between April and mid-August, but thereafter again repeatedly expressed her wish to return home. Nonetheless, it is important to highlight that as early as 18th April Kannu was expressing a wish to return home, to sort out her finances, but a social worker not allocated to explore this until 26th August. If the pandemic was the reason why relatives and practitioners were concerned to ensure that Kannu was in the safest place possible, no risk assessment has been seen by the independent reviewer that weighed up the risks from Covid-19 of remaining in the care home against the risks of returning home and shielding. Further, if as recorded at the end of August Kannu agreed to stay in the nursing home until a face-to-face assessment was possible and her own home had been made ready, this was not then completed in a timely manner.
- 5.5. At reflection events there was an acknowledgement that the approach to engaging with Kannu had not been person-centred. Amongst the acknowledged practice shortfalls were a lack of professional curiosity in terms of exploration of options to enable Kannu

to return home. There appeared to have been an acceptance that the home environment was problematic rather than detailed exploration, even after Kannu's son had confirmed that the boiler had been repaired. No review of the care package was undertaken to explore whether increased care and support would have facilitated her return home. Family members were not advocating her return home but their position does not appear to have been challenged, nor explored in terms of what support the son and daughter-in-law might have felt able to offer in the context of the pandemic.

- 5.6. There were risks if Kannu were to return home. However, it appears that she was accepting of the risks and it is possible that a more creative, multi-agency response to her needs and the risks involved, might have facilitated her return home¹⁴. She was clearly safe in the nursing home since, for example, the risk of falls could be minimised but she was increasingly unhappy. An enhanced care package might have enabled her to live at home, not without risk but with reduced risk¹⁵. She would have been happier.
- 5.7. Part of making safeguarding personal, of a person-centred approach, must be a deep appreciation of and respect for a person's culture, heritage and religion. Kannu's daughter has reminded the independent reviewer that "very often the spiritually advanced Hindus begin to reduce their food intake when they feel, deep down that they are ready to depart this world ('spiritual cleansing')." A core component of professional curiosity is having conversations about what each individual draws upon for strength and sense-making.
- 5.8. The second component of the evidence-base focuses on *assessment and responses to health, mental health and mental capacity*. The evidence-base advises thorough assessments of health, mental health and care and support, with updated planning and regular reviews. Thorough assessment of mental capacity should include a focus on executive capacity. Comprehensive assessments should include a focus on risk, especially in cases of service refusal.
- 5.9. Feedback to the independent reviewer from those practitioners and managers with knowledge of the case includes an acknowledgement that dieticians could have been involved at a much earlier stage, alongside exploration of whether or not Kannu's limited intake of food/drink was due to physical ill-health.
- 5.10. Kannu's son and daughter clearly recognised that her mental capacity could fluctuate. They thought that a temporary placement in a nursing home was the right decision at the time but had different views about her decisional capacity then. Her son felt that his

¹⁴ The independent reviewer understands that commissioners have a night-time offer as part of their forward plan for home care provision.

¹⁵ The case of *Westminster City Council v Sykes* [2014] EWHC B9 (CoP) is illustrative here. The Court of Protection declined to authorise deprivation of liberty and to require Manuela Sykes to remain in a nursing home. She returned home with the maximum care package that was possible, provided by the local authority and NHS, with some support from her only relative.

mother did not have decisional capacity regarding her living arrangements, and did not understand the risks of returning home. Her daughter was less certain but did query whether she understood the implications of Covid-19.

- 5.11. There were divergent views concerning Kannu's mental capacity with respect to care and treatment before her admission to the nursing home. This divergence does not appear to have been explored or resolved. Subsequently, whilst acknowledging that mental capacity is time and decision specific, it does appear that when it came to Kannu accepting the need to remain in the nursing home during the first lockdown, her decisional capacity was not questioned; when she was expressing a wish to return home, doubts about her decisional capacity were expressed against a backdrop of family concern. There were, as the combined chronology outlines, long delays in resolving the question about decisional capacity with respect to her wish to return home. It is quite possible that Kannu had decisional capacity with respect to her place of residence for much of the time when she was living in the nursing home, including in August 2020; she was only assessed as lacking that capacity shortly before her final hospital admission.
- 5.12. At the reflection events it was recognised that opportunities for earlier referral for mental health assessment were missed, perhaps because monthly multi-disciplinary group meetings had been suspended due to the pandemic. Mental health providers suggested that this was not a unique case and emphasised the importance of early referrals where the impact of physical health concerns, such as acute kidney injury, had already been considered. As it was, to mental health providers, the late referral seemed more medical than mental health in terms of needs.
- 5.13. Risks to her physical wellbeing were clearly documented in assessments that resulted in her admission to the nursing home, envisaged initially as a short-term placement. However, there was no plan to enable her return home and the risks attached to her remaining in the nursing home were not identified. Nor were assumptions about the suitability of her home environment, with or without adaptations, questioned. After her nursing home admission no practitioner visited her home as part of any assessment. Her son and daughter described their mother as a compulsive hoarder but were adamant that the house was clean. Although cluttered, according to her son and daughter, there was only one bedroom that could not be used for the purpose for which it was intended. Other rooms were usable and the boiler was mended by August 2020.
- 5.14. The independent reviewer has been told that multi-agency risk assessments, presented to the High Risk Panel¹⁶, have been of variable quality with insufficient detail. Risk assessments completed for her nursing home admission were detailed about the events that were seen as precipitating her placement. What was missing was any assessment of care and support alternatives before admission or option planning subsequently.

¹⁶ Recently established as a result of findings and recommendations in SSAB's SAR – Andy and SAR – Eric. It had not been established and was not in operation at the time practitioners were working with and providing support to Kannu.

- 5.15. The third component of the evidence-base refers to *working with the family*. This comprises seeking information from family members that may help to shape assessment and intervention, and offering carer assessments and support. It does not appear that the son and daughter-in-law were offered carer assessments as part of any exploration of how to facilitate Kannu remaining at home or returning after her nursing home admission. They were involved in the arrangements for her care at home. They did feel involved by services when Kannu was living at home, knew that she was adamant that she wished to remain at home, and were aware of risks, including eating out-of-date and/or mouldy food. They felt that services were doing their best at this time but that Kannu needed more support, especially at night, as she was weak and distressed at losing her independence. They did not know in the run-up to her nursing home admission that she was becoming frightened, especially at night, being informed later of this by a friend.
- 5.16. Neither the son nor the daughter could recall any practitioner talking through possible legal options. The son, daughter-in-law and daughter appeared to have had different awareness of Kannu's advance care plans. For the daughter, being stuck abroad was especially painful, with communication by telephone "terrible" because of Kannu's hearing disability and the quality of the connection, and no iPad apparently available to assist with maintaining some degree of contact. Some of the practitioners involved were aware of this. Kannu's daughter was also distressed that she did not know whether her mother had received and been able to read her letters and email communications.
- 5.17. The son described the nursing home as being very, very strict on protecting residents, with any supplies or gifts having to be left at the front door. Yet, it is also known that Kannu felt isolated and that she felt that no-one cared. Indeed, practitioners at the reflection events acknowledged that Kannu's wellbeing was affected by her not being able to see her son. The independent reviewer was told that the nursing home had offered the possibility of a visit with PPE but it was understood by several services that the son was shielding. Kannu's son has clarified, however, that he was not shielding; rather, he was being cautious and following national and local guidance. Again, electronic communication could have been offered to the son and daughter, both of whom were interested and concerned.
- 5.18. Kannu was consistent in her wish to return home and used the means available to her to protest about her situation. In that context, given that her son and daughter-in-law in particular were supporting a continuation of the nursing home placement, and her daughter was recorded by Adult Social Care as agreeing that it was better for Kannu to remain in the nursing home during the Covid-19 pandemic, earlier referral to *advocacy* would have been appropriate. As stated at a reflection event, family members can be compromised emotionally. Indeed, the son and daughter-in-law recalled how they were called numerous times, including late into the night, when Kannu was living at home; it had been frightening for everyone. They felt nursing home admission was the only option. They sent a letter detailing the risks that they felt had been present when Kannu was living at home, and the risks that would arise if she returned home. The referral to advocacy was "quite late", the consequence being that the appointed advocate was not able to meet Kannu and assist her to engage in assessments.

- 5.19. In summary a sense was conveyed at the reflection events that the pandemic disrupted how practitioners worked with individuals requiring assessments and care and support. Face-to-face assessments were rendered much more difficult for GPs and social workers. Visits were restricted unless absolutely necessary. For the family too the pandemic was a complicating factor. Her son was shielding and her daughter had to return to her home abroad and could not visit again to support her mother. She had hoped that travel restrictions would be temporary. The independent reviewer has been told that Kannu became “lost in the system” due to Covid-19.
- 5.20. However, not all the practice shortfalls could be attributed to the pandemic. Kannu knew what she wanted, informed by her medical training and knowledge, clearly expressing her wishes both when she was assessed as having decisional capacity and when not. Some of her refusals of medications may have been due to historic and possibly contemporary experience of side-effects. Feedback to the independent reviewer has acknowledged that lessons still need to be learned about the importance of a person-centred approach, people being central to, and involved in all decision-making and care planning. That did not happen consistently in this case. There was no robust action plan, with a timescale, to facilitate her return home from the point of her short-term nursing home admission.

Team around the person

- 5.21. Balancing a person’s wishes and autonomy against a duty of care is often a significant challenge in cases of self-neglect¹⁷, which is why multi-agency risk management meetings form part of the recommended evidence-base, enabling options to be appraised and reviewed. Embedded within this case is this moral/ethical dilemma, verbalised by Lord Justice Munby: “what good is it making someone safer if it merely makes them miserable?”¹⁸ It was very difficult for those present at the three strategy meetings to navigate through the ethical dilemma with which they were presented, namely whether or not to respect an advance care plan. However, Kannu’s situation relating to her continued presence in the nursing home, despite her stated wishes when she both had and did not have decisional capacity, and in relation to her ongoing ill-health for which the prognosis was poor, should have been addressed explicitly months before the three strategy meetings in what turned out to be the last week of her life.
- 5.22. One component of this part of the evidence-base refers to *seeking specialist advice*. It was acknowledged at the reflection events that safeguarding specialists in the CCG and the local authority had not been consulted sufficiently early, with missed opportunities consequently for early intervention and prevention. Legal advice was only sought very shortly before Kannu died when earlier legal options about the use of covert medication, the applicability and legal standing of her advance care plans, and possible deprivation

¹⁷ Braye, S., Orr, D. and Preston-Shoot, M. (2017) ‘Autonomy and protection in self-neglect work: the ethical complexity of decision-making.’ *Ethics and Social Welfare*, 11(4), 320-335.

¹⁸ Re MM (An Adult) [2007] EWHC 2003 (Fam)

of liberty were all indicated. This highlights the importance of another component of the evidence-base, namely *legal literacy*. From the point of her first request to return home, immediately after her nursing home admission, legal rules were engaged but do not appear to have been recognised.

- 5.23. During the reflection events considerable disquiet was expressed regarding Kannu's final admission to hospital, which was felt by some of those attending to have contravened an advance care plan. Some practitioners expressed the need for guidance about advance care plans and the circumstances when they should be respected or deemed inapplicable. Others expressed a lack of clarity about how to proceed when the Mental Capacity Act 2005 and the Mental Health Act 1983 might both be engaged, additionally complicated by the existence of advance care plans. These concerns clearly arose at a time when Kannu was acutely ill and lacked decisional capacity regarding her place of residence, treatment and long-term care needs. There was also concern regarding what "home" meant to Kannu; did it mean the nursing home or her own home? Everyone seemed clear, however, that Kannu had not wanted to be treated in hospital, although it was acknowledged that there had also been occasions when she had indicated acceptance of hospital treatment.
- 5.24. Two points arise here. Firstly, as case law emphasises¹⁹, local authorities must recognise when care plans, such as admission into a nursing home, will amount to a deprivation of liberty, to evaluate whether such plans are necessary and proportionate or whether a less restrictive option is possible, to obtain the necessary lawful authority before such deprivation of liberty occurs, and to keep cases under constant review. This should have happened from the first occasion when Kannu requested to return home.
- 5.25. Secondly, the Code of Practice for the Mental Capacity Act 2005²⁰ does not refer to advance care plans but does refer to advance decisions. This enables a person with capacity to make an advance decision to refuse medical treatment. Such a refusal must be respected if valid and applicable to current circumstances. In the event of doubt or dispute, the Court of Protection is available to resolve disagreement. Treatment is permitted whilst the Court of Protection is considering any submission²¹. If the advance decision refuses life-sustaining treatment, it must be in writing, be signed and witnessed, and state clearly that the decision applies even if life is at risk.
- 5.26. Whilst clinicians are protected from liability for failing to provide treatment if they reasonably believe that a valid and applicable advance decision to refuse treatment exists, for some of those attending the third strategy meeting this position had not been proven. It does not appear that Kannu made an advance decision to refuse treatment.

¹⁹ AJ (Deprivation of Liberty Safeguards) [2015] EWCOP 5.

²⁰ Department of Constitutional Affairs (2007) Mental Capacity Act 2005: Code of Practice. London: The Stationery Office.

²¹ Section 26, Mental Capacity Act 2005.

- 5.27. The independent reviewer has seen two advance care plans. One, dated 13th June 2019, identifies that Kannu's preferred place of care was her home and her preferred place of death was either her home or a hospice. It also records that she would like to be readmitted to hospital "in the event of a deterioration in her health related to her heart or otherwise." The second advance care plan, dated 16th September 2020, clearly states that no advance decision to refuse treatment had been made. It states that, where possible, Kannu wished to receive any treatment for any health deterioration within a care home setting following review and assessment by her GP. In the event of a heart attack or stroke, she wished the focus to be on symptom control and to avoid hospital admission. For end of life care, she wished to remain in the care home with support from her GP and the palliative care team. She wished to be transferred to hospital in the event of a fall causing fractures, head injury or uncontrolled bleeding.
- 5.28. It does not appear that those providing legal advice at this late stage had been shown the advance care plans in order to give an opinion on whether they constituted an advance decision and, if so, were valid and applicable in the circumstances pertaining at the time. Advance care plans are what the Mental Capacity Act 2005 refers to as advance statement of wishes. Section 4(6) of the 2005 Act requires decision-makers to consider a person's present and past wishes, in particular any written statement made when they had decisional capacity. Section 4(7) requires decision-makers to take into account anyone named to be consulted and anyone caring for the person or interested in their welfare. However, an advance statement of wishes is not legally binding in the same way as an advance decision to refuse treatment²².
- 5.29. Thus, those attending the strategy meetings, most especially the third, had to decide whether her advance statement of wishes covered the precise circumstances at the time, namely whether or not she was end of life, and whether hospital admission was in her best interests.
- 5.30. This illustrates another component of the evidence-base regarding how practitioners and agencies work together, namely the *referral process*. There are several aspects here. The first is the pathway for accessing legal advice. In a previous SAR in Salford²³, it appeared that there were different organisational cultures with respect to seeking legal advice. In Kannu's case, both the local authority and SRFT sought legal advice from different sources. When advice is sought by more than one agency, it is imperative that the advice received is brought together in one decision-making process.
- 5.31. The second is the content of referrals. In that same previous Salford SAR, clarity was advised in terms of what is being requested in any referral and why. Other SARs²⁴ have

²² Grimshaw, K., Brown, K. and Lyne, M. (2020) *Advance Care Planning*. Bournemouth University National Centre for Post-Qualifying Social Work and Professional Practice.

²³ Salford SAB (2019) SAR - Andy.

²⁴ For example, Wiltshire SAB (2019) Adult C.

also pointed out that referrals, including from GPs, need to highlight clearly what is being asked for. Lawyers in Kannu's case were provided with a general chronology but were not asked specific questions, such as whether an advance care plan constituted an advance decision and, if so, whether it was valid and applicable. The advice given included a suggestion that Kannu be told that a return home was an option but should be preceded by treatment in hospital first. Unfortunately, events did not allow that conversation to take place.

- 5.32. *Information-sharing* is a key component of best practice identified within the evidence-base. As detailed in the chronology, there were many occasions when information was exchanged between the practitioners involved with Kannu. This included the sharing of assessments.
- 5.33. Information-sharing is one aspect of another component of the evidence-base, namely *inter-agency collaboration*. This includes the use of multi-agency meetings to pool information and share assessments of risk and mental capacity, to agree risk management and contingency plans, and to consider legal options. During the first part of the chronology, when Kannu had several hospital admissions, there were multi-disciplinary meetings to plan her discharge. However, not all agencies were consistently involved. When at home and with her health declining, there was a missed opportunity to convene a multi-agency, multi-disciplinary meeting to review a care and risk mitigation plan, and to explore options. There was a missed opportunity to convene a similar meeting immediately after her nursing home admission, with the result that there was no apparent plan for her longer-term care and support. There was a further missed opportunity to convene a multi-agency risk management meeting in August 2020 when Kannu wished to return home and had decisional capacity but with family and practitioner concerns about the risks involved.
- 5.34. The first multi-agency meeting was only held on 17th November. This, and the meetings that followed, were convened at short notice. It is commendable that senior managers, safeguarding specialists and practitioners came together in this way. However, those attending the reflection events acknowledged that this was "too late." It was suggested that this was partly because practitioners did not feel able to convene or to suggest multi-agency meetings. As concerns had not been escalated earlier, for example with safeguarding specialists in the CCG or local authority, the senior staff attending the first of three strategy meetings were unaware of the chronology.
- 5.35. However, there were other shortcomings with the convening of the strategy meetings. At none of the three strategy meetings was a lawyer present. Staff from the nursing home were not present either, and disagreements surfaced at the reflection events concerning whether or not the nursing home had been invited. In any event the views of nursing home staff were not sought, either about a concern that emerged at the second strategy meeting regarding fluid and nutrition monitoring that was resolved at the third meeting, or about whether or not to arrange for Kannu's admission to hospital. The social worker was not present at the first and second strategy meetings. Mental health services were not present or invited to the first meeting. For those attending the

reflection events a concern therefore arose as to how Kannu's voice was heard during these meetings.

- 5.36. There also appeared to be some debate as to which manager should chair the meetings and what issues were to be addressed and, therefore, decisions to be made. No formal minute taker was available for any of the three meetings. The independent reviewer has been advised that minute taking remains a cause for concern. Legal advice appears to have been sought only after the second strategy meeting. The legal advice that was received does not seem to have assisted decision-making at the third strategy meeting regarding whether the advance care plan should be respected or whether, because some of those attending were of the view that there was a chance that Kannu could recover with treatment, it should ultimately be discounted.
- 5.37. Clearly, as acknowledged at the first strategy meeting, concerns should have been picked up much earlier, with practitioners and services meeting together to explore whether it would be possible to facilitate Kannu's return home, to direct completion of care and support, mental capacity and mental health assessments, and to seek legal advice. A core component of the evidence-base is *safeguarding literacy* but no adult safeguarding concerns appear to have been referred. An ambulance crew did submit an adult welfare notice requesting an assessment on 26th March 2020. It appears that care providers only raised concerns with Kannu's daughter-in-law and not with Adult Social Care about her non-concordance with medication in the month leading up to her nursing home admission.
- 5.38. Referrals of adult safeguarding concerns represent one escalation pathway and might have led to an enquiry. However, concerns were not escalated in this way despite Kannu having care and support, experiencing abuse/neglect (in this instance self-neglect, including not eating/drinking) and potentially unable to protect herself²⁵. It has been suggested to the independent reviewer that one of the lessons to emerge is the need for a wider understanding of what constitutes adult safeguarding.
- 5.39. Although, as the evidence-base recommends, an *escalation procedure* was in place with respect to adult safeguarding concerns, those attending the two reflection events were less clear about the escalation pathway to follow in relation to face-to-face visits in nursing homes during the pandemic. Some practitioners, such as a chiroprapist, did enter the nursing home during the pandemic, using PPE, but social workers were told by the nursing home that face-to-face visits were not possible. This contributed to the significant delay in completing a mental capacity assessment concerning Kannu's wish to return home. Since exceptional visits were allowed by local guidance, it is surprising that concern about the prohibition on social worker visits to complete a statutory duty was not escalated. A sense was conveyed at the reflection events that clarifying escalation pathways was still work in progress, the use of duty principal managers being one

²⁵ Section 42(1) Care Act 2014.

option. It has been suggested to the independent reviewer that the need exists for a clear structure to follow when serious concerns arise.

- 5.40. There was a failure to *use policies and procedures* that did exist, namely on self-neglect and also the non-concordance pathway. Additionally, what emerged at the reflection events was a misunderstanding over whether Adult Social Care or Funded Nursing Care was the *lead agency* and should take the leadership position. This confusion may have arisen because Kannu was admitted to the nursing home from her own home rather than from hospital. It accounts in part for the combined chronology's silence between April/May and mid-August, at least from Adult Social Care's viewpoint since she had agreed to remain the nursing home during the Covid-19 outbreak and Funded Nursing Care was assumed to hold leadership responsibility for reviewing the placement. Funded Nursing Care saw their role as leading on hospital discharge and placement finding during the pandemic and not to lead commissioning or oversee Kannu's care. The independent reviewer has seen guidance to the effect that for nursing home placements, a social worker needed to monitor and maintain as an open case until further notice regarding Covid-19 funding.
- 5.41. In summary a sense was conveyed at the reflection events that the pandemic disrupted how services and practitioners worked together. Pressures on hospitals were given primacy nationally and this led to changes in how teams operated locally. Some practitioners reported that accessing other services became really difficult. However, it was also acknowledged that not all of the shortcomings revealed in this case could be attributed to the pandemic. There are clear parallels between this review and both SAR – Andy and SAR – Eric with respect to missed opportunities to use multi-agency risk management meetings, to refer adult safeguarding concerns and initiate enquiries, to seek legal advice in a timely way in order to maximise the efficacy of prevention, intervention and recovery, and to escalate concerns. It has been suggested to the independent reviewer that there has been mixed engagement with respect to implementation of procedures regarding self-neglect.

Organisational support for the team

- 5.42. One component of the evidence-base in this domain is the *provision of clear policies and procedures* to provide a framework within which practitioners can act. Much of the time practice in this case took place during lockdown and the grip of the Covid-19 pandemic. Statutory functions relating to care and support, and adult safeguarding were not eased. Local guidance²⁶ was produced in response to central government guidance on practitioners visiting nursing homes that referred to the need for caution but permitted

²⁶ NHS Northern Care Alliance NHS Group (undated) *Statutory safeguarding practice guidance for Adults practitioners during Covid-19*.

face-to-face visits in exceptional circumstances. This local guidance reiterated that safeguarding duties had not been eased.

- 5.43. Local guidance²⁷ was also issued to care homes with respect to mental capacity and deprivation of liberty. It too emphasised that statutory duties remained in force. It focused particularly on how to manage situations where care home residents might not comply with social distancing or other restrictions. It did not focus explicitly on the types of situation encountered in this case.
- 5.44. Decision-making in relation to the importance of completing mental capacity assessments did not follow local guidance. This may have been the result, in part, of an “overwhelming volume” of guidance for commissioners and providers, without subsequent detailed oversight of how such guidance was being implemented. The guidance was also perceived to “change often.”
- 5.45. Research has also spotlighted the risks attached to policy overload²⁸. Simply having a procedure does not mean that people will be safeguarded because knowing that a policy may exist is different from understanding and working through its contents. At the reflection events uncertainty was expressed by providers about what constituted “essential visits”, with recognition that the guidance may have been misunderstood. Certainly a priority for nursing homes was to focus on PPE and avoid infection outbreaks. This was in a context of high death rates in nursing homes in Salford during the first lockdown. It was also not clear to providers what guidance other services/agencies had received.
- 5.46. It is important to acknowledge, however, that the local authority was in weekly contact with care and nursing homes, with link workers available to discuss any (safeguarding) concerns. There was a weekly care home forum, open to all care homes. This was good practice but does not appear to have been perceived as an escalation pathway in respect of concerns surrounding Kannu.
- 5.47. SSAB published self-neglect procedures before the SAR – Andy review. However, SAR – Eric highlighted the need to further embed the self-neglect procedures in practice and an opportunity to use the procedures in this case was missed when Kannu began to refuse medications, food and drink more consistently. One explanation put forward is that policies, such as the self-neglect procedures, are very general and not always easy to apply to specific complex scenarios, such as refusal of medications. Equally, practitioners may have missed out on training or have insufficient access to reflective support. The independent reviewer has been advised of a significant increase in self-neglect referrals and concerns being raised with safeguarding specialists, both locally in

²⁷ MCA/DOLS guidance for care homes in Salford (undated).

²⁸ Northway, R., Davies, R., Mansell, I. and Jenkins, R. (2007) ‘Policies don’t protect people, it’s how they are implemented: policy and practice in protecting people with learning disabilities from abuse.’ *Social Policy and Administration*, 41, 1, 86-104.

Salford and also nationally²⁹, further highlighting the importance of use of available procedures. The same applies to the non-concordance pathway that now exists.

- 5.48. Another component of the evidence-base, therefore, is *management support and oversight, and supervision*. There were management changes in the nursing home due to the pandemic. Although there was weekly contact during the pandemic with nursing homes, those attending the reflection events questioned both the dissemination of guidance and whether sufficient support was given to nursing homes when they were really challenged. There were outbreaks of Covid-19 infection in the nursing home when Kannu was resident there and daily updates were required from nursing homes, adding to the pressures that they experienced.
- 5.49. As was commented in one reflection event, “the rug had been pulled from under our feet”. Information was being interpreted by different services “as best they could.” Those attending reflection events also acknowledge that practice took place within a context of media scrutiny and negativity about deaths in nursing homes.
- 5.50. When the fourth social worker was attempting to conclude a mental capacity assessment, management advice was sought, to the effect that a face-to-face assessment was necessary. However, at the reflection events concerns were raised regarding the volume and frequency of the guidance made available to GPs and other practitioners, and whether practitioners recognised when situations they were encountering should trigger the seeking of advice. This finding also emerged in SSAB’s SAR – Andy and SAR – Eric. A question was raised at a reflection event concerning whether adult safeguarding specialist are sufficiently visible to practitioners. Feedback by staff to questions posed by the independent reviewer has included that senior managers were not sufficiently available to provide direction to practitioners.
- 5.51. A further feature of the evidence-base in this domain is *attention to workforce and workplace issues, featuring workloads, training and staffing levels*. There were delays in allocating a social worker due to workloads in August 2019. Kannu was the responsibility of four different social workers, a situation recognised by Adult Social Care as neither desirable nor usual. It was attributed in reflection events to some workers having to shield, changing job roles to meet the demands of the pandemic, staff expertise regarding mental capacity assessments, and limited staff availability. At the reflection events, increased workloads as a result of the pandemic were highlighted.
- 5.52. Suggestions for further training have been given to the independent reviewer, for end of life conversations, supporting family members to communicate with each other, use of escalation, and best practice with people who self-neglect.

²⁹ Care and Health Improvement Programme (2021) Covid-19 Adult Safeguarding Insight Project (2nd Report). London: LGA and ADASS.

- 5.53. A final feature of the evidence-base of relevance here is *commissioning*. At the beginning of the time period under review, one hospital discharge appears to have been delayed due to lack of care provider capacity.
- 5.54. No intermediate care beds were available, which resulted in Kannu's admission to the nursing home. As the care package did not appear to be sufficient in the run-up to that admission, with concerns being expressed to Adult Social Care about her low mood, self-neglect, and home conditions, the option of adding to the care package does not appear to have been considered, for example more personalised provision with respect to night-time support. The independent reviewer has been told that this is a gap in the home care market offer.

6. Revisiting the Terms of Reference and Key Lines of Enquiry

- 6.1. As the analysis has shown, there does not appear to have been anyone who was actively supporting Kannu to participate in care planning at crucial times. The first of these was the run-up to her admission into the nursing home, when no-one appeared to be exploring with her any option that might have enabled her to remain at home, not without all risk but with risks mitigated. The second of these was when she was expressing a wish to return home and apparent acceptance to remain in the care home during the first lockdown. **Key learning from this case is to ensure early referral for advocacy and to ensure that every interaction is person-centred.**
- 6.2. There is evidence that Kannu's son, daughter and daughter-in-law were consulted about plans both when Kannu was living at home and subsequently when she was resident in the nursing home. However, it is much less clear that the legal rules relating to deprivation of liberty were explained to them. It appears there was concordance between family and practitioner views that it was in Kannu's best interests to be admitted and then to remain in the nursing home. It does not appear that how to reach that conclusion lawfully was fully discussed with Kannu's son, daughter and daughter-in-law. **Key learning from this case is that practitioners must work through all the options with both the individuals they are working with and their relatives, and not simply accept what may have become a dominant view³⁰.**
- 6.3. Article 5 of the European Convention on Human Rights, the right to liberty, together with the Mental Capacity Act 2005 and Article 8, the right to private and family life, were engaged from the moment when admission into the nursing home was considered. When Kannu had decisional capacity, she could determine what was in her best interests. When there was doubt about her mental capacity, a thorough and timely assessment was required of her decisional and executive capacity, followed where indicated by best interest decision-making and use of the deprivation of liberty safeguards if warranted. **Key learning from this case is that there were shortfalls of legal literacy.** Only once was Kannu lawfully deprived of her liberty, for one week from late October to early November. Case law has provided regular reminders that the power to act on the basis of safeguarding concerns and intervene in the lives of adults at risk must be found within statute or common law in order to avoid breaches of Article 5 and Article 8³¹. There were no insurmountable barriers to Kannu's return to her own home, at least in the early months of her stay in the nursing home, and when there were concerns as to her decisional capacity, assessment was not timely³². Although practitioners were clearly aware of the Mental Capacity Act 2005 and the deprivation of

³⁰ See, for example, Brent SAB (2021) Safeguarding Adult Review – Leocardo.

³¹ Milton Keynes Council v RR [2014] EWCOP B19.

³² Essex CC v RF and Others (Deprivation of Liberty and Damage) [2015] EWCOP 1

liberty safeguards, but there were delays in completing necessary procedures to safeguard Kannu lawfully. Consequently, it is hard to escape the conclusion that Kannu was unlawfully deprived of her liberty.

- 6.4. **Further key learning from this case highlight other aspects of legal literacy and working with individuals and their relatives in relation to advance planning.** One aspect relates to the distinction between an advance statement of wishes and an advance decision to refuse treatment. A second relates to ensuring the wording of advance statements, or advance care plans, very explicitly addresses the precise circumstances that are in scope, so that their applicability can be more easily established. The third emphasises the importance of beginning the process of advance planning as soon as possible, especially when potentially life-limiting conditions are in focus. GPs, social workers and members of palliative care teams have particular roles and responsibilities to capture precisely the wishes, choices and decisions when adults have decisional capacity, to keep advance plans under continuous review and to involve others who are interested in the person's health and welfare where appropriate³³.
- 6.5. Further, on the theme of legal literacy, the Equality Act 2010 was engaged and should have been explicitly considered in this case. Kannu was a disabled person, having a hearing impairment. She was also an individual of Sri Lankan heritage and Hindu faith. She thus falls within the protected characteristics as defined by the Equality Act 2010 relating to race, culture, religion and language, and disability. Reasonable adjustments should have been made to facilitate communication with her son, daughter and daughter-in-law when she was resident in the nursing home, and active consideration given to how she could express her spirituality if she wished to do so. This is not just a question of law, however; it is also an obligation derived from human rights, professional values and ethics. **Key learning from this case includes this obligation to ensure that person-centred practice, including professional curiosity, includes exploration of what a person draws on for strength and sense-making.**
- 6.6. Assessment and risk assessment are absolutely key. Whilst risks involving falls at home, exposure to Covid-19, non-concordance with medication, and limited eating and drinking were recognised, these risks do not seem to have been weighed in the balance against the decision as to whether Kannu should live at home or in a nursing home. As one judge expressed it: "The fact is that all life involves risk, and the young, the elderly and the vulnerable are exposed to additional risks and to risks they are less well equipped than others to cope with. But just as wise parents resist the temptation to keep their children metaphorically wrapped up in cotton wool, so too we must avoid the temptation always to put the physical health and safety of the elderly and the vulnerable before everything else. Often it will be appropriate to do so, but not always. Physical health and welfare can sometimes be bought at too high a price in happiness and emotional welfare. The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to

³³ Grimshaw, K., Brown, K. and Lyne, M. (2020) *Advance Care Planning*. Bournemouth University National Centre for Post-Qualifying Social Work and Professional Practice.

tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person’s happiness. What good it is making someone safer if it merely makes them miserable?”³⁴ **Key learning from this case is that risk assessments must be timely and thorough, which must include the avoidance of bias and taking account of all relevant consideration. That standard, derived from administrative law³⁵, was not met in this case. Key learning from this case also includes the importance of supervision to ensure critical reflection of the approach being taken and to consider alternative ways of proceeding.**

- 6.7. A clear focus is evident in the chronology on Kannu’s physical health. Consideration of her mental wellbeing was given less emphasis until the later part of time in the care home. Mental health was a core concern in both SAR – Andy and SAR – Eric. Other SARs³⁶ have also highlighted the importance of early consideration of mental health and mental wellbeing in situations where people are refusing nutrition and hydration, and where this may indicate an underlying depressive illness or mental distress. **Key learning here emphasises the importance of comprehensive assessments embracing both physical and mental health.**
- 6.8. No adult safeguarding concerns were referred in order to prompt an enquiry using the provisions of Section 42 Care Act 2014. No practitioner appears to have escalated concerns about what was happening until the final week when the first strategy meeting was convened. Senior managers and safeguarding specialists appear to have been unaware of this case, again until the first strategy meeting. Indeed, it also appears that some senior leaders in Adult Social Care were unaware of the case even at this late stage. Previous SARs completed by SSAB³⁷ have highlighted concerns about safeguarding literacy – the absence of adult safeguarding referrals, the late use of multi-agency meetings and the absence of escalation. The recent introduction of the high risk panel is welcome. The non-concordance protocol continues to be rolled out, including to care and nursing homes. SSAB has already disseminated its self-neglect procedures. **Key learning from this case, however, is that pathways to convene multi-agency meetings concerned with adults at risk, before criteria for the high risk panel, need to be revisited. Further scrutiny of the use of Section 42 Care Act 2014 by SSAB appears indicated. Further consideration also appears indicated of pathways for escalation of concerns. Put another way, what is safeguarding needs renewed focus.**

³⁴ Re MM (An Adult) [2007] EWHC 2003 (Fam)

³⁵ Preston-Shoot, M. (2019) Making Good Decisions: Law for Social Work Practice. London: Red Globe Press.

³⁶ Newham SAB (undated) SAR – Ann. Hampshire SAB (2017) SAR – Mr C.

³⁷ Preston-Shoot, M. (2019) Safeguarding Adults Review – Andy. Salford Safeguarding Adults Board. Preston-Shoot, M. (2020) Safeguarding Adults Review – Eric. Salford Safeguarding Adults Board.

- 6.9. There was a clear misunderstanding of roles and responsibilities between Adult Social Care and the Funded Nursing Care Team. **Key learning from this case is the importance of clearly agreed roles and responsibilities for the review of placements. Agreement on how services work together with respect to convening and managing strategy meetings, and obtaining and considering legal advice would also be helpful³⁸.**
- 6.10. Finally, there is **key learning from this case regarding the governance arrangements for safeguarding adult reviews**. SSAB's SAR sub-group has responsibility for making recommendations about the commissioning of reviews following referral. It has also assumed responsibility for managing and overseeing the conduct of reviews, and expressing a view about the suitability of the final report and the recommendations within it. There has been a process in place for managing declaration of interest. The learning from this review does not lead to a proposition that the role of the sub-group should change with respect to making recommendations about whether or not referrals should result in either a mandatory or discretionary review being commissioned. However, learning from this case does result in the proposition that the sub-group members should consider whether they are always best placed to act as the panel contributing to the management of the review process itself.

³⁸ Also highlighted in SAR – Eric.

7. Recommendations

- 7.1. Arising from the analysis undertaken within this review, the SAR Panel and independent reviewer recommend that the Salford Safeguarding Adults Board:
 - 7.1.1. Revisits the recommendations contained within SAR – Andy and SAR - Eric, assesses the evidence for the impact and outcome of these recommendations, and identifies further steps to embed learning in policy and practice.
 - 7.1.2. Considers revising its procedures for safeguarding adult reviews with particular focus on distinguishing the roles and responsibilities of the SAR sub-group from a panel established to assist independent reviewers in managing the review process itself.
 - 7.1.3. Seeks assurance regarding understanding and use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, with particular attention to:
 - 7.1.3.1. the timely completion of mental capacity and deprivation of liberty safeguards assessments;
 - 7.1.3.2. the use of advance statement of wishes (advance care plans) and advance decisions;
 - 7.1.3.3. the use of covert medication;
 - 7.1.3.4. ensuring that practitioners have the knowledge to engage in discussions with individuals and their relatives regarding lasting power of attorney arrangements, advance decisions and advance statement of wishes.
 - 7.1.4. Considers the need for further guidance to define exceptional circumstances where face-to-face visits and assessments are required, involving residents in care and nursing homes, in order to enable completion of a statutory duty.
 - 7.1.5. Seeks assurance that the roles and responsibilities of the Funded Nursing Care Team and of Adult Social Care are clearly understood with respect to arranging and reviewing placements.
 - 7.1.6. Provides guidance for health and social care practitioners and managers on when to seek legal advice and on precise wording of referrals for guidance so that the questions on which legal opinion is requested are clearly articulated.
 - 7.1.7. Seeks assurance that safeguarding specialists and senior managers are clearly sighted on complex cases, especially where mental capacity may be unclear or fluctuating, where it is unclear how to balance and/or mitigate risks, and where human rights are clearly engaged.
 - 7.1.8. Considers with partners the introduction of a risk register, to which any practitioner can add information via the lead agency and key worker with case

responsibility, to ensure that supervisors and senior managers are clearly sighted on complex and challenging cases.

- 7.1.9. Seeks assurance from commissioners regarding flexibilities in commissioning packages of care to enable people to remain in, or return to their own homes when that is clearly their expressed capacitous choice.
- 7.1.10. Considers the need for further guidance and continuing professional development on risk assessment and management that reflects making safeguarding personal and provides a framework for how to balance self-determination against a duty of care.
- 7.1.11. Seeks assurance, for example through case audits, that early referrals are made for mental health assessments, as part of a holistic approach to health and wellbeing, and that mental health support is accessible, for instance through the introduction of Living Well in Salford.
- 7.1.12. Seeks assurance about referrals for, and provision of advocacy, with particular emphasis on early identification of the need for statutory or non-statutory advocacy and the timeliness and effectiveness of provision.
- 7.1.13. Conducts a sequence of appreciative enquiries or temperature checks through the medium of learning/reflection events to ensure that recommendations from SAR – Andy, SAR – Eric and SAR – Kannu have resulted in service improvement and enhancement.