Briefing Document for Kannu

Salford Safeguarding Adults Board

This short briefing summarises the key themes and lessons to be learned following a Safeguarding Adults Review (SAR) undertaken by Salford Safeguarding Adults Board (SSAB).

1. About the Adult

Kannu died in November 2020 in hospital. Her nationality was British and her ethnic background Sri Lankan. The cause of her death was as old age, frailty congestive cardiac failure, ischemic heart disease, hypertension and type 2 diabetes.

From a pen picture provided by family, 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 primarily a Hindu but had an interest in other faiths such as Christianity and Buddhism. She was a spiritual/religious person, becoming more so after her retirement.

Kannu had two children. Her son lives in the UK and her daughter lives abroad. She lived in what has been described as a "busy home". She lived alone and has been described as "very independent". She had lots of books, videos and CDs, together with many souvenirs of her travels. Her house was not described as "unlivable", she kept her possessions because they helped her to feel "at home". 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. She had a history of complaining about the side-effects of her medication.

Kannu had been known to Adult Social Care (ASC) for some time and received commissioned services. 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.

Kannu moved into the nursing home at the start of the Covid-19 pandemic and the first national lockdown.

2. What happened?

Almost immediately Kannu expressed a wish to return home, a position which she consistently maintained. However, this did not happen, partly because of repairs being needed in her home, and due to the challenges, that came with national lockdown. Kannu remained in the nursing home until shortly before her death.

Whilst initially Kannu agreed to go to the nursing home, she continually asked to return home and it was thought that she had the capacity to make that decision until her health started to deteriorate a number of months later.

Whilst in the nursing home concerns were periodically expressed about self-neglect, her physical health, not eating/drinking (which had been documented as being a protest to not being able to return

home), refusal of medication and low mood. The completion of formal mental capacity assessments were delayed as a result of responses to the Covid-19 pandemic.

Adult Safeguarding concerns were raised in November 2020. After a number of meetings, a best interest decision was made for Kannu to be transferred to hospital because it was felt that with acute medical care her ill-health might have been reversible and that giving intravenous fluids to Kannu in the nursing home was not an option. It was felt that her advance care plan was not legally applicable in her current situation and the decision was made to try and save her life.

Kannu was then transferred from the nursing home into hospital, on arrival at the hospital she was deemed to be at end of life and sadly passed away the following day.

3. Reason for the Review

A Safeguarding Adult Review Referral was submitted to the Salford Safeguarding Adult Board (SSAB).

The SAR Panel considered the information and decided that the criteria had been met for a Mandatory SAR, Professor Michael Preston-Shoot was commissioned as the independent author.

4. Key Learning from the Review

Whilst it was acknowledged that the pandemic cause disruption and additional pressure on how services and practitioners worked together, statutory functions relating to care and support needs and adult safeguarding were not eased.

The Independent Review identified there were parallels between this review and previous Safeguarding Adult Reviews for Andy and 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 to maximise the efficacy of prevention, intervention and recovery, and to escalate concerns.

Other areas for key learning relate to;

- Early referral for advocacy and to ensure that every interaction is person-centred.
- 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 view.
- It was felt there were shortfalls of legal literacy and working with individuals and their relatives in relation to advance care planning.
- On the theme of legal literacy, the Equality Act 2010 was engaged and should have been considered in this case. Kannu was disabled, had a hearing impairment. She was also an individual of Sri Lankan heritage and Buddhist 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 to facilitate communication with her son, daughter and daughter-in-law when she was in the nursing home should have been made,

and active consideration given to how she could express her spirituality if she wished to do so.

- The need for risk assessments to be more timely and thorough, which include the avoidance of bias and taking account of all relevant consideration was highlighted.
- Recognizing the importance of supervision to ensure critical reflection of the approach being taken and to consider alternative ways of proceeding.
- Importance of comprehensive assessments embracing both physical and mental health where there may be underlying depressive illness or mental distress.
- Pathways to convene multi-agency meetings concerned with adults at risk, before criteria for the High Risk Advisory Panel need to be revisited with further scrutiny of the use of Section 42 Care Act 2014.
- Further consideration should be given to pathways for escalation of concerns.
- The importance of clearly agreed roles and responsibilities for the review of placements.
- It was felt that agreement on how services work together with respect to convening and managing strategy meetings and obtaining and considering legal advice would also be helpful.
- Review governance arrangements for safeguarding adult reviews.

5. What are we going to do?

- Full report for the Safeguarding Adult Review for Kannu is published on the SSAB website.
- Wider Learning Event has been held, facilitated by Michael Preston Shoot. If you couldn't attend the session, there is a recording of the full session available on request via SSAB@salford.gov.uk.
- Briefing document has been written, published on the SSAB website and shared across single agencies.
- An action plan has been created and the learning from the review will be implemented. If you would like further information, please feel free to contact the support team for the SSAB.

6. Signposting and Resources

If you are concerned about an adult who may be at risk or is suffering from harm, abuse or neglect (including self-neglect) then please report it to ensure the adult gets the rights support. Please do not hesitate to **raise your concerns.**

The **SSAB webpage** has a number of different resources available to support good practice relevant to this review which includes information regarding

- MCA and Safeguarding Adults
- Multi Agency Safeguarding Policy
- 7-minute briefing on Mental Capacity Act

Hyperlinks on this document were reviewed by HB in April 2024.

- Making Safeguarding Personal [1]

Salford Together website offers support and guidance for individual who wish to consider Advanced Care Planning

SCIE offers a free e-learning course regarding 'Independent advocacy under the Care Act 2014'

Advocacy Services - Advocacy helps you to explain your views and concerns, use information and services and look at your options. MindinSalford provides an independent advocacy service if you need someone to help you with your health and social care.

7. Next Steps – we ask that you

- Share the briefing document within your own agencies, within your local teams and share with individuals who you may feel will benefit from the learning from this review.
- Make yourself familiar with the training and additional resources referenced above.
- For professionals, if you are concerned about someone you're working with, do not hesitate to escalate the concerns to your line manager or senior leaders.

Learning has been shared with all agencies involves a robust Action Plan developed to address the key themes and learning which will be monitored on a regular basis.

The SSAB will develop further mechanisms to disseminate learning for practitioners to raise the profile of lessons learned and areas of good practice from this case and other SARs in the system in due course.

For more information visit our website https://safeguardingadults.salford.gov.uk/.

or feel free to contact us on ssab@salford.gov.uk

If you feel you need further information regarding the Salford Adult Safeguarding Adult Board (SSAB) or any other Board/Partnerships within Salford, please visit Partnerships in Salford webpage which will direct you to the individual Boards and Partnership.

[1] This link was reviewed in April 2024 and is no longer valid. Please see Making Safeguarding Personal toolkit | Local Government Association.

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