Worcestershire Safeguarding Adults Board

Mrs Kaur

A Safeguarding Adults Rapid Review Report

V9 – Final

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CONTENTS

Version	Date	Changes
1	31/01/2023	First draft
2	03/02/2023	Second draft following circulation to Rapid Review Team
3	08/03/2023	Third draft following comments from sub group and addition of Appendix 1
4	19/06/2023	Final report with recommendations added following meeting and consultation.
5	19/07/23	Further amend following inaccuracy raised by HWHCT
6	16/04/2024	Post family meeting
7	28/06/2024	Post feedback on V6
8		Following Board sign off comments and HWHCT meeting and feedback.
V9	29/10/2024	Resolution of Recommendation 3 wording HWHCT and ICB

1. INTRODUCTION

1.1. Mrs Kaur was an 82-year-old Indian lady whose first language was not English, albeit that family informed the author that Mrs Kaur's English was very good. Mrs Kaur was a devout and baptised Sikh. Mrs Kaur was receiving an end-of-life package of care due to end stage kidney disease which was funded via Continuing Health Care. Mrs Kaur had moved to live with a family member when her care needs increased, and she was unable to manage alone at home any longer.

1.2. A Safeguarding Adults Review (SAR) referral was received from the police following reports by the GP practice that Mrs Kaur had died and there were concerns regarding the management of end-of-life medication and delivery of care by the main family carer, that may have been over and above what would be usual for a family carer, who in this case was a registered nurse.

2. PROCESS AND SCOPE

2.1. The referral was triaged, and scoping information was requested from involved agencies. A Rapid Review meeting assessed the information available, resulting in a decision that the criteria was not met for a mandatory SAR but was met for a discretionary SAR as it was believed that there was valuable learning for agencies. The learning obtained and discussed within the Rapid Review meeting suggested that there was sufficient information to be able to produce a learning report, for rapid dissemination. It is of note that due to the ongoing police investigation on behalf of the coroner, the methodology used was rapid, but the SAR was not able to be completed until after the police investigation had been concluded and the author was permitted to engage with the family.

3. FAMILY INVOLVEMNT IN THE REVIEW

3.1. A key part of undertaking a SAR is to gather the views of the family and share findings with them. The Rapid Review Chair informed the family of the review. Contact with the family was guided and advised by the police. Information and perspectives from the family has been added following contact which was some time after the conclusion of the initial rapid review report.

4. BACKGROUND

4.1. Mrs Kaur had been known to agencies in the locality for two years prior to her death when she moved to live with family. Mrs Kaur had an array of care packages initially funded via social care, then privately and then ultimately Continuing Health Care funded.

5. FINDINGS AND LEARNING

Professional/Carer Boundaries

5.1. The care agencies and the healthcare professionals who visited the home and had telephone contact, faced various questions and challenges from the main family carer. Some professionals reported disrespectful comments whilst others, particularly the district nurses, were challenged regarding medication regimes and other care that was being provided albeit this was in line with the care plan. Staff reported being made to feel very uncomfortable by the manner of the challenges. As

an experienced and registered specialist nurse it could be seen that the family carer wanted to deliver care to their family member with the seniority of some staff delivering care being challenged. It was not always clear in the records if there were other household or family members involved in supporting and delivering care to Mrs Kaur.

5.2. It appears that many professionals had concerns about what was happening that resulted in professionals challenging back, seeking advice and in some instances terminating care packages. There was no agreement or discussion on what care it was acceptable for the family carer to provide and what would be over and above that which would be considered as appropriate. Records do show that staff explained to daughter that staff needed to do the nursing role and the family member should focus on being in the family member role. This caused blurred boundaries with professionals sometimes not challenging the family carer carrying out care thereby allowing the family member to support care sometimes but on other occasions challenging care provided by the family carer. The family carer told the author that they considered that professionals appeared intimidated by the level of knowledge of the family carer as a senior nurse. The family carer told the author that it was only in Mrs Kaur's best interests and consent that they acted. E.g. when the urinary catheter was blocked, the family carer had called the district nurses. They had not visited and on a further call it was apparent that the call to the home would not be until the evening. In the meantime, Mrs Kaur was in considerable and increasing discomfort. Mrs Kaur agreed to the family carer removing and re catheterising her which the family carer did in line with their nursing competencies. The district nursing records do not show delays in visiting to replace the catheter. Whilst many may consider this inappropriate action it can easily be seen how one would do that for a person, they loved who was in pain and discomfort. As stated above, the boundaries were not discussed and were not clear.

5.3. As a family carer, eldest child, eldest sibling, mother and full-time working nurse, the family carer found many pressures and needs that needed to be fulfilled by them. It would have been good practice to have considered the pressure that the family carer was under and to have offered a carers assessment and put them in touch with the association of carers.

5.4. There was also a multi-disciplinary team (MDT) meeting recorded by the GP practice but there is no record of what was discussed, who attended or what the proposed outcomes were. It is the case that if there are no change of plans or outcomes, then the fact that an MDT will simply be recorded as having taken place.

Learning:

- Where agencies have cause to challenge the behaviour of a family carer, there should be multi agency conversations to understand whether there is an issue across agencies or with one.
- When concerns are raised regarding a person who is a registered professional, consideration should be given to early alerts to the employer and the relevant professional regulator
- Clear recording of who is in the household and who is spoken to helps clarify who is involved in delivering care to a person.
- Clear care planning should evidence what care is required and how and who should be delivering the care including what could be delivered by family members with the right competencies.
- Difficult relationships should not be a barrier to offering a carers assessment.

The Voice of Mrs Kaur, Mental Capacity and Decision Making

5.5. Mrs Kaur's first language was not English. There is some evidence from professionals that Mrs Kaur understood some basic English. The family member told the author that in fact Mrs Kaur had a very good command of English, learning English from a friend she had made on coming to England in the 1960s. Mrs Kaur had worked in several jobs where she needed to communicate in English. The family carer agreed that as their mother became more unwell, she found it more difficult and reverted to her first language of Punjabi. Information discussed within the review indicated that interpreters were sometimes used but not on all occasions where they should have been to achieve best practice. It is not always possible to use interpreters for every visit when those visits are daily but is best practice when key decisions being considered. This was done when end of life care was being discussed.

5.6. Mental capacity was not always considered as part of the decision-making process; It appears that Mrs Kaur's voice was mainly heard through the voice of the family carer, without clarifying with Mrs Kaur that this was acceptable to her.

5.7. There were cameras in the house through which the family carer could communicate with those carrying out visits, this resulted in the family carer being able to speak for Mrs Kaur when they were at work. It was not clear if Mrs Kaur agreed to have care recorded or other decisions that were being made on their behalf. The family member told the author that the cameras were there to support the family being confident that Mrs Kaur was well when they were at work and that in fact one of these was a portal so that a family member living away could have contact with their loved one. None of the cameras were used to record care. The family carer stated that it was useful for professionals as they could communicate with them whilst at work if any clarification was needed.

5.8. It was also believed that there was a Power of Attorney for Health and Well Being. Professionals did not ask for the evidence, and it was identified that a Power of Attorney did not exist. A Lasting Power of Attorney for Health and Well-being can only be used if a person lacks capacity to make their own decisions about their health and well-being so even if one had existed, it would only have been valid if there was evidence that Mrs Kaur lacked capacity to make her own decisions.

Learning:

- The voice of the person must be heard via the use of professional interpreters where there is a need to plan care and record the wishes and feelings of a person.
- A lasting power of attorney for Health and Welfare must be registered and can only be used if a person lacks capacity to make their own decisions.
- Mental Capacity should be assessed where there is reason to doubt capacity and a decision is required and should be more formally assessed and recorded on appropriate documents where the decision is greater.
- Any Best Interest Decision should be preceded by a mental capacity assessment to identify that the person lacks capacity to make the decision and therefore a decision has been made in their best interests.

Medicines Management within the home setting

5.9. It was noted that there were sometimes discrepancies in the amount of prescribed medication that should have been available in the home compared to what was actually in the home. It was not clear if some of the discrepancies were due to wastage or medication actually missing. Some of this related to controlled drugs for pain relief as well as within the syringe driver. A syringe driver was changed as it was believed that it may be faulty. There were also concerns regarding the fact that as a qualified nurse, Mrs Kaur's main family carer had knowledge of drugs and on occasion adjusted the regime of not only the pain relief drugs but also other prescribed medication. This was challenged by the district nurses, but it does not appear that this changed the behaviour as the carer stated that they understood their mother's needs. It is apparent that all medication issues and concerns were reported using the incident reporting mechanisms within the NHS Trust. Safety plans were introduced as well as a drug safe and removal of the universal key for the syringe driver which had been left within the household as there were different nurses visiting. This had previously been standard practice but meant that the key was available within the home despite developing concerns regarding missing medication.

5.10. It appears from later information from the Police investigation post Mrs Kaur's death that there was an auditing/recording error with conflicting evidence that a box of medication had not been issued rather than gone missing and that the amount of medication in the syringe driver that could not be accounted for was 0.8ml. This leads to learning as indicated below regarding the importance of medication records and stock control of controlled drugs in the home.

Learning:

- Learning here links to the recording of medicine discrepancy incidents and challenge that requires follow up.
- There should be clarity regarding the storage and amount of controlled drugs within a home where professionals are visiting.
- A review of the medicines in the home policy may be helpful to ensure that professionals are protecting themselves from allegations and that missing medication is noted immediately.
- The updating of care plans with regard to administering of medication should show any issues and management around this.

Culture and religion

5.11. Mrs Kaur was a devout and baptised Sikh. Albeit that it is documented in the chronology for this review, its significance was not discussed further at the Rapid Review meeting. On discussion with the family member, it appears that as well as some of the practice concerns that the daughter raised with professionals regarding the care delivered, it also appears that the family carer had discussed, how as a devout Sikh, that Mrs Kaur should be washed and cared for so as not to breach Sikh religious and cultural beliefs and norms that were extremely important to Mrs Kaur and the family. When these practices were ignored, it caused difficulties and challenges with paid carers, resulting on some occasions for the family to request new carers. Paid carers stated that they had felt disrespected. These issues could have been discussed and resolved by an MDT meeting that included family so that there was clarity in communication and what the family wanted for their mother and why it was so important.

5.12. This was also an issue when it came to end of life care and the point of passing. It is noted in the chronology what would happen in Sikh religion, but this was not shared more widely or understood when staff visited to confirm death. The family noted that they felt disrespected when they were praying over the body of Mrs Kaur. When the family carer asked the doctor and nurses to undertake the death confirmation etc. quietly to allow them to continue to pray, this was interpreted as being told to be quiet. This was all part of the Sikh beliefs in the passing of the soul out of the body happily to be reincarnated.

5.13. The ensuing post-mortem examination also caused great distress as the hair was cut which is against Sikh beliefs in the five K's, one being kesh (uncut hair).

5.14. Human rights law and the Equality Act are clear about the need to respect and offer services that do not discriminate. It could be suggested that an organisation offering care could have a legitimate aim to care but not be able to wash a person in the way that a religion dictates due to limitations of being able to practically carry that out, especially for a bed bound patient. There should be, however, reasonable attempts to respect the beliefs and discuss and agree what can and cannot be carried out. It should also be included in the care plan and the end-of-life plan.

Learning:

- It is a legal requirement to consider each person's religious and cultural beliefs so that they are treated with dignity and respect when they are no longer able to care for themselves.
- Family members can help in interpreting what needs to be done differently so that care is delivered in a way that is acceptable or there is a discussion as to why this cannot be carried out.

Safeguarding

5.15. In terms of considering this situation as a safeguarding concern, there was one discussion the year before Mrs Kaur died where a care agency stated that a district nurse had been concerned that Mrs Kaur was frightened of their main family carer. This was not taken forward and no further discussions were held with other agencies. The concerns regarding the ongoing discrepancies in medication as well as the concerns that the main family carer had not amended their actions when challenged by the nursing team, were referred to Adult Social Care just 15 days before Mrs Kaur died and therefore investigation had not progressed. The police then received a referral following the death of Mrs Kaur concerning missing medication and concerns that the syringe driver had less than was expected following the death of Mrs Kaur. The family carer was made aware of the missing medication and that as a result a safeguarding referral was being made.

5.16. Had these concerns been investigated as safeguarding concerns as and when they arose, it would have enabled a conversation with Mrs Kaur to ascertain her wishes and feelings. This would have provided clarity on what Mrs Kaur had allowed her family member to do for her.

Learning:

- Where there are concerns that a carer may be administering care that is against prescribed care or is over and above what would be expected of a family carer, the nature of the impact on a person with care and support needs should be considered in terms of safeguarding risk.
- Internal investigations that are of a safeguarding nature and could indicate risk to a person with care and support needs should be shared with adult social care in order that concerns can be logged- only the local authority can coordinate safeguarding enquiries.
- Where several agencies are involved, and concerns are being expressed, there must be a sharing of information to decide as to whether a safeguarding concern should be reported.
- When adult social care is in receipt of concerns that suggest that another agency may have a concern, it is best practice to contact the other agency for clarification.
- Complex information must be clearly and simply reported to facilitate understanding by professionals of a different discipline.

6. Summary and Conclusion

6.1. In this case there were several care agencies, nursing professionals and GPs who had concerns regarding a person with care and support needs and the way that care was being delivered by a family member. The family member was a qualified senior nurse. There was a lack of clarity on how much care a qualified nurse should or could undertake as a family carer.

6.2. The voice of Mrs Kaur was only heard through the family carer without a clear recording of Mrs Kaur's capacity to make her own decisions or to allow her family member to speak for her. The family member told the author that Mrs Kaur was very happy for the family carer to speak to professionals on her behalf.

6.3. There was a discrepancy between agencies medication records, leading to a belief that medication had gone missing, when it may not have been issued but this had led to concerns and investigation as to how and why there were apparent discrepancies.

6.4. Mrs Kaur as a person with devout Sikh beliefs was not able to always be cared for in a way that was prescribed in the Sikh culture leading to challenges between professionals and family that made the family feel disrespected and that Mrs Kaur had not been treated with dignity. It appears that professionals may have misunderstood the importance that the practices held for the family.

6.5. Although Information was shared amongst the professionals who had concerns; there was no multi agency meeting therefore the assessment of safeguarding risk on Mrs Kaur as a person with care and support needs was not evident. The issues between the family carer and the professionals was not resolved by any mediation or agreements and clarity of what Mrs Kaur wanted in her last months of life.

7. RECOMMENDATIONS

1. Professional /Family Carer Working and Boundaries

WSAB to ensure that the learning from this Rapid Review is included in the work that is currently being undertaken with Worcestershire Association of Carers. The suggested output from this review is that the WSAB produces a guidance document/Learning Briefing covering the following areas:

- Carers assessments offered for ALL carers.
- Recording of those family members delivering care and who else is within the household.
- Effective use of Care Plans to agree and collaborate with the person and their family (where appropriate) care to be delivered. This can then be used to challenge care delivery outside of what has been agreed.
- Use of the Mental Capacity Act (with an interpreter) to discern if a carer is required to make decisions on behalf of the care recipient.
- Ensuring that any registered LPA is evidenced.
- Managing relationships between professionals and family carers.
- The video recording and monitoring of care recipient and care delivery by family/others.
- Raising concerns regarding a carer

(Direct work with the person)

2. Voice of the person.

a. WSAB should produce a briefing regarding working with a diverse population that includes:

- CQC Requirements for regulated care providers to ensure that in order to deliver safe care that person centred care, privacy and dignity is included in this standard and therefore interpreters must be used at key points in decision making, care planning and care delivery.
- Care plans must include the need for an interpreter in communication/inclusion section.

b. WSAB should suggest that, with advancing technology, that recording and photography policies and/or practice guidance within organisations cover the use of live feed and video recording within the home and that consent of the person being monitored/recorded has been gained.

(Direct work with the person)

3. Medicines management in the home

WSAB to ensure, in light of the learning from this review and the vulnerabilities of families and professionals where missing controlled medication cannot be accounted for, that HWHCT review their processes to ensure robust recording and monitoring of all controlled medications in the home where their professionals are delivering care. In the event of any discrepancy, they will liaise with the dispensing pharmacy and GP surgery as relevant to investigate without delay.

(Interagency Team around the individual)

4. Culture and Religion

WSAB should remind all partner agencies of the need to adhere to the Equality Act and Human Rights Act and ensure that care is delivered in accordance with a person's wishes wherever possible. To do otherwise may be interpreted as discriminatory. Assessments, Care plans and Documentation

must document religion and beliefs and ensure that care is prescribed and planned with culture and beliefs in mind.

5. Safeguarding

a. WSAB must ensure that partners are reminded of the importance of the local authority being able to collect patterns and trends of abuse and referrals for a person from multiple sources. It may be that the local guidance is updated to include:

- Enabling the duty under the Care Act that may lead to the local authority undertaking a S42 enquiry or causing others to do so.
- Including where agencies may be undertaking internal investigations and offering safeguarding support to professionals on issues that may be deemed low risk but is being caried out in isolation of other agencies who may be sharing concerns.

b. WSAB must request that the safeguarding referral form be updated with a prompt that professionals must not use organisational jargon in referrals regarding complex information. Referrals must provide clarity of concerns and explain impact of any concerns to facilitate understanding by professionals of a different discipline.

(Safeguarding Adult Board Governance)

6. General Learning

a. WSAB must produce a learning briefing/Video/podcast of the general learning from this SAR and identify if this case should be presented in a practitioner event.

b. Agencies should use an anonymous version of this SAR as a case study in relevant training and for discussion in team meetings etc.

Appendix One Terms of Reference (REDACTED)

1. Introduction

A SAB must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

The Care Act Statutory Guidance 2014 states that in the context of SAR's "something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect".

All Safeguarding Adults Reviews will reflect the 6 safeguarding principles as set out in the Care Act and SAB multi-agency procedures. In addition, SARs will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- Be proportionate according to the scale and level of complexity of the issues being examined;

- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;
- Develop an understanding of who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;
- Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to panels;
- Make use of relevant research and case evidence to inform the findings of the review;
- Identify what actions are required to develop practice;
- Include the publication of a SAR Report (or executive summary);
- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

2. Case Summary

7.1. Mrs Kaur was an 82-year-old of British Asian origin whose first language was not English. Mrs Kaur was receiving an end-of-life package of care funded via Continuing Health Care. Mrs Kaur had moved to live with a family member when their care needs increased, and they were unable to manage alone at home.

7.2. A Safeguarding Adults Review (SAR) referral was received from the police following reports by the GP practice that Mrs Kaur had died and there were concerns regarding the management of end-of-life medication and delivery of care by the main family carer, that may have been over and above what would be usual for a family carer, who in this case was a registered nurse.

3. Decision to hold a Safeguarding Adults Review

3.1. The SAR referral was received in November 2022. Initial scoping information was gathered, and a Rapid Review meeting was held on 24th January 2023, chaired by an independent Rapid Review Chair. Members of the Case Review Subgroup and invited guests who had been involved with the care of Mrs Kaur attended. After hearing all of the information It was agreed that the criteria for a Discretionary Safeguarding Adults Review were met. It was agreed that the information that had already been gathered was sufficient to identify multi agency learning. It was therefore agreed that a Rapid Review Report would be written. The WSAB Independent Chair endorsed that decision.

4. Scope

The review will cover key issues for learning between April 2020 October 2022.

5. Method

5.1. The Care Act 2014 Statutory Guidance states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

5.2. WSAB chose to use a methodology that uses the information gathered and discussed in the Rapid Review meeting to formulate a Rapid Review Report in order that learning could be disseminated promptly.

6. Key Lines of Enquiry to be addressed

Learning will be related to the key learning identified from the Rapid Review Meeting

- **Professional/ Carer Boundaries**
- **The Voice of Mrs Kaur, Mental Capacity and Decision Making**
- **Medicines Management within the home setting**
- **Safeguarding**
- **Good Practice**

7. Independent Chair and Report Author

The named independent chair for the Rapid Review meeting was **Jon Chapman**; the named independent Rapid Review Report author is **Karen Rees.**

8. Organisations involved with the review:

- Adult Social Care
- Police
- Acute Hospitals NHS Trust
- Ambulance Service
- Health and Care NHS Trust

- ICB for GP
- ICB CHC Team
- Home Care Organisations x6
- Hospice

9. Family Involvement

A key part of undertaking a SAR is to gather the views of the family and share findings with them. The Rapid Review Chair informed the family of the review. Contact with the family will be as guided and advised by the police and Information from the family will be added following contact. In the interest of learning the findings will be published prior to family contact and any additional learning will be shared when possible.

10. Dissemination of learning

Learning will be recorded on the WSAB Learning Framework and disseminated via Board members and other associated partners via the Learning And Development Subgroup.

11. Publishing

It should be noted by all agencies that the SAR report will be published once complete unless it would adversely impact on the adult or the family.

Reference to the adult in the report may be anonymised further prior to publishing. This will be following consultation with the adult/family and time allowed to reflect on how they would like the adult to be referred to.

Any media strategy around publishing will be managed by the Learning, Development, Practice and Communication subgroup of the WSAB and communicated to all relevant parties as appropriate.

Consideration should be given by all agencies involved in regard to the potential impact publishing may have on their staff and ensure that suitable support is offered, and that staff are aware in advance of the intended publishing date

Whenever appropriate an 'Easy Read' version of the report will be published.

12. Administration

It is essential that all correspondence with identifiable information is sent via secure methods only. This would be via a secure e-mail account. Failure to do so will result in data breach.

The Board Co-ordinator will act as a conduit for all information moving between the Chair, Author and the Case Review Subgroup.

13. **Confidentiality**

All reports and documentation relating to the SAR are confidential and must be treated as such by all parties. No items should be shared without prior consent from the SAR Independent Author or the SAR Subgroup Chair.