Brenda Review Summary Briefing

The Background

Brenda died in December 2018 from lung cancer after being admitted to hospital with a suspected infection. Brenda had a history of self neglect, substance misuse, homelessness and mental health diagnoses; she had been involved with the Community Mental Health Team since 2007. Since early 2010s Brenda was estranged from her family.

Safeguarding Concerns

Between 2013 and 2018 there were numerous safeguarding concerns raised with Adult Social Care in respect of Brenda's living conditions and self neglect. In March 2018, a multi-disciplinary team meeting was held which highlighted that Brenda had not been seen by services for eighteen months, did not want any input, was not on any medication and was not engaging. A historic risk of self-neglect was noted but with no current risk.

In November 2018 Brenda was found to be living in squalor conditions. She was managing her own finances and her mental health was described as 'stable' though she had stopped being prescribed any medication. However, Brenda's living conditions deteriorated as she became more and more isolated. She had no gas or electricity leaving her with no cooking facilities and limited heating. She was sleeping on the floor, had no furniture and ate out as she was unable to cook at home and it is suspected she lost a lot of weight. Brenda had previously withdrawn her consent to information being shared with her family and she also ceased contact with support services, except for the support worker who stayed with her despite the contract for the support service being transferred to different agencies.

The Incident

In November 2018, Brenda's support worker became so concerned for her when her physical health suddenly dramatically deteriorated, that he contacted her GP Surgery; an Advanced Nurse Practitioner visited the following day and Brenda was admitted to hospital and treated for a suspected infection. When she did not respond to her treatment, further tests were carried out and she was diagnosed with stage 4 lung cancer with distant metastasis. Brenda's family only found out about her death when they were contacted by an agency seeking the Next of Kin of someone who had died 'in testate'; it took the agency less than 24 hours to find the family.

The Review

The Safeguarding Adults Board (SAB) did not consider that Brenda's case met the criteria contained in s44(1) of the Care Act 2014 that would place a duty on them to commission a Safeguarding Adult Review but agreed that a discretionary review be commissioned under power contained in s44(4) of the Care Act 2014. The timeframe under review was 1st January 2013 to 21st December 2018.

Good Practice

- GP Practice implementing Did Not Attend Policy when Brenda did not respond to letters inviting her to appointments.
- Safeguarding Adults Referral Forms submitted by Police when they had concerns for Brenda and follow up with requests for information from support services to enable them to better support Brenda.
- Consultant Psychiatrist deferred their assessment of Brenda until a time where she may have been more lucid in order to pursue the least restrictive option in providing her with support.
- Brenda's landlord raised a safeguarding concern with Adult Social Care when they took over responsibility for her tenancy
- When Brenda was transported to hospital, the information supporting her admission from the Advanced Nurse Practitioner was full and timely, containing the basis of her Best Interests Decision to make the admission.
- Arrangements for planning for Brenda's discharge were put in place soon after her admission; given the circumstances of her admission and her concern about the permanency of her tenancy, doing so should have provided her with some assurance of the reasons for her admission.
- A consistent figure in Brenda's life for most of the Review period was her support worker; he was the only person who appears to have had regular and frequent contact with her and from whom she was willing to accept support. He also appears to have been the primary source of information that other agencies relied upon to inform their own decisions about Brenda's care and support needs. His commitment to her went beyond what was required of him or could have been reasonably expected; this is acknowledged by the Independent Author and by Brenda's brother.

Learning

- Brenda's quality of life could have been improved if agencies had worked together better to assess and offer to meet her care and support needs and thereby assess and manage the attendant risks to her health and wellbeing.

- The level of self-neglect experienced by Brenda was predictable; she had a long history of mental health issues, failure to engage with services and self-neglect. Recent research has shown that much self-neglect can be linked to issues relating to loss or bereavement. At no stage was there any evidence of any attempts to actively seek Brenda's engagement other than by her support worker or to work with her to identify the causation of her self-neglect.

Useful links for Best Practice

- Brenda Full report and recommendations
- 4LSAB MARM and appendices
- 4LSAB Working with Self Neglect Guidance
- 4LSAB Escalation Policy
- Fluctuating Capacity and the Law – Community Care Briefing (Tim Spencer Lane)
- One Minute Guide to Self Neglect
- One Minute Guide to Advocacy