Brenda Multi-Agency Review Summary Briefing

SSAB
SOUTHAMPTON SAFEGUARDING ADULTS BOARD

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 the 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, had not wanted any support, was not on any medication and was not engaging. A historic risk of self-neglect was noted.

In November 2018 Brenda was found to be living in squalid conditions. She was managing her own finances and her mental health was described as 'stable' though she had stopped being prescribed 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 Brenda had previously withdrawn her consent to information being shared with her family and she also ceased contact with support services, except for the support worker who had stayed in touch with her, despite the contract for the support service being transferred to different agencies.

The Incident

In November 2018, the support worker became very concerned for Brenda, because her physical health suddenly and dramatically deteriorated. He contacted her GP and an Advanced Nurse Practitioner visited the following day. Brenda was then admitted to hospital and treated for a suspected infection. When she did not respond to treatment, further tests were carried out and she was diagnosed with 'stage 4' lung cancer with distant metastasis. Brenda's family were unaware of her death because the hospital could not establish any links to their contact details. Her family were consequently informed about her death when they were contacted by an agency seeking the Next of Kin of someone who had died 'in testate'. Brenda's family were devastated to find out about her death in this way and it took the agency less than 24 hours to find the family.

The Review

The Safeguarding Adults Board (SAB) agreed that a discretionary review be commissioned under power contained in s44(4) of the Care Act 2014, in order to establish if agencies could have worked better together, to have prevented the self-neglect that Brenda experienced. The scoping period for the Review was agreed as being from 1st January 2013 to 21st December 2018.

Learning

- Brenda's quality of life could have been improved if agencies had worked better together to assess and offer to meet, her care and support needs and manage the attendant risks to her health and wellbeing. Brenda's family could and should have been given the opportunity to exercise their rights to seek support for her, which may have enabled them to be part of her last days; arrange for her funeral and grieve for her properly.
- 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 had experienced self-neglect in the past. Recent research has shown that much self-neglect can be linked to issues relating to loss or bereavement which Brenda had also experienced. During the scoping period there was no evidence of any agency actively seeking Brenda's engagement, or an attempt to support her to identify the causation of her self-neglect, other than the support worker who had befriended her.
- Brenda's history of not engaging with services and not recognising the need to engage, would suggest that the chances of successful work with Brenda to try and change her behaviour were very limited. This may have been due to the impact of her mental health issues on her behaviour, because her diagnosis of Paranoid Schizophrenia may have made Brenda suspicious and untrusting of those who tried to help. The Review concluded that even with radical interventions in her life, such as admissions to hospital under the Mental Health Act 1983, and/or, the continuation of a Guardianship Order (with requirements to manage her behaviour), it is not necessarily the case that her self-neglect could have been prevented or reduced.
- Brenda was referred to Adult Safeguarding under the Multi-Agency Safeguarding Adult's Procedures, however procedures were found to be poorly implemented or not co-ordinated appropriately and Self-Neglect Procedures, - of which some agencies were unaware - were not taken into account.
- The Mental Health Act 1983 grants particular rights to a person's Nearest Relative, which would have been Brenda's brother. The Community Mental Health Team held his contact details as he had formerly attended Care Programme Approach meetings with his sister. Brenda's brother should have been advised of his rights, and if this had happened, he would almost certainly have requested that Brenda be assessed under the Mental Health Act – which may have enabled services to support her in relation to management of her self-neglecting behaviour; and where oversight and monitoring could have prevented her rapid deterioration.

Good Practice

- The GP Practice implementing Did Not Attend (DNA) Policy when Brenda did not respond to letters inviting her to appointments.
- When the Police made Safeguarding adult Referrals in relation to concerns for Brenda and follow up requests for information from support services.
- The Consultant Psychiatrist deferred Brenda's assessment, in the hope she may become 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 the Best Interests Decision made, in order to enable 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 about why she had to be admitted and the security of her home.

Good Practice continued

- A consistent figure in Brenda's life for most of the Review period was the support worker; who was the only professional who appeared to have maintained regular and frequent contact with her and from whom she was willing to accept support. He also appeared to have been the provider of information, whom other agencies relied upon to inform their own decisions about Brenda's care and support needs. His commitment to her went beyond expectation, which was acknowledged by the Review and by Brenda's brother

Recommendations (grouped by themes)

Management and Support to Individuals:

1. The SSAB should seek assurance that Adult Social Care and the relevant health agencies are effectively monitoring the CPA process to ensure it is being implemented and recorded correctly.
5. The SSAB seek assurance that Adult Social Care and the relevant health agencies are ensuring that adults at risk are seen appropriately, their mental health assessed adequately to ensure the effective assessment and management of any risks and concerns are escalated when this is not possible.
6. The SSAB seek assurance that Adult Social Care and relevant health agencies are ensuring that Nearest Relatives are correctly identified and appropriately advised of their rights under the Mental Health Act 1983 and supported in exercising them.
7. The SSAB seek assurance that Adult Social Care, as part of its triage processes to identify those who should be offered assessments of their care and support needs under the Care Act 2014, checks to see if adults referred to it are known to other multi-agency forums and procedures
10. The SSAB seek assurance that Integrated Commissioned Services have reviewed and revised as appropriate their procedures and practice when transferring a service to a new provider, including ensuring a review of individual service users' care and support needs.
11. The SSAB seek assurance that Adult Social Care and the relevant health agencies are ensuring that, when the CPA process is closed for an individual, that decision is taken within a properly convened CPA Review and that it is supported by a review of the individual's care and support needs under the Care Act 2014.
12. The SSAB seek assurance that ASC and the relevant health agencies are ensuring that adults leaving the CPA process are appropriately transferred to alternative care and support services in a planned and coordinated manner.
13. The SSAB seek assurance that Adult Social Care has reviewed, and where necessary revised, its policies, procedures and practice in triaging repeated low-level concerns re self-neglect, particularly in cases of known mental health or learning disabilities.
14. The SSAB seek assurance from other local partnerships that Southampton has fully implemented the MARM process and forum to identify and coordinate a multiagency response to cases of self-neglect that don't meet the criteria of Section 42 Care Act 2014.
15. The SSAB seek assurance that member agencies are consistent in their usage and understanding of the terminology relating to the safeguarding procedures in order to prevent confusion.
16. The SSAB seek assurance that Adult Social Care and the relevant health agencies are ensuring patients are fully and appropriately assessed before being deemed 'medically fit for discharge'

Recommendations continued

17. That the SSAB seek assurance that member agencies, particularly Adult Social Care and University Hospital Southampton, have reviewed and revised their policies and practice, in cases where patients die 'in testate', to maximise the opportunities to identify Nearest Relatives/ Next of Kin.

Safeguarding Policies, Process and Procedure:

2. The SSAB should seek assurance that safeguarding concerns are being recorded, triaged and responded to in accordance with the Care Act 2014, its supporting Statutory Guidance and Making Safeguarding Personal.

3. The SSAB should seek assurance that the multi-agency Safeguarding Adults Procedures are being monitored effectively and that appropriate escalation processes are in place.

4. The SSAB should seek assurance that member agencies and those services they commission have policies and procedures such as DNA and support systems for staff in place that are sufficiently flexible in their implementation to enable them to encourage those patients or service users who are not engaging with services to do so

19. The SSAB seek assurance from ASC and relevant health agencies that they have developed and implemented effective monitoring systems to ensure that multi-agency working is accurately and consistently recorded.

Training and Supervision of Staff:

8. The SSAB seek assurance that Adult Social Care and relevant health agencies are ensuring their staff, and staff in services they commission, are receiving appropriate professional supervision and support to enable them to reflect on their professional practice, particularly in cases of possible self-neglect, and adults who are difficult to engage with.

9. The SSAB seek assurance that Adult Social Care and relevant health agencies are ensuring that their staff, and those in services they commission, are appropriately trained and their practice monitored to ensure they practice in accordance with the Mental Capacity Act 2005 and its supporting Code of Practice, particularly, in self-neglect cases, 2.11 of the Code of Practice.

Recognising Good Practice:

18. That the SSAB formally recognise the good practice of the agencies and individuals identified.

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