Hillingdon Safeguarding Partnership

Executive Summary

Angela and Chris

Thematic Safeguarding Adults Review:

Self-Neglect

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1. Introduction

Hillingdon Safeguarding Partnership asked the Social Care Institute for Excellence (SCIE) to undertake a Safeguarding Adults Review (SAR) into how local services responded to the needs of two adults who sadly died in Hillingdon in the context of self-neglect, and how services worked together to safeguard these two adults. This document is a summary of the full SAR report. Please find the full report here.

A Safeguarding Adults Review (SAR) is a legal requirement, set out in section 44 of the Care Act 2014, where:

- an adult with care and support needs has died as a result of abuse or neglect,
- **or** suffered non-fatal serious abuse,
- **and** there is cause for concern about how services worked together to safeguard the adult.

This SAR sought to:

- identify any lessons we can learn about the way professionals and agencies have worked together,
- review the effectiveness of our safeguarding services and interventions ,
- consider what could have been done differently to prevent a similar circumstance from happening again, and
- inform and improve practice across the Hillingdon Safeguarding Partnership

SARs do not seek to lay blame with any individual nor organisation.

2. Angela and Chris

'Chris' (65) and 'Angela' (64) both had severe and enduring mental illness and had been well known to local services for many years. They both died, in the context of self-neglect, from physical illness. They had been unable to meet their own physical and mental health care needs in the lead up to their deaths.

3. How SCIE conducted the SAR

Hillingdon Safeguarding Partnership chose to use SCIE's *Learning Together* model for reviews. The reviewers drew from existing internal agency investigations that had already been completed and

group discussions with practitioners and managers who had been directly involved with 'Angela' and 'Chris'. Workshops were also held with the senior managers representing the agencies involved.

4. Key findings

There were delays and difficulties for local services in recognising and responding to their physical ill health and self-neglect until they were critically ill. If their difficulties had been identified earlier, and if they'd been responded to in a coordinated and urgent manner they could have been more effectively safeguarding from self-neglect and their quality of life could have been improved.

Five key themes were identified that contributed to the response of local services:

- Community mental health service responses to patients' physical health needs
- Diagnostic overshadowing
- Recognition and response to self-neglect where someone is believed to have mental capacity.
- Triage of safeguarding referrals within Adult Social Care led Multi-Agency Safeguarding Hub
- Collaboration between primary care services and secondary mental health services

a. Community mental health service responses to patients' physical health needs

The review identified that opportunities were missed by the mental health clinic staff to identify Angela's deteriorating physical health and self-neglect and to intervene to safeguard her. They concluded this was as a result of workload pressure on '*depot clinic*'[1] staff and inappropriate clinic space, meaning that the staff cannot routinely or reliably undertake physical health checks or physical monitoring for patients, nor reliably identify patterns or changes in a person's underlying condition. This is particularly concerning where a patient does not routinely see any other professionals to monitor their physical or mental health, which is not uncommon for patients of depot clinics and other similar clinics. People on long-term antipsychotic medication are at higher risk than the wider population of poor physical health and life limiting illnesses so physical health checks are of vital importance.

[1] In secondary mental health care some patients receive their mental health care through a Community Psychiatric Nurse who administers an injection of antipsychotic medication (often called a 'depot' injection) once or twice a month, and they see a psychiatrist once or twice a year, or when there are worries about their mental health. The clinic that these patients attend for their injections and contacts with a psychiatric nurse are locally referred to as a 'depot clinic' or a medication maintenance clinic.

b. Diagnostic overshadowing

'Diagnostic overshadowing' refers to an unconscious bias whereby practitioners wrongly assume that legitimate symptoms of physical illness are instead a symptom of mental illness or learning disability. It can also mean that people's focus on managing a mental illness or learning disability can result in physical health needs being missed or de-prioritised. This results in people with mental illness and/or learning disability missing out on thorough and timely physical health care. It is well known that adults with mental illness are significantly more likely to die prematurely or suffer chronic physical illnesses than the general population and diagnostic overshadowing contributes to this.

For both Chris and Angela, diagnostic overshadowing contributed to delays in professionals identifying and treating their serious physical illnesses, and delays in recognising self-neglect of their physical health needs. For Angela, a professional explicitly attributed shortness of breath to anxiety, when in fact she was suffering from a terminal lung disease. For Chris, he had stopped taking medication for his multiple physical illnesses, lost weight rapidly, and had a fall. Yet the social and health care system around him was focused solely on assessing his mental health and re-establishing his antipsychotic medication.

c. Recognition and response to self-neglect where someone is believed to have mental capacity.

For Angela and Chris, practitioners either assumed they had mental capacity without assessing it, or determined they had mental capacity to make decisions about their care and treatment and, on this basis, did not consider any intervention around self-neglect to be necessary. Angela and Chris' choices were considered to be "unwise decisions" and this appeared, inappropriately, to prevent consideration of safeguarding interventions.

When someone with poor or deteriorating health turns down support from health care professionals, this can be self-neglect. This includes if they cease taking prescribed medication/attending appointments. Making decisions which result in self-neglect is a good reason to doubt capacity, explore the person's reasoning and their understanding of the risks they faced.

Even where people do have capacity to make decisions about their self-care and treatment, self-neglect is still a safeguarding concern that requires exploration, risk assessment and risk reduction.

Unmet health needs can carry high risks and, therefore, in cases where people are neglecting their own physical health care it may be appropriate to override an individual's wishes and for practitioners

to work together to assess and reduce risks. Good safeguarding practice means finding creative ways to help people to keep themselves safe - it does not mean walking away when people decline support. Assertive engagement and developing relationships with people, through a safeguarding process, can often help them to shift and change their own views and wishes about their situation and can empower them to embrace positive change.

d. Triage of referrals into the Adult Social Care-led Multi Agency Safeguarding Hub

In Hillingdon's Adult Social Care-led Multi Agency Safeguarding Hub (MASH) referrals are initially screened by Adult Social Care (ASC) staff. If social care staff identify a safeguarding concern the referral is then 'triaged', which involves Adult Social Care MASH staff contacting multi-agency safeguarding partners (e.g. CNWL, Primary care, housing services) to help them risk assess and safety plan, and to establish if there is a need for further enquiries to safeguard an adult at risk of abuse, neglect or self-neglect.

The SCIE reviewers were concerned that multi-agency information gathering is only done when a safeguarding concern is identified as such. In Angela's case the referral that was received by Adult Social Care from the Police was not triaged as a self-neglect concern but was instead passed straight through to a social work team for an assessment of need. The apparent self-neglect was missed at that point because Adult Social Care did not automatically collate and analyse information from other involved organisations as part of their routine screening process.

e. Collaboration between General Practitioners and mental health services.

Repeatedly, Chris' GP's and brother's concerns were expressed to mental health services. Their concerns were not given sufficient weight, and this resulted in underestimations of risk and unrealistic care planning by mental health services and adult social care.

When people are referred to specialist or crisis services it is important to value and incorporate the knowledge, wisdom and experience available from other professionals, and friends and family, who have longer-standing relationships with them. Third party information about a person's usual mental state and behaviour, and perceived changes, should be given sufficient weight and used to inform assessments and interventions of specialist services.

5. How has Hillingdon Safeguarding Partnership responding to the findings of the Safeguarding Adults review?

The Safeguarding Partnership has convened a group of senior leaders across the partnership to explore how local organisations can change their services and systems in response to the review and how the learning can be shared across frontline practitioners. Progress will be quality assured and monitored by the Safeguarding Adults Board.

The findings of the review have already been used to inform all relevant safeguarding training that is commissioned by the Partnership. An online learning event scheduled for September 2022 will share the key findings. A briefing has been produced to communicate the key learning points to frontline practitioners.