Hillingdon Safeguarding Partnership

Learning from a Safeguarding Adults Review: "Angela and Chris"

'Chris' (65) and 'Angela' (64) were two adults who lived and died in Hillingdon. They 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. There were delays and difficulties for local services in recognising and responding to their self-neglect until they were critically ill.

If their difficulties had been identified as self-neglect and responded to in a coordinated and urgent manner the care they received would have been improved. Hillingdon Safeguarding Partnership commissioned a Safeguarding Adults Review to identify the system learning from their experiences, this was undertaken by Social Care Institute for Excellence. The full report can be accessed here.

Key lessons for practice

1. Self-neglect can include refusal of medical assessment or treatment

When someone with poor or deteriorating health turns down assessment or support from health care professionals, this can be self-neglect. This includes if they cease taking prescribed medication/attending appointments. Self-neglect is a safeguarding concern that warrants exploration, risk assessment and risk mitigation. Unmet health needs can carry high risks and, therefore, in such cases there may be grounds to override an individual's wishes and work with partners to assess and mitigate risks. Safeguarding interventions can empower people to change their choices and behaviour through skilled support, relationship-based working and professional persistence. Making Safeguarding Personal means finding creative ways to help people to keep themselves safe - it does not mean walking away when people decline support. Check out this Making Safeguarding Personal Myth Buster.

What we can do differently:

- **Robust risk assessment - gather background information from the adult AND from other relevant professionals to inform risk assessment**
- **Explore the adult's reasoning and their understanding of the risks**
- **Don't take their refusal and given reasons at face value - respectful challenge and fact checking is critical**
- **Gather information and seek to mitigate risks, and liaise with your manager or safeguarding lead**
- **If risks persist consider raising a safeguarding concern with the Adult Social Care**

2. People who repeatedly put themselves at risk, or whose reasoning or behaviour appears out of character or irrational, may lack capacity. Do not assume mental capacity in such situations.

The House of Lords Select Committee found that the assumption of capacity *"is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm".* Setting the threshold for doubt too high puts people at risk of harm. For Chris and Angela, capacity was wrongly assumed at key moments, and when it *was* assessed executive capacity and fluctuating capacity were not consistently considered.

What we can do differently:

- **Do not assume capacity where a person's behaviour or circumstances give reason to doubt it**
- **When you consider capacity, it is important to start by supporting the person to make a decision themselves. The sort of steps you should take will be specific to the person's individual circumstances and needs**
- **An assessment of capacity related to self-neglect needs to include consideration of executive capacity. It will require more than a single conversation and will need to take account of information from the professional and family network around the person**
- **An assessment of capacity should include in depth exploration of the person's reasoning, their view of the risks, and a realistic sense of their ability to act on the intentions and beliefs they express**
- **Read the Safeguarding Partnership briefing on the Mental Capacity Act to support your practice**

3. Diagnostic overshadowing presents significant risks to people's health

'Diagnostic overshadowing' refers to an unconscious bias whereby practitioners wrongly assume that genuine symptoms of physical illness are instead a symptom of mental illness or learning disability. It can also mean that over-focusing on managing mental illness/learning disability can result in physical health needs being missed or de-prioritised. For Chris and Angela this contributed to delays in professionals identifying and treating serious physical illness, and delays in recognising self-neglect of their physical health care. Diagnostic overshadowing was evident for multiple practitioners working to support them. It is well established 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.

What we can do differently:

- **Undertake holistic assessments, gathering input from professionals involved in both mental and physical health - don't undertake assessments in isolation from the wider professional network**
- **Ensure people with Mental Illness or Learning Disability receive an annual health check from their GP - practitioners should proactively support adults to engage with annual health checks**
- **Maintain alertness of diagnostic overshadowing through reflective supervision, which should include explicit check and challenge around assumptions**
- **Clear recording of contact with service users can support practitioners to reflect on and critique their own assumptions**

4. Partnership working between specialist services and professionals/family who know the person best results in more effective interventions

When people are referred to specialist or crisis services it is important to gather and value the person-specific knowledge and experience available from other professionals, and friends and family, with whom the adult has longer-standing relationships. Longstanding personal and professional relationships should be harnessed, rather than side-lined, in order to promote robust clinical, social care and risk assessment. Third party information about a person's usual mental state and behaviour, and perceived changes in them, should be given sufficient weight and used to inform assessments and interventions by specialist services. Repeatedly, Chris' GP's and brother's concerns were not given sufficient weight and this resulted in underestimations of risk and unrealistic care planning by crisis and specialist services. They were also not consulted to enable identification of Chris by professionals who were meeting him for the first time.

What we can do differently:

- **Plan joint visits, where possible, by crisis/specialist practitioners and either family members or professionals with longer term involvement - especially at the point of introduction**
- **Sense check care plans and risk assessments with family and/or professionals who have greater knowledge of the person - professional expertise needs to be paired with person-specific knowledge for robust assessment**
- **Don't ignore alarm and concern from family or other professionals - humility and co-production will enhance the service the person receives.**
- **Don't withdraw involvement of crisis or specialist services without discussion with people who know the person best.**

Further reading

Raise safeguarding concerns for adults with care and support needs with the Multi-Agency Safeguarding Hub. Click on the icon to access the form

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NB For urgent concerns call 01895 556633 and then complete the form

Hillingdon Safeguarding Partnership Briefing: 'Mental Capacity: What Practitioners Need to Know'

Research in Practice toolkit: working with people who self neglect

Rethink Mental Illness: Why physical health checks matter