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Practice Safeguarding Adults Leads Network November 2017

Dr Dee Hora Named GP Safeguarding Adults
Vikki Gray Designated Nurse Safeguarding Adults

Welcome and Introduction

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- 1st Adult Safeguarding leads network – aiming for 6 monthly
- Assumption made about prior knowledge/training
- Why not combine with Child Safeguarding?
- Why is it relevant to our practice?
- Help us to help you and your practice
- Helpful comments and feedback welcome…….

Session Aims

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- Share learning from a recent Camden Domestic Homicide Review
- To support the identification and response to self neglect in general practice.
- To share the slides with practice safeguarding leads to deliver the session to colleagues
- An opportunity to meet the CCG leads and for peer support

Domestic Homicide Reviews

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Domestic Homicide Reviews (DHRs) are statutory reviews under the Domestic Violence, Crime and Victims Act 2004 and accompanied by statutory guidance

It is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) a person to whom (s)he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as him/herself,

Note that an 'intimate personal relationship' includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexual orientation.

DHRs are commissioned by local Community Safety Partnership Boards with a view to identifying the lessons to be learnt from the death.

Domestic Abuse

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- 2015/15 50 male and 107 female domestic homicide victims aged 16 and over with the most common method of killing being a sharp instrument or knife
- Mental health issues present in 25 of 33 intimate partner homicides
- Substance misuse present in over half of all DHRs
- Recording, risk assessment, information sharing/communication and training were all highlighted as issues in the analysis of DHRs
- Women experience an average of 35 incidents of domestic violence before reporting an incident to the police
- Response in 43 police force data returns for last 12 months until 31 August 2013 showed on average every 30 seconds someone contacted the police for public assistance in domestic abuse
- Prevalence figures for the LGBT community are hard to come by but commonly 6-10% is estimated

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf

Domestic Abuse and Health

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DVA is one of the most common causes of injury in women and a range of other conditions such as:

- increased minor infectious illnesses (Schornstein SL, 1997)
- chronic pain including headaches & back pain (as above)
- neurological symptoms including fainting and dizziness (as above)
- GI disorders including chronic IBS (Coker A et al, 2002)
- raised blood pressure and coronary artery disease (Tollestrup K et al, 1999)

- Gynaecological problems:
- Most consistent, longest lasting and largest physical health difference
- 3x increased risk of gynaecological problems, with dose-response relationship and increased risk with combination of sexual and physical abuse (Campbell J et al 2002)
- STIs
- vaginal bleeding and infection
- painful intercourse
- chronic pelvic pain
- recurrent UTIs

DHR Findings

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- Review completed – awaiting Home Office approval - not yet published
- A woman from the BME community in her sixties murdered by her long term partner - who has been convicted of murder
- No disclosure of domestic abuse to health or other services
- Adult children disclosed history of domestic abuse following the murder
- Attended GP frequently in last years of her life c/o back pain and menstrual problems. Several contacts requesting emergency contraception and a head injury with a 4/7 delay in seeking consultation.

- Several visits to obtain emergency contraception were an opportunity to explore the circumstances. No evidence the victim was raped but sexual violence is common is DVA
- Head injury cause was not explored or the delay in seeking examination
- Frequent visits for back pain and sick notes issued

Developments and Resources
IRIS Project – in its infancy at the time of the murder
RCGP Toolkit - Responding to Domestic Violence: Guidance for General Practices

Self Neglect

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- What is self neglect?
- Known signs, symptoms and challenges of self-neglect
- How can we achieve better outcomes?

Definition in Statutory Guidance

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14.17 Care and Support Statutory Guidance 2016

‘This covers a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding. It should be noted that self-neglect may not prompt a section 42 enquiry.

An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult’s ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support’
https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Key research https://www.scie.org.uk/publications/reports/report46.asp

Types of Self Neglect

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Lack of self-care

- Personal hygiene
- Care of daily needs (e.g. nutrition)
- Non-compliance with services (especially medical)
- ‘Risky’ behaviour

Lack of care for environment

- Living in squalor
- Hoarding
- Animal collecting

What is known about the phenomena

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Often a complex interface between:

Physical health issues: Impaired physical functioning; pain; nutritional deficiency

Mental health issues: Depression; mental health problems; frontal lobe dysfunction; impaired cognitive functioning, Substance misuse/Alcohol dependence

Psychological and social factors: Diminished social networks; limited economic resources; lack of access to social or health services; personality traits; traumatic histories and life-changing events; personal philosophy

- No particular overarching explanatory model for understanding
- Need for understanding of the meaning of self-neglect in the context of each individual's life experience
- Differs from other safeguarding work as there is no 'perpetrator'

Some signs and symptoms

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- Dehydration, malnutrition (or obesity), untreated medical conditions, poor personal hygiene. USA studies have linked self neglect in older people to increased mortality risks in cardiovascular, pulmonary, neuropsychiatric, endocrine and metabolic conditions (Dong, X. (2017). elder self-neglect: research and practice. *Clinical interventions in aging*, *12*, 949.)

- Hazardous living conditions e.g. improper wiring, no indoor plumbing, no heat, no running water

- Unsanitary living quarters e.g. animal / insect infestation, no functioning toilet, excrement present

- Inappropriate and / or inadequate clothing, lack of the necessary medical aids e.g. glasses, hearing aids, dentures

- Grossly inadequate housing or homelessness

Mental Capacity

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- The MCA is law
- Assume capacity and support decision making
- Capacity should not equate to abandonment
- Follow the statutory Code of Practice https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf
- Fluctuating capacity – time and decision specific
- In couples or families – see the adult behind the carer
- Respectful curiosity and challenge
- Record assessments and decisions
- Seek support if required

Mental Capacity Assessment

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The MCA applies from age 16 and is founded on five statutory principles:

- A presumption of capacity
- Support individuals
- Right to make an unwise decisions
- Best interest
- Less restrictive option

Mental Capacity is the ability to make a decision e.g.

- Daily life decisions.
- Serious or significant decisions
- Decisions that may have legal consequences.

These decisions must be viewed as

- Time specific
- Decision specific

Capacity Assessment

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Stage 1

Does the person have an impairment of or a disturbance in the function of their mind or brain?

Proceed to stage 2 only if YES to this question.

Stage 2

Does the impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

A person is deemed unable to make a decision if once given the relevant information they cannot

Understand it (Evidence)
Retain it (Evidence)
Use or weigh it (Evidence)
Communicate their decision (Evidence)

(p44 MCA Code of Practice)

Challenges in Practice

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- Engaging with the individual
- Jumping to conclusions in defining a persons 'unwillingness' and 'inability'
- Understanding underlying causes
- Uncertainty about a safeguarding referral
- Preoccupation with diagnosing
- Uncertainty about legal frameworks especially the interface between the Mental Capacity Act and Mental Health Act
- Thresholds for intervention/managing risk
- Frustration, anxiety, not knowing 'what works'

SAR

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Section 44 of the Care Act 2014 Safeguarding Adult Review - Published November 2017 the case of YY

YY suffered from multiple physical conditions, anxiety and depression and resided with his elderly mother. YY often made decisions not to consent to assessments and/or treatment for his conditions but also stated he did not want to die. A fall contributed to the development and deterioration of pressure ulcers and his decisions not to consent to treatment to treat the ulcers such as increasing diet, fluids and regular turning which resulted in further deterioration during his time in hospital and subsequently a nursing home.

YY was an 'unreliable historian' and also had a very low BMI – 11 at time of death, and had a complex relationship with food and anxiety around hygiene. YYs GP encouraged him to follow advice and attend secondary care appointments and made referrals to mental health even where this made YY angry. He was not referred to the eating disorder service by any agency. He had a very restrictive diet which excluded any dairy products, wheat / flour of any kind, salt, or sugar. He also declined all supplement drinks. The Psychiatrist concluded he had capacity to make his own decisions - which the dietician disagreed with. From the nursing home, YY deteriorated and was taken by ambulance to hospital where a safeguarding referral was completed due to his pressure ulcers being 'the worst ever seen'. YY sadly died with acute sepsis, pressure ulcers, malnutrition and dehydration were identified as being contributing factors.

Key findings

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- Lack of professional curiosity
- Lack of legal literacy
- Lack of respectful challenge to individual – quality of assessment/executive capacity?
- Lack of escalation and challenge where professionals disagree
- Lack of referral for a Mental Health Act Assessment – re: eating disorder
- Lack of guidance and tools for professionals working with self neglect
- Lack of recognition of safeguarding issues early on
- Lack of multi-agency coordinated risk assessment and rapid response to disengagement– especially when discharging from hospital to community

- Recommendations have been made around these areas and a specific one was made around more involvement from general practice in adult safeguarding

What is effective?

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- Understanding and accepting that there are complex psychological mechanisms at work
- Address immediate physical needs
- Safeguarding ?Section 42/ Obtain Adult Social Care Section 9 Assessment and Section 10 if a carer involved
- Identify the other agencies involved and communicating
- Gentle, persistent contact, building trust with an individual, over an extended period of time
- Person centred approach – what does this mean?
- A clear framework and plan which can be produced and shared with the individual
- Flexibility, negotiation and proportionality

Development of Tools

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http://hoardingdisordersuk.org/wp-content/uploads/2014/01/clutter-image-ratings.pdf

High Risk Panel

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The panel is made up of representatives from ASC, Housing, Environmental Health, Mental Health, Health, Substance Abuse, Voluntary sector groups, and the London Fire Brigade. Police are joining soon

The panel can advise you on cases that present with significant risks that you are concerned about or have tried various interventions which have not resolved the risks reasonably. It is a very useful multi – disciplinary discussion that can help un-pick cases that might be stuck.

Refer through usual safeguarding adults referral route – see last slide

NB. Currently under review following SAR

Key legislation

Mental Capacity Act 2005
Human Rights Act 1998
Care Act 2014
Equality Act 2010
Environmental Protection Act 1990
Mental Heath Act 1983
Animal Welfare Act 2006
Rights of Entry (Gas and Electricity Boards) Act 1986

Contacts

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Advice and support

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Referrals and Advice

Camden Adult Social Care Safeguarding Adults – 020 7974 4000 select option1

asc.mash.safeguarding@camden.gov.uk.cjsm.net

To request MHA assessment, please contact Approved Mental Health Professional Team on 020 3317 6845 (daytime) or 020 7226 0992 (after 17:00)

Metropolitan Police non-emergency - 101

RCGP Toolkit Safeguarding Adults

http://www.rcgp.org.uk/clinical-and-research/toolkits/safeguarding-adults-at-risk-of-harm-toolkit.aspx