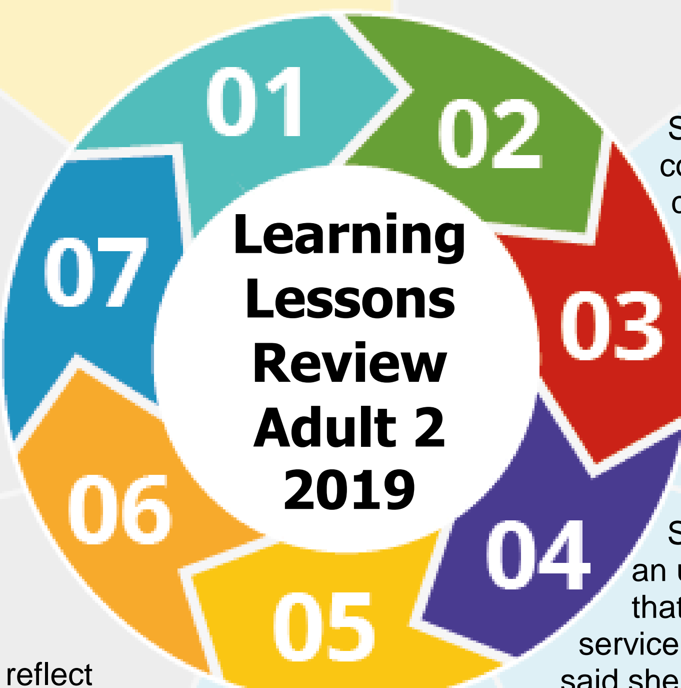
01 Background:

This Learning Lessons Review considers agency engagement with Adult 2 who had care and support needs as defined in the Care Act 2014. She tragically died in a house fire which is thought to have been caused by smoking in bed. Family, neighbours and agencies had been concerned about the welfare of Adult 2 for some time due to her excess use of alcohol and her self-neglect and hoarding behaviours. Although concern for Adult 2's well-being was evident over many years, attempts to intervene to positively improve her situation were not successful. The only support she actively sought was that of her GP in respect of physical health issues, many of which resulted from her alcohol abuse. In this she was inconsistent and would seek help but then not keep appointments.

02 Background:

Adult 2 often actively rejected support, though sometimes appeared to agree to accept it but then avoided it. There are, none-the less, some examples of good practice: On a number of occasions the GP went beyond what might be expected, made visits at the request of Adult Social Care, and followed up with neighbours when unable to get Adult 2 to answer the door; The PCSO who assisted Adult 2 to get back home, when she was found drunk in the town centre, was thorough, made a detailed record of the condition of the house, noted concern about bedding and lack of food in the fridge and made a comprehensive report. She made appropriate referrals.



03 Learning:

Staff in all agencies need to be confident about issues of mental capacity and in complex cases need to be able to call on support in making an assessment. Assessment of mental capacity should be recorded as a matter of routine.

04

Staff in all agencies need to have an understanding of those things that might lead to a refusal of service. In this case Adult 2 herself said she was embarrassed and ashamed about the state of the house. Staff need to be confident in providing reassurance and encouraging trust in order to initiate preventative support.

Staff in all agencies need to be sighted on the risks associated with self-neglect and hoarding, and be confident in assessing associated risks.

Staff in all agencies need to be sighted on risk and prevention of harm, even where the individual themselves rejects the offer of support.

05 Information:

Where there is concern about risk, then the likely seriousness of the potential harm should be assessed and recorded and where an adult who is deemed to have mental capacity is at risk of serious harm or death through self-neglect, risk taking behaviour or refusal of services should use the MRM process.

The circumstances in which it is appropriate to seek a specialist fire safety assessment from the GMFRS should be clear and specific criteria recorded when a referral is considered.

06 Questions:

To what extent do I critically reflect on cases?
How do I avoid fixed thinking?
To what extent do I understand the effects of alcohol abuse, the risks of relapse and the impact on the person?
Have I identified all sources of support for the adult and explored family connections?
Is information being shared appropriately?

07 What to do?

For more information on the Adult 2 Review, and on reviews in general, visit Rochdale Safeguarding Partnership Board - Safeguarding Adult Reviews and Audits

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