Mr C Safeguarding Adult Review

June 2022

1. What happened?

Mr C was a proud and independent man who maintained a strong determination to live his life as he chose. He experienced a number of health conditions including possible dementia, excessive alcohol use and poor eyesight. There were concerns around his living conditions for many years resulting in infestation and fire risks. He was served notice to leave his home against his wishes and whilst he was in a care home his property was cleaned. When he returned home his utilities were cut off and Mr C cooked using makeshift barbeques and lit the house with candles and oily rags in wine bottles. There was more than one house fire as a result and he was treated in hospital for the effects. Mr C died of ischemic heart failure during a fire at his house.

2. Learning from the review

- There was a lack of a coordinated and multi-agency response to Mr C's self-neglect
- Agencies didn't understand enough about Mr C, his previous trauma, his likes and dislikes, his lifestyle choices and how this impacted on engagement
- Practitioners assumed Mr C had the mental capacity to make decisions and the ability to execute these decisions, but this was never formally assessed
- Assessments and care planning did not mitigate the known fire risks
- Many of the issues in this review were similar to previous reviews – transforming learning into improved practice must remain a priority

3. Good practice

There was evidence of some good community engagement providing a drop in location for Mr C.

The district nurse team established and maintained a positive relationship that showed persistence in efforts to make contact.

A & E records were detailed, and Mr C had a positive relationship with the care home staff.

4. Recommendations

Gain assurance from partners about:

- Developing a trusting relationship through a trauma informed approach
- Risk assessment and planning in complex cases
- Identifying and responding to self-neglect
- Effective multi-agency safeguarding and information sharing response

5. Recommendations cont.

- Ensure that complex cases are appropriately managed through existing policies and procedures.
- Improve legal literacy including the Mental Capacity, executive functioning and inherent jurisdiction
- Seek assurance of multi-agency care planning, coordination, and communication to address self-neglect.
- Innovative ways to provide assertive outreach
- Professional curiosity, escalation and challenge processes should be understood and promoted across the partnership.
- Ensure that there is appropriate management oversight, audit and supervision processes in place for complex cases

6. Multi-agency Learning

Missed appointments particularly when there are known risks, should be appropriately followed up

Carefully consider, assess and record mental capacity for decision making when someone is self-neglecting especially when they are making high risk decisions.

Trauma informed approaches can help to engage people who face barriers to accessing support.

Take a multi-agency approach to self-neglect and hoarding concerns.

Seek safeguarding supervision oversight in cases involving complex needs.

7. Resources

Multi-agency Professionals Meeting Guidance

Calderdale Safeguard Guide Professional Curiosity and Challenge

CSAB-Self-Neglect-policy-2018.pdf

ma-safeguarding-adults-policy-procedures-2019

Resolving-Professional-Disputes-and-Escalation-Procedure.pdf