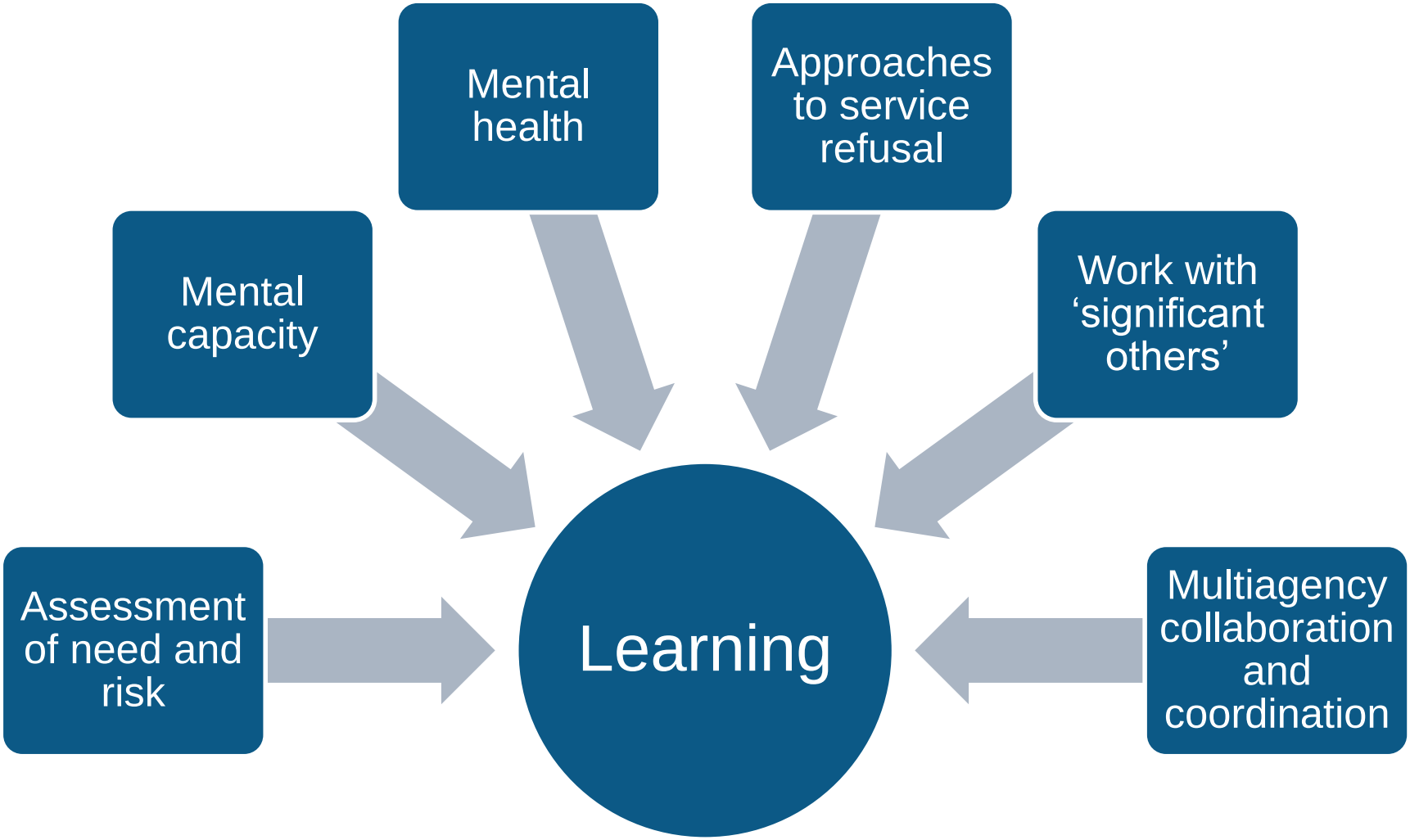
# Mr Bs Life

- Early 60s; mild learning disability; living in family home; parents death left him isolated
- Befriended; Friend moved in as a ‘carer’; concerns about home conditions/hygiene; serious hoarding/fire risks
- Suffered a Stroke; impaired mobility & speech; difficulties securing adaptations;
- Further decline in personal care & state of house; episodic involvement with agencies; assumptions of mental capacity
- Reluctance to accept help and support at home;
- Safeguarding concerns: neglect; financial exploitation
- Interagency work to secure change in hygiene and conditions; hostility and aggression from carer; gradual development of relationship; mental capacity assessments
- Compliance with health and personal care intervention; referral to mental health services; refusal to change home conditions
- Died with his fiend in accidental fire June 2017

# Emergent learning themes



# Assessment of need and risk

- Early missed opportunities to conduct care & support needs assessment: “no identified needs”
- Outcomes of OT assessment frustrated by absence of home ownership proof
- Safeguarding concerns identified but:
  - Difficulty engaging with AM – relationship with friend / carer
  - No evidence of care & support needs assessment
  - No comprehensive risk assessment – fire / willful neglect
- Delicate balance of negotiated vs imposed solutions
- Trust-building interventions pursued without appropriate risk-management strategies
- Lack of momentum in the safeguarding plan

# Mental capacity

- Reliance on assumption of capacity rather than formal process of assessment

- Mental capacity assessments
  - (i) finding of capacity not evidenced
  - (ii) examples of excellent practice

- Significance of absence of capacity
  - No explicit best interests decision-making process

# Mental health

Mental health needs recognized late in the process

# Approaches to service refusal

AM's assurances taken at face value

- Absence of professional curiosity
- Failure to pursue proactive engagement warranted by level of risk
- Culture of case closure resulting from resource and caseload pressures

Loss of momentum in response to continued refusal to deal with the state of the property

# Relationships with significant others

- Friend/carer's needs not fully recognized
- Coercion and control of AM recognized but not addressed
- Intermittent contact with AM's family - missed opportunities

# Interagency collaboration & coordination

- Some good practice
  - Effective communication over specific matters
  - Safeguarding meetings provided effective forum for some agencies to coordinate their involvement, strong legal presence
  - Effective communication between ACS and NSFT
- But - missed opportunities; disagreements about responsibilities
- Significant gaps in communication/coordination
  - Fire Service
  - Police
  - GP
- How effective was the safeguarding process? – delay in moving forward

# How we are …

- Further development of the SNH policy
- Engaging with hard to reach clients - training
- Mental capacity assessments  - improve undestanding
- Training on self-neglect across partnership
- Service responses to self-neglect – Fire risks