Suffolk Safeguarding Adults Board

‘Mr. B’ Case Study – Self Neglect and Hoarding

Mr. B’s Story.

Mr. B lived a sheltered life in the property in which he was raised by his parents. On the death of his parents 1992, he received support from an aunt and uncle and Adult and Community Services (ACS).

Mr. B was befriended by C who moved into his property and acted as his “carer”.

Mr. B’s property deteriorated to a soiled and cluttered state and he was reported to be neglected regarding his personal hygiene. The pets in the house were removed by the RSPCA.

ACS along with other agencies including Environmental Health, Police, Fire attempted to assist Mr. B & C but they were reluctant to engage with services.

Mr. B suffered a stroke which affected his mobility, communication skills and ability to process and retain information, Concerns were raised about C’s treatment of Mr. B which now reached the threshold for the involvement of adult safeguarding.

Mr. B was found to be in a severely neglected state and the property was filthy throughout, cluttered with household waste and hoarded objects. The property was also without heating, hot water and was identified as a fire risk.

Mr. B agreed albeit reluctantly, to attend community facilities where he could be assisted to have a shower and for his clothes to be washed. Several visits were undertaken to the property by the fire service, but they were unable to carry out a fire safety visit.

Until relatively recently, the professional view was that Mr. B had mental capacity to make choices about his care, treatment and living conditions. However, in 2017, following assessments under the Mental Capacity Act 2005, he was found to lack capacity to manage his financial affairs and to make decisions about his personal care and living conditions.

A multi-agency approach was adopted through safeguarding meetings working with Mr. B, to assist him to adopt changes at a pace at which he was able to accept.

Sadly, in Summer 2017 a fire broke out at Mr. B’s property. Both Mr. B and C died at the scene.

The coroner’s inquest report confirmed the cause of Mr. B’s death as smoke inhalation due to a house fire with the background of serious social self-neglect and coronary artery atheroma. The likely cause of the fire was an electric toaster found in the kitchen. There was no suggestion that the fire was deliberate.

What went well?

- There was good communication between agencies and a commitment by partners to work together, through safeguarding case conferences to attempt to implement identified changes.
- There was extensive engagement between agencies to support and work with Mr. B at a pace that he was able to adopt over a sustained period of time.

What were we worried about?

- Early missed opportunities to conduct care & support needs assessment.
- Reliance on assumption of capacity rather than formal process of assessment.
- Mental health needs recognised too late in the process.
- AM's assurances taken at face value - absence of professional curiosity.
- Loss of momentum in response to continued refusal to deal with the state of the property.
- Coercion and control of Mr. B recognized but not addressed.
- Some evidence of a lack of multi-agency communication and collaboration.
- More proactive communications with Mr B's family could have resulted in a stronger presence for them in his life.

What is the learning from this case?

- The appropriate application of the Mental Capacity Act, especially regarding the presumption of capacity, best interests and executive capacity is vital is such cases.
- The needs for mental health assessments needs to be recognised early in the engagement process.
- Partners need to recognise the impact of coercive and controlling relationships on the risk assessment process.
- Consideration should be given to the need for a mental capacity assessment for carers where doubt exist about their ability to make specific decisions.
- Comprehensive multiagency strategies are needed during the relationship-building work, notably to ensure that key agencies such as the Fire Service and Police were able to input to discussion and decision-making.
- There needs to be collective ownership of self-neglect cases, core membership of multi- agency meetings, and nomination of a case coordinator.

A range of resources to support practitioners including the **Self-Neglect and Hoarding Policy and risk assessment** is available on the SAB website at:

https://www.suffolkas.org/safeguarding-topics/self-neglect-and-hoarding/