# Adult Discretionary Review (LLR)
# Practitioner Briefing Paper
# Philip and Loraine


## The Learning Lessons Review

A review was commissioned by Darlington Safeguarding Partnership to consider the multi-agency response to concerns about hoarding and self-neglect following the tragic deaths of Philip and Loraine in a house fire in 2023. It explored practitioner's understanding and knowledge of self-neglect and hoarding and the application of the Mental Capacity Act and capacity assessments in these circumstances, fire safety and the fire risks of hoarding and smoking. The review was conducted by an independent author, Keith Wanley and considered what information was known about Philip and Loraine leading up to their deaths and how agencies worked together to help understand and identify lessons to be learnt to change how agencies work with people with similar needs in future.

## Understanding the Family

Philip and Loraine were father and daughter both of whom had needs for care and support, they lived in a privately owned home and in May 2023, a fire occurred at the property and sadly both Philip and Loraine died. There was evidence of hoarding and self-neglect and concerns about how effectively agencies had worked together. Philip's wife (Loraine's mother) died suddenly in 1995, and both began to hoard which built up over time. Philip became increasingly reclusive , he was a heavy smoker with Type 2 diabetes and received a care package to help with the preparation of food and drink and clearing up. Loraine had Type 1 diabetes and was insulin dependent and had significant mobility issues as a result of arthritis, but with the use of a motorised wheelchair she was able to leave the family home. A stairlift was installed and she was able to walk to the bathroom unaided, when at home she spent most of her time in her bedroom. Loraine also had a care package, and both made it clear that they wished to remain in the family home. At the time of death both were deemed to have capacity and neither had a formal diagnosis of hoarding disorder. Both were known to Adult Social Care but were closed to services at the time of death.

## Practice Themes to Make a Difference

- Understanding the root cause of self-neglect and hoarding
- Understanding Hoarding Disorder
- Smoking and fire risk
- Mental Capacity Act and Code of Practice Awareness
- Mental capacity assessments
- Information sharing
- Practice issues relating to multi-disciplinary meetings

# Key Learning

## Understanding of Self-Neglect and Hoarding

Self-neglect was a feature for Philip and Loraine as there was substantial evidence of hoarding type behaviour, concerns around hygienic conditions and out of date food in the kitchen and concerns over the amount of unused medication in the family home.

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## Understanding Hoarding Disorder

Hoarding Disorder is now a recognised medical condition, and although Philip and Loraine were never formally diagnosed with hoarding disorder, they demonstrated hoarding behaviour. The review highlighted efforts by agencies to address the symptom of hoarding with attempts to reduce the clutter, however this often led to them becoming distressed and agitated. Had agencies explored the root cause, there may have been opportunity for onward referral to GP. Practitioners should be more curious to understand what is important to the adult and how this may be used to influence positive changes in lifestyle.

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## Smoking and Fire Risk

Smoking and fire risks were never fully explored. It was known Philip was a chain smoker and smoked throughout the property. Both Philip and Loraine had mobility issues and used a stairlift. In 2019, the Fire and Rescue Service conducted a home visit and due to risks associated with Philip's smoking provided a flame -retardant bed pack. Information about this was not passed onto other agencies who were unaware the equipment was in the property, and it had remained in its box and unopened until Care Agency raised the matter in 2022, this was followed up twice, however Philip refused the first visit. A second visit took place, and advice was provided on various fire risks including keeping escape routes clear in event of a fire and additional fire-retardant equipment was provided. The home was recorded as very high risk but again information was not communicated to other agencies.

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## Multi-Agency Practice issues

It was highlighted that multi-agency safeguarding processes had not been fully followed, including documentation, designed to provide structure were not fully completed with sections incomplete, which was a missed opportunity to document considerations and decisions of the group. Key agencies were not invited to further strategy discussions, leading to missed opportunities to raise concerns. All individuals in household should be considered in an enquiry, not just the person which is the subject of the concern.

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## Mental Capacity Act assessment

The review noted that agencies felt that both Philip and Loraine had the capacity to make decisions and therefore no formal capacity assessment was undertaken in relation to their understanding of the risks associated with their excessive hoarding and their decision to have items removed to reduce the clutter. Loraine had no diagnosis of cognitive impairment, Philip did have memory issues and there were concerns around capacity, however there were no grounds under the MCA to warrant an assessment

## Recommendations for Partnership Include:

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| 1 | **Professional Challenge Briefing/Strength Based Approach:** The Professional Challenge briefing will be revisited following the learning in this review and shared across the Partnership. The DBC strength/asset-based approach link will be shared in the DSP website. |
| 2 | **Mental Capacity Act (MCA) Training:** DSP is preparing a MCA briefing document and will promote the MCA e–learning module across partner agencies. It plans to undertake a mapping exercise to understand how single agencies access MCA training. An additional e –learning module on Self Neglect is also available. |
| 3 | **Self-Neglect and Hoarding Practice Guidance:** DSP revised the Self-Neglect Practice Guidance document to include a risk assessment tool and other resources. This was launched at the Self-Neglect Conference in July 2024. The guidance and the briefing document will be further revised to incorporate appropriate signposting and updated case law. |
| 4 | **Joint Fire Safety Plans:** County Durham and Darlington Fire and Rescue Service and Adult Social Care (Darlington Borough Council) will develop a joint fire safety plan (including incorporating an evacuation plan in the event of an emergency) which will be shared with GP, carers and anyone working with the individual/family. |
| 5 | **Whole Family Approach:** DSP multi-agency practice guidance and procedure will be strengthened to highlight the need to ensure all individuals in a household are considered in strategy meetings and multi-agency meetings. |
| 6 | **Risk Enablement Forum (REF):** The REF has been introduced. This is a multi-agency forum for senior managers which considers high risk and complex cases where individuals are unable to engage and remain at risk or a risk to others. |
| 7 | **Implementation of Learning**: All agencies will implement the learning from the review and DSP will seek assurance from agencies that this has been completed. |
| 8 | **Quality Assurance:** DSP will undertake multi-agency quality assurance activity in respect of cases involving self-neglect and hoarding to ensure that practitioner learning has been embedded. The audit activity will be led by the Quality and Performance Management sub-group. |

## What can you do?

- ⇒ Strengthen your knowledge in understanding self-neglect and hoarding, understand the root causes of hoarding and recognise the importance of knowing and understanding the family history and background to the hoarding and use evidence-based tools and skills such as a strength/asset-based approach that support relational and trauma informed approaches to addressing hoarding.
- ⇒ Ensure your practice follows the multi-agency guidance and expectations and is underpinned by the six principles of safeguarding.
- ⇒ Understand your responsibilities in seeking and sharing information and its critical importance in understanding what is happening in a family.
- ⇒ Ensure that all individuals in a household are considered in an assessment of risk, not just the subject of the concern and work collaboratively with colleagues in Children's Services if there are children in a household.
- ⇒ Ensure that you have accessed training in the Mental Capacity Act and conducting mental capacity assessments.
- ⇒ Access training, resources and the tools (DSP website) to assist with risk assessments and to evidence what helps and to reflect and improve your own practice, skills and knowledge. Ask for help when dealing with complex issues.
- ⇒ Understand the Darlington Safeguarding Partnership Professional Challenge procedure and your responsibility to respectfully challenge practice and challenge assumptions, bias and attitudes and use critical thinking skills to inform professional challenges.
- ⇒ Use supervision to reflect and challenge assumptions and seek support for complex cases.

### Want to learn more?

There is a range of information, procedure, guidance, tools and signposting relating to Self-Neglect and Hoarding available on DSP website:

DSP Website—Self Neglect and Hoarding Guidance and Resources

DSP Training—Adult Self Neglect and Mental Capacity Awareness e-learning

DSP Learning Lessons Review Self-Neglect Briefing

National Health Service (2022) Hoarding Disorder

HM Government (2005) Mental Capacity Act 2005

HM Government (2014) Care Act 2014

Hoarding Disorders UK (2014) Clutter Image Rating

39 Essex Chambers— Mental Capacity Guidance


**Access to the report**

The full report and Executive Summary Report are available on the DSP Website.

Click here to access