1. Eileen and Alan

Eileen and Alan were a much-loved mother and son who lived together. They both provided care and support to each other. Alan had spina bifida and used a wheelchair to mobilise. Eileen was in her 90s with memory and mobility difficulties following a stroke. They relied on each other for support and care.

2. Fire death

Both Eileen and Alan died in a house fire. She was 92 and he was 54. The coroner's inquest recorded the deaths as accidental. However a non statutory learning review was undertaken by Social Care to explore the lessons which could be learnt from the deaths of Eileen and Alan. This was done in conjunction with their family.

3. Think fire

It is believed that the fire started in Alan's bedroom due to an electrical fault. He also had in his room boxes of dressings, emollient creams and an air-flow mattress all of which can increase the speed and intensity of fire. More guidance on preventing fire deaths can be found here: PowerPoint Presentation (shropshiresafeguardingcommunitypartnership.co.uk)

8. Communication

There were occasions in which family were told that referrals had been made, but there is no evidence of the referral. Although family raised concerns we cannot always see what happened. As a basic rule if you say that you are going to do something then do it, and do communicate with the family (within the limits of confidentiality). With appropriate support the last months of their lives would have been more comfortable and their deaths were possibly preventable.

4. Inter-related needs

Although Eileen and Alan came into contact with professionals from health and social care, few considered their needs together or indeed, individually. They were both caring for each other, and any arrangements to support them needed to take this into account. This includes consideration of their inter-related needs at the point of hospital discharge.

7 Professional curiosity

Although a number of professionals were involved there was a lack of curiosity about the relationship between Eileen and Alan, their living conditions, their inter-related needs, her declining physical and mental health and the impact on Alan. No one thought to make a fire referral. A referral to the fire service for a home visit should have been made. You can do this here.

6. Think carer

Referrals were not made by any professional involved with the family for carers assessments. Do remember that people with disabilities themselves can also be carers. More information on identifying and supporting carers can be found here: PowerPoint Presentation (shropshiresafeguardingcommunitypartnership.co.uk)

5. Visiting the home

Professionals failed to identify concerns about the living environment, despite family having raised these concerns with professionals. Where appropriate we recommend that professionals visit people in their own home. This will allow an assessment of the living conditions and environment.

Eileen and Alan