Redbridge Safeguarding Adults

Redbridge Safeguarding Adults Board

Safeguarding Adult Review (SAR):

Hilary

Report Author & Independent Reviewer:
Anna Berry

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Glossary

Abbreviation	Definition
SAB	Safeguarding Adult Board
SAR	Safeguarding Adult Review
GP	General Practitioner
PRLE	Practitioner Reflection and Learning Event
S42	Section 42 (of The Care Act)
MCA	Mental Capacity Act
MHA	Mental Health Act
RAABIT	Redbridge Access, Assessment and Brief Intervention Team
EDT	Emergency Duty Team
IAPT	Improving Access to Psychological Therapies
STR	Support, Time, and Recovery worker
OT	Occupational Therapy
CRT	Community Recovery Team
LBR	London Borough of Redbridge
MARM	Multi Agency Risk Management (protocol)

Foreword by Independent Chair

On behalf of the Redbridge Safeguarding Adult Board, I would like to say that first and foremost our thoughts are with the family of Hilary following her tragic death. Secondly, to express our gratitude for their contribution to this review. Their input has been invaluable in giving insight into Hilary and her life.

Having commissioned this independent Safeguarding Adult Review, the Board welcomes this comprehensive report, which provides invaluable learning for all our partner agencies in their ongoing work with people with complex needs and the impact of the environment in which they live.

Our Board will strive to ensure that the recommendations in this report will improve the way we work with people in similar situations, and, to that end, a detailed action plan will be developed. The Board will monitor the implementation of these actions and the impact on improving the safeguarding and wellbeing of adults needing care and support. The report will also be shared with the Redbridge Community Safety Partnership to consider the findings as it shapes its response to exploitation in partnership with the Board.

Finally, I would also like to express thanks to Anna Berry, the independent reviewer and colleagues in all organisations involved for their transparency and commitment to learning and making the changes that will help to prevent similar deaths in the future.

Eileen Mills

Independent Chair

Redbridge Safeguarding Adult Board

1. Introduction

1.1. Under Section 44 of the Care Act 2014 there is a duty for Safeguarding Adult Boards (SABs) to arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult. If the SAR criteria, are not met but the relevant SAB feels that there are lessons to be learnt, an alternative review may be undertaken.

1.2. The purpose of conducting a review is to enable members of the SAB to:

- Establish whether there are lessons to be learnt from the circumstances of the case about, for example, the way in which local professionals and agencies work together to safeguard adults at risk.
- Review the effectiveness of procedures and their application (both multi-agency and those of organisations).
- Inform and improve local inter-agency practice by acting on learning (developing best practice) in order to reduce the likelihood of similar harm occurring again.
- Bring together and analyse the findings of the various reports from agencies in order to make recommendations for future action.

1.3. Further information on the local SAR process can be found in the Redbridge Safeguarding Adult Board (RSAB) SAR Protocol, 5th Edition 2023[i].

1.4. SARs are required to reflect the six safeguarding adults' principles, as defined in the Care Act. These are empowerment, prevention, proportionality, protection, partnership, and accountability.

1.5. The aims of the SAR are to contribute to the improved safety and wellbeing of adults with care and support needs and, if possible, to provide a legacy and support family and friends. There are clear review objectives which have been addressed to achieve these aims. Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the facts (what happened), an analysis and findings (what went wrong and what went right), the recommendations to improve services and to reduce the risk of repeat circumstances, and a shared action plan to implement these recommendations. It is not the purpose of the review to re-investigate the suspected abuse or neglect, or to apportion blame to any party.

1.6. The review process to meet these aims and objectives has followed a clear path. The methodology chosen for this review is a "Learning Together" approach. This included a panel to agree terms of reference and a focus on themes, patterns, and factors together with family and practitioner discussions. The Independent Reviewer has conducted research by analysing the information provided culminating in an overview report for the RSAB. The review covers the period of 2018 to October 2022.

1.7. Agencies that have contributed to this review are:

- NHS North East London Integrated Care Board (NHS NEL ICB)
- Primary Care - GP
- London Borough of Redbridge (LBR) - Community Safety Team
- LBR Integrated Adult Health and Social Care
- North East London NHS Foundation Trust (NELFT) - Adult Mental Health Services
- London and Quadrant Housing Association(L&Q)
- LBR Housing Service
- Westminster Drug Project (WDP) (now known as Via)
- London Fire Brigade (LFB)
- Metropolitan Police Service (MPS)

2. Overview of the case and circumstances leading to the review

2.1. The SAR referral was received on 20 October 2022 from the Local Authority Community Safety Team, the case was considered on 02 December 2022 and the review endorsed and commissioned.

2.2. This review is about a 67-year-old lady who died in October 2022. Hilary was murdered in March 2022 by a person known to her. They will be known in this report as 'Person Two'.

2.3. On the date of her death, Hilary had been approached by Person Two for money which she refused to provide. Person Two strangled Hilary leaving her for several days until he disclosed the event to a relative who contacted the police. Person Two proceeded to take Hilary's bank card and spend amounts of money throughout that timeframe.

2.4. Hilary lived alone in a rented flat owned by a housing association, she was known to Mental Health Services and had come into contact with Adult Social Care (ASC) and Police in the years leading up to her death, due to ongoing concerns about vulnerability and financial abuse.

2.5. There were a number of professionals involved throughout the timeframe of this review, namely the GP, mental health provider, adult social care, and police.

2.6. The SAR Panel acknowledged that there were areas of improvement identified for the planning and coordination of multi-agency care.

3. Key Themes

The key themes identified in the review are:

Approaches to complex safeguarding concerns

- Multi-agency working and risk formulation
- Professional curiosity
- Information sharing
- Current ways of working with “complex” cases
- Legal literacy

Adult Mental Health

- Do mental health assessments, and ongoing coordination of mental health services recognise and inform safeguarding processes relating to increased risk of exploitation?

Understanding the person

- Background
- Daily lived experience
- Social circle of support
- Impact of the COVID-19 pandemic

Connectivity of community safety aspects to the safeguarding of individuals

- Working together through a proactive wider system lens
- Consideration of the connectivity of “housing” when there are concerns about the safety of one or more individuals within a community.

4. About Hilary

4.1. Hilary was 67 years old when she was murdered in her own home in October 2022. Hilary had been under the care of adult mental health services for a number of years and in receipt of support services due to her complex needs which included hoarding. In the years leading up to her death, she was financially exploited by different members of the community living around her. There are two people in particular who will be referenced within this report. Person One, who features earlier in the timeframe, and Person Two, who financially exploited Hilary later in the timeframe and who is now convicted of her murder.

4.2. Hilary’s GP identified a diagnosis of Obsessive Compulsive Disorder.

4.3. Hilary’s psychiatrist recorded a diagnosis of “hoarding behaviour in the context of personality disorder (dependent type).

4.4. It is important that this review explores the agreed terms of reference with Hilary at the centre and in order to do this, it is essential to get a sense of her as a person so that the events leading up to her death do not define her. This will also allow episodes of care and action to be seen through the lens of Hilary’s own experiences.

4.5. Hilary was born in 1955 and lived in the London Borough of Waltham Forest until the age of 14 when she moved to the London Borough of Redbridge. She grew up with two parents and two younger sisters.

4.6. Hilary's sisters provided a full family history that added important context and insight to some of the challenges she faced through her life. This history went back to the generation of grandparents and provided a sound chronology of Hilary's childhood. Hilary was the eldest of three sisters who were all born within 5 years of each other and hence they had close friendships/ relationships throughout early childhood. All three children were very capable academically and Hilary's sisters described how their parents made sacrifices to ensure they lived in the right catchment area (Woodford) for a good school.

4.7. The family were very private, described by one sister as "insular" with reflections that their parents, particularly father demonstrated hoarding behaviour. This was felt likely to be a post war issue in that the family did not like to waste anything and therefore saved and re used items wherever possible. Hilary's sisters recall spending a lot of time outdoors and having nice family holidays visiting grandparents and spending time on the beach in Whitstable, Kent.

4.8. Hilary did not like loud noises as a child and she found it difficult to socialise from an early age and had only a few strong friendships with people who enjoyed the same interests namely around science. Hilary often struggled to organise and manage herself with tasks that were required to get by at school and at home. She completed A- levels in maths, biology, and chemistry, and later went on to complete a biology and bio-chemistry degree at the University of London.

4.9. One sister recalls a particular incident from late teenage years that provides a very early context for Hilary's subsequent mental health presentations. This was when she was required to go on a geography field studies course and returned in a highly anxious and stressed state because she was not able to cope with being away from home in a different setting. This incident prompted her sister to highlight its significance to their parents and recommend that she should attend university away from home to gain independence and coping skills in a different environment. However, Hilary chose to commute to the University of London and continued to live at home.

4.10. Following this she commenced employment at a paint factory utilising her scientific knowledge and qualification. Hilary was made redundant from this job and was never in paid employment again. However, she did have several voluntary roles including one at a garden centre where she met a boyfriend and maintained this relationship for some time.

4.11. Hilary had a close relationship with her mother who she cared for up until her death in 2014. This caring role formed an important part of Hilary's routine, and it can be observed that after her mother died, this affected Hilary profoundly. During the few years leading up to the death of her mother in 2014 she was motivated to get up in the morning to go and care for her. One sister said caring for her mother gave her a purpose and role and there was no unpredictability. Their relationship was very special, and Hilary took this caring responsibility very seriously and also took pride in looking after her mother's garden. She described the effect on Hilary of losing her mother as a "sledgehammer".

4.12. To note, the review has not explored this earlier timeframe in detail but notes that Hilary was discharged from mental health services shortly after her mother's death and her hoarding behaviours increased in the subsequent years.

4.13. Hilary had first become known to mental health services as a young adult. One sister described the difficult and sometimes acrimonious relationship that Hilary had with her father. This was largely related to her own hoarding behaviour that had become worse when she started to bring refuse home to "recycle". It was at the point that her father started to clear out her "hoarded" items that Hilary became very traumatised and unwell, resulting in her being sectioned under the Mental Health Act on the first occasion. Her sister considers this to be a significant event that traumatised her for many years and demonstrates the extent to which Hilary became distressed and anxious when significant change happened around her and particularly without her consent.

4.14. Hilary spent a considerable amount of time in hospital from thereon, following which she lived in supported accommodation before her move to independent living with self-funded support workers. Hilary had lived in her flat for 18 years prior to her death and when she first moved in, the community around her felt safe and secure, she had trusted neighbours, attended church and gospel choir group and overall and her life was more predictable.

4.15. Already mentioned, Hilary did not cope well with change and when significant events or changes occurred, this would manifest itself as an escalation in hoarding behaviours. In terms of other indicators, she suffered from trichotillomania (hair pulling) and at times over the years she pulled out most of her hair and eyebrows. In the few years leading to her death a few significant events happened that proved to be very traumatic for Hilary which will be considered throughout the review. These can be summarised as:

- a change or cessation in support workers
- frequent changes of care coordinators
- the death of her mother and resulting loss of her daily routine
- changes in the community around her and ongoing financial exploitation from at least 2015
- COVID-19 pandemic and the isolating measures

4.16. Her family unequivocally said that she did not cope well with change, and this is supported by professionals who knew Hilary. However, also a frequently made point is that that she did have insight into the times when she knew she was stressed and in particular she often felt embarrassed and ashamed about the state of her flat which in turn increased her stress levels and symptoms.

4.17. Hilary was described by family and professionals as being a very intelligent and extremely kind person. She had a strong Christian faith and took comfort from the church and enjoyed participating in the gospel choir, rarely missing a practice until it ceased to take place. It is an interesting point to consider that although Hilary struggled to maintain close and ongoing one to one relationships, she had always participated in group and community activities throughout her life and thus enjoyed having a sense of belonging and pride in the activities she liked. In fact, the Gospel Choir sang at her funeral service which was testament to how well thought of she was.

4.18. Hilary's nieces describe her as "selfless and loving" and highlight the extent to which she cared for their grandma in her final years. What comes across most strongly in the words of her family is the extent to which she prioritised other people's needs, never forgetting birthdays or other important events and checking in on everyone else's wellbeing, news or issues whilst minimising her own.

4.19. Hilary did struggle to get to church as some of her routines and behaviours increased- for example her increasingly nocturnal hours affected her daytime functioning, and she would need to follow a particular routine for preparing breakfast which meant she could not be ready on time. This also affected her ability to attend morning appointments and in particular the local hoarding group.

4.20. Hilary's direct neighbours changed over the years and he community around her became a complex situation of interdependence with neighbours reportedly helping, supporting, and exploiting each other at different times, with prevalent issues of drug addiction and financial problems. Hilary had a strong sense of wanting to help those around her and thus took responsibility for community members when they were reporting difficulties. Hilary also spent time during the night trying to help homeless people in the local area.

4.21. Her sisters became aware of her being financially exploited around 2015 with reference to a neighbour (Person One) who she had helped on a number of occasions amounting to a significant amount of money. He had a drug addiction and financial difficulties and Hilary continued to give money to him when it was requested.

4.22. Whilst her sisters both agreed that she had insight and did understand the complexity of the issues around her , for example drug addictions, they both felt there was a level of naivety in so much as she would try to see the best in people and also that she was not risk aware and did not recognise the capacity of people around her with drug addictions to be high risk.

4.23. Of her two sisters, one was able to physically visit more frequently due to her geographical location. She spoke about trips out with Hilary that they both thoroughly enjoyed. She described Hilary as a chatterbox who loved a good day out and enjoyed wildlife and plants. She has lots of nice memories of these times with Hilary. Her other sister described weekly phone calls lasting hours where they would chat and laugh about many different things.

4.24. Hilary took her role in the community and in the world very seriously, she felt a strong sense of duty to help people and to make the world a better place.

5. Engagement with Family

5.1. Engagement with family members and listening to their perspectives and experiences is essential to develop learning when undertaking a SAR. A focus on their understanding about how their family member was supported on a daily basis and their experience of services and whether they found these to be helpful, provides a more personal insight into how agencies managed events.

5.2. The statutory guidance requires early discussions with the individual (where possible), family and friends to agree how they wish to be involved. It further requires that families

should be invited and understand how to be involved, with their expectations managed appropriately and sensitively[ii].

5.3. Hilary's family contributed significantly to the review, providing multiple examples, anecdotes, and information. This provided a much wider context to the information that was available. Their contribution provided a rich and meaningful understanding of Hilary's personality, life experiences and perspectives at different times.

5.4. Hilary's two sisters and her nieces were able to provide significant insight into her life and experiences which have helped to identify the learning for future practice. This was provided in the context of their bereavement, trauma and whilst coping with the process of the criminal proceedings and they are to be commended for their contributions.

5.5. The family believe that there is meaningful learning that can be gained from reviewing Hilary's case. They hope that agencies will use this learning to improve practice.

6. Parallel processes

6.1. For reference, background, and context it is helpful to consider the formal cause of death and other relevant statutory process and their conclusions.

6.2. The criminal trail concluded in March 2023 where Person Two entered a guilty plea and was convicted of Hilary's murder. The cause of death on the death certificate is recorded as compression to the neck. The Coroner reviewed the outcome of the criminal proceedings, and the scheduled coronial inquest has now been stood down.

7. Key learning episodes

7.1. Within the information provided for this review there is evidence of at least 60 episodes of contact with services including:

- Metropolitan Police Service (East Area Basic Command Unit)
- GP
- Mental Health Services (NELFT)
- Adult Social Care (LBR)
- London Fire Brigade

The chronology below includes the key points of contact with these services. It should be noted that Hilary's full contact with services was more extensive.

DATE	EPISODE
April 2016	Concerns raised to the police by the bank after Hilary drew money out to give to a male. A Merlin was created and sent out adult social care. (The Merlin system was created as a vehicle for police officers to deal with vulnerability. This allows the recording and sharing of concerns with partners in order to effectively safeguard members of the public).
July 2016	Police were contacted by a neighbour who reported Hilary to be missing. A Merlin was created but not shared as she returned home safe.
July 2017	Concerns raised when Hilary was noted to be withdrawing money from the bank for a neighbour (Person One). Merlin was created and shared with

	adult social care. Person One was spoken to by police, but no offence was identified.
December 2017	Hilary's bank card was stolen from her at a cash machine and £1000 taken from her account. Police contacted and Merlin created.
Points: **These episodes were pre-timeframe but add context to the length of time that Hilary was providing money to Person One.**	
2018	
January 2018	Merlin received by adult social care and an urgent assessment meeting was held with Hilary and her support worker. It is noted that Hilary was found to have mental capacity and there was a formal MCA recorded on the system. Hilary refused support regarding financial abuse stating she felt sorry for the neighbour as he had a drug habit and he was unable to access benefits to pay for it, so she was choosing to help him. It was noted that Hilary was hoarding, and self-neglect was considered. A "blitz clean" was refused and she did not consent to any further safeguarding or police action.
30 January 2018	Support worker contacted mental health services with concerns of deterioration in view of increased hoarding, she was noted to have been discharged from all mental health services in 2015 and the support worker was advised that a referral would need to come from Hilary's GP.
March 2018	Hilary's support worker raised concerns with police due to ongoing occasions when a male neighbour (Person One) was getting Hilary to withdraw money for him. Merlin was created and shared with adult social care. Neighbour was spoken to by the police, but no offence was identified.
March 2018	Hilary attended the police station with her support worker to discuss ongoing issues with Person One who kept asking her for money. Hilary agreed that she would pursue a harassment warning if it continued.
March 2018	Telephone assessment by social worker, Hilary expressed concern for her neighbour and requested that he receive some help. She refused any further safeguarding action or support for herself.
April 2018	Hilary's sister contacted police to raised concerns that she was being repeatedly financially exploited by a male neighbour (Person One). Merlin created and shared with adult social care. No further police action as there was no offence identified, Hilary recorded as being willing to give the money to the neighbour.
April 2018	Welfare visit by adult social care. Hilary was recorded as having "full capacity". She reported to have given Person One £6000 since 2014 and expressed she could not continue to do this to support him. Hilary had insight into Person's Ones behaviour, stating that he built relationships with vulnerable people to get money and highlighted he was also doing the same to another neighbour. Hilary said Person One does not enter her flat but waits for her and persists in calling her. Hilary said that she gave him money out of sympathy and knew that he used it to buy illegal substances.
June 2018	Person One was arrested and charged with harassment after he continued to ask Hilary for money although she had asked him not to. Merlin created and shared with adult social care.
09 August 2018	The GP made a referral to the mental health team at NELFT for assessment. It was noted that she had been discharged from mental health services in 2013. The letter referred to self-reports, and carer reports that hoarding behaviour had worsened, and that Hilary was being financially exploited. There was no safeguarding action taken.

17 August 2018	Redbridge Access, Assessment and Brief Intervention Team (RAABIT) Duty Team assessment, safeguarding issues noted regarding financial exploitation and Hilary shared her experiences about giving money to Person One.
22 August 2018	Strategy meeting facilitated by RAABIT to consider the issues of financial exploitation. Mental capacity assessment and liaison with the police planned.
23 August 2018	Mental capacity assessment carried out, Hilary was not found to lack capacity, support worker was present. Safety plan and advice provided regarding the financial exploitation.
03 September 2018	Further strategy meeting held to consider the actions taken over the previous few weeks, a protection plan was put into place with Hilary, liaison with police took place, follow up appointment with team provided. Adult social care were not present in line with the S75 agreement between Local Authority and NELFT (S75 is a partnership of equal control whereby one partner can act as a "host" to manage the delegated functions, including statutory functions of both partners who remain equally responsible and accountable for those functions being carried out in a suitable manner).[iii]
14 September 2018	RAABIT attended the police station for a meeting after Hilary had reportedly given money again to Person One only two days after the last strategy meeting. Harassment order served on Person One.
23 September 2018	Hilary contacted the RAABIT to say that she could not attend her appointment. Reason for this was not given or explored.
29 October 2018	Mental health emergency duty team (EDT) contacted by police as Person One had breached the harassment order. Information passed to the RAABIT.
05 November 2018	RAABIT mental health assessment, Hilary was discharged from the service as there was no mental health need identified and referred to Improving Access to Psychological Therapies (IAPT). The safeguarding concern was closed down at this point.
14 December 2018	Referral to secondary psychology via the IAPT Team.
December 2018	Merlin referral received by adult social care with concern about financial abuse. Hilary was noted to go through bins for food despite having food in the flat and giving money to homeless people and people with addictions. On this occasion Person One was arrested for breaching the harassment order.

Points:

- **Financial exploitation is prevalent throughout the year and correlates with concerns that Hilary's mental health was deteriorating with increased indicators of hoarding behaviour.**
- **There may have been opportunity to gather agencies together with Hilary and her family to consider both the increased hoarding, and the continued financial issues.**
- **The SG enquiry was carried out by NELFT under the S75 agreement, however once Hilary was discharged from the RAABIT, the safeguarding activity also ceased although the issue of financial exploitation continued.**
- **It can be noted that Merlins were created and shared with adult social care. It may have been helpful to review all of these occasions as part of the wider safeguarding activity. The Merlins are sent to adult social care on one IT system, whereas the mental health team who conducted safeguarding activity use a different case management system and don't directly receive them. It is not clearly evidenced that there was clear oversight of all Merlins on the occasions when the mental health team conducted safeguarding activity.**

2019	
January 2019	Hilary's sister contacted police with concerns that Person One was continuing to ask for money and Hilary was giving it to him. Merlin created and shared with adult social care. No further police action as no offence identifies.
15 January 2019	Started psychological session, running until October 2019
26 January 2019	Psychology session. Hilary expressed concerns that she felt Person One was watching her as he seemed to be there when she left her flat and she had given him money again, she said her sister has reported this to the police.
February 2019	Merlin referral received by adult social care, Person One had been to court and ordered to repay money to Hilary. Noted that Hilary has capacity.
April 2019	Recorded by Police that Hilary continued to give money to Person One. Hilary and Person One were both spoken to, but no offences identified. Merlin created and shared with adult social care
21 May 2019	Psychology session, Hilary reported continuing issues with Person One asking for money, this was discussed with the NELFT Safeguarding Team and a concern raised and passed to the RAABIT.
May 2019	Hilary's sister contacted London and Quadrant (L&Q) Housing Association to report antisocial behaviour from the flat below. Noise and concerns about drug dealing related to the son of the resident who seemed to be staying at the property (subsequently the perpetrator). The matter was reported to the Police, but Hilary did not want any further action to be taken by L&Q.
June 2019	L&Q reported the observed drug dealing behaviours to the Police.
July 2019	A safeguarding referral was received by adult social care from Redbridge psychology services stating Person One had not repaid £250 as ordered by the court. Social Worker review states that Person One had stopped financially abusing Hilary since the court order and Hilary expressed that she might like to move house . She reported she was due an Occupational Therapist (OT) visit from RAABIT to help with this and assess her home environment. Case closed from adult social services.
12 August 2019	RAABIT Senior OT met Hilary and her sister regarding increased concerns about hoarding, a home assessment was arranged, and Hilary reported that the financial exploitation had stopped.
30 August 2019	OT conducted home visit, the flat was noted to be very unhygienic and a fire risk. Hilary reported during this visit that another neighbour was asking her for money. A protection and safety plan was discussed, capacity assessment was completed and Hilary asked for help about the hoarding, continued long term mental health input was considered.
24 September 2019	Hilary was reluctant to allow anyone to visit her at home due to the hoarding, she also did not want anyone to remove any of her items.
24 September 2019	RAABIT had discussions with Hilary's support worker who would no longer visit Hilary in her property but would facilitate community visits, this was due to the infestations of flies in the property. A discussion took place with Hilary's sister who reported increased hoarding, continued financial exploitation and concerns that Hilary was likely to disengage as she was feeling under pressure about the hoarding and conditions in her flat.
09 October 2019	Psychology sessions completed. RAABIT considered the longer term needs and a referral was made to the Mental Health Community Recovery Team (CRT) where a care coordinator would be allocated. Hilary was worried about

	another person taking over. Hilary was also allocated a care act advocate at this time.
13 December 2019	A strategy meeting was coordinated by the RAABIT with Hilary and her sister due to increasing concerns about rotting food and hoarding behaviour, there were also reports of Hilary giving money to the relative of a neighbour (Person Two who was subsequently responsible for her death).
Points: - **There may have been opportunity to contact and work with Person One in light of persistent issues with money and reported drug addiction. This is because the issues he was facing persistently relied on Hilary to support him financially and she raised concern about his wellbeing on more than one occasion.** - **The involvement of Hilary's sisters was crucial to provide ongoing insight into Hilary's presentation.** - **There may have been an opportunity to build rapport and engage with Hilary earlier in 2019 when she was asking for help and considering a property move, later in 2019 she has started to disengage with services and her sister had advised agencies of this likelihood.** - **There may have been opportunity for "complex case discussion" across multi agencies to include Hilary, her sisters, the housing association, police, psychology, and mental health. This may have yielded a wider safeguarding view and support plan in respect of increased hoarding and continued financial exploitation.** - **It can be noted that Hilary had now started to give money to Person Two.** - **There may have been an opportunity for L&Q to consider the intelligence they have of the behaviours observed in Hilary's immediate vicinity and to her vulnerabilities in that context.**	
2020	
03 January 2020	RAABIT record that Person One has started to ask Hilary for money again, Hilary has kept a log of multiple occasions that she had given money to him. She did not want to report this to Police.
16 January 2020	Formal transfer from RAABIT to CRT.
23 January 2020	CRT referred environmental safety concerns to the London Fire Brigade.
January 2020	Letter to the GP from NELFT after Hilary was reviewed by the Psychiatrist in the presence of care coordinator. Diagnosis recorded as "hoarding in the context of personality disorder- dependent type". There is reference to safeguarding arrangements being put into place as Hilary was extremely vulnerable to financial abuse. There is also reference to assessment by a fire officer. Hilary was referred for psychological treatment and for review in three months. Hilary noted to be seen regularly by her care coordinator and STR (Support, Time & Recovery) worker.
27 February 2020	CRT made a safeguarding referral in respect of another neighbour as Hilary had reported that she was concerned that Person One was also financially exploiting him.
04 March 2020	Hilary informed her care coordinator that she had received a letter from the downstairs neighbour raising concerns about infestation of flies and the noise levels at night.
March 2020	Fire Safety Visit carried out by the London Fire Brigade, alarms fitted, no persons at risk alert raised.

18 March 2020	Care coordinator review of care plan and support package. It was noted at this review that the referral for psychology input would not be processed due to the imminent COVID measures
01 May 2020	New care coordinator allocated, telephone contact due to COVID and Hilary raised concerns about adjusting to a new worker. No face-to-face appointments due to COVID-19 measures. Hilary reported that she is still being approached by Person One for money.
June 2020	Telephone review by psychiatrist. Hoarding noted to have worsened and there was discussion about "blitzing" the flat, again noted to be extremely vulnerable to financial exploitation and references to ongoing "safeguarding" activity, no new safeguarding actions taken.
July 2020	Police record that Hilary was a victim of theft after money was taken from her bag.
September 2020	Letter sent to Hilary from Psychological Services as Hilary hadn't replied to any communication to "opt in " to the services, therefore she was discharged.
16 September 2020	Face to face appointment with care coordinator- Hilary reported that she was still giving money to Person One, she also said that didn't want anyone to come to her home.
26 November 2020	Care coordinator telephone call, Hilary reported that Person One had died as a result of an overdose.
November 20020 - April 2021	Mostly telephone contacts with care coordinator, no face-to-face visits recorded.
Points: - **Throughout 2020 there was persistent reports that Hilary continued to give money to Person One, however there was no new safeguarding activity or multi-agency discussion despite the "vulnerability" being noted by the psychiatrist and continued reports of financial exploitation.** - **Due to COVID- 19 measures there was little face-to-face contact with Hilary and thus little physical view of the state of the flat.**	
2021	
07 May 2021	New care coordinator allocated and home visit undertaken.
02 July 2021	Telephone review carried out by psychiatrist who suggested discharge from mental health services. Hilary was very unhappy about this as she didn't feel ready to be discharged.
July 2021	Letter to GP following psychiatrist review, discharged back to GP, ongoing "vulnerability" noted. It is documented that Hilary did not want to be discharged.
August 2021	Care coordinators raised concerns about the discharge from mental health services and it was decided to keep Hilary under the team due to increased concerns about hoarding.
June 2021 - September 2022	STR worker starting working regularly with Hilary, regular home visits, no further discussion reflected within the records about financial exploitation.
Points: - **Agency records and contacts yield little information about financial issues. However, it should be noted that Person One was deceased, and Person Two did not actually live in the immediate community.** - **No evidence of safeguarding action between GP and Psychiatrist.**	

2022	
22 February 2022	New care coordinator allocated.
16 March 2022	Hilary reported that she had given a large amount of money to charity.
24 March 2022	Hilary reported on a second occasion that she had given a large amount of money to charity. It is not clear whether she gave money on two occasion.
May 2022	Letter to GP from Psychiatrist after review, Hilary was reluctant to have the review as it was a different doctor however did continue with the session. She reported that she has lent money to a neighbour (*doesn't specific who) and that she had written a letter to him to say she was not going to lend him anymore. Hilary explained that it has been difficult for her having several different care coordinators and that she would like her new one to go through her care plan, she also requested some additional support with her flat- de cluttering and getting new clothes and a new bed. Hilary was recorded to have a fair amount of insight into mental state and capacity to make decisions about her mental health and treatment.
23 June 2022	New care coordinator allocated.
August 2022	Letter to GP after psychiatric review. Hilary reported that her biggest issues was her OCD behaviours and her hoarding and went through strategies and goals that she had been working on with her STR worker. She reported that her sister had been staying with her and helping her.
05 October 2022	Person Two was reported to be residing in his mother's address, below Hilary, as a result of his own property being cuckooed on the 5 October 2022 (reported to the police on 5 October 2022). To note, cuckooing is the practice of taking over the home of a vulnerable person in order to establish a base for illegal drug dealing and criminal activity[iv].
12 October 2022	Hilary was found deceased in her flat.
Points: - **Hilary found the turnover of staff difficult and therefore her care coordinator and psychiatrist did not know her well.** - **There was an opportunity to explore Hilary's disclosure of further financial exploitation issues in the context of previous long-standing concerns.** - **No evidence that the RSAB Self Neglect and Hoarding Protocol had been applied.**	

8. Initial summary of findings

- There was an absence of professional curiosity.
- Insufficient multi agency analysis in the context of safeguarding.
- Absence of multi-agency meetings or discussions to consider the presenting issues and risks.
- Absence of a complex case pathway or formal hoarding process.
- Person centred care planning was not as evident as it could have been and limited evidence of the time taken to explore Hilary's daily lived experience using the legal tools available.
- Self-neglect was not frequently referred to in the context of hoarding and/or its relevance to financial exploitation.
- The COVID-19 pandemic lockdown measures contributed to Hilary's increasing sense of isolation and interrupted consistency of service offer and oversight.
- Staff turnover was frequent.

9. Overarching Learning

9.1. The review has identified learning following consideration of areas of practice established during review process, highlighted within the agency reports, and discussed at panel, during the practitioner event and with family members.

Areas of learning:

- **Self-neglect, hoarding and complex safeguarding**
- **Multi-agency approaches**
- **Community Safety through a safeguarding lens**
- **Understanding the person (including the impact of COVID-19)**

10. Analysis of findings

10.1. Self-Neglect, hoarding and complex safeguarding:

10.1.1. The Care Act 2014 recognises self-neglect as a category of abuse and neglect. It is helpful to consider what we mean by self-neglect and how this relates to hoarding.

10.1.2. Self-neglect is an extreme lack of self-care, it is sometimes associated with hoarding and may be a result of other issues. The Care Act 2014 clarified the position of self-neglect and safeguarding. Under the Act, self-neglect now falls under the definition of causes to make safeguarding enquiries. To note, Care and Support Statutory Guidance (2016) clarified that self-neglect may not necessarily prompt an enquiry under section 42 of the Care Act (often referred to as a 'Section 42 enquiry').

10.1.3. An assessment should be made on a case-by-case basis, and a decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. However, there may come a point when they are no longer able to do this without external support. Section 42 of the Care Act states:

'Enquiry by local authority

(1) This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) – (a) has needs for care and support (whether or not the authority is meeting any of those needs), (b) is experiencing, or is at risk of, abuse or neglect, and (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

(2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.'

10.1.4. The most common type of abuse identified in the National SAR analysis was self-neglect[v].

10.1.5. Under the S75 agreement, NELFT operationally manage Adult Social Care as well as Mental Health services and this arrangement has been in place since 2016. If a person is under the care of mental health services, the safeguarding investigation would be directed to them. Otherwise, Adult Social Care would receive the safeguarding referral and carry out the investigation if appropriate. Therefore, as demonstrated in the chronology, during the time frame when adult mental health services were involved, they took responsibility for the safeguarding oversight. Regarding the overarching safeguarding arrangements, Redbridge commissioned a safeguarding review in 2022 which made recommendations to strengthen the "front door" safeguarding arrangements and this work is currently underway.

10.1.6. Within the MPS, Merlins are all contained together with the Merlin system. Outside of the MPS and within the integrated arrangement described above, there are two IT systems being used (Care First and Rio) which do not link together, meaning that sharing of information may on occasion not be apparent to the mental health teams e.g. this may include a Merlin. There is no clear evidence to suggest that this happened in Hilary's case however it may be the case that when conducting safeguarding enquiries, the Merlins were not all contained in the same place. There is a new adult social care case management system currently being implemented by the Local Authority that should overcome this issue for the future.

10.1.7. In applying Hilary's presenting issues alongside the definition of self-neglect, we know that she was often reluctant and sometimes refused to work consistently with services that were offered. There is evidence of this in 2019 when Hilary expressed earlier in the year that she required some help with her flat but subsequently declined support. Hilary's sister had advised that it was likely that she would disengage as she had started to feel under pressure about the hoarding situation in the flat. Again in 2020 she declined psychological services.

10.1.8. Having considered the timeline and chronology, and a coherent view of Hilary's presentation it can be seen that indicators of risk and vulnerability were evident for a number of years. It is therefore noted by panel members and practitioners that there was a lack of exploration and recognition of self-neglect in respect of Hilary. In fact, the occasions when a safeguarding investigation was carried out tended to focus more on the financial exploitation issues and less on the hoarding/ self-neglect indictors whereas there was an opportunity to consider both and think about the impact of one on the other.

10.1.9. To support this view, we can see that there was an absence of more safeguarding referrals, a lack of multi-agency discussion, little exploration of the frequency of significant events and lived experience. This could be described as an absence of professional curiosity and will be further explored.

10.1.10. As identified, self-neglect can include hoarding behaviour. It is useful to consider the clinical classification of hoarding. There are two main recognised diagnostic manuals commonly used around the world today. These are the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM). Whilst both manuals generally tend to complement each other, there are some differences in the descriptions they use. In ICD, 'Hoarding disorder' is listed under the OCD category. Whereas In DSM-5, Hoarding Disorder sits within "Obsessive-Compulsive and Related Disorders" *as* a subcategory. Hilary's history within mental health services reflects several elements of these subcategories (hoarding disorder, trichotillomania, and obsessive compulsive disorder).

10.1.11. Hilary had been known to mental health services for many years but closed in 2015 and re-opened in 2018 due to increased hoarding and ongoing safeguarding issues of financial exploitation. Her diagnosis is consistently recorded by her psychiatrist as "hoarding behaviour in the context of personality disorder (dependent type). Additionally, her GP also records an earlier diagnosis of Obsessive Compulsive Disorder (OCD). At the time of her death Hilary was subject to care coordination because her hoarding symptoms had worsened. To reiterate, the safeguarding activity was more focused on the continual issues of financial exploitation rather than self-neglect, and the exploration and linkage of the two issues is limited.

10.1.12. In Hilary's case the panel, the practitioner learning event and the family all considered the level of Hilary's hoarding to constitute self-neglect. It is certain that someone who self neglects and hoards will need agencies to work together closely in line with safeguarding adult processes. Thus, professionals' meetings should be used to help that joint working especially when a number of risks have been identified.

10.1.13. Hilary's hoarding behaviour was largely managed through a mental health lens and less so through a safeguarding lens. As mentioned, safeguarding activity tended to focus on the issues of financial exploitation and the determination of "self-neglect" was explored to a lesser degree. The review has considered the hypothesis that the hoarding (under the bracket of self-neglect) was likely to have increased Hilary's vulnerability to financial exploitation, which in turn increased her stress, anxiety, and hoarding behaviour as a cumulative cycle effect. Therefore, her care and support needs and the vulnerability to financial exploitation were inextricably linked.

10.1.14. This can be demonstrated on the occasion when Hilary was discharged from mental health services for a short period in 2019 and the safeguarding activity also ceased. Whereas there may have been a sound clinical judgement that mental health services were not required at that time, that did not mean that there wasn't a safeguarding need as she was still hoarding, there were indicators of self-neglect, and she was still being financially exploited. The review does note that she was referred and opened to secondary psychological services at this time.

10.1.15. The above point suggests that there was a focus on the role of individual agencies and when they ceased to be involved, the overarching issues of self-neglect and financial exploitation lost traction despite being ever present. Multi agency working will be considered further within this review.

10.1.16. Regarding the above points it is timely to consider the degree of self-neglect and financial exploitation in the context of the legal frameworks and safeguarding responses.

10.1.17. "*Safeguarding duties will apply where the adult has care and support needs, and they are at risk of self-neglect and they are unable to protect themselves because of their care and support needs. In most cases, the intervention should seek to minimise the risk while respecting the individual's choices. In terms of hoarding, it is rare that a total transformation will take place and positive change should be seen as a long-term, incremental process."*[vi]

10.1.18. To recap, Hilary had many characteristics of self-neglect; for example obsessive hoarding, poor personal hygiene, and repeated episodes of financial exploitation. At times when Hilary was particularly stressed or anxious, her hoarding behaviour

worsened and that impacted on her ability to function; she was unable to bathe for a long period of time because she obsessively bought fruit which she could not throw away, therefore the bath tub was full of rotten fruit causing infestations of flies.

10.1.19. According to her sister, in the couple of years prior to her death, she was showing significant signs of deterioration and stress, the hoarding of fruit was given as an example. Although Hilary did try her best to wash, she had not been able to fully bathe or wash properly throughout this time and she became *"completely resistant to change in so much as she would not wear her new glasses and was walking about with shoes with holes in them despite having a new pair of shoes".*

10.1.20. Hilary's previous care coordinator (pre timeframe) worked with her for quite some time and offered a good insight into her personality, likes and dislikes. She reported that Hilary was a lovely lady whose faith was very important to her. Interestingly her view was that she worked well with services that engaged her in the "right way" and took her role in society seriously with a great sense of responsibility to others. She liked structures and consistency and quickly destabilised when things changed. Her distress levels could be very high at such times and some of the ways that this manifested itself would be hoarding and trichomania.

10.1.21. One sister suggests that Hilary may have had an undiagnosed neurodivergent condition of autistic spectrum disorder. It is important to note that this was not assessed, and it would be conjecture to apply consideration of this within the review. Shortly before her death, Hilary informed her sister that she had asked her care coordinator to refer her for an assessment and was waiting for an appointment, this review has not found evidence of a referral. The reason for this being mentioned is that both sisters considered this to be a constant barrier to how services were able to work with her because no one ever understood the root cause of all her challenges. As in the point above, Hilary previous care coordinator identified that there was a "particular" way to work with Hilary that she would respond to. We also know that the turnover of staff did not help this as relationships were not able to be built.

10.1.22. In terms of responses, Redbridge has a self-neglect and hoarding protocol that was published in 2018 and reviewed in 2021. This protocol is readily available for practitioners to refer to on the Safeguarding Adult Board website[vii]. This is introduced as a *"multi-agency protocol for the identification and management of cases involving people who are at high risk of harm due to self-neglect and hoarding"* and it sets out a framework of how agencies should work together to manage cases involving individuals who are at high risk of significant harm and or death due to self-neglect, lifestyle choice and/or refusal of services.

10.1.23. In Hilary's case it is important to consider not only the degree of self-neglect but the extent to which it increased her vulnerability and exposure to other types of risk, for example financial exploitation which was a consistent issue from at least 2016 to the time of her death. There was no reference to, and little evidence that the protocol was considered or applied in Hilary's case. Additionally, there was a general lack of awareness of the protocol at the PRLE.

10.1.24. Now considering the persistent indicators of self-neglect alongside the known incidents of financial exploitation; we know that from 2018 there were at least 28 episodes where financial exploitation was raised as a concern (there are likely to be many more incidents). Some of these resulted in a Merlin from the Police, there was

one adult social care investigation and two NELFT coordinated safeguarding investigations.

10.1.25. In summary so far, we know that:

- The self-neglect and hoarding protocol was not clearly referenced or applied in Hilary's case.
- The safeguarding investigation(s) focused on financial exploitation and not in the context of self-neglect and hoarding.
- Hoarding was managed and seen through a mental health lens and not a safeguarding lens.
- Financial exploitation continued to occur throughout the timeframe.
- Application of professional curiosity was limited.

10.1.26. The use of The Care Act will be further considered. However, it can be seen that Hilary was well known as a "hoarder" but there was limited exploration of that in the context of self-neglect. This is evident in the absence of application of multi-agency working (to be further explored).

10.1.27. The review would specifically like to draw out the point of awareness, ownership, and application of procedures. In this instance self-neglect was not thoroughly explored and had there been a more strengthened multi-agency approach to Hilary's situation this may have been considered further alongside the financial abuse issues. Furthermore, the self-neglect and hoarding protocol can be applied by any agency, and this may not be commonly understood across the agencies. It can be observed that both the GP and the Psychiatric Doctor both specifically recorded on more than one occasion that Hilary was vulnerable to financial exploitation, and both were aware of her long history of hoarding but there is no evidence of proactive action to explore this any further. Included in their correspondence was reference to an understanding and assumption that safeguarding activity was taking place but there was no further evidence of action, liaison or information sharing related to this.

10.1.28. We have found that there was a lack of evidence that self-neglect had been explored to a great extent however considering the findings so far, we can put this into the context of the legal powers available when there are safeguarding concerns outlined in S42 of the Care Act:

- *needs for care and support (whether or not the authority is meeting any of those needs)*
- *is experiencing, or is at risk of, abuse or neglect*
- *as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*

10.1.29. We know that Hilary comes under this category by virtue of this SAR and because she had an untimely death broadly related to her ongoing care and support needs. We also know that irrespective of the event that caused her death, she was persistently being financially exploited, her hoarding behaviour was worsening and thus the safety and safeguarding risks were increasing. It is helpful to consider the legal powers that may be applied.

10.1.30. The review carefully considered the discussions of the PRLE with recognition that certain legal frameworks such as how The Care Act (2014), The Mental Capacity Act (2005) and the Mental Health Act (2007) could be used to help people but there was uncertainty about how, and a general consensus that The Care Act should have been better used but that the other legal powers had been applied appropriately.

10.1.31. As a point of clarification, all of the legal frameworks that could have been considered are evident throughout Hilary's case, therefore exploration of these powers is a reflective view of how they could have been considered differently. Let us take each framework in turn and explore how Hilary's circumstances apply to each:

- The Care Act (with the inclusion of self-neglect as a form of neglect)
- The Mental Capacity Act
- The Mental Health Act

10.1.32. We have found that whilst there were several safeguarding investigations focusing on financial exploitation, there was not enough weight given to considering Hilary's situation from a self-neglect perspective and the local self-neglect and hoarding protocol was not applied effectively. The review has considered the reasons for this and did not find evidence of robust professional curiosity. Professional curiosity is a recurring theme in SARs, Local Child Safeguarding Practice Reviews (LCSPRs - children) and Domestic Homicide Reviews (DHRs) nationally. Broadly it describes the capacity and communication skills to explore and understand what is happening with an individual or family.

10.1.33. Enhancing professional curiosity in practice encourages practitioners to challenge the assumption that people "choose" or "like" an abusive or self-neglecting lifestyle; and outlines alternative ways of thinking about these people and the reasons for the challenges they face.

10.1.34. The safeguarding investigations were focused too much on financial exploitation whereas the hoarding was considered through a mental health lens; this could have been better aligned. Strengthening this connectivity and exploration would have added value to the statutory safeguarding investigation that were carried out under The Care Act.

10.1.35. In terms of Hilary's decisions to continually give money to Person One and Person Two, there is evidence of regular consideration of capacity as well as capacity assessments, this was positive practice. The issue of capacity was discussed with panel members, practitioners and family who all shared the view that Hilary did not lack capacity.

10.1.36. There is often a perception that a person cannot be vulnerable or self-neglect if they have capacity, for example they can choose their lifestyle and thus make a conscious choice to self- neglect. Under the Care Act 2014 and the Social Services and Well-being (Wales) Act 2014, you do not need to lack mental capacity to be vulnerable or self-neglecting. Even if someone appears to be making 'free' choices that lead to self-neglect, it is still self-neglect and action is required.

10.1.37. This means that assessing that someone has capacity does not automatically mean there is no longer a case for taking action to safeguard them, a duty of care still exists on professionals to explore why the adult is making an unwise choice and what

can be done to support them in caring for themselves. This is the relationship and application of the legal tools and provisions of the Mental Capacity Act and the Care Act.

10.1.38. The family considered the question of capacity and on balance they felt that she often made unwise decisions but would not have said she lacked capacity to do so. In terms of the decision to continue to give money to those exploiting her, one sister offered the explanation that she perhaps felt frightened and intimidated and although she did not articulate that, it could have been considered and explored. She expressed several times that she did not want to create difficulties with the neighbours and although she was aware of the background issues and drug use of those around her, she possibly perceived it to be the safer option to continue to "help" them where she could. There is absolutely no doubt though, that she wanted it to stop because she told people about it, she asked for help and she reported when Person One breached his harassment order.

10.1.39. The first principle of the MCA is to assume the adult has capacity unless proven otherwise. The correct application of the presumption of capacity in s.1(2) MCA[viii] is a difficult question and often misunderstood by those involved in care. It is sometimes used to support non-intervention, lack of engagement or non-concordance with treatment but this can leave people with care and support needs exposed to risk of harm. In Hilary's case her capacity was considered and formally assessed on several occasions.

10.1.40. With reference to principle 3 of the MCA, the Code of Practice[ix] highlights *"the difference between unwise decisions, which a person has the right to make, and decisions based on a lack of understanding of risks or inability to weigh up information about a decision, particularly if someone makes decisions that put them at risk or result in harm to them or someone else".*

10.1.41. The current Mental Capacity Act Code of Practice highlights that it is important not to judge mental capacity based solely on behaviour, appearance or "*assumptions about [someone's] condition"* (Department for Constitutional Affairs, 2007)[x]. However, neither should it be assumed that they have capacity because of "*good social or language skills, polite behaviour or good manners*". Hilary was an articulate, intelligent, and extremely likeable person who appeared to have insight into the motives of those around her but despite this made the decision to continue to give money.

10.1.42. It is also important to explore both decisional and executive capacity in the context of Hilary's case. This is a particularly relevant and helpful consideration when applying self-neglect processes, thus a person would be assessed to articulate their decision and demonstrate how they would carry it out.

10.1.43. The extent to which executive capacity was explored was less evident. Considering Hilary's diagnosis and presentation, midlife people with hoarding disorder have been found to have neurocognitive impairment particularly in the areas of executive functioning[xi]. Executive dysfunction is strongly correlated with hoarding severity. In terms of Hilary, she may have been assessed to have capacity, to appreciate and understand her situation and agree to work within a safety or protection plan but then struggle to execute the plan thus continue to give money when asked. This adds weight to the importance of fully exploring the financial issues in the context of hoarding/self-neglect.

10.1.44. Moving on to the Mental Health Act, Hilary was well known to mental health services and open to care coordination at the time of her death. The review finds that it is unlikely that the Mental Health Act could or should have been applied as a legal framework to address the safeguarding issues that Hilary faced.

10.1.45. It is noted that self-neglect can be a difficult area for intervention as issues of capacity and lifestyle choice are often involved, which includes individual judgments about what is an acceptable way of living and degree of risks to self. Even in cases where it appears the risk to the individual may be significant, there may be no clear legal grounds to intervene. In Hilary's case, the ongoing issue of her providing money to people around her was seen as a personal choice, although that sat uncomfortably with professionals and family members. We have found that this could have been more strongly investigated under the Care Act in the context of hoarding, self-neglect and being mindful of executive capacity.

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10.2. **Multi-agency approaches:**

10.2.1. We have found that the safeguarding issues include hoarding in the context of self-neglect, and financial exploitation- considered already is the extent to which Hilary was safeguarded using the legal frameworks available. In summary that the Care Act was utilised on several occasions but largely in consideration of the financial aspects. Additionally, professional curiosity could have been better applied and executive functioning could have been further considered. The next step is to consider how agencies worked collectively.

10.2.2. We have explored the Redbridge self-neglect and hoarding protocol which sets out a framework of how agencies should work together to manage cases involving individuals who are at high risk of significant harm and or death due to self-neglect, lifestyle choice and/or refusal of services. The general view is that when a person is self-neglecting and hoarding behaviour poses a serious risk to their health and safety, interventions from professionals may be required using a multi-agency approach.

10.2.3. Whilst the reason for mental health input was predominantly hoarding, and the reason for safeguarding investigations was predominantly focused on financial abuse, there is little evidence that this was managed in a multi-agency way.

10.2.4. We can see that Hilary was in receipt of a care and support package that evolved and changed over the years preceding her death. However, it can be observed that Hilary's needs may have been changing, the environment around her was de stabilising and the indicators of this were evident in the increase in hoarding, the changes to her routine and the decisions that she was making around her finances. More professional curiosity could have led to a coherent approach on the increasing number of occasions that she was coming to the attention of agencies. This may have offered a good opportunity to get services together with Hilary and her family.

10.2.5. It is noted that a strategy meeting did take place on one occasion as part of a safeguarding investigation. However, there is an absence in Redbridge of a robust multi-agency mechanism which is often the key to an effective approach to more complex and ongoing issues.

10.2.6. The review finds that there were three elements that may have strengthened the response to the ongoing issues:

- Clear recognition of self-neglect and consideration of the protocol
- Facilitation of a multi-agency meeting or discussion
- Application of a complex case protocol

10.2.7. Family members did describe the challenges that Hilary experienced with turnover of staff. Complex issues such as hoarding often needs longer term involvement to build relationships, identify and work on any past trauma; and the workers involved need to come together to support the person to understand and manage any specific risks where possible. This was a challenge for Hilary due to changes of staff and the isolation caused by COVID lockdown measures. It was known that any lack of consistency or significant changes were triggers for Hilary that she didn't cope well with.

10.2.8. In terms of safeguarding action and multi-agency working, it is demonstrated that the safeguarding actions taken did not improve or change the situation experienced by Hilary in terms of repeated financial exploitation and increased self-neglect. The review explored how agencies could or should have come together differently to explore Hilary's situation and needs. Situations such as Hilary's can often be an ongoing complex care or risk management issue rather than a clear safeguarding concern and may require a different approach.

10.2.9. This is where a complex case pathway, or sometimes known as a multi-agency risk management protocol (MARM) can be helpful. This may have been particularly helpful in order to understand Hilary's decision making. This may also have been complemented by a clearly agreed hoarding pathway that practitioners could follow. There is an absence of both of these tools in Redbridge.

10.2.10. Regarding approaches to hoarding and self-neglect, there were occasions in the timeframe where terminology such as "blitz cleaning" was used by professionals, followed by a pattern of Hilary disengaging from services when she felt under threat of this activity. Using such terminology is likely to distress the hoarder and indicates a lack of agreed pathways and approaches. To note, there had been past occasions where Hilary's belongings had been removed or cleared without her permission and she was severely traumatised and fearful of this happening.

10.2.11. In terms of the financial exploitation, this was an ongoing and related issue over many years with several safeguarding investigation and capacity assessment being completed with little impact or change seen. Therefore, a methodology for agencies to come together and consider all their information may have assisted with the following aspects:

- A review of capacity and executive capacity.
- The identification of a clear lead agency or practitioner
- Identification of the best environment and time for Hilary to work with professionals.
- Ensuring that all the right people been consulted, this may include housing and community safety colleagues.
- Ensuring that Hilary had all the right information about risk management and safety planning.

- Regular reviews.
- Timely information sharing and holistic risk assessment.
- Shared decision making and responsibility for managing risk.
- Improved involvement and engagement with Hilary and her family, which leads to improved outcomes.

10.2.12. Therefore, MARMs or complex case protocols can provide multi agency ways of supporting individuals with complex needs presenting with potential high risks to secure positive and person-centred outcomes.

10.2.13. In Hilary's case the general consensus was that mental health services were the lead agency, however this was somewhat flawed because at the points when Hilary no longer met the criteria or threshold for continued coordination under the Mental Health Act, the other issues such as oversight of the safeguarding, self-neglect and financial exploitation issues ceased and relied on new referrals, Merlins and concerns being raised on each new occasion that someone became concerned about financial exploitation.

10.2.14. In terms of a coordinating or lead agency role, this does not need to be prescriptive and could have been established within a robust multi agency meeting. Generally, a lead professional role would be someone who is integral to the majority of the care provision and less often a speciality clinical team.

10.2.15. Alongside the self-neglect and hoarding protocol, there were several other forums mentioned by panel and practitioners. There was a complex case forum but this seems to be adult social care led in one geographical area, rather than a formally embedded multiagency complex case pathway. There was also the Community Safety Problem Solving Group (PSG) which will be considered shortly. Some practitioners were also aware of a "hoarding group" that Hilary had attended on occasion.

10.2.16. Each of these forums and groups have a different focus and criteria and the overarching governance and accountability was unclear. In terms of practical application, it was clear from the PLE that there was a lack of awareness or confusion about what pathways and processes are available and when they should be used. This is not a criticism of the services, simply an observation that if the frontline workforce do not know or understand them, then they cannot be used collectively to their full effect.

10.2.17. The Self-Neglect and Hoarding protocol is duly noted within this review however the evidence of awareness and application was less clear. Additionally, there is absence of a MARM/ Complex case pathway that would complement the effectiveness of the protocol by providing a jointly agreed platform and methodology to manage cases with complex features such as Hilary's.

10.2.18. It was noted at the PLE that general awareness of hoarding and application of the aforementioned protocol is inconsistent and there is an absence of a "hoarding panel" (which again would align with a MARM/complex case pathway). It was also observed that some of the language and approaches described by practitioners did not resonate with current thinking, research, and models of working.

10.2.19. Each individual component within the wider multi agency team has their own service specification and responsibilities, however there is always strength in coming together for the benefit of the service user. However, this needs to be facilitated in the

context of a good awareness of complex issues such as hoarding, and with the right tools and pathways in place.

10.2.20. In summary, the absence of a MARM/complex case pathway and specific hoarding processes created a barrier to effective facilitation of a multi-agency approach. Additionally, the existing self-neglect and hoarding protocol was not effectively applied in Hilary's' case, this could be because professionals were not aware of it, or they didn't recognise that they needed to use it.

10.2.21. Therefore, there were increased indictors, continued financial exploitation and escalating risk without a collective risk-aware responses from agencies.

10.3. **Community safety through a safeguarding lens:**

10.3.1. Considered throughout the review so far is the issue of the community around Hilary. We can see that she was financially exploited by at least two people connected to or living within her local community.

10.3.2. To note, the housing association reported that they were not aware of Hilary's hoarding, self-neglect, or financial exploitation, although they did receive a complaint from family members about suspected drug dealing. This meant that Hilary was managed through "general tenancy" and did not receive any additional visits or checks in light of her vulnerability. This again raised the absence of multi-agency working including an effective hoarding process which should always include the relevant housing provider.

10.3.3. In terms of general tenancy there are certain regular safety checks that are carried and her family report that she always facilitated access to the property. Therefore the review notes that this activity did not prompt a report back to the housing association from employed or contracted workers that attended Hilary's property. This could be because they did not observe any issues such as hoarding, or they were not aware that this would constitute a safeguarding concern that required action.

10.3.4. The review also considered the local processes to draw on wider community intelligence and the panel identified the Problem-Solving Panel (PSP) which is a weekly community safety meeting where any emerging issues, themes or geographical hot spot areas may be identified. This posed the question of how people with known vulnerabilities may be identified as having increased risk.

10.3.5. It is useful to consider the definition of safeguarding adults which is defined as *"living a life which is free from harm and abuse is a fundamental right of very person*". This leads one to consider this in its widest sense and to think about responsibilities around prevention. The aim of prevention should be to enable adults to live an independent life free from harm, whilst making their own choices and decisions. Hilary was enabled to live safely and independently with a care package for some time, however when the community around her changed, this is when she started to feel unsafe in her home and financially compromised.

10.3.6. This review has considered the role that the wider community safety functions may have to identify when a person with vulnerabilities may be experiencing harm or risk from the community around them. The PLE yielded information that there was some intelligence in the near vicinity that there was an increase in some behaviours such as cuckooing, substance misuse and an increase of sex working and rough sleepers.

10.3.7. In this case the immediate location hadn't particularly been identified as a "hot spot" however the process of this review has yielded information about several neighbours, drug addiction, antisocial behaviour and multiple allegations of financial exploitation that could have been considered from a "community" perspective in order to safeguard people with vulnerabilities living at the centre of it. There is an opportunity to consider how "safeguarding intelligence" feeds into "community safety" and vice versa. This could be strengthened with the implementation of an effective MARM.

10.3.8. In summary at different times, different agencies had knowledge of activity going on around Hilary, drug use, financial , and anti-social behaviour. Hilary and her sisters flagged this multiple times to different agencies. Therefore, this could have prompted agencies to scan the wider community and consider how intelligence could have been shared with a community focus.

10.4. **Understanding the person:**

10.4.1. It was not difficult to capture a sense of Hilary's voice from the agencies who had contact with her, in fact people seemed to know her well, spoke fondly about her and were able to articulate the challenges and difficulties she experienced. In order to understand her daily experiences and get a sense of her perspective, the review has drawn on conversations with family, exploration of practitioner views and some of the significant factors that may have strongly contributed to vulnerability.

10.4.2. Hilary's sisters made reference to several people who had worked very effectively with Hilary. There was one particular support worker that the family recalled as she worked very well with Hilary. They report that she managed to get a good balance between social activities such as outings to art exhibitions and walks, but also worked with Hilary to actively and continuously clean and clear the house. She had a good rapport with Hilary who trusted and liked her. However, her sisters both articulate that there was a significant turnover of staff allocated to her over the years and thus it was difficult for her to build meaningful relationships because they changed so frequently. This included a change of GP in 2018 and Hilary was not able to build new relationships with the new practice, also several care coordinators, support workers and a change of psychiatrist. One sister has maintained several folders over the years to keep a record of care and support, multiple changes of staff are reflected in those.

10.4.3. It is evidenced that COVID-19 created unprecedented pressure on people working in health and social care. But even before the COVID-19 outbreak, it is noted that the NHS and social care workforce faced significant staffing and funding pressures. High staff turnover, measured in terms of the proportion of staff who leave their roles in a given year, can be problematic as it points to low staff retention rates. Research suggests that low retention rates have negative implications for the quality and continuity of care[xii]. It is seen that Hilary was upset on multiple occasions when staff changed because she was self-aware of the destabilising effect that this had on her. This is not a criticism of the services involved but an observation of the current climate that agencies are working within.

10.4.4. The Royal College of Psychiatrists considered how the pandemic affected their ability to provide face to face interactions. The College predicted a tsunami of mental health problems caused by the impact of COVID-19 which is borne out in subsequent data with a significant increase in presentations of "mental distress" and increased anxiety[xiii].

10.4.5. We can see when the COVID restrictions were at their height, reviews and appointments were restricted to telephone albeit frequently. There was some delay in access to psychological services (which Hilary did not opt in to) and Hilary reported an increase in hoarding during this time. Additionally, COVID measures affected her routine significantly and although the services she was receiving didn't necessarily change, the way they were delivered did. This enabled Hilary to avoid professionals coming to her home but also created isolation.

10.4.6. Therefore, whilst recognising that there was certainly a detrimental consequence of the lockdown measures in respect of increasing isolation from normal routine and family visits, there is no direct evidence that COVID-19 was a causal or contributory factor to the way services worked together in this case insomuch as the safeguarding response did not vary prior to and during the time period.

10.4.7. Regarding the financial exploitation, the family were aware from 2015 that neighbours living around Hilary were financially exploiting her. This was related to one particular person over several years (Person One) and although Hilary was fully aware he did have drug addictions, she frequently felt sorry for him and gave him large amount of money. She also expressed that she didn't want to create "difficulties" with her neighbours, and this may have been why she continued to provide money because she didn't want to "rock the boat" or she may have been fearful of the consequences albeit there is no direct evidence of that.

10.4.8. As discussed, it is difficult to judge the extent to which Hilary was "risk aware". Her sisters explained that her strong faith and inherent kindness led her to see the best in people and take what they were saying at face value. She had led a very sheltered life up until living independently in her flat, in particular when the neighbours living around her changed. One sister stated that she was an extremely intelligent person, but naive and may not have been able to consider the capacity of others around her to be harmful to her, and to truly understand their addictions and the behaviours that went alongside that.

10.4.9. It can be seen through the timeframe that on one occasion Hilary tentatively explored the notion of moving home, but this was followed by a level of disengagement. This pattern was seen several times after she reported increased hoarding and asked for help, she would disengage if she felt under threat that extreme action such as "blitz cleaning" might occur. It is difficult to get a sense of how seriously Hilary had considered a move, and whether it was because she was frightened, felt unsafe, or simply wanted the requests for money and the antisocial behaviour to stop.

10.4.10. Her sisters had both considered a strategy for Hilary to start thinking about a move to be nearer her sister living in the south of the country. They were worried about her current situation as well as her future care and support needs, unfortunately they did not get the opportunity to start to explore this before she died.

10.4.11. Hilary's sisters report that she could be stubborn at times and particularly when she was fearful of her belonging being taken away, she would disengage. Additionally, she would try to prevent or put off homes visits because she was embarrassed about her home which was getting worse, more cluttered and was affecting her functioning in so much as her personal and dental hygiene was poor. However, she took her physical wellbeing seriously, she took vitamins and was in reasonably good physical health. Her

sister described how one would have to approach certain conversations (usually around change or suggestions of support) very cautiously or she would disengage; it is certainly clear that any mention of extreme action or "blitz" cleaning frightened her and caused her to pull away from services. This supports the view that Hilary found it difficult to adjust to changes of staff because they did not know her well enough to understand the best way to work with her.

10.4.12. We can't say Hilary didn't engage with services as there is evidence that she took her situation very seriously, had insight into occasions when she was unwell and spoke to her family and professionals about concerns she had. Although she may have underreported the occasions she was giving money to Person One and Person Two, she sought help and discussed this issue multiple times and was clear that she wanted it to stop.

10.4.13. Reflected in some of the agency records and mentioned by all of the family members and friends was the matter of how deeply Hilary had been affected by bereavement, specifically the loss of her mother. Attached to this was the loss of routine and duty that Hilary had proudly encompassed, going to look after her mother each weekend in her final years.

10.4.14. Considering additional significant factors may provide some insight into Hilary's experiences, perspectives, and turmoil:

- Long term mental health disorders.
- Loss of parents (1999 and 2014).
- New neighbours.
- Changes of staff (support workers, care coordinators, psychiatrist, GP)
- Isolation caused by COVID.
- Ongoing financial exploitation.
- Anti-social behaviour occurring around her home.
- The trauma of world events and politics (energy price increase, changes of Prime Minister, the war in Ukraine and death of the Queen are examples provided by family).

10.4.15. Trauma is defined as "*an event, series of events, or set of circumstances that is experienced by an individual as harmful or life threatening. While unique to the individual, generally the experience of trauma can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional, or spiritual well-being"*[xiv]*.*

10.4.16. So whilst we know that Hilary's mental health disorders were known and services facilitated when required, cumulatively over the latter years, the experiences that happened to her were traumatic. We know that even minor changes could be destabilising but ongoing traumatic life events would have an impact too. The limited amount of professional curiosity and joint response meant that the opportunity to understand this collectively was lost. Therefore there were multiple factors that may have elicited a trauma response and contributed to the extent of hoarding, self-neglect, and vulnerability to financial abuse.

10.4.17. To truly create a person centred approach to Hilary, better professional curiosity and a strengthened multi-agency response may have made a difference. This is

supported by Braye, Orr and Preston-Shoot (2014) who state that *"at the heart of self-neglect practice is a complex balance of knowing, being and doing*"[xv], they go on to define this as:

- Knowing, in the sense of understanding the person, their history and the significance of their self-neglect, along with all the knowledge resources that underpin professional practice.
- Being, in the sense of showing personal and professional qualities of respect, empathy, honesty, reliability, care, being present, staying alongside and keeping company.
- Doing, in the sense of balancing hands-on and hands-off approaches, seeking the tiny opportunity for agreement, doing things that will make a small difference while negotiating for bigger things, and deciding with others when the risks are so great that some intervention must take place.

10.4.18. On balance, services that predominantly knew Hilary such as mental health services and support workers can articulate a good knowledge and understanding of Hilary's personality and the approaches that worked well. However, there was an absence of her voice when it came to the financial abuse, for example it is difficult to conclude on whether she felt unsafe or frightened and the extent to which this exploitation continued to the increased hoarding and self-neglect. The panel and practitioners agree that there was sufficient cause for the self-neglect and hoarding protocol to have been followed, yet the safeguarding enquiries focused on the financial aspects and did not necessarily keep Hilary at the centre of it.

10.4.19. In terms of Hilary's support package, which was reviewed in 2020, it is an observation of this review that the extent to which Hilary's sister was trying to support her was largely unknown. Certainly services knew her as she was often present during appointments and consultations, however on the regular occasions that she visited it may have been helpful to explore this more formally.

10.4.20. It is helpful to consider what a carers assessment is. The Care Act 2014 (section 9 and 10)[xvi] uses the term 'assessment' to refer to either a Care Act assessment of an individual's needs for care and support (in this case Hilary) and/or a carer's needs for support and determination of eligibility (in this case her sister).

10.4.21. In terms of the 'carers assessment; when a carer is found to have support needs following assessment under section 10 of The Care Act 2014, the local authority must determine whether those needs are at a level sufficient to meet the "eligibility criteria" under section 13 of the Act.

10.4.22. It is noted that that Hilary's sister was providing increasing amount of care over the last couple of years to Hilary, despite having other significant responsibilities at home. This placed a great strain on her, she is very familiar with the term "carer" and is very actively involved in a carers group but feels that the level of her input was perhaps not understood which may have masked the level of support that Hilary needed. In fact, both of Hilary's sisters were carers within their own households as well as contributing to Hilary's care. This point sits outside the terms of reference for this review. However, it is a relevant one to make.

11. Key Findings

Finding	Key Points
Recognition	Despite the length of time Hilary had been known to services (specifically Mental health), there was insufficient attention given to assessing her level of vulnerability in the context of risk of exploitation, particularly after it was known that she HR had been giving money to people living within her community. There was limited awareness of self-neglect compounded by poor awareness of the self-neglect and hoarding protocol procedure. There was an absence of holistic safeguarding action that encompassed self-neglect, hoarding and financial exploitation together.
Multi-agency coordination	There were multiple practice episodes between 2018 to 2022 that could have prompted multi agency coordination. In particular these opportunities presented themselves throughout 2019 and early 2020 and could have facilitated a “complex case” meetings, the identification of a lead professional and collective consideration of risk, capacity, and safeguarding concerns. A multi-agency approach would have provided the platform for Hilary’s voice to be clearly heard and the six principles of adult safeguarding to be enacted. There was an absence of a coordinated approach to the management of “complex safeguarding” themes- in this case hoarding, self-neglect, and exploitation. There is not currently a consistent process for multiagency risk management (when statutory safeguarding thresholds MAY not be met). With specific reference to hoarding, there is an absence of a dynamic hoarding process and the review found there to be a lack of understanding of hoarding in general. In particular this raised the question of how mental health services join up with the wider system to consider trauma informed approaches.
Professional Curiosity	Professional curiosity is the capacity and communication skill to explore and understand what is happening within a person’s situation rather than making assumptions or accepting things at face value. Curiosity is required to support practitioners to question and challenge the information they receive, identify concerns, and make connections to enable a greater understanding of a person’s situation[xvii]. There was an absence of professional curiosity insomuch as the known concerns and indicators of risk were not coherently recognised and explored. In particular “self-neglect” was not considered in any multi-agency arena during the timeframe of the review. This demonstrated

	insufficient legal literacy meaning that practitioners may not always be prompted to or know how to apply legal powers to safeguard people.
Person Centred Care	The review finds that safeguarding processes could have been more effectively applied to Hilary, this includes The Care Act, consideration of the concept of executive capacity and the Mental Capacity Act, and the local processes that have been developed including the self-neglect and hoarding protocol. Therefore, Hilary did not remain central to planning and her voice and lived experience was not consistently considered.
Community Safety	There is a disconnect in terms of how "community safety" processes interact with "safeguarding" processes so that people with known vulnerabilities are considered in geographical "hot spots" or known areas of vulnerability within communities. This includes the collective strengths of and interface with housing associations.

12. Improvements made

12.1. The panel discussions and PLE demonstrated areas of improvement where learning has already been taken forward and implemented. These developments are all relevant and ongoing assurance of effectiveness should be sought on a continual basic.

12.2. Progress to note at the point of reporting includes:

- The London Borough of Redbridge commissioned an internal review of its current pathways and the findings from this are currently under consideration, this will consider the "front" door and safeguarding pathways.

- The Local Authority adult health and social care services have recently implemented a new Case Management System (CMS) which should support improvements in relation to record keeping and visibility to those teams within the Local Authority

- RSAB have started to map the various forums, groups, pathways, and protocols to consider its approaches to the management of complex cases.

- The London Borough of Redbridge have commenced work through a multi-agency task and finish group to consider approaches to hoarding and self-neglect.

13. Summary

13.1. The issues that Hilary experienced in the latter stage of her life encompassed many different complex safeguarding themes including self-neglect, hoarding and financial exploitation which proved to be difficult to respond to in a connected and multi-agency way.

13.2. This is a theme frequently seen in SARs that highlight self-neglect signs and symptoms as a factor in or indicators of subsequent serious events that have resulted in life threatening consequences, or even death. When seen in isolation, self-neglect and/or hoarding behaviours may not give rise to safeguarding intervention.

13.3. It is not possible without hindsight bias to comment on whether there could have been a different outcome, however Hilary may have experienced an improved approach if the following areas had been strengthened.

- Understanding of the connectivity of the issues (self-neglect, hoarding and financial exploitation)
- Listening and hearing voice and daily lived experience.
- A strong multi-disciplinary approach with the person at the centre, and an identified lead professional.
- Confidence in the skills, knowledge, and experience of the workforce to consider individual circumstances.
- An understanding of the wider community functioning and its impact on vulnerable people in its midst.

13.4. In view of the above findings, whilst people working with Hilary did strive to understand her views, personality, likes and dislikes, the way that her daily lived experience increased her risk was not evidenced in approaches to working with her. This was compounded by a lack of protocol, insufficient understanding of hoarding and the capacity of services to work consistently with her.

14. Conclusion

14.1. This SAR Report is the Redbridge Safeguarding Adults Board's response to the death of Hilary to share learning that will improve the way agencies work individually and together.

14.2. Without hindsight bias it is difficult to conclude whether different interventions may have resulted in a different outcome for Hilary. The issues with Person Two were less visible that that of Person One, and the review cannot identify a specific event that would have predicted the level of risk leading to the event of her death.

14.3. However, the life she lived for the last four years of her life leading to her death may have been avoided and is a tragedy to her family. Hilary was a 67-year-old person living alone in a community that she did not recognise, and her vulnerability stemmed from a range of issues and presenting factors that were not explored in a multi-agency way.

14.4. The review has found gaps in knowledge related to self-neglect and hoarding. It is important that assurance and oversight of this is robust to evidence effectiveness of future care delivery.

14.5. The continued issues with Hilary giving money to people was consistently concluded as a personal choice, albeit with recognition that it did not sit comfortably with professionals. There was insufficient attention given to self-neglect and the relationship between that and the decisions she was making. There is an absence of agreed tools and pathways to aid multi agency working in this field of safeguarding.

14.6. Without a thorough understanding of how to work with this client group, professionals will not be able to respond effectively to their needs and protect them from harm. This review also reaffirms that much work remains to be done to improve adult safeguarding in this area. At the most general level, the workforce needs to better understand and respond to people who hoard and self-neglect, and more specifically they need a well embedded process to work within.

14.7. It is hopeful that the outcomes from this review will recognise thematic areas of learning from previous reviews. The findings and recommendations should be monitored for compliance, implementation, and assurance by the RSAB.

15. Recommendations

15.1. It is noted that progress has been made in Redbridge against the areas of findings. However, the recommendations made in this review should be applied as learning for the system where deeper and continual assurance is required and an action plan developed against them.

15.2. Arising from the analysis in this review the following recommendations are made to the Redbridge Safeguarding Adult Board:

No.	Recommendations	
1	Multi-agency working	The Redbridge Safeguarding Adult Board (RSAB) is asked to review the approaches and guidance currently available relating to multi-agency working within the workforce. The RSAB is asked to develop an overarching "Complex Safeguarding Strategy" which will include a multi-agency pathway approach for: • **Complex Safeguarding** • **Hoarding** The RSAB should ensure: - Assurance of their effectiveness - Alignment of the various pathways, groups, procedures, and protocols - Evidence of impact across the partnership - Oversight in managerial and professional supervision
2	Alignment with community safety	The RSAB is asked to consider current alignment with the Community Safety Partnership with particular reference to strengthening connectivity and sharing of intelligence between the two functions.
3	Workforce Knowledge and Skills	The RSAB is asked to seek assurance from commissioners, providers, and partner agencies on arrangements for ensuring that staff have the necessary knowledge, experience, and skills to recognise and act upon self-neglect with a specific focus on hoarding.

		With reference to the specific findings of this review this should include: • Relevant training for all frontline staff on the use of legal frameworks with this group of people. • Relevant training and awareness raising on the use of local pathways and protocols. • Ongoing assurance should be sought to ensure that good quality training happens regularly and is included in the professional development programmes of all relevant agencies.
4	Making Safeguarding Personal	The RSAB is asked to seek reassurance that Making Safeguarding Personal is accurately understood, and that understanding is embedded in practice across partner agencies. Additionally, the RSAB should continue to promote professional curiosity in practice and: • Consider its effectiveness measures to continually seek assurance that professionals are routinely applying professional curiosity in their practice and that this is proactively informing decision making. • Strengthen single and multi-agency supervision models and reflective practice opportunities. • Promote exploration of life experiences that are contributory to hoarding and self-neglect, and thus apply trauma-informed approaches by practitioners.

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