Haringey's Multi-Agency

Self-Neglect and Hoarding Procedure

2022-2025

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Document Objectives: To set out the procedure and guidance for organisations that may come across a resident of Haringey who self neglects or hoards.		
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Contents

1.0 Introduction

The Care Act 2014 has now clarified the relationship between self-neglect and safeguarding. It has made self-neglect a category of harm about which the Local Authority, in conjunction with local partners, has a duty to make enquiries and assess need with the promotion of well-being at the heart. Self-neglect can cover a wide range of behaviours such as neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. The need of adults that self-neglect are generally long standing and recurring and may frequently put themselves and others at high risk.

Hoarding and self-neglect behaviours are not the same and do not always present together. However, there are often similarities in terms of health and social issues e.g. isolation of the individual and lack of engagement with services that can present a real challenge to practitioners where there is ongoing and significant risk of harm. Managing the balance between protecting adults at risk from self-neglect or hoarding behaviours against their right to self-determination is also a challenge for services.

The purpose of this document is to set out the procedure and guidance for organisations which may come across a resident of Haringey who self neglects or hoards. It provides support to practitioners in the engagement of customers and the management of risk. Multi-agency partnership working is key to engaging with adults that self-neglect or hoard.

This procedure has been developed to highlight the importance of preventing and reducing needs and putting people at the centre of their care and support needs. An assessment and enquiry must be person centred, involving the individual and any carer that the adult has, or any other person they might want involved.

2.0 Aims & Objectives of the procedure

The aims and objectives of the Haringey Multi-Agency Self-neglect and Hoarding Procedure are as follows:

- coordinating a joint approach to dealing with cases where residents self-neglect or hoard, with a view to reducing costs and time taken to deal with cases;
- providing a support network of organisations and agencies, including contact details;
- providing guidance, support and sharing of best practice;
- monitoring cases (themes, triggers, duration, number of cases, etc);
- developing an understanding of the psychological reasons why a person self-neglect or hoards;
- to understand when a hoarding case should be considered by Community Mental Health or Social Care & Health;
- to highlight when a self-neglect or hoarding case is also a safeguarding case;
- to assist in improving the quality of life for individuals and help them to live safely, access support and sustain their independence;
- to assist staff from partner organisations to identify connected risks and prioritise actions; and
- to identify a range of support and enforcement measures, including legal routes and assist/help members in determining appropriate and effective measures.

3.0 Definitions of self-neglect and hoarding

3.1 Self-neglect

Self-neglect is defined in the Care Act Guidance as a wide range of behaviors that involve neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

Self-neglect is often defined across three domains; neglect of self, neglect of the environment and a refusal to accept help.

Neglect of self may include the following:

- Poor hygiene
- Dirty/inappropriate clothing
- Poor hair care
- Malnutrition
- Dehydration
- Medical/health needs unmet e.g. Diabetes- refusing insulin, treatment of leg ulcers
- Eccentric behaviour/lifestyle leading to harm
- Alcohol/substance misuse
- Social isolation
- Where there is evidence that a child is suffering or is at risk of suffering significant harm due to self-neglect by an adult

Neglect of the environment may include:

- Unsanitary, untidy or dirty conditions, which create a hazardous situation that could cause serious physical harm to the individual or others.
- Hoarding
- Fire risk e.g. Smoker with limited mobility/hoarder
- Poor maintenance of property
- Keeping lots of pets who are poorly cared for
- Vermin
- Lack of heating
- No running water/sanitation
- Poor finance management e.g. Bills not being paid leading to utilities being cut off, unexplained money being drawn from accounts.

The above is often accompanied by a refusal to engage with services.

It is important to recognise that assessments of self-neglect and hoarding are grounded in, and influenced by, personal, social and cultural values and professionals should always reflect on how their own values might affect their judgement. Professionals dealing with self-neglect and hoarding must find the right balance between respecting a person's autonomy and meeting their duty to protect the person's wellbeing.

3.2 Hoarding

Hoarding can be described as collecting and being unable to discard excessive quantities of goods or objects. Hoarding can also become a concern for others when health and safety are threatened by the nature or amounts of 'clutter' accumulating within, and sometimes overflowing from, the sufferer's environment.

It can be difficult to identify a person who hoards as the indicators are not always clear and not all hoarders carry the same characteristics. A case may be considered as hoarding, if for example "the clutter is so severe that it prevents or precludes the use of living spaces for what they were designed for". See Appendix 5: Clutter Image Rating Scale.

At its most severe, compulsive hoarding can provide the right ingredients for fires, vermin and insect infestations, hazards which could give rise to injuries as well as other health and safety concerns. It is when it impacts on the life of the person in the case of self-neglect or their neighbours that it tends to come to the attention of the housing provider or statutory agency to deal with.

Some hoarders may keep large numbers of animals as pets but not have the ability to properly care for them. Hoarders may be deeply attached to their pets but they are not able to provide them with proper care. Animals kept in this way are likely to be living in filthy and overcrowded conditions. They may suffer illness and starvation, but the owner may be oblivious to this and very reluctant to let the pets go.

Some hoarders manifest the following characteristics:

- isolated or extremely private individuals, often living alone;
- showing signs of self-neglect and/or 'eccentric' behaviour; and
- experienced loss or trauma - death of a close relative, separation or divorce, redundancy or other serious life event.

However, many hoarders may be well-presented to the outside world, appearing to cope with other aspects of their life quite well, and giving no indication of what is going on behind closed doors.

Health implications may include:

- living in squalid conditions, infestations and associated diseases;
- limiting cooking, bathing, heating. Sometimes without connected utilities;
- self-neglect, leading to other medical complications;
- lack of mental capacity;
- anxiety and depression; and
- serious risk to life.

Disorders associated with self-neglect and may include:

- Anxiety and depression;
- Psychosis;
- Personality Disorder;
- Learning Disability;
- Post-traumatic stress disorder (PTSD);
- Obsessive–compulsive disorder (OCD);
- Dementia;
- Diogenes syndrome;
- Autism; and
- Asperger's syndrome.

The risk of a fire starting is increased by hoarding disorder as combustible materials are more likely to be stored close to, or in contact with, heat sources such as cookers and heaters. This risk is increased further when clutter in the home reaches extreme levels as utilities to the home may be disconnected leading to unsafe practices such as the use of camping stoves for cooking and

candles for lighting. Access and egress to and from the home can also be restricted which means the person's escape may be slowed down or prevented in the event of a fire.
Fire loading in hoarding properties presents risks to neighbours too as it increases the likelihood of fire travelling to their properties. If there is a fire, the structural integrity of the building may be compromised during and after firefighting operations, due to the absorption of water by the hoarded materials.

The deep-seated smouldering fires associated with hoarding require a significant weight of attack over a protracted period of time, creating physically demanding conditions for firefighters. In addition, fire loading in hoarding properties is likely to increase the severity of a fire, impede access and egress to the building and could lead to abnormal fire growth and development.

4.0 Multi-agency working

Within the context of the safeguarding duties set out in the Care Act, safeguarding partnerships can be a positive means of addressing issues of self-neglect. The Haringey Safeguarding Adults Board (HSAB) is a multi-agency group that is the appropriate forum where strategic discussions can take place on dealing with what are often complex and challenging situations for practitioners and managers as well as communities more broadly. (Care Act 2014 guidance p260)

Haringey social care services have lead responsibility for coordinating a Safeguarding Concern. However, it is recognised that the sheer complexity of the multiple causes in any given case of hoarding or self-neglect requires a multi-agency approach.

There is an expectation that all professionals and agencies engage in full partnership working to achieve the best outcome for the adult who chooses to hoard or self-neglect whilst satisfying organisational responsibilities and duty of care. The focus should be on person centred engagement and risk management.

Where it is deemed that safeguarding actions have been concluded it is key that agencies continue to work together to ensure the safety of the individual. Case co-ordination between agencies to ensure best outcomes for the person is essential and should not be the responsibility of one individual or one agency to maintain. In cases where there is ongoing complexity or levels of risks it may be necessary to have a named case co-ordinator. They will have oversight of partner agencies involvement ensuring that sufficient actions have been taken to reduce the ongoing risks that the individual may face. Agencies should utilise the self-neglect/hoarding risk assessment to support decision making. See Appendix 2: Self-Neglect/Hoarding Risk Assessment Tool.

5.0 Carers

For the first time, carers have the same rights as service users under the Care Act 2014.

Circumstances in which a carer (for example, a family member or friend) could be involved in a situation that may require a safeguarding response include:

- a carer may witness or speak up about abuse or neglect;
- a carer may experience intentional or unintentional harm from the adult they are trying to support or from professionals and organisations they are in contact with; and
- a carer may unintentionally or intentionally harm or neglect the adult they support on their own or with others (taken from Care Act Regulations).

Where a carer is supporting someone who self neglects, has hoarding behaviours or where the carer lives with them, the carer themselves needs support and protection. This should be done

through the carer's assessment which should also determine the sustainability of the caring role itself- both practically and emotionally

6.0 Children

Any instance where the self-neglect by an adult impact on a child in their care must be considered under children protection procedures and referred to Children's Services. Adult Social Care and all partners must work closely with children's assessment and child protection teams.

7.0 Capacity and the Mental Capacity Act

The Mental Capacity Act 2005 states that there should always be a presumption of capacity, unless the adult has been assessed and found to lack capacity for a particular decision. Assessing the person's decision-making whilst taking account of the risks and safety implications of the decisions being made is a crucial aspect of risk management.
The Acts five principles should always be observed:

1. Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise;

2. The right for individuals to be supported to make their own decisions - people must be given all appropriate help before anyone concludes that they cannot make their own decisions;

3. That individuals must retain the right to make what might be seen as eccentric or unwise decisions;

4. Best interests - anything done for or on behalf of people without capacity must be in their best interests; and

5. Least restrictive intervention - anything done for or on behalf of people without capacity should be an option that is less restrictive of their basic - as long as it is still in their best interests.

This is a two stage test:

- Stage 1: Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?
- Stage 2: Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

All mental capacity assessments undertaken must be documented and stored within organisations IT systems.

In order to assess capacity, the following must be undertaken:

- Identify the decision you are assessing e.g. "Does XX have capacity to make a decision about receiving a care package to assist with personal care in their home?"
- Then, carry out the capacity assessment, ensuring the following four questions are answered:
    - *Does the person understand the information given to them about this specific decision?*
    - *Can the person retain the information relevant to this specific decision?*
    - *Can the person use and weigh the information relevant to this decision? and*

- *Can the person communicate their decision (this is not just via verbal communication)?*

- If the answer to one of these is no, the person lacks capacity about *that specific decision.*

Respect for the persons wishes and beliefs needs to be central to our approach. Professionals need to find creative, sensitive ways to work with people who hoard, understanding what the behaviour means to them and how they themselves wish to address the problem. However, the Mental Capacity Act gives professionals the authority to override the wishes of people who lack capacity to make a decision about specific matters if this is in their best interests and a proportionate response to the harm that would otherwise occur.

Capacity should be reassessed, when appropriate, as an individual's capacity may change over time, in different circumstances and for different decisions. Only a qualified professional can make a formal assessment of mental capacity. The MCA states that the person carrying out the intervention carries out the capacity assessment. So, a social worker assessing care needs would be able to carry out the capacity assessment.

It is important to consider whether it is appropriate to intervene at all. If there is no evidence of an impairment or disturbance in the function of the mind or brain or lack of capacity with regard to the self-neglect or hoarding and if there is no danger to public health, it may be difficult to justify intervention. Where the person has capacity, they may still be offered or signposted to appropriate support. **See Partner Contact *List* (Appendix 1).**

Although the Mental Capacity Act is clear that someone should not be deemed as lacking capacity just because they make unwise decisions there is a responsibility on practitioners to take the necessary steps to test an individual's capacity in circumstances where the person has or is suspected of having a disturbance of mind or brain and they continue to make unwise decisions or a decision that places them at a high level of risk. In such circumstances it is the responsibility of the professional to ensure that the person's mental capacity is sufficiently tested through a formal mental capacity assessment.

An Independent Mental Capacity Advocates (IMCAs) may be instructed where local authorities or NHS bodies 'propose to take or have taken, protective measures in relation to a person who lacks capacity to agree to one or more of the measures' and where safeguarding adults' proceedings have been instigated. People at risk may be supported by an IMCA regardless of any involvement of family or friends. The IMCA service in Haringey is provided by Voiceability. More information on IMCA's can be found here.

Given the complexity of these cases, being able to document a clear rationale for the decision taken is essential involving partner agencies in discussions around what, if any intervention is appropriate, should ensure all the circumstances of the case are considered, and a range of knowledge and experience is shared.

8.0 Data Protection and Information Sharing

Personal information stored and passed on (relating to people who hoard) must be in line with the six Caldicott Principles which are the following:

1. Justify the purpose of using confidential information;
2. Don't use personally identifiable - All personal information regarding people, who hoard must be removed from attachments, hoarding assessment forms, etc sent via emails. This includes details such as the name, address and other personal information regarding Hoarders.

3. Only use the minimum amount of information;
4. Information is shared on a 'need to know' basis;
5. Everyone should be aware of their responsibilities; and
6. Understand and comply with the law – Data Protection Act 1998[1].

All staff are legally required to keep information confidential. The Data Protection Act 1998 and GDPR sets certain standards which have to be satisfied when we are recording, holding or passing or disposing of personal information. The Data Protection Act 1998 and GDPR also sets out the rights and protection that individuals have to ensure the data we hold, and use is lawfully processed, relevant and accurate.

The Information Sharing Agreement (ISA) in the updated London Multi-Agency Safeguarding Policy & Procedures (April 2019) sets out how information relating to safeguarding should be shared between partners.

Sharing Information with Consent

Adults have a right to independence, choice and self-determination. This right extends to them being able to have control over information about themselves and to determine what information is shared. Even in situations where there is no legal requirement to obtain written consent before sharing information, it is good practice to do so.

Sharing Information without Consent

The Data Protection Act 1998 allows the sharing of information without consent where it's in the adult's vital interest. This is to enable professionals to assess the risks and options.
The Act will:

- permit sharing of information where it is critical to prevent serious harm or distress or in life threatening situations.
- for the protection of others who may be at risk from these behaviours.
- practitioners have a duty to share the information with relevant professionals to prevent harm to others.

It is good practice to inform the adult at risk that this action is being taken unless doing so would increase the risk of harm.

9.0 Disagreements and Complaints

If there are any disagreements between agencies that cannot be resolved, then appropriate action must be taken in line with Haringey's Inter-Agency Safeguarding Adults Board Escalation Protocol.

The complaints procedure of the local authority or other relevant partner organisation, depending on the nature of the complaint of the case in question should be followed should a complaint be made.

[1] Data Protection Act 1998 http://www.legislation.gov.uk/ukpga/1998/29/data.pdf

10.0 Self-neglect/hoarding pathway

Detection/Referral/Undertake Hoarding/Self Neglect Screening Assessment
(All agencies)

Q: Are there signs of hoarding/self neglect or has there been a referral to Adult Social Care?

Then use the following tools:

- Self neglect/Hoarding Assessment Tool (Appendix 2)
- Self neglect/Hoarding Form (Appendix 3)
- Clutter Image rating scale (Appendix 5)
- Where necessary, a Mental Capacity Assessment should be undertaken
- Where necessary, consider the use of an advocate

Q: What level of risk on the Self neglect/Hoarding Assessment Tool (Appendix 2) is the adult assessed at?

If the adult has the mental capacity to make an informed decision, and there is no danger to public health, then that person has the right to make their own choices.

Low Risk Self neglect/Hoarding Assessment Tool (Appendix 2)

- Carefully document and continue to monitor the adult, signpost to information and advice, refer to voluntary sector organisations and consider any preventative interventions.

Moderate or High Risk Self neglect/Hoarding Assessment Tool (Appendix 2)

- **Undertake full self neglect/hoarding assessment** (Haringey Adult's Safeguarding Team)

Moderate or High Risk who CONSENT to intervention
A concern needs to be raised and a Section 42 Enquiry undertaken, where appropriate. Or other intervention (See Appendix 5)

Should be carefully documented and case management commenced in line with the agreed safeguarding plan.

Moderate to High Risk who DO NOT CONSENT to intervention
A Multi-agency strategy meeting should be held within 5 working days of the referral; safeguarding plan and interventions put in place on a case-by-case basis.

Any adults at immediate risk should have urgent referrals or assistance via 999.

Q: Is the case escalating, complex, high risk or reached 'sticking point'?

NO

Continue with Case management- Provide aftercare and continue monitoring the case

YES

Refer to the **Multi-Agency Solutions Panel (MASP)**

10.1 Detection, Referrals and Screening Assessment

Detection

The first step of the pathway it to detect whether there are any signs of/methods to detect hoarding or self-neglect? Some issues that can be indicators of self-neglect/hoarding include (this list is not exhaustive):

Access Issues

- gaining access – as this is generally not welcomed;
- don't always request repairs or have debt issues that may trigger reactive visit;
- gas checks and necessary repairs – e.g. leaks into neighbouring properties – do contractors know when appropriate to report an issue; and
- Decent Homes – action if holding up certain necessary works – e.g. electrics, though not all work as people can choose not to have a new kitchen.

Neighbours, Friends & Family

- Smell or obvious pest problem – usually when it becomes noticeable in neighbouring properties;
- Concerned neighbours or complaint;
- Items creeping into communal areas or outdoor space, overgrown gardens; and
- Concerned friends and family may make a report to partners.

Un/scheduled Visits

- welcome visits / tenancy check (indicates early on if potential problem);
- periodic occupancy checks (home visit not by phone);
- GP, Fire or ambulance service – tends to be at crisis point such as hospitalisation;
- meals on wheels or other domestic / carer / safety / occupational therapist visits
- social workers/housing support worker;
- down-sizing / under occupiers; and
- responsive visits e.g. repairs.

General

- Information from a previous landlord; and
- Case notes/handover between teams and sometimes between landlords.

Referrals

Referrals can come from a range of sources including the person themselves, neighbours, family, friends or referrals from other professionals.

All referrals made should come via the Adult Social Care First Response Team using a safeguarding concern form.

The contact details are:

Email: Firstresponseteam@haringey.gov.uk
Telephone: 020 8489 1400: 24hrs services 7days a week

Feedback must be provided to the referrer on a need-to-know basis.

10.2 Hoarding and Self-neglect Assessment

Screening Assessment

If signs of self-neglect and/or hoarding are identified or a referral is made, then a hoarding and self-neglect screening assessment will be undertaken. This should usually be undertaken by the lead agency.

To do this you should use the Self-neglect/Hoarding Risk Assessment Tool found at (Appendix 2 & 3). The Clutter Image Rating pictures (Appendix 4) should also be used to assist with this.

It may be beneficial to undertake a joint assessment with a mental health practitioner.

From the very beginning of the assessment stage, consideration should always be given to the wishes of the adult and the outcomes they wish to achieve. This may include involving family, friends and neighbours to provide support where appropriate. If no suitable representative is available, a referral for an independent advocate should be made as soon as possible.

Outcomes of the screening assessment

If the outcome of the screening assessment is:

- **Low Risk on the Self neglect/Hoarding Assessment Tool (Appendix 2),** the adult should be carefully documented, and, if they consent, be given information and advice, be referred on to voluntary sector or for preventative mental health interventions.

- **Moderate to High Risk on the Self neglect/Hoarding Assessment Tool (Appendix 2)** then the person **must be referred to the Haringey Adult's Safeguarding Team** who will ensure a full self-neglect/hoarding assessment is completed.

Please note: Where partners identify hoarding that is at **level 5** or above on the clutter scale (See Appendix 5) a referral should always be made to London Fire Brigade.

10.2 Full self-neglect/hoarding assessment

The Safeguarding Adults Team will undertake a full self-neglect/hoarding assessment. The assessment needs to take into account the following factors which would assist in determining the safeguarding plan:

- Physical health
- Psychological state and mental health- e.g. depression
- Personality traits
- Functional and cognitive abilities
- Nutritional intake and the availability of food
- Fluid intake and the availability of fluids
- Social networks
- Ability to perform activities of daily living
- Social and medical histories
- Understanding the person's perception of the situation and motivations
- Risk assessment of the home and the individual
- Historical perspective to inform whether the current situation derives from a life pattern
- Economic resources to the individual

- Alcohol and/or substance abuse
- Traumatic histories and life-changing events
- The adult's perceived self-sufficiency and receptiveness to support

Those who consent to intervention

These cases should be carefully documented, and case management commenced in line with the agreed safeguarding plan.

It should be noted that self-neglect may not prompt a section 42 enquiry (See 10.3). An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by understanding their own behaviour and possible risks associated with this. There may come a point when they are no longer able to do this, without external support.

There are also a number of other powers available to agencies to address self-neglect and hoarding that should be considered where appropriate. A list of these powers can be found at Appendix 4.

Those who do not consent to or engage in intervention

A multi-agency meeting should be arranged by Adult Social Care or the Mental Health Trust within 2 weeks of the referral being received. (See 10.5) Any adult that is at immediate risk should have an urgent referral or assistance via 999.

10.3 Care Act Statutory Section 42 Enquiries

When an adult who self neglects and/or hoards and is unable to protect themselves by controlling their own behaviour comes to notice, a Safeguarding Concern **must** be raised and sent to the Adults Social Care service to commence an enquiry. Local authorities have a duty to undertake a Statutory 42 Enquiry. See: Haringey's Multi Agency Section 42 Enquiry Framework & Guidance .

This enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

a. It needs to ensure that the safeguarding pathway is person centred
b. Ensure the engagement of all appropriate agencies in responding to the referral and the ongoing work.
c. Make a referral for an Advocate or Independent Mental Capacity Advocate if the person does not have a representative.
d. Refer onto the Multi-Agency Solutions Panel.

It is likely that in most cases, particularly where the person engages with the enquiry and effective interventions to reduce the risks are established, the safeguarding process can be concluded and transferred to case management or the care programme approach and review.

Often, the cases that give rise to the most concern are those where an adult refuses help and services and is seen to be at grave risk as a result. If an agency is satisfied that the adult has the mental capacity to make an informed decision on the issues raised, then that person has the right to make their own choices. **But**, this should **not** be seen as 'an all or nothing' strategy. It is in these circumstances staff needs to follow the procedures in this document.

10.4 Care Act Section 44 Safeguarding Adults Reviews (SAR)

If during the course of professional interventions an adult dies or suffers permanent or serious harm as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult, then a referral should be sent to the Safeguarding Adults Board for consideration to implement a safeguarding adults review.

See Haringey Safeguarding Adults Review Procedure

10.5 Safeguarding Strategy Meeting

At this stage, a multi-agency meeting will be held and a safeguarding plan will be developed.

All relevant agencies need to be invited to the strategy meeting eg. Environmental Health, London Fire Brigade, Mental Health Trust, Community Health Services, Housing, etc. This is to ensure a wide range of professional views are obtained and intelligence is shared, initial actions can be undertaken immediately, i.e. Fire safety assessment. (See Appendix 4) Consideration should be given to invite the person who is self-neglecting or hoarding to the meeting. This may be one way to effectively engage the individual in the issues.

The purpose of the meeting is for each service to share information and contact history. This helps to build up a picture of the adult, establish assessed need and the level of risk to the individual and others. It should include information on engagement and intervention, what decisions are required and what the person's mental capacity is in relation to these decisions e.g, to accept health support.

Establishing the mental capacity of the individual is a **vital** aspect of care planning and risk assessment when working with an adult who is self-neglecting or hoarding and refusing services. This can be difficult if the person is not engaging, however the person who has the best relationship should be the one to attempt this in the first instance, with support from other professionals on suitable questions to test the specific decision required.

Following the multi-agency strategy meeting, a safeguarding plan should be developed. The safeguarding plan will outline the interventions put in place and these will be decided on a case-by-case basis.

If the adult remains high risk, complex and / or refuses all engagement and intervention following the implementation of the safeguarding plan, then a referral to the Multi-Agency Solutions Panel should be made.

10.6 Multi-Agency Solutions Panel (MASP)

If, at this stage, the case is considered complex, high risk, or have reached a 'sticking point' (i.e. such as access being denied) and where your organisation has exhausted its internal procedure, it should be referred to the MASP.

This panel is designed to complement and enhance the work that should already be on-going for adults deemed to be at moderate to high risk. This is to ensure all options have been explored

including attempts to engage the individual.

The person completing the referral form will need to come to Panel to present the case or send a representative.

The MASP will discuss cases which have been presented to them, with a view to determining next steps and supportive / collaborative interventions with the adult who hoards, particularly where cases are complex.

The Panel's role is to challenge and advise the presenting organisation, as well as assisting with the coordination of cases where cross-organisational barriers may surround the case. The Panel will be expected to consider any vulnerability or equality and diversity issues within their recommendations.

The Panel will review previously presented cases, to analyse whether its recommendations have been put in place and which solutions have been effective. It will also seek to establish how many presented cases remain 'unresolved'. Members will be expected to share best practice or legal changes, especially within their specified field, with the rest of the Panel. This knowledge will also be shared with partner organisations who have signed up to this protocol.

The Chair and Vice Chair will be responsible for agreeing the agendas with members, overseeing the effective running of meetings and ensuring that identified action points are correctly followed up.

How to submit a case to MASP?

The Panel is available to professionals working with all adults at risk who live in, or are otherwise the statutory responsibility of, London Borough of Haringey.

Any professional can make a referral into the but must ensure that the referral form (appendix 4) and risk assessment (appendix 5) have been completed and the criteria met for the referral to be valid. The process has been designed to better support multi-agency working as a default a key finding in recent Haringey Safeguarding Adult Reviews.

The MASP email address is: masp@haringey.gov.uk

10.7 Aftercare

Short sharp solutions may resolve any immediate issues that need to be dealt with but tend not to be sustainable. Hoarding behaviour can often return if the underlying cause is not dealt with. Some aftercare solutions can include:

- support package;
- domiciliary or healthcare package;
- counselling;
- cognitive behaviour therapy;
- assistance with moving home or property adaptation;
- home fire safety visit by the London Fire Brigade; and
- power of attorney or authorised advocacy provision.

11. Monitoring

Each organisation will be responsible for deciding how to monitor the application of this procedure within their own organisation, depending on its structure (e.g. performance reports within your organisation or any records/reports to multi-agency panel or local authority, attendance at multi-agency meetings etc). Each organisation has a key contact (see Partner Contact List - Appendix 1) who, for the purpose of this procedure, will assist on behalf of their organisation in the co-ordination of any joint monitoring information requested by the Panel.

The HRP will also gather case details for monitoring trends in hoarding and gathering a catalogue of best practice/lessons learned.

12. Useful references

London Multi-agency adult safeguarding policy and procedures.

Professional Practice Note: Hoarding and how to approach it

SCIE Report 46: Self-neglect and adult safeguarding: finding from research.

Self-neglect policy and practice: research messages for managers, Social Care Institute for Excellence: http://www.scie.org.uk/publications/reports/69-self-neglect-policy-practice-building-an-evidence-base-for-adult-social-care/

American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5) : http://www.psychiatry.org/dsm5

Chartered Institute of Environmental Protection: Hoarding and how to approach it - guidance for Environmental Protection Officers and others http://www.cieh.org/uploadedFiles/Core/Policy/Publications_and_information_services/Policy_publications/Publications/Hoarding_PPN_May09.pdf

Preston-Shoot, M (2016) Towards explanations for the findings of serious case reviews: understanding what happens in self-neglect work., Journal of Adult Protection, Vol 18 no.3, pp131-148

Useful Links

AMERICAN PSYCHIATRIC ASSOCIATION: http://www.psychiatry.org/hoarding-disorder

ANXIETY CARE UK: www.anxietycare.org.uk/docs/hoarding.asp

ANXIETY UK: www.anxietyuk.org.uk/about-anxiety/anxiety-disorders/compulsive-hoarding/

BRITISH PSYCHOLOGICAL SOCIETY: http://www.bps.org.uk/news/psychological-perspective-hoarding

CHILDREN OF HOARDERS: http://childrenofhoarders.com

COMPULSIVE HOARDING: www.compulsive-hoarding.org/Support.html

COMPULSIVE HOARDING NETWORK: health.groups.yahoo.com/group/H-C

HELP FOR HOARDERS: www.helpforhoarders.co.uk/resources/

NHS: www.nhs.uk/Conditions/hoarding/Pages/Introduction.aspx

OCD ACTION: www.ocdaction.org.uk

OCD FOUNDATION: www.ocfoundation.org/hoarding

OCD UK: www.ocduk.org

Appendix 1: Organisational Contact details

London Fire Brigade
Borough Community Safety Manager
Hornsey Fire Station
108 Park Avenue South
N8 8LS

Email: ian.thompson@london-fire.gov.uk
Phone: 020 8555 1200 Stn 84152 Office 11321 | Mob 07825 996255

First Response Team
London Borough of Haringey
2nd Floor, River Park House, 225 High Road
Wood Green
London N22 8HQ
Email: Firstresponseteam@haringey.gov.uk

Tel: 020 8489 1400
Opening Hours 9am - 5pm, Monday – Friday

Out of hours

During weekends, and between 5pm and 9am on weekdays, contact the Emergency Duty Team on 020 8489 0000

Appendix 2: Self-Neglect/Hoarding Risk Assessment Tool

This tool is based on Newham's Self-neglect/hoarding risk assessment tool. The tables and matrix below should be used to assess the level of risk and required actions.

Definitions

A **hazard** is anything with the potential to cause harm; every hazard has likelihood and a consequence. A hazard can be absolutely anything – person, behaviour e.g. non engagement/ refusal of services, personality, object, illness, medical condition, disability impairment, incapacity, addiction, dependency, environmental factor, or situation.

Risk is the likelihood that a hazard will cause a specified harm and usually qualified by some statement of the severity of the harm or consequence.

Likelihood is a measure of the chance that the hazard will occur. Example of low likelihood is where a person is engaging with the risk management plan and the risks are reduced. Example of a high likelihood is where the person has been assessed as having capacity but is refusing to engage with services to reduce the risks.

Consequence is the outcome of the hazard. It is assessed according to the impact the event had on the person. A severely cluttered house occupied by a frequent smoker could result in catastrophic consequence for the service user and others.

How to use this Risk Assessment Tool

Consider the description of each consequence level (1-5) and consider which is most appropriate for the individual you are assessing. Then consider the likelihood level (1-5) of the consequences occurring. The risk level is calculated by multiplying the two scores together and plotting the total figure on the risk assessment decision making matrix below.

Likelihood x Consequence = RISK

Table 1 – Consequences

This is the descriptor and scores for the 'Consequences'

Consequences Level	Injury/risk of harm to Customer	Injury/risk of harm to others	Cost to individual/and others
5 =Catastrophic	• Imminent fire risks (Consider: Flammable materials, working smoke alarms, evidence of previous fire/smoke damage anywhere) • Hoarding items severely limiting free movement including entry/exit. • Unstable piles/avalanche risk leading to severe injury, permanent disability,	• Severe infestation to neighbours and surrounding properties. • Fire spreading from affected property. • Inability to safely access and use communal areas due to clutter impinging on these areas from affected property. • Severe odour in	• Death, significant deterioration in physical and/ or mental health and wellbeing, relapse to using substances, total loss of independence etc • Enforcement by Environmental health which will be charged to the individual.

	• Noncompliance with medication or treatment. • Development of pressure areas grade 3 or above, or other wounds • Lack of continence management. • Disconnection of utilities • Eviction/ legal enforcement by Environmental health and/ or housing. • Severe infestation that could spread, causing infection or injury, • Malnutrition/ severe weight loss • Severe odour • Limited or no financial viability	communal areas • Clutter spreading to the garden and surrounding areas	
4 =Major	• Major permanent loss of function related to self-neglect, lack of compliance with medical treatment. • Significant self-neglect requiring hospitalisation, • Development of pressure areas grade 2 or above, • Poor continence management • Severe infestation that could spread • Unable to use most rooms, lack of utilities • Non fatal fire • Strong odour • Limited ability to maintain nutrition	• Limited safe access to communal areas, • Infestation. • Moderate odour in communal areas	• Prolonged medical admission, change to living arrangements, total loss of independence, impact on physical and/or mental health and well-being
3=Moderate	• One or more rooms unusable, or use severely impaired by level of clutter, this may include rubbish. • Some items may	• May be some small items in communal area, but not constantly. • Light odour in	• psychological, anxiety, depression as a reaction requiring medical intervention, pain

	increase risk of severity of fire – such as hoarded paper. • Some loss to independence, some level of self-neglect/non-compliance, i.e. inconsistent engagement with medical staff or medication management. • Poor engagement with continence management but some compliance	communal areas.	and discomfort, semi-permanent, loss of independence etc
2 =Minor	• Small collections of items, not rubbish and not causing obstructions. • Moderate level of engagement with medication and care, • Responds to relationship building and rapport with professionals.	• Residents and communal areas unaffected	• No real loss to independence or level of function
1= Insignificant	• Some small collections of items, not impacting on use of any rooms. • Engages fairly well with support.	• Resident and communal areas unaffected	• No loss of independence

Table 2 – Likelihood

This table scores the frequency of the assessed consequences in the self neglect / hoarding behaviour and is used in conjunction with Table 2

Likelihood Descriptor Levels	Description	Score
Almost certain	Will probably occur frequently	5
Likely	Will probably occur frequently but not as a persistent issue	4
Possible	May occur	3
Unlikely	Not expected to occur	2
Rare	Would only occur in exceptional circumstances	1

Risk Assessment Decision Matrix

Consequence

Likelihood					
5	5	10	15	20	25
4	4	8	12	16	20
3	3	6	9	12	15
2	2	4	6	8	10
1	1	2	3	4	5
	1	2	3	4	5

The traffic light ratings set out in the matrix above are:

15-25	**HIGH RISK**-Convene emergency multi-agency strategy meeting to agree actions and responsibilities with referral to High Risk Panel for risk discussion and safeguarding planning
5-12	**MODERATE RISK** -Multi agency strategy input required and referral to High Risk Panel if required
1-4	**LOW RISK**-Liaise with other professionals, offer info to Customer

Capacity and advocacy

When identifying risks, one must take into consideration the mental capacity for decision making of person/s at risk. Capacity issues highlight the level of control the adult may have over his/her current situation and his/her ability to make decisions relating to taking risks and accepting support that might reduce the risks.

If the person is found not to have capacity and a best interest decision is required in regard to their accommodation, one must ensure that the person's right to advocacy is upheld. Where the person is not represented with no family or carer, an IMCA must be instructed to act as the advocate for

the vulnerable adult if a long-term move is proposed. If they do meet the criteria for IMCA involvement, or it is felt that the family or carer is not acting in their best interests, an advocacy referral should be made.

Note: The risk assessment is not a definite science, it is a decision-making support tool and the risk score can change over any period of time or with different intervention

Appendix 3: Self Neglect/Hoarding Form

The form is based on the Newham HOMES Multi disciplinary hoarding risk assessment. It is intended as an *initial* and *brief* assessment to aid in determining the nature and parameters of the hoarding problem and organising a plan from which further action may be taken-- including immediate intervention, additional assessment or referral.

HOMES can be used in a variety of ways, depending on needs and resources. It is recommended that a visual scan of the environment in combination with a conversation with the person(s) in the home be used to determine the effect of clutter/hoarding on **H**ealth, **O**bstacles, **M**ental Health, **E**ndangerment and **S**tructure in the setting.

The Family Composition, Imminent Risk, Capacity, Notes and Post-Assessment sections are intended for additional information about the hoarded environment, the occupants and their capacity/strength to address the problem.

Health

Task	Y/N	Notes
Presence of spoiled food		
Presence of insects/rodents		
Presence of faeces/Urine (human or animal)		
Presence of mould or Rubbish overflow		
Cannot locate medications or equipment		
Chronic dampness		
Risk of Falls		

Obstacles

Task	Y/N	Notes
Cannot move freely/safely in home		
Unstable piles/avalanche risk		
Inability for EMT to enter /gain access		
Egresses, exits or vents		

blocked or unusable		
Cannot access bathtub/shower		
Cannot access food to preparation areas.		
Cannot access the toilet		
Cannot access the bed		
Cannot access stove/fridge/sink		

Mental health (Note that this is not a clinical diagnosis; use only to identify risk factors)

Task	Y/N	Notes
Does not seem to understand or is aware of the seriousness of problem		
Lacks capacity to make a decision about receiving care at home to support with the hoarding		
Defensive or angry		
Unaware, not alert, or confused		
Does not seem to understand or accept likely consequence of problem		
Appears anxious or apprehensive		

Endangerment (evaluate threat based on other sections with attention to specific populations listed below)

Task	Y/N	Notes

Threat to health or safety of child/minor		
Threat to health or safety of person with disability		
Threat to health or safety of older adult		
Threat to health or safety of animal		

Structure & Safety

Task	Y/N	Notes
Unstable floorboards/stairs/porch		
Leaking roof		
Electrical wires/cords exposed		
No running water/plumbing problems		
Flammable items beside heat source		
Caving walls		
No heating/electricity		
Blocked/unsafe electric heater or vents		
Storage of hazardous materials/weapons		

Household Composition

Number of Adults _____ _____ Number of Children _____ number and kinds of Pets _____
Ages of adults: _____ Ages of children: _____
Person who smokes in home Yes No
Person(s) with physical disability_____
Language(s) spoken in home_____

AssessmentNotes:_____
_____
_____

Risk Measurements

Imminent Harm to self, family, animals, public:
_____Threat of Eviction: _____
Threat of condemnation:_____
Score on the Risk Assessment Matrix: _____

Capacity Measurements

Instructions: Place a check mark by the items that represent the strengths and capacity to address the self neglect or hoarding problem.

Awareness of clutter	
Willingness to acknowledge clutter and risks to health, safety and ability to remain in home/impact on daily life	
Physical ability to clear clutter	
Psychological ability to tolerate intervention	
Willingness to accept intervention assistance	

Capacity Notes:
_____
_____
_____

Post-Assessment Plan/Referral

_____
_____
_____
_____

Date: _____ Client Name: _____

Assessor: _____

Appendix 4: Haringey Multi-Agency Solutions Panel Referral f

Haringey Multi-Agency Solutions Panel (MASP)
Referral Form

Residents Name			
Residents Date of Birth			
Residents Address			
Residents contact number / email			
Please do not assume the answers to the following questions even if you think it is obvious, please ask the resident and use their words to complete the questions.			
Gender		Sexuality	
Ethnicity		Nationality	
Religion		Disability/Long-term conditions	
First Language/ Language Needs			

Referrer Name	
Role and Organisation	
Contact number and email address	

Please provide an overview of the resident's current circumstances, including what is important to them, their strengths and goals, as well as areas of concern and risk:

Please describe the support/input that you would like the MASP to offer:
Please let the panel know about other agencies, services or supporters working with this resident:
Please describe any concerns related to the safety of workers that the panel should be aware of:

Referral Checklist

Has a multi-agency risk assessment been completed?	Yes/No
Has the risk assessment scored 6 or higher?	Yes/No
If the score was between 6-12, has a multi-agency case discussion been held?	Yes/No

Have actions from this meeting failed to reduce the risk of harm?	Yes/No

If you have answered 'No' to any of the above questions, you should not refer into the MASP at this time.

Please ensure the risk assessment tool is sent with the referral.

Please email the completed referral to MASP@haringey.gov.uk at least 6 working days prior to panel. Please password protect any documentation if not sent via a secure email account.

Appendix 5: Multi-Agency Solutions Panel Risk Assessment

Haringey Multi-Agency Solutions Panel (MASP)
Risk Assessment

This risk assessment tool has been developed to help identify and support residents where there are concerns relating to their safety and wellbeing. This tool will help to assess and balance someone's strengths alongside their vulnerability to risk to determine if a referral to the MASP for multi-disciplinary advice and problem-solving support is appropriate.

This tool has been developed in response to the Safeguarding Adults Review (SAR) for Ms Taylor (2019) and Thematic Homelessness SAR (2021). These reviews identified gaps in multi-agency risk identification and management, including lack of shared goals and responsibilities, missed opportunities to identify lead workers/agencies and insufficient communication to help vulnerable adults remain safe.

Who should use the risk assessment?

The risk assessment has been developed to support all workers in Haringey to make timely and informed decisions about how best to support people experiencing complex issues related to harm, safety and wellbeing. We want to ensure that we work with all partners on an aligned response to supporting our residents, and that risks and opportunities to achieve positive outcomes are shared between relevant organisation and practitioners.

This tool is primarily to identify if a referral is appropriate for the Haringey Multi-agency Solutions Panel (MASP) but you are welcome to use it to explore risk and protective factors with anyone you are supporting.

How to use the risk assessment[2]

Workers should first consider the **likelihood** of the risk occurring (Table 1). Where a risk is identified, referrers should then use Table 2 to identify the potential **impact** the risk might have on the individual.

The risk decision matrix can be used to determine the likelihood and impact of the risk.

[2] This risk assessment was adapted from one devised as part of the Haringey Multi-Agency Self Neglect and Hoarding Procedure: https://www.haringey.gov.uk/sites/haringeygovuk/files/haringey_multi-agency_self_neglect_and_hoarding_procedure.pdf

Finally, workers should consider the **protective factors** helping to keep the person safe or manage the risk of harm using Table 3. The 'Protective Factors' score then reduces the overall risk level to take into consideration what the person is already doing to keep themselves safe.

When these three figures have been determined, the overall risk figure can be worked out like this:

(Likelihood x Impact - Protective Factors = Total Risk)

Table 1 – Likelihood

This table is your guide for scoring how likely it is the risk will take place.

Likelihood Level	Description	Score
Almost certain	Will almost certainly take place action isn't taken to reduce risk, may occur with frequency	**5**
Likely	Will likely occur if action isn't taken to reduce risk, but may be a one-off event	**4**
Possible	May occur	**3**
Unlikely	Not expected to occur	**2**
Highly unlikely	Would only occur in exceptional circumstances	**1**

Table 2 – Impact

This table is your guide for scoring the impact of harm if the risk did occur. This is not an exhaustive list so choose the level which feels the most appropriate based on your knowledge.

Impact Level	Description	Score
Catastrophic	Preventable/accidental death, multiple or severe injury, repeated/sustained abuse, building fire, significant and long-lasting physical/emotional harm to or from others, risk of criminal victimization (e.g. rape or murder)	**5**
Major	Major/permanent loss of function, self-neglect or mental health episode requiring urgent hospitalisation, physical/emotional harm to or from others, risk of street homelessness, risk of imprisonment, risk of criminal victimization (e.g. assault/GBH)	**4**
Moderate	Long term but recoverable harm to physical/emotional health, loss of independence, risk of eviction, risk of criminal justice involvement, risk of criminal victimization (e.g theft), some level of self-neglect, mistrust or non-engagement with practitioners etc.	**3**
Minor	Low level injury, short term impact on physical/emotional wellbeing.	**2**
Negligible	Little to no harm of any lasting or significant nature	**1**

Risk Assessment Decision Matrix

Impact

Likelihood						
5	5	10	15	20	25
4	4	8	12	16	20
3	3	6	9	12	15
2	2	4	6	8	10
1	1	2	3	4	5
	1	2	3	4	5

Table 3

This table is your guide for scoring strengths and protective factors that a person has in their life, reducing the risks. This is not an exhaustive list, so choose the level which feels the most appropriate based on your knowledge.

Protective Factors	Description	Score
Significant	Person has a coordinated team of practitioners working with jointly them, strong family and friend relationships, socially connected or involved in community, good understanding of risks to self/others, in secure accommodation, employed/economically active, not in debt	**6**
Moderate	Person is in touch with relevant services, engaging with health services, an improving or stable-distant relationship with family, peers and friends, some understanding of risk to self/others, maintaining accommodation, employed/in receipt of income	**4**
Minor	A single agency providing support, limited or chaotic relationships with friends and family, registered with a GP, uncertain/changing awareness of risk and harm to others, living in temp accommodation.	**2**
Negligible	Housebound, refusing to engage with services, socially isolated/excluded, no awareness of risks to self/others, homeless	**0**

Risk & Safety Assessment

Risk Type	Likelihood	Impact	Protective Factors	Risk Level (L x I – PF = Risk Level)
Fire Risk (including due to hoarding, smoking, bedbound, unmet mental health needs)				
Self-Neglect (including personal care, medication, nutrition and hydration)				
Harm to self or others (including accidental, self-inflicted, gang-related, chaotic drug or alcohol use, suicide attempts)				
Harm from others (including mate crime, network abuse or cuckooing, substance or alcohol dependency, anti-social behaviour, street drinking, unsafe/risky sexual behaviour, hate crime, domestic abuse)				
Wandering, missing episodes, rough sleeping				
Multiple disadvantage (the person has a minimum of 3 of the following needs: physical health, mental health, substance/alcohol dependency, rough sleeping & criminal justice involvement)				
Other Please specify				

Please describe the protective factors in the person's life, which includes their personal

skills and strengths (as described in table 3). This will help MASP members to better understand how they can support this resident.

Risk Level and Next Steps

The score you reach after considering the severity, likelihood and protective factors will give you a risk level of High, Medium or Low and a set of required actions, as below:

Risk Score	Risk Level	Action Required
15- 25	HIGH RISK	Convene emergency multi-agency case discussion to agree immediate protective actions. Identified lead worker/agency to make a referral to Multi-Agency Solutions Panel.
6-12	MODERATE RISK	Convene a multi-agency case discussion forum to agree actions and protective factors. Establish a Lead Worker who will share information between agencies and coordinate actions of all involved.
1-5	LOW RISK	Continue providing support and regularly review risks and protective factors. Identify what is working well for this resident and encourage/enable this. Seek advice and support from manager, colleagues & professionals.

If you think that an individual you are supporting may have care and support needs (i.e. mental health, learning disability, long-term health conditions, frailty) **and** is at risk of abuse or neglect, then a safeguarding alert should be raised with the Council's First Response Team **immediately** on:

- Telephone: 020 8489 1400
- Email: firstresponseteam@haringey.gov.uk

Appendix 6: Clutter Image Rating Scale

Clutter Image Rating Scale: Kitchen

Please select the photo below that most accurately reflects the amount of clutter in your room.

Clutter Image Rating: Bedroom

Please select the photo that most accurately reflects the amount of clutter in your room.

1

2

3

4

5

6

7

8

9

Clutter Image Rating: Living Room

Please select the photo below that most accurately reflects the amount of clutter in your room.


1


2


3


4


5


6


7


8

9

Appendix 6: Possible powers available to various agencies

AGENCY	LEGAL POWER AND ACTION	CIRCUMSTANCES REQUIRING INTERVENTION
All Agencies	**Mental Capacity Act 2007** The MCA when making decisions or acting for that person. This applies whether decisions are life changing events or more every day matters and is relevant to adults of any age, regardless of when they lost capacity. The underlying philosophy of the MCA is to ensure that those who lack capacity are empowered to make as many decisions for themselves as possible and that any decision made, or action taken, on their behalf is made in their best interests. The Act has five statutory principles which are the benchmark and must underpin all acts carried out and decisions taken in relation to the Act. • Principle 1: A presumption of capacity . • Principle 2: Individuals being supported to make their own decisions • Principle 3: Unwise decisions – people have the right to make decisions that others might regard as unwise or eccentric. • Principle 4: Best interests – anything done for or on behalf of a person who lacks mental capacity must be done in their best interests. • Principle 5: Less restrictive option • MCA Code of Practice https://www.direct.gov.uk/prod_consum	Where the person lacks capacity to make decisions in relation to support offered and interventions. Careful attention should be paid to the assessment of mental capacity, especially with regards the person's ability to weigh up and make use of information. It is important to be aware that people can be articulate and superficially convincing regarding their decision making but when probed about their behaviour are unable to identify risks and indicate how they are able to address the concerns of others. The nature of any intervention will to a certain extent centre on the question of whether the adult concerned has the mental capacity to make decisions. Consideration should also be made for people who may fall under the substantial difficulty criteria. Respect for the persons wishes and beliefs needs to be central to our approach. Professionals need to find creative, sensitive ways to work with people who hoard, understanding what the behaviour means to them and how they themselves wish to address the problem. However, the Mental Capacity Act gives professionals the authority to override the wishes of people who lack capacity to make a decision about specific matters if this is in their best interests and a proportionate response to the harm that would otherwise occur.
LBH Adult Social Care/ Health	**Care Act 2014** Part 1 - Care and Support Local authorities will have a general duty, when undertaking adult social care functions with an individual,	Councils have a legal duty to assess needs where a concern has been raised about a person's health and well being.

	to promote their well-being. Local authorities must exercise its functions regarding adult social care with a view to ensuring the integration of care and support provision with health provision and health-related provision where it considers that this would, among other things, promote the well-being of adults in its area. A local authority must assess a person's needs for care and support unless that person refuses an assessment. But an assessment cannot be refused, and the local authority must carry it out, if the person lacks capacity to refuse and carrying it out would be in their best interest, or the adult is experiencing, or is at risk of, abuse or neglect. **Statutory 42 Enquiries and 44 Safeguarding Adults reviews** SAB Information sharing agreements	
Environmental Health	**Section 83 Public Health Act 1936 Filthy /Unwholesome premises** which are prejudicial to health or verminous. Service of Notice requiring clearance/cleansing/pest control treatment. No appeal. Council has powers to enter premises by warrant if reasonable access not given after giving notice. This will be to assess the conditions or carry out works in default. Possible prosecution and Council can recover expenses for works in default.	Where hoarded materials result in filthy, unwholesome or vermin infested premises. This is often where there is a lack of engagement or co-operation of occupier. There must be likelihood of adverse health effect to occupant or rodents or insects present. There may also be complaints from neighbours which must be investigated by the Council
	Section 79/80 Environmental Protection Act 1990 Statutory Nuisances Service of Abatement Notice requiring action to remove nuisance and/or prevent a recurrence. Appeal against notice possible. Warrant powers similar to above.	Council has a legal duty to investigate complaints of statutory nuisance and must take action if nuisance proven. The premises must be in such a state that they are prejudicial to healthy or a nuisance to neighbours. This may be from condition of the premises,

	Possible prosecution and Council can recover expenses for works in default. Injunctive proceedings may be taken.	accumulations, deposits or even animals kept in unsanitary conditions. Intervention often prompted by complaints from neighbours. For exceptional situations where widespread nuisance to neighbours continues after intervention and usually after service of notice
	Housing Act 2004 Housing hazards such as Domestic Hygiene, Pests and Vermin, Excess Cold, Fire. Service of Improvement or Hazard Awareness Notice usually on owner of premises requiring building defects being rectified to reduce the hazards. Council can charge for costs incurred serving notices. Appeal provisions. Possible prosecution and Council can recover expenses for works in default	Relates to possible health and safety effects on occupier. Hoarding can lead to fire hazards from accumulated materials. Due to hoarding, there may be a lack of repair/maintenance of property leading to other health effects on occupier such as lack of heating (excess cold) or washing/sanitary facilities. Usually used in private rented dwellings.
	Prevention of Damage by Pests Act 1949 (section 4) Service of Notice to keep land free from rats or mice No warrant powers Possible prosecution and Council can recover expenses for works in default	Powers usually used for accumulations of rubbish or items attracting/harbouring rodents on private land. This is usually used for external parts of property e.g. gardens.
Social Landlords including Councils and Housing Associations	Injunctive or possession proceedings by Landlord for breach of tenancy or lease conditions under relevant **Housing Acts** depending on type of tenure	Enforcement of tenancy conditions can include an injunction (a court order to comply with the conditions of the tenancy, breach of which can lead to a fine) or a possession order to evict the tenant from the property for breach of tenancy conditions related to the hoarding. This can include damage to the premises and nuisance caused to the Landlord and/or neighbours
Metropolitan police	**Power of Entry – (S17 of Police and Criminal Evidence Act)** Person inside the property is not responding to outside contact and there is evidence of danger.	Information that someone was inside the premises was ill or injured and the Police would need to gain entry to save life and limb
London Fire Brigade	**Prohibition or Restriction of use (Regulatory Reform**	If a premises involves such risk to persons so

	(Fire Safety)Order 2005) The fire brigade can serve a prohibition or restriction notice to an occupier which will take immediate effect. In some circumstances this can apply to domestic premises including single private dwellings where the appropriate criteria of risk to relevant persons apply.	serious that the use of the premises ought to be Prohibited or Restricted notice can be served on the responsible person (owner/occupier). This will not apply to a **house** used as a single private dwelling.
Animal Welfare agencies such as RSPCA/Local authority e.g. Environmental Health/DEFRA	Animal Welfare Act 2006 Offences (Improvement notice) Education for owner a preferred initial step, Improvement notice issued and monitored, if not complied can lead to a fine or imprisonment	Cases of Animal mistreatment/ neglect. The Act makes it not only against the law to be cruel to an animal, but that a person must ensure that the welfare needs of the animals are met. See also: http://www.defra.gov.uk/wildlife-pets/.
Foundation Trust	Mental Health Act 1983 Section 135(1) Provides for a police officer to enter a private premises, if need be by force, to search for and, if though fit, remove a person to a place of safety if certain grounds are met. The police officer must be accompanied by an Approved Mental Health Professional (AMHP) and a doctor. In general practice an AMHP would apply for the 135(1) warrant at the appropriate Magistrates Court. Section 135(1) permits removal to a place of safety for up to 72 hours with a view to the making of an application under the provisions of the Mental Health Act or other arrangements for the person's care or treatment. NB. Place of Safety is usually the mental health unit but can be the Emergency Department of a general hospital, or anywhere willing to act as such.	Evidence must be laid before a magistrate by an AMHP that there is reasonable cause to believe that a person Is suffering from mental disorder, and is being - Ill-treated, or - Neglected, or - Being kept other than under proper control, or - If living alone is unable to care for self And that the action is a proportionate response to the risks involved
	Section 4 of the Mental Health Act 1983. Admission for assessment in cases of emergency. In any case of 'urgent necessity'. The criteria for detention mirror Section 2 (below) but Section 4 may be used in cases of emergency where it has not been possible to secure an assessment by a second doctor. This section expires after 72 hours unless a second medical recommendation is received within this time	In any case of 'urgent necessity' an application may be made by an AMHP or Nearest Relative and founded on one medical recommendation made by, if practicable, a doctor with previous knowledge of the person or a Section 12 approved doctor

	period.	
	Section 2 of the Mental Health Act 1983. Admission to hospital for assessment. Application can be made by an AMHP or Nearest Relative based on 2 medical recommendations in the prescribed form by 2 independent doctors. The person may be detained for a period of up to 28 days.	The following grounds must be met: The person is suffering from a mental disorder of a nature or degree which warrants the detention of that person in hospital for assessment (or assessment followed by treatment). That the person ought to be detained in the interests of his/her own health or safety or with the view to the protection of others.
	Section 3 of the Mental Health Act 1983 Admission to hospital for treatment. Application can be made by an AMHP or Nearest Relative and is based on 2 medical recommendations in the prescribed form by 2 independent doctors. The person may be detained initially for a period of up to 6 months for the purposes of treatment	The following grounds must be met: That the person is suffering from a mental disorder of a nature or degree which makes it appropriate for him/her to receive medical treatment in a hospital. That it is necessary for the health or safety of the person or for the protection of others that he/she should receive this treatment and it cannot be provided unless the person is detained under this section. That appropriate treatment is available for him/her.

Appendix 7: Checklist for Person-Centred Fire Risk Assessment

F9321 CS/V1: 07.11.17

Checklist for Person-Centred Fire Risk Assessment

LFB LONDON FIRE BRIGADE

Name of resident			
Full address			
Date	DD / MM / YYYY	Form completed by	

1. Does the individual have an increased fire risk?

Yes ☐ If yes, tick all the fire risk factors they exhibit

No ☐ Skip to next question

- ☐ Smoking – with signs of unsafe use of smoking or vaping materials (e.g. smoking in bed).
- ☐ Use of emollient creams that are petroleum or paraffin based.
- ☐ Air pressure mattress or oxygen cylinders are used.
- ☐ Unsafe use of portable heaters (e.g. placed too close to materials that could catch fire).
- ☐ Unsafe cooking practices (e.g. cooking left unattended).
- ☐ Overloaded electrical sockets/adaptors or extension leads.
- ☐ Faulty or damaged wiring.
- ☐ Electric blankets used.
- ☐ Previous fires or near misses, burns or scorch marks on carpets and furniture.
- ☐ Unsafe candle/tea light use (e.g. left too close to curtains or other items that could catch fire or within easy reach of children or pets).
- ☐ Other (please specify): _____

2. Would the individual be less able to react to an alarm or fire?

Yes ☐ If yes, tick all the fire risk factors they exhibit

No ☐ Skip to next question

- ☐ Mental health issues (e.g. dementia, anxiety or depression).
- ☐ Cognitive or decision making difficulties.
- ☐ Alcohol dependency or misuse of drugs.
- ☐ Sensory impairments (e.g. hard of hearing or sight loss).
- ☐ Other (please specify): _____

3. Does the individual have a reduced ability to escape?

Yes ☐ If yes, tick all the fire risk factors they exhibit

No ☐ Skip to next question

- ☐ Have restricted mobility, are frail or have a history of falls.
- ☐ Are blind or have impaired vision.
- ☐ Lacks capacity to understand what to do in the event of a fire.
- ☐ Is a hoarder, or there are cluttered or blocked escape routes.
- ☐ Are bed or chairbound.
- ☐ Internal doors are left open at night.
- ☐ Would be unable to unlock front door to escape.
- ☐ Other (please specify): _____

4. Are there any smoke or heat alarms fitted within the individual's home?

Yes ☐

No ☐

If yes, please specify which rooms have them fitted:

5. Has a carbon monoxide alarm been fitted anywhere that gas or solid fuels are used?

Yes ☐

No ☐

If yes, please specify which rooms have them fitted:

What to do next

If there are any questions in sections 1–3 that have been answered 'Yes', or you have identified that there are no smoke or heat alarms fitted, or they are broken or poorly sited, this suggests there is a risk from fire. Immediate actions are required to ensure agreed safety measures are in place:

If you are a family member or an informal carer:
Contact London Fire Brigade to arrange for a free home fire safety visit: **Tel** 0800 028 4428 **Text/SMS** 07860 021 319
Email smokealarms@london-fire.gov.uk
Web london-fire.gov.uk/HomeFireSafetyVisit
In addition, extra support and advice can be sought from Adult Social Care Teams and your housing provider or landlord where serious risk has been identified.

If you are employed by a company or organisation:
Return this checklist to your manager for a full Person-Centred Risk Assessment to be conducted where necessary.

- Inform the resident or other family members of the risks identified, if you are certain they will understand.
- If a care plan exists, all actions taken should be noted in that plan.
- Ensure appropriate partnership referrals are made as required.

Fire safety in the home

What happens during a home fire safety visit? Firefighters or trained staff will visit the home and offer advice based on individual needs, this includes information on how to **prevent** fires, the importance of smoke alarms to **detect** a fire and having **escape** plans in the event of a fire. They will also fit smoke alarms if required.

A 'Fire Safety in the Home' booklet is available from London Fire Brigade and can be downloaded from our website. Some basic fire safety advice has also been provided below.

Prevention

- It is safer not to smoke; but anyone who does should try to smoke outside and always make sure cigarettes are put out properly.
- Never smoke in bed, or anywhere else, if there's a chance of falling asleep.
- Use fire-safe ashtrays and fire-retardant bedding, nightwear and throws.
- Ensure paraffin based emollient creams are replaced with non-flammable alternatives.
- Candles, tea lights and incense burners should only be placed in stable, heat-resistant holders. Keep these items or any other type of naked flame well away from curtains, furniture and clothes.
- Sit at least one metre away from heaters and keep them well away from anything that can catch alight.
- Don't overload electrical sockets.
- Close all doors at night as this helps to prevent fire and smoke spreading.
- Switch off and unplug electrical items such as TVs and avoid charging devices like mobile phones whilst asleep.

Early warning and detection of a fire is essential

- As a minimum, fit at least one smoke alarm on every level of the home and in any room where a fire could start. The ideal position for these are usually in rooms that are used the most, in hallways and anywhere electrical equipment is left switched on.
- Fitting multiple linked smoke alarms, that all activate together, is the best way to be alerted in the event of a fire. For some, the provision of a Telecare monitoring system may also be beneficial.
- Specialist alarms can be fitted for people who may have a delayed response to escape – for example; strobe light and vibrating pad alarms for the deaf or hard of hearing.
- Remember to test all alarms monthly.

Escape

- Make sure escape routes are kept clear of anything that may slow down or block exit routes.
- Ensure security gates can be easily opened from the inside without the need for a key. Keep door and window keys where everyone can find them.
- Mobility aids and any methods of calling for help should always be kept close to hand (e.g. mobile phone, link alarm/pendant).