Cornwall and Isles of Scilly Safeguarding Adults Board

Multi-Agency Protocol
‘People that hoard - A joined up approach for Cornwall’
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1. Introduction

A hoarding disorder is where someone acquires an excessive number of items and stores them in a chaotic manner. The items can be of little or no monetary value and usually result in unmanageable amounts of clutter.

It's considered to be a significant problem if:

- The amount of clutter interferes with everyday living – for example, the person is unable to use their kitchen or bathroom and cannot access rooms
- The clutter is causing significant distress or negatively affecting the person's quality of life or their family's – for example, they become upset if someone tries to clear the clutter and their relationships with others suffer.

People with hoarding disorder often don't see it as a problem, making treatment challenging. Others may realise that they have a problem, but are reluctant to seek help because they feel extremely ashamed, humiliated or guilty about it. People who hoard have little awareness of how it's impacting their life or the lives of others.

It's really important to encourage a person who is hoarding to seek help, as their difficulties discarding objects can not only cause loneliness and mental health problems, but also pose a health and safety risk. If not tackled, it's a problem that will probably never go away, and will put the person at further significant risk of harm.

Across Cornwall and The Isles of Scilly, a significant number of people living in the community have needs that relate to hoarding that may challenge services in assessing their needs appropriately. Similarly, determining the most suitable lead agency where there are a range of services from which the person may benefit can be problematic. This can lead to increased risk and a decline in wellbeing for the individual. In such cases a range of factors in the person’s life, their behaviour, or past experiences can make an individual less likely to be able to access services that could offer them some support around hoarding.
This protocol sets out a multi-agency framework to facilitate better partnership work, using an outcome focused, solution based model to reduce hoarding and its associated health, safety, social and environmental impacts. The protocol offers clear guidance to operational staff and managers on how the needs or presenting issues of people who hoard should be addressed.

The protocol includes reference to guidance, best practice and legislation that may be relevant and helpful in working with this group of people. Details of the legislative framework are covered in Appendix 1.

This protocol is to be read in conjunction with the Cornwall and Isles of Scilly Safeguarding Adults Board Multi-Agency Policy for Safeguarding Adults and Homelessness and Self-Neglect Policy.
Example 1 Cornwall – Extract from a Cornwall Serious Case Review
(The Reassurance of Disengagement, September 2014) Full details of this report can be found by following

We refer to the gentleman in this case as Mr L”. The case is about an eighty one year old who lived in accommodation which was deemed unsafe by fire services due to excessive hoarding of items/rubbish. The excessive hoarding is described by agencies involved as more prolific and concerning than any other case encountered. In December 2012 fire, police and ambulance services were in attendance following concern from neighbours that Mr L had fallen and was trapped in his home by the amount of items hoarded. After considerable efforts by three fire crews, totalling sixteen fire fighters in attendance, Mr L was taken to hospital for assessment and treatment for an infection. Despite fire and ambulance services concerns and specific detail of the unsafe home environment being conveyed to the hospital about risk to Mr L and others, Mr L was discharged home. No follow up care was arranged by the statutory services to address the concerns raised by fire and ambulance services. Mr L died in July 2013. He was found dead at his property after neighbours raised their concern when there had been no sighting of him for a few days. Mr L’s body was found on the floor in what was believed to be the main living area downstairs. Mr L was found on his back, with his legs raised. His belongings had caved in around him. It looked like he had fallen backwards. The only part of the body visible in the rubbish was his face. The home environment is best depicted in the pictures below.

Kitchen

Lounge
Example 2 Cornwall

This second case is about a 55yr old lady Mrs “C” who lived alone in social housing accommodation which was deemed unsafe by fire services and the landlord due to excessive hoarding of items. The extent of the hoarding is described by agencies involved as every room, from front to back and floor to ceiling hoarded with narrow walk ways between the stacked items. For 12 months Fire and other partners attempted to highlight the extreme risks within the property, emphasizing that of the high fire loading, poor escape and potential collapse on top of her. In June 2016 a housing support worker called to see Mrs C and found her trapped under one of the collapsed stacks of her possessions.

It transpired that she had been entrapped for at least 3, possibly 4 days and was severely de-hydrated. Mrs “C” was taken to RCHT where she remained for a number of weeks recovering, and was subsequently placed in alternative accommodation for her safety.

A multi-Agency approach has now ensured that the property is made safe and de-cluttered prior to the discharge of Mrs “C”.
2. Partners to the protocol

- Cornwall Council
- Cornwall Housing
- Devon and Cornwall Police
- South Western Ambulance Service NHS Trust
- Cornwall Fire and Rescue Service
- NHS Kernow Trust
- Kernow Clinical Commissioning Group
- Cornwall Foundation Trust
- Coastline Housing

Which organisations does the protocol apply to?

This protocol applies to all statutory Housing, Health, Social Care and Emergency Services staff and is also provided as guidance to all voluntary and community sector organisations that may come into contact with people who hoard through the course of their work.

As previously described the protocol relies on the expectations that the agencies in question engage fully in partnership working to achieve the best outcomes for the person whilst also continuing to satisfy their respective codes of practice, organisational responsibilities and duties.

This protocol sits alongside the Safeguarding Adults Board self-neglect procedure and should be considered in conjunction with this procedure.

This protocol aims to work with people who hoard

Primarily the protocol is targeted at people who self-neglect in a way that manifests in hoarding or other risk behaviours within the living environment. This can apply to people who:

a) Believe that the benefits of their living environment outweigh its risks

b) People who have mental capacity over specific decisions relating to hoarding but have a limited understanding of the impact that their choices have on their long term health and wellbeing.
People who may benefit from the application of all or part of this protocol are:

- Vulnerable people who ‘hoard’ excessively and this impacts on the living environment causing health and safety concerns for them and/or their neighbours
- People who show signs of serious self-neglect, regularly reported by the public or other agencies but no change in circumstances occur leading to a reduction in contact or complete service disengagement
- People whose personal or domestic hygiene exacerbates an existing or preventable medical condition and could lead to a further serious health problem
- People whose home environment is unhygienic and is a potential health risk
- People who are not meeting the terms of their tenancy agreement which could lead to eviction and/or homelessness
- People who are without basic amenities such as heating and water and who are resistant to resolving the issue or moving home
- There are structural problems with the property which the person cannot afford to repair or the person refuses to consider alternative accommodation
- There are health and safety issues around gas, water or electricity and the vulnerable individual refuses or cannot afford to get the appliances repaired
- The person engages in anti-social behaviour that intimidates others and causes social isolation
- The conditions in the property cause a potential risk to people providing support or services e.g. paid carers.

NB. This list is not exhaustive and there may be other areas of concern or a mixture of the above that highlight a difficulty for the person in question or those who work with them

**Mental Capacity, Choice and Risk**

The Mental Capacity Act 2005 provides a statutory framework for people who lack capacity to make decisions for themselves. The act has 5 statutory
principles and these are the values which underpin the legal requirements of the act. They are:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practical steps have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done or decision made, under this act for or on behalf of a person who lacks capacity must be done, or made in his or her best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.

While there is a presumption of capacity, each Mental Capacity Assessment should be decision specific. So it may be that the person has capacity to make some decisions about their lifestyle choices, but not others. Each choice should be assessed separately, but in relation to each other, to ensure that the individual understands the consequence of their decision to hoard. If continuing to do so in tenanted properties they could be evicted. In most instances of hoarding, the individual is deemed to have mental capacity, but when presented with the risks or when informed that formal legal action is being considered, they decline the suggested resolutions. The historical risk of a lack of engagement can mean that there is increased likelihood of social isolation, verbal abuse, homelessness and a risk to health and wellbeing escalating.

**Causal Factors**

Research has highlighted some emerging themes about the perspective of individuals who hoard. These drivers include:

- a pride in self sufficiency
- a sense of connectedness to place and possessions
- a drive to preserve continuity of identity and control
- a traumatic life event(s) that had life changing effects
• a sense of shame about the issue which leads to the person hiding the condition of the residence from others

There are often underlying causes for hoarding such as diagnosed or undiagnosed mental health problems, cognitive impairments or other social issues.

(See Appendix 3 - Background information on chronic hoarding, causal factors and self-neglect)
3. Rationale for the protocol

People who hoard can have diverse needs that often fall between different agencies and in some cases these issues can be longstanding and recurring.

Across Cornwall it is estimated that there is a minimum of 1,500\(^1\) complex hoarders, of which 50% will also be suffering from long-term depression. In real terms this equates to around 25 incidents per annum. Aside from the potential for psychological and social harm to the person, the risks associated with complex hoarding include:

- Serious Fire Loading in property
- Severe Risk of Collapse (Hoarded items and structural)
- Blocked/choked escape routes
- Increased slips trips and falls
- Risk to professionals – Responding Fire Crews, Support Workers and maintenance workers
- Inability for utility services to carry out routine maintenance (e.g. gas/water)
- Environmental conditions that are a risk to health
- Additional risks to neighbours and visitors to the property
- There is no straight forward solution to meet the needs of people that hoard. Working with people who hoard can be very time consuming and stressful for staff.

The effects of the behaviours associated with hoarding can be challenging and costly for public services and housing providers to rectify. For example, responding to concerns or complaints raised by neighbours or family/friends;

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\(^1\) Statistical information from Royal College of Psychiatry supported by additional evidence from

housing repairs; deep cleaning and in some cases, bespoke, unusual, and innovative solutions.

In general, research in this area suggests that the most effective interventions are those which take a multi-agency, multi professional and multi-disciplinary approach. Therefore, this protocol aims to ensure that there is a clearly coordinated plan of engagement and intervention across agencies and stakeholders in order to reduce duplication, improve the identification of people who hoard and are at are risk and, wherever possible, to achieve a positive outcome for the person. It aims to assist managers and staff to make the best possible decision in each case with a clear, transparent record as to how it was reached.

### 4. Aims of the protocol

- To facilitate a safe environment for the person to remain and live independently at home
- To improve the effectiveness of the support offered for people who hoard
- To improve the coordination of services between agencies, agreeing actions and timescales for the management and support of people who hoard
- To raise awareness of the full range of services available and to effectively signpost
- To establish best practice guidance
- To improve knowledge of the relevant legislation for all stakeholders to fully cooperate in the implementation of the protocol
- To increase awareness and improve communication across all agencies in relation to this protocol

This protocol sits alongside the Safeguarding Adults Board self-neglect procedure and should be considered in conjunction with this procedure.
5. What could trigger a multi-agency case conference?

Most agencies have policies or procedures for managing the situations outlined in this protocol. There are also ‘duties’ laid down in statute for enforcing actions deemed to be in the individual’s or public’s interest and these are listed in Appendix 1.

Although policies, procedures and statutory powers are useful in providing a framework, they can also encourage professionals and agencies to work within narrow boundaries. As previously stated, the guidance laid down in this protocol is designed to encourage collective multi-agency working to achieve the best outcome for the individual. By being outcome focused, the protocol looks at who is best placed to engage with the vulnerable person and how a coordinated multi-agency/multi-disciplinary/multi-professional approach could assist in achieving the best possible outcome for the person.

6. When should this protocol be used?

The protocol should be considered when:

- There are repeated issues of a nature outlined on page 4 of the protocol or an agency’s usual practice and engagement has not worked and:
- No other options appear available, or enforcement under criminal or civil statute is being considered
- There are serious concerns for the health and wellbeing of the person, the worker(s) or other members of the public of a nature that require an immediate response
- Where the individual’s presenting behaviour is not fully understood and there maybe concerns about their mental health or mental capacity

NB The potential situations that agencies may be faced with are wide ranging and the examples in the protocol are a guide only. A pragmatic decision on whether to instigate the protocol will need to be made by each agency if a new situation occurs.
If the worker feels that the protocol should be applied they should discuss with their line manager who will advise them as to whether a multi-agency case conference should be convened.

It is vital that the person in question should be informed and invited by the lead of the instigating agency that a meeting will be taking place and why agencies feel it is needed. This should be done in a format that the person will understand (i.e. reasonable adjustments should be made such as an ‘easy read’ format to a letter) and in a way which considers their communication preferences. Reasonable efforts should be made to have the views of the person expressed at the meeting including an advocate where appropriate or by taking a statement etc. The outcomes and actions from the meeting once held should be shared promptly with the person in the same way.

7. Multi-agency/multi-professional/multi-disciplinary approach

After the initial notification and referral, a multi-agency meeting needs to be set up within 14 days.

When the worker and the manager (from any organisation) have agreed that the situation requires a multi-agency/multi-professional/multi-disciplinary approach an ‘alert’ form should be completed and sent via e-mail or post to:

   a) Safeguarding Adults Triage Team where safeguarding thresholds are met
   b) Safeguarding Children where safeguarding risks for children are identified
   c) (Single point of contact to be identified) where safeguarding thresholds are not met

The respective managers as identified in the points above will then instigate an initial multi-agency meeting. If an urgent response is required key people should be invited by telephone. A Service Manager, equivalent or delegated officer should chair the multi-disciplinary meeting.

The meeting will aim to arrive at the “best possible decision” as it is acknowledged that in many circumstances there are no straightforward
solutions. Representatives at the meetings should have the appropriate level of authority to make decisions.

It is important that the meeting is accurately recorded so that the thinking and processes used in reaching the decisions made/action points are clear.

A key person will be identified to take the lead in engaging with the vulnerable person, it is important that appropriate support is also provided from relevant professionals when needed. It is often the complex cases where significant time has been spent with the client in an effort to convey the risks, vulnerabilities and attempts to persuade de-cluttering. Practice so far has shown that the person developing the trust must be present to co-ordinate the de-cluttering when any other service or organisation is called in to support this process. The lead can liaise between the client and the other services/contractors to ensure that minimum anxiety is caused, the de-cluttering is carried out as agreed with the client and to mitigate any complaints.

Coordinating information in relation to actions completed and future actions to be carried out in between multi-agency/multi-professional/multi-disciplinary meetings is a key part of the process. Careful thought should be given as to who takes responsibility for coordinating the sharing of information and what means and format is used for sharing information. This should be agreed at the multi-agency meeting.

**Escalation**

When the issue cannot be resolved through a multi-agency approach, the referral is to be escalated to the next level within the lead service.
8. Public Health

The local authority's principal power to deal with filthy and or verminous premises is contained in Section 83 of the Public Health Act 1936 which states:

'Where a local authority, upon consideration of a report from any of their officers, or other information in their possession, are satisfied that any premise -

• are in such a filthy or unwholesome condition as to be prejudicial to health, or
• are verminous,

The local authority shall give notice to the owner or the occupier of the premises requiring him to take such steps as may be specified in the notice to remedy the conditions of the premises'.

The steps which are required to be taken must be specified in the notice and may include;

• Cleansing and disinfection
• Destruction or removal of vermin
• Removal of wallpaper and wall coverings
• Interior of any other premises to be painted, distempered or whitewashed

There is no appeal against a Section 83 Notice and the Local Authority has the power to carry out the works in default and to recover costs by means of a recharge against the property.

Environmental Health (Community Protection) should be consulted for any hoarding cases that are considered filthy and verminous.
9. Waste Management

Due to the specific sensitive nature of dealing with those affected and potentially the large quantity and types of waste that could be generated, it is the advice from the Council’s Waste Management Team to utilise specialist teams, with the appropriate training for house clearance and dealing with potentially hazardous waste. In the past well-meaning volunteers or organisations such as the fire service (due to the waste potentially becoming a fire risk to properties), have been called in to help remove the waste. This approach, although pragmatic, can cause all sorts of issues around waste disposal, transportation, dealing with hazardous waste, health and wellbeing of those requested to collect and dispose of any waste items.

To ensure appropriate services are in place to remove waste in timely and sensitive fashion with regards to hoarding, Council’s Waste Management Team will put in place specialist contractual arrangements to remove hoarding material from households identified through this protocol. This service will be commissioned and authorised through the Multi-Agency meeting.

Providing a qualified and approved contractor to undertake the work will help to reduce these risks, and to potentially provide a more flexible service. This approach also requires a central budgeted sum of money to help pay for services.

It has been agreed with the Environment Service Director that this approach will be piloted for a 12 month period, with quarterly reviews being completed by a member of the Council’s Waste Management Team and a member of the Safeguarding Steering Group to provide assurance that the framework has been appropriately applied. Monitoring will be undertaken of the requests, the tonnages, waste types and resources required and the costs incurred. Dependant on the circumstances, the Council will seek to either recover the costs from the householder, place a ‘charge’ on the property, or to recharge the housing management company or landlord involved.

Appendix 7 sets out the current position around waste services in Cornwall provided by the Council, legislation and why it needs to be a different service to deal with the waste (separate to the current household waste service contract).
10. Financial considerations

The financial implications of any agreed actions should be kept out of the multiagency/multi-professional/multi-disciplinary case conference. This will allow the operational professionals to focus on the best outcome for the adult at risk and not be distracted by discussions around resources. Where possible the case conference will provide a provisional costing of the recommended actions and the relevant service managers or agencies will negotiate who is responsible for funding the actions. Associated costs attracted to dealing with the individual will be covered by the relevant services.

If the resource implications are substantial the service manager should escalate to their head of service for a decision before any actions are instigated. The urgency of decision-making will be based on the level of risk that has been identified.

Costs for the waste extraction will be covered under the Council’s Waste Management budget and will be reviewed on a quarterly basis during the 12 month pilot. As outlined in Section 9 above, the Council will seek to recover these costs.
11. Human Resources needs and lessons learned

Working in a complex and demanding situation can be stressful for operational staff. As part of the final case conference, the staff involved in the work should be asked if a debrief is required. The multiagency/multi-professional/multi-disciplinary meeting will agree what form this should be in, individual, including lessons learned from the multi-agency approach.

Consider access to other support services, each individual should use own framework in governance to get support.

12. Ongoing support for the vulnerable person

Before the multi-agency meeting concludes, any ongoing needs for the individual or their family and carers should be clearly identified and communicated to the relevant agencies. If the agency was not part of the intervention it is suggested that the chair of the meeting takes responsibility for conveying the ongoing needs to the relevant agency.
13. Flow Chart – Referral

Worker has exhausted all usual processes to engage the vulnerable person. The person is at serious risk or statutory powers are being considered.

Yes

Discuss with line manager. Is a multiagency meeting required?

Yes

Contact MARU 0300 123 1116

No

If no risks or vulnerabilities identified the agency should follow their normal policies & procedures.

Yes

If unsure whether a person is at risk of harm or not consult with the safeguarding team.

Refer to Cornwall Council’s Waste Management Team 0300 1234 141 Ask for the Waste Collection and Cleansing Team.

Is the property filthy and verminous? Section 83 Public Health Act 1936

No

Yes

Contact Environmental Health (Community Protection) 0300 1234 212

Meeting date set to review actions See Review Meeting Flow Chart

Alert form completed & sent to senior manager in key agencies with date & time of multi-agency meeting

Line manager to agree who needs inviting to multi-agency meeting and who should chair

Referring agency to complete risk assessment ready for first multi-agency meeting.

Multi-Agency meeting takes place. Actions agreed with timescales.

Safeguarding referral required? (CFT staff to refer to Safeguarding Leads)

Safeguarding Referral to identify Hoarding Material Type in Section C

Define the option for the collection and disposal of waste – See Appendix 7
Flow Chart - Review Meeting

Review Meeting

Have the agreed actions been completed? Has the presented issue around hoarding been resolved?

No

- a) Multi-agency meeting reviews action plan and whether an alternative approach is required
- b) Does the level of risk allow for more time to be taken?
- c) Do relevant legal powers need to be used?
- d) Is legal advice required?

Yes

- a) Any on-going support to be clearly identified and agreed by relevant agencies
- b) Any learning and good practice to be recorded and incorporated in the protocol

Meeting date set to review actions

Multi-agency meeting disbands
### Appendix 1 - Consideration of the statutory options

<table>
<thead>
<tr>
<th>Possible interventions</th>
<th>Statutory grounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removal from home</td>
<td>Powers of entry under the Environmental Protection Act 1990 and the Public Health Act 1936 to address conditions prejudicial to health. Under section 16 (2) of the MCA, the Court of Protection can make an order, making decisions on behalf of a person who lacks the capacity to make them, including deciding where they should live or restricting contact with specified people. With the permission of the Court, the council can apply to it to facilitate access to an adult who lacks capacity, or where there is a reason to believe they lack capacity, to make decisions about their safety, and access is impeded. The Court of Protection can only make an order under section 16 if it is established that the person lacks capacity to take the relevant decisions. Under section 48 of the MCA, the Court can make an interim order or declaration if there is reason to believe that the person lacks capacity and is in their best interests to make an order without delay. However, this would be of no use where the person does have capacity.</td>
</tr>
<tr>
<td>Eviction</td>
<td>Consider possible breach of the implied terms of a tenancy agreement i.e. not taking proper care of the property. Person may be declared intentionally homeless under the Homeless Persons Act 1977. Eviction may be disputed by reference to the Disability Discrimination Act 1995.</td>
</tr>
<tr>
<td>Compulsory admission into hospital under the Mental Health Act 1983</td>
<td>The existence of defined forms of mental disorder, and for the individual’s own health or safety or to protect other persons.</td>
</tr>
</tbody>
</table>
Guardianship

<table>
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<tr>
<th>Under s.7 of the Mental Health Act 1983</th>
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<tr>
<td>What short term or long term solutions would result, given the limited powers under guardianship provisions?</td>
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</tbody>
</table>

Declaration of Mental Incapacity

<table>
<thead>
<tr>
<th>The Mental Capacity Act 2005 enshrines the presumption of capacity.</th>
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<tr>
<td>Incapacity must therefore be proved. Decisions and interventions in respect of people lacking capacity must be in their ‘best interests’</td>
</tr>
</tbody>
</table>

Any other possible intervention?

Appendix 2 - Legislation

A Note on Appropriate Use of Statutory Powers in Hoarding Cases

Understandably there are often concerns for the mental health, physical safety and wellbeing of people who hoard, especially where there appears to be compromised hygiene or increased fire risks. Alongside this there are often significant numbers of complaints made to local authorities which can lead to negative social impacts for communities. Where the person in question is resistant to intervention, there is a growing body of legislation which can be utilised in different circumstances by health agencies and local authorities. Nevertheless, in practice, much use of compulsory powers raises tricky ethical issues, in particular where hoarders retain mental capacity and no-one else is being materially harmed. Such legislation can be difficult to apply and most would agree should be used only where there are compelling reasons to do so and then only to the minimum degree necessary, respecting the subject’s autonomy as far as possible. In this respect, however, there is some evidence that different professions may strike the balance in different places, possibly leading to disappointment and even conflict when their respective views on case management diverge.
The Care Act

The Care Act (2014) has been described as the most significant change in social care law for 60 years. It applies to England and replaces a host of out-of-date and often confusing care laws. The legislation sets out how people’s care and support needs should be met and introduces the right to an assessment for anyone, including carers and self-funders, who may be in need of support. The Act’s “wellbeing principle” spells out a local authority’s duty to ensure people’s wellbeing is at the centre of all it does.

Within this legislative framework, self-neglect is now seen as a separate form of abuse and neglect in The Care and Support Statutory Guidance (DOH 2014) with specific duties on the Local Authority in relation to self-neglect. The guidance defines self-neglect as:

‘a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding.’

The Act places a further duty on partner agencies to co-operate with the local authority by sharing information and contributing to those enquiries. The Act also stresses that enquiries should be proportionate, with the least intrusive response appropriate to the perceived risk, as well as one that is personalised to the wishes and desired outcomes of the person.

Section 42 of The Act states that The Local Authority must make, or cause to be made, whatever enquiries it thinks necessary to enable it to decide what action should be taken in an adult’s case, when the Local Authority has reasonable cause to suspect that an adult in its area has needs for care and support, is experiencing, or is at risk of, self-neglect, and (as a result of those needs) is unable to protect himself or herself against self-neglect, or the risk of it.

If the adult has ‘substantial difficulty’ in understanding and engaging with a Care Act Section 42 Enquiry, the local authority must ensure that there is an appropriate person to help them, and if there isn’t, arrange an independent advocate.

The Mental Capacity Act

The Mental Capacity Act (2005) provides a statutory framework for people who lack capacity to make decisions for themselves. The act has 5 statutory principles and these are the values which underpin the legal requirements of the act. They are:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practical steps have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done or decision made, under this act for or on behalf of a person who lacks capacity must be done, or made in his or her best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.

When a person’s hoarding behaviour poses a serious risk to their health and safety, professional intervention will be required. With the exception of statutory requirements, any intervention or action proposed must be with the person’s consent. In extreme cases of hoarding behaviour, the very nature of the environment should lead professionals to question whether the customer has capacity to consent to the proposed action or intervention and trigger a capacity assessment. This is confirmed by The MCA code of practice which states that one of the reasons why people may question a person’s capacity to make a specific decision is “the person’s behaviour or circumstances cause doubt as to whether they have capacity to make a decision” (4.35 MCA Code of Practice, P. 52). Arguably, extreme hoarding behaviour meets this criterion.

Any capacity assessment carried out in relation to hoarding behaviour must be time specific, and relate to a specific intervention or action. The professional responsible for undertaking the capacity assessment will be the person who is proposing the specific intervention or action, and is referred to as the “decision-maker”. Although the decision-maker may need to seek support from other
professionals in the multi-disciplinary team, they are responsible for making the final decision about a person’s capacity.

If the person lacks capacity to consent to the specific action or intervention, then the decision maker must demonstrate that they have met the requirements of the “best-interests checklist”. In particularly challenging and complex cases, it may be necessary for the local authority to refer to the Court of Protection to make the best interests decision. Any referral to the Court of Protection should be discussed with legal services and the relevant service manager. In order to decide whether an individual has the capacity to make a particular decision you must be able to answer yes to both of the two following questions:

- Is there an impairment of or disturbance in the functioning of a person’s mind or brain?
- Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?

The Four Stage Test:

The MCA says that a person lacks capacity over a specific decision if they cannot do one or more of the following four things:

1. Understand information given to them
2. Retain that information long enough to be able to make the decision
3. Weigh up the information available to make the decision
4. Communicate their decision – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

Every effort should be made to find ways of communicating with someone before deciding that they lack capacity to make a decision based solely on their inability to communicate. Also, you will need to involve family, friends, carers or other professionals.

The assessment must be made on the balance of probabilities – is it more likely than not that the person lacks capacity? You should be able to show in your records why you have come to your conclusion that capacity is lacking for the particular decision.
Best Interests

If a person has been assessed as lacking capacity then any action taken, or any decision made for or on behalf of that person, must be made in his or her best interests (principle 4). The person who has to make the decision is known as the ‘decision-maker’ and normally will be the carer responsible for the day-to-day care, or a professional such as a doctor, nurse or social worker where decisions about treatment, care arrangements or accommodation need to be made.

The Act provides a non-exhaustive checklist of factors that decision-makers must work through in deciding what is in a person’s best interests. A person can put his/her wishes and feelings into a written statement if they so wish, which the person determining capacity must consider. In addition, people involved in caring for the person lacking capacity have to be consulted concerning a person’s best interests.

If a person has been assessed as lacking capacity then any action taken, or any decision made for or on behalf of that person, must be made in his or her best interests

For more detailed information you should refer to the Mental Capacity Act Code of Practice which can be found at:


The Mental Health Act

Within the field of health and social care services, a person suffering from a mental disorder may be detained under the Mental Health Act (1983 amended 2007) if it is necessary for his own health or safety or for the protection of other people and treatment cannot be provided otherwise. An assessment under section 2 may be appropriate if an underlying mental disorder is suspected and section 135 of the Act allows an Approved Mental Health Professional to obtain a warrant to enter and remove a person from their home for this purpose. However it is important to note that the Mental Health Act may not apply in up
to 35% to 50% of people who hoard as they would be considered to have no discernible psychiatric disorder.

The Mental health Act is available online at http://www.legislation.gov.uk/ukpga/2007/12/contents

Environmental Health Legislation

Environmental Health services are part of the regulatory arm of local authorities, indeed the principal part of that arm, but while there are more ways than one of fulfilling that role they do have access to a range of enforcement powers which may come into play in hoarding cases. These are divisible, broadly, into two groups: those concerned with some definition of health, and those concerned more with local amenity.

The Health Powers

The oldest available in England and Wales among the first group is the duty under section 83 (aa) of the Public Health Act (1936) to require the cleansing (by disinfecting and decorating) of any premises which are either in such a ‘filthy or unwholesome condition as to be prejudicial to health or are verminous’. Filthy or verminous premises are properties that are considered verminous (including rats, mice, insects or parasites including their eggs, larvae and pupae) or in such a filthy condition as to be prejudicial to health (this usually means that there is a large amount of rotting food or human or animal excrement inside the property). Such properties are frequently characterised by an accumulation of material that can make access to premises difficult and that may present a physical or fire risk to the occupants or those of adjoining premises.

Unusually there is no appeal as such against a statutory notice given under this section. Though the authority may be required to justify its actions in the course of any summary proceedings brought subsequently for a failure to comply, householders have no other obvious avenue for challenge and EHPs should tread carefully for those reasons if no other. The expenses of carrying out their requirements in default of owners are recoverable by instalments if necessary,
secured by a charge on the property or ultimately under a power of sale, and from occupiers as a simple contract debt.

There is a complementary duty in section 84 to cleanse or, if necessary, destroy filthy or verminous articles (clothing, furnishings etc.) found in any premises at the local authority’s expense and a power to cleanse verminous persons requesting that or to do so compulsorily pursuant to a Magistrate’s Order (section 85). Few, if any, cleansing stations for this purpose remain and the task usually now falls to a reluctant NHS.

The mere age of these powers has attracted scrutiny of them recently, with the suggestion that they have been overtaken by amendments made in 2008 to the Public Health (Control of Disease) Act (1984), introducing co-called ‘Part 2A Orders’. Providing powers to require the disinfection (probably including disinfestation) of persons, things and premises, that was not, however (and despite the shortcomings of the 1936 Act powers) their aim and the need to show risk of spread of infection or contamination is likely to be hard to satisfy.

More modern, and more widely used (at least in other contexts) is another reincarnation of a Victorian concept, that of statutory nuisance. Part 3 of the Environmental Protection Act (1990) provides powers for local authorities to require the abatement of a range of problems including ‘any premises in such a state as to be prejudicial to health or a nuisance’ and ‘any accumulation or deposit’ which meets the same test. ‘Premises’ includes open land such as a garden.

Decisions of the courts in recent years have confirmed a quite restrictive construction for the term ‘prejudicial to health’ here (and which applies equally to the duty described in 7.7 above) which means likely to cause a threat of disease, nevertheless that is probably wide enough to deal with conditions giving rise to infestations or a serious lack of hygiene, for example. ‘Nuisance’ has its common law meaning of something which materially interferes with the use of another’s land (or some right over it) (a private nuisance) or (less likely to apply) which affects the comfort or convenience of the population at large (a public nuisance), and in either event, reflecting the origins of these provisions, is of a public health flavour. Local authorities’ power to undertake works in default
of compliance carry with it a power to recover their reasonable costs from the person responsible and, where that person is the owner of any premises, from his successors in title.

Where the circumstances are right, it is important to note that the use of these powers is mandatory, that is they are statutory duties rather than merely powers though their application involves some discretion in any event.

Since many subjects will guard their privacy closely, use may have to be made of the powers of entry, if need be under Warrant, contained in section 287 of the 1936 Act or sch. 3 of the 1990 Act. These provide powers to enter premises (in the case of domestic premises after giving notice, except in an emergency) to ascertain whether or not circumstances exist requiring any action by the council, or a statutory nuisance exists respectively, and for the purpose of taking any appropriate action consequently. Powers of entry in general are currently under review by the government and may be restricted in future.

Thirdly, and with a similar aim to the Public Health Act power above, the Prevention of Damage by Pests Act (1949) allows local authorities to require steps (such as the removal of materials providing food or harbourage) to be taken by occupiers to keep land clear of rats and mice. Whereas the Public Health Act power tends to be used for internal clearance, the Pests Act power tends to be used for clearing gardens; arguably, the presence of relevant pests must be shown first.

The Amenity Powers

Situations may arise where the loss of amenity affects neighbours seriously, or where a problem persists for a long period, or gets worse over time. In this respect, the Refuse Disposal (Amenity) Act (1978) allows a local authority, after giving notice, to remove anything abandoned on land in the open air and to recover their costs but the occupier would first have to disclaim ownership. Alternatively, section 215 of the Town and Country Planning Act (1990) provides a power to require the owner or occupier of land which is adversely affecting the amenity of an area to return it to an appropriate condition. On similar lines, where land which is open to the air is defaced by litter or refuse so
as to be detrimental to the amenity of the locality, the local authority may serve a Litter Clearing Notice under section 92A of the **Environmental Protection Act (1990)** on the occupier.

The primary purpose of local authorities in using their powers to deal with amenity problems is to protect the interests of neighbours and the wider community rather than the hoarder, the person seen as the cause of the problem. Many would, nevertheless, use such legislation only reluctantly in the case of a person suffering from a mental illness or disorder.

**A. Injunction Preventing Nuisance and Annoyance (IPNA)**

**ASB, Crime & Policing Act 2014**

The above Act came into force in October 2014 and streamlined 19 existing powers to 6 faster and more effective tools to tackle anti-social behaviour (ASB). The new powers saw the abolishment of the ASBO (Anti-Social Behaviour Order) which has been replaced by the Criminal Behaviour Order (CBO). Anti-social behaviour is defined as where there is persistent conduct which causes or is likely to cause alarm, distress or harassment or an act or situation which is, or has the potential to be, detrimental to the quality of life of a resident or visitor to the area. A CBO is a court order applied for by the Anti-Social Team at Cornwall Council and Devon & Cornwall Police. This would be used as a last resort where other prevention measures did not have the desired effect. Other relevant powers within the Act include the Civil Injunction and the Community Protection Notice (CPN). The CPN is mainly used to deal with environmental issues and are issued by Environmental Protection Officers at Cornwall Council.
B. Misuse of Drugs Act 1971

Section 8

A person commits an offence if, being the occupier or concerned in the management of the premises, he knowingly permits or suffers any of the following activities to take place on those premises:

S8 (a) - Producing or attempting to produce a controlled drug

S8 (b) - Supplying or attempting to supply a controlled drug to another or offering to supply a controlled drug to another

S8 (c) - Preparing opium for smoking

S8 (d) - Smoking cannabis, cannabis resin or prepared opium
Appendix 3 - Background information on chronic hoarding

“Hoarding behaviour is defined here as the excessive collection and retention of any materials to the point that it impedes day to day functioning and creates a hazard or potential hazard for the individual, in older adults it usually represents a complex set of psychological, physical and sociological factors that requires multi-level responses”

General characteristics

- long term behaviour pattern – decades of conscious collecting often following depression
- socially isolated – usually live alone, alienate family/friends, may have large number of animals that also cause problems with neighbours etc.
- socially eccentric – not necessarily mentally ill
- mentally competent – often able to make decisions although social isolation can reduce awareness of impact on others
- lacking in self-care – appears unkempt/dishevelled clothes
- sees nothing wrong with chosen lifestyle
- inability to differentiate rubbish from valuables
- more common in women than men

Causal Factors

A wide range of explanations are offered:

d) It may result from an organic and/or psychological cause

e) there may be an underlying personality disorder, depression, dementia, obsessive-compulsive disorder, trauma response, severe mental distress, and/or neuropsychological impairment

f) it may be associated with diminishing or already limited social networks and/or economic resources

g) it may reflect previously functional behaviours and personal philosophy (pride in self-sufficiency, sense of connectedness)

h) it may represent attempts to maintain continuity (preserve and protect self) and feel in control
i) physical and nutritional deterioration is sometimes also observed, but is not established as causal

**NB** Whilst there are a range of cognitive impairments which could result in hoarding behaviours, the protocol is designed to be situation based and not diagnosis or behaviour specific. Professionals must consider in all cases the individual’s right to self-determination and further advice should be sought where necessary.

### Background information on self-neglect

(Taken from the Cornwall and Isles of Scilly Safeguarding Adults Board – Procedure for Responding to concerns about self-neglect and Rough Sleeping)

Whilst self-neglect is referred to in the Statutory Guidance for the Care Act it does not provide a definition of what it is and there is plenty of space left for professional discretion about what it means to the individual worker or agency. Braye, Orr and Preston-Shoot (2013) have helped to define the subject in terms of a:

1. Lack of self-care and/or
2. Lack of care of one’s environment and a
3. Refusal of services that might alleviate these issues.

The impact of the above factors on the adult (this is not a subject area that concerns just older people) will need to be considered in terms of the level of risk to the individual and those people living with them and to their neighbours. A fire in the house of a person who has been hoarding (if indeed hoarding is seen as self-neglect) does just not stop at the property boundary of the person.

**Every person is different**

There can be no stereotypical type of person who self-neglects. In one Council there have been three Serious Case Reviews into the circumstances of individuals who have self-neglected. Their circumstances were unique. The consistent finding in these cases was how the agencies involved did not appropriately respond to the presentations of self-neglect.
Capacity is a highly significant factor in both understanding and intervening in situations of self-neglect.

Building good relationships is seen as key to maintaining the kind of contact that can enable interventions to be accepted with time and decision-making capacity to be monitored.

There are tensions between respect for autonomy and a perceived duty to preserve health and wellbeing. The former principle may extend as far as recognising that an individual who chooses to die through self-neglect should not be prevented from doing so; the latter may engage the view that action should be taken, even if resisted, to preserve an individual’s safety and dignity. Human rights arguments are engaged in support of either perspective.

The autonomy of an adult with capacity is likely to be respected and efforts directed to building and maintaining supportive relationships through which services can in time be negotiated. Capacity assessments, however, may not take full account of the complex nature of capacity; the distinction in the literature between decisional and executive capacity is not found in practice and its importance for determining responses to self-neglect may need to be considered further. Strong emphasis needs to be placed by practitioners on the importance of interagency communication, collaboration and the sharing of risk.

**Interventions**

a) **Assessment**

Sensitive and comprehensive assessment is of critical importance - an accurate assessment of the client’s mental status, partly because lifestyle and personality traits are often involved, sometimes triggered or aggravated by a stressful event such as loss or physical illness. Assessment should include individual health status, family dynamics, depression and/or dementia, cultural beliefs and family coping patterns. Assessment is crucial in evaluating what can be attributed to self-neglect versus underlying illness or disease. Assessment, they suggest, should therefore be multi-agency and multidisciplinary, and components should involve a physical examination, a detailed social and medical history, a historical perspective of the person and the situation, the person’s perception of the position, willingness to accept support, observation and self-reporting.
Interviewing family members and people in the individual’s network may assist in gathering facts and gauging someone’s decision-making capacity.

Risk assessment should cover observation of the individual and the home, activities of daily living, functional and cognitive abilities, nutrition, social supports and the environment.

**b) Building a relationship**

There is some research evidence that in building a relationship with the person that self-neglect, they can be encouraged to accept some practical help.

**c) Risk assessment**

It is important for staff to recognise that any risk-taking approach must be balanced with their responsibilities in relation to safeguarding adults and children, care standards and health & safety legislation.

The fundamental principle is that support is provided to individuals to enable them to receive personalised care/support that meets their needs within a framework of risk assessment and management that is collaborative, transparent and enabling.

Most models of risk assessment accept that it is not possible to eliminate risk entirely.

Unlike working with children, adults with mental capacity are able to take “unwise decisions”. In the context of risk management, this makes the assessment of mental capacity even more important. Even where people lack capacity, actions taken in their best interest must be least restrictive.

A risk assessment can only identify the probability of harm, assess the impact of it on adults at risk and suggest intervention strategies which may diminish the risk or reduce the harm. Often the focus is upon risk assessment without consideration of risk management - however without a risk management plan the assessment will only identify the risk and not reduce it.
Social workers are expected to balance rights and responsibilities in relation to risk, regularly re-assess risk, recognise risk to self and colleagues and work within the risk assessment procedures of the Department.

A few principles to consider:

- risk assessment should be based on sound evidence and analysis
- risk assessment tools should inform rather than replace professional judgement
- all professionals involved in risk assessment should have a common language of risk and common understanding of the main concepts
- information sharing for risk assessment should be based on clearly agreed protocols and understanding of the use of such information
- risk assessment should not be seen as a discrete process but as integral to the overall management and minimisation of risk

Risk factors: Static risk factors may include age, gender, offence history, mental health/health record which can be viewed as more reliable indicators of risk as they remain constant. Dynamic factors can include events which have occurred in an individual's life, such as traumatic events, changes in employment, housing, addiction, new illness/disability. These can often change and in most occasions be outside the control of the individual, and therefore viewed with less reliability in assessing future risk. NB. past risk factors are often a good indicator of possible future risk.

Risk Management: can be the process by which an organisation tries to reduce negative outcomes and also a means of maximising potential benefits in which the service user can also play an important role in managing the risk.

A defensible decision is one where:

- All reasonable steps have been taken to avoid harm
- A person’s mental capacity (including executive capacity) has been taken into consideration and guided by the Mental Capacity Act Code of Practice
- Reliable assessment methods have been used and information has been collected and thoroughly evaluated
• Decisions are recorded succinctly and in line with the agencies’ recording policy, and decisions and related actions are communicated to all relevant parties with outcomes reported back to the lead agency

• Practitioners and their managers adopt an approach that is proactive, investigative and holistic, taking into account all aspects of the individual and the wider family and any risks

• All appropriate services are arranged to mitigate identified risk and meet the assessed needs of the individual concerned as far as that person, with capacity to do so, is prepared to accept such services

• Any occurrence of a risk event subsequently will require a review of the plan in relation to that risk

• Policies and procedures have been followed and due adherence to statute and government and professional guidance is maintained.

Ultimately, the local authority has a statutory duty of care and a responsibility not to agree to support a care plan if there are serious concerns that it will not meet an individual’s needs or if it places an individual in a dangerous situation.
Appendix 4 – Safeguarding Referral Form

Please consult with your professional safeguarding lead and refer to the SAB Decision Making Standards before sending in an Inter-Agency Adult Safeguarding Referral Form. Please refer to the SAB Guidance Notes when completing this form.

<table>
<thead>
<tr>
<th>Personal Details of Person about Whom Concern is Raised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency Ref. No.:</td>
</tr>
<tr>
<td>NHS Number:</td>
</tr>
<tr>
<td>Surname: Forename(s):</td>
</tr>
<tr>
<td>Preferred Name: Date of Birth or Age:</td>
</tr>
<tr>
<td>Permanent Address: Postcode:</td>
</tr>
<tr>
<td>Telephone No <em>(Inc dial code)</em>:</td>
</tr>
<tr>
<td>Mobile No:</td>
</tr>
<tr>
<td>Current Address <em>(If Different)</em>:</td>
</tr>
<tr>
<td>Postcode:</td>
</tr>
<tr>
<td>Telephone No <em>(Inc dial code)</em>:</td>
</tr>
<tr>
<td>Sex: Male Female Unknown Indeterminate Title Mr Mrs Ms Miss Other Other If Other, detail</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Conditions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Long-Term Condition - Physical - Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>☐ Long-Term Condition - Physical - Cancer</td>
</tr>
<tr>
<td>☐ Long-Term Condition - Physical - Acquired Physical Injury</td>
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<tr>
<td>☐ Long-Term Condition - Physical - HIV / AIDS</td>
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<tr>
<td>☐ Long-Term Condition - Physical - Other</td>
</tr>
<tr>
<td>☐ Long-Term Condition - Neurological - Stroke</td>
</tr>
<tr>
<td>☐ Long-Term Condition - Neurological - Parkinsons</td>
</tr>
<tr>
<td>☐ Long-Term Condition - Neurological - Motor Neurone Disease</td>
</tr>
</tbody>
</table>
- Long-Term Condition - Neurological - Acquired Brain Injury
- Long-Term Condition - Neurological - Other
- Sensory Impairment - Visual
- Sensory Impairment - Hearing
- Sensory Impairment - Other
- Learning/Development - Learning Disability
- Learning/Development - Autism
- Learning/Development - Asperger Syndrome / High Functioning Autism
- Mental Health – Dementia
- Mental Health - Other
- No Relevant Long-Term Reported Health Conditions

<table>
<thead>
<tr>
<th>Ethnicity:</th>
<th>Sub-Ethnicity:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ White</td>
<td>☐ Cornish</td>
</tr>
<tr>
<td></td>
<td>☐ English / Welsh / Scottish / Northern Irish /</td>
</tr>
<tr>
<td></td>
<td>British</td>
</tr>
<tr>
<td></td>
<td>☐ Irish</td>
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<tr>
<td></td>
<td>☐ Gypsy or Irish Traveller</td>
</tr>
<tr>
<td></td>
<td>☐ Any other White background</td>
</tr>
<tr>
<td>☐ Mixed / Multiple</td>
<td>☐ White and Black Caribbean</td>
</tr>
<tr>
<td></td>
<td>☐ White and Black African</td>
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<tr>
<td></td>
<td>☐ White and Asian</td>
</tr>
<tr>
<td></td>
<td>☐ Any other mixed / multiple ethnic background</td>
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<tr>
<td>☐ Asian / Asian British</td>
<td>☐ Indian</td>
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<tr>
<td></td>
<td>☐ Pakistani</td>
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<td></td>
<td>☐ Bangladeshi</td>
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<td></td>
<td>☐ Chinese</td>
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<tr>
<td></td>
<td>☐ Any other Asian background</td>
</tr>
<tr>
<td>☐ Black / African / Caribbean /</td>
<td>☐ African</td>
</tr>
<tr>
<td>Black British</td>
<td>☐ Caribbean</td>
</tr>
<tr>
<td></td>
<td>☐ Any other Black / African / Caribbean background</td>
</tr>
<tr>
<td>☐ Other Ethnic Group</td>
<td>☐ Arab</td>
</tr>
</tbody>
</table>
Any other ethnic group

<table>
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<tr>
<th>Other</th>
<th>Refused</th>
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</thead>
</table>

**Religion or Belief:**

**First language:**

**Interpreter/signer required?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</table>

**Comments:**

**Any other special / cultural needs:**

**Does the person have a disability?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Primary Support Reason:**

- Learning Disability Support
- Mental Health Support
- Physical Support
- Sensory Support
- Social Support
- Support with Memory and Cognition

**GP Name:**

<table>
<thead>
<tr>
<th>GP Practice:</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Tel No:</td>
</tr>
<tr>
<td>GP Email:</td>
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</table>

**Source of Concern**

Details of the person raising this Concern

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
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<tbody>
<tr>
<td>Role:</td>
</tr>
<tr>
<td>Agency:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Tel No (inc. Bleep):</td>
</tr>
<tr>
<td>Alternative Tel No:</td>
</tr>
<tr>
<td>Email address:</td>
</tr>
<tr>
<td>When can you be contacted:</td>
</tr>
<tr>
<td>Relationship to subject of this Concern:</td>
</tr>
</tbody>
</table>

Can your details be shared with third parties?

| Yes | No |

If No, please supply reasons:

Has the person been transferred from another local authority?

| Yes | No | Not known |
If Yes, which local authority:

<table>
<thead>
<tr>
<th>Details of Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has a Concern been made in the last year as a victim of abuse?</td>
</tr>
</tbody>
</table>

There is an expectation that you tell the person that you are making a referral and that they have given informed consent. Any exception to this policy must be agreed by your manager and recorded.

<table>
<thead>
<tr>
<th>Is the person aware of this Concern?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

If No, please supply reasons:

<table>
<thead>
<tr>
<th>Does the person consent to the Contact?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

If No, please supply reasons:

<table>
<thead>
<tr>
<th>Does the person know the reason their information is being shared?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

If No, please supply reasons:

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### Significant others/other family members/carers

<table>
<thead>
<tr>
<th>Surname</th>
<th>Forenames</th>
<th>M/F</th>
<th>AKA</th>
<th>Address/Tel No.</th>
<th>Date of Birth</th>
<th>Relationship of Person</th>
</tr>
</thead>
</table>

### Agencies/Professionals known to be involved

- **Name:**
  - **Agency:** Tel No (inc. code):
  - **Name:**
    - **Agency:** Tel No (inc. code):
  - **Name:**
    - **Agency:** Tel No (inc. code):
Name:

Agency: ___________________________ Tel No (inc. code): ___________________________

Has consent been given for the Multi Agency Referral Unit to contact the named agencies?

☐ Yes ☐ No

If No, give reasons:

What is your involvement with the person (include how long you have known the person, in what capacity and what work you have been doing to support them):

Nature of current risk of harm (you can tick more than one):

☐ Discriminatory ☐ Domestic Abuse

☐ Financial and Material ☐ Modern Slavery

☐ Neglect and Omission ☐ Organisational

☐ Physical ☐ Psychological / Emotional

☐ Self-Neglect ☐ Sexual

Give specific evidence for the Contact (include strengths and difficulties and any specific incidents that have prompted your concern):

Who do you think the alleged perpetrator is?

Name: ___________________________

Date of birth: ___________________________

Address: ___________________________

Are they a member of staff? ☐ Yes ☐ No

Name of their Organisation: ___________________________

Role in their Organisation: ___________________________

Telephone No (inc dial code): ___________________________

Relationship to the
person:

Do they live with the person?  
☐ Yes  ☐ No

Is the alleged perpetrator the main carer?  
☐ Yes  ☐ No

Is the alleged perpetrator aware that a Concern has been raised?  
☐ Yes  ☐ No  ☐ Not known

Does the alleged perpetrator have access and do they pose a risk to children or other adults?  
☐ Yes  ☐ No

What do you see as the specific risks? What do you think needs to happen and who should be involved? (indicate what needs and risks are most concerning you):

Do you have any reason to doubt the person’s capacity to agree to this Concern being raised?  
☐ Yes  ☐ No

Details:

Can the person protect themselves from risk or experience of abuse or neglect?

What are the views and desired outcomes of the person you are concerned about?

What do they want to happen next?

What do you want to happen next (be specific about focus for any enquiry and who you think should contribute to that enquiry)?

Signature of Contact:

Date:

NOTE: You should be informed about the outcome of your Contact within 2 working days. However, if you have not heard from the MARU about the outcome of your Contact within this timescale, there is an expectation that you will follow it up.

To contact the MARU in hours phone 0300 1231 116 and out of hours 01208 251300
The Interagency Adult Safeguarding Referral Form should be emailed to:

Multi Agency Referral Unit
North Wing
3rd Floor
New County Hall
Truro, TR1 3AY

Secure Fax Number 01872 323653

Secure Email MultiAgencyReferralUnit@cornwall.gcsx.gov.uk

Standard Email accessteam.referral@cornwall.gov.uk
ADULT SAFEGUARDING PROCESS FORM V1.4

CFT staff making alert to complete sections A – G

(CFT staff do not complete the audit boxes)

Send form to the secure generic email box

cpn-tr.cftadultsafeguardingteam@nhs.net
cpn-tr.cftadultsafeguardingteam@nhs.net

<table>
<thead>
<tr>
<th>Section A</th>
<th>ADULT SAFEGUARDING ALERT / CALL OF CONCERN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Alert/Call of Concern</td>
<td></td>
</tr>
<tr>
<td>Time of Alert</td>
<td></td>
</tr>
<tr>
<td>Alert Sent to Adult Safeguarding generic email box</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Details of Adult at Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Adult at Risk</td>
</tr>
<tr>
<td>Date of Birth</td>
</tr>
<tr>
<td>NHS Number</td>
</tr>
<tr>
<td>RiO number</td>
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<tr>
<td>Hospital Number</td>
</tr>
<tr>
<td>Mosaic ID Number</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>Telephone Number</td>
</tr>
<tr>
<td>Email Address</td>
</tr>
<tr>
<td>Communication needs i.e. Bliss board, Makaton, BSL, hear loop, interpreter.</td>
</tr>
<tr>
<td>Ethnicity</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>Service User Group</td>
</tr>
<tr>
<td>Adult General Health</td>
</tr>
<tr>
<td>Adult Mental Health</td>
</tr>
<tr>
<td>Learning Disability</td>
</tr>
<tr>
<td>Complex Care and Dementia</td>
</tr>
<tr>
<td>Physical Disability</td>
</tr>
<tr>
<td>Older Person</td>
</tr>
<tr>
<td>GP</td>
</tr>
<tr>
<td>Surgery Address</td>
</tr>
<tr>
<td>Telephone Number</td>
</tr>
</tbody>
</table>

**Section B**

**Details of CFT Staff Making Adult Safeguarding Alert**

<table>
<thead>
<tr>
<th>Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Job Title</td>
<td></td>
</tr>
<tr>
<td>Service/Team</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Line Manager</td>
<td></td>
</tr>
<tr>
<td>Telephone Number</td>
<td></td>
</tr>
<tr>
<td>Office</td>
<td></td>
</tr>
<tr>
<td>Mobile</td>
<td></td>
</tr>
<tr>
<td>Email Address</td>
<td></td>
</tr>
</tbody>
</table>
### Section C

**Details of the Concern/Abuse**

Give details of what you are concerned about?

**Type of abuse**

---

### Section D

**Details of Alleged Perpetrator(s) of Abuse**

<table>
<thead>
<tr>
<th>Name (Individual or Organisation)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Telephone Number</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Is the alleged perpetrator aware of the concern and if so how this person was made aware?</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Organisation (Domiciliary Care Agency/Care Home/Day Centre/Hospital Ward or Dept.)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Telephone Number</td>
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</tbody>
</table>

| Is the alleged perpetrator aware of the concern and if so how was this person made aware? |  |
### Section E

**Current Protection Plan**

What has been done to protect the adult

Has the plan been discussed and formulated with the person?

Has a care plan been formulated on RiO?

Where are the details of this plan recorded (Oceano, Nursing/Medical notes, RiO, Systmone)

### Date Line Manager informed


### Date incident form completed / Incident Form Number


### Section F

**Capacity to Consent**

<table>
<thead>
<tr>
<th>Does the Adult at Risk have capacity to consent to Adult Safeguarding process?</th>
<th>Yes/No</th>
</tr>
</thead>
</table>

**If person lacks capacity**

Date of capacity assessment

Name of professional who undertook assessment

Date of assessment recorded

Where is assessment recorded

**Audit**
The Adult at Risk consented to the safeguarding process?

Met

Not met

Reason for variance

---

Section G  
Views and Wishes of Adult at Risk

<table>
<thead>
<tr>
<th>Date Adult was asked about their wishes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

What does the Adult at Risk want to happen about the concern?

---

Audit

Practice Standard 4. The timeliness in seeing the person and ascertaining their wishes and feelings before proceeding further is at the heart of personalisation. The standard for seeing the Adult is within 5 working days of the decision to undertake an enquiry made at the strategy discussion/meeting.

Adult at Risk or their Representative’s views and desired outcomes recorded.
Met

Not Met

Reason for variance

CFT Adult Safeguarding team to complete sections H – O

**Section H**

CFT Adult Safeguarding Team Information Gathering

Include Date/Agencies and Staff Spoken to/Designation/Contact Details

<table>
<thead>
<tr>
<th>Date of Referral to Police Central Safeguarding Team if Required.</th>
</tr>
</thead>
</table>

**Section I**

CFT Adult Safeguarding Team Assessment of Alert/Call of Concern

(please choose one)

- Adult Safeguarding Concerns About Abuse Requires Adult Safeguarding Process  Yes/No
<table>
<thead>
<tr>
<th>Bailey Healthcare Excellence</th>
<th></th>
</tr>
</thead>
</table>

- Not Adult Safeguarding Concern – Advice Only
  - Record Advice – Save in Advice File on Shared Drive
  - Copy advice given and enter into client RiO progress note

- Adult Safeguarding Abuse, Requires Process but Adult at Risk does not want the Adult Safeguarding Process.

  Concern Passed to:
  - Complaints Process
  - Performance Management
  - Risk Management
  - Support to Mediate
  - Other process (PPMF)

  Name of manager taking other process forward 

Other Process

Name of Manager responsible for other process

Adult Safeguarding process without persons consent

Reason

Date of Referral to LADO process if required
### Section J Adult Safeguarding Process

#### Strategy Discussion

<table>
<thead>
<tr>
<th>Date</th>
<th>Name of Professionals Involved/Agency</th>
<th>Actions Allocated to Named Professionals</th>
<th>Plan of Enquiry</th>
<th>Escalation to SSU for Independent Chair and Admin Support</th>
<th>Yes/No</th>
<th>Date</th>
</tr>
</thead>
</table>

**Audit**

**Practice Standard 2.** The timeliness of holding a strategy discussion/meeting when an alert/call of concern is assessed as meeting the threshold for the safeguarding process should be no more than 2 working days.

Met

Not Met

Reason for variance
**Practice Standard 3.** The timeliness of getting a safeguarding enquiry started following a strategy discussion/meeting should be 2 working days from the completion of the strategy discussion/meeting.

<table>
<thead>
<tr>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Met</td>
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</tbody>
</table>

Reason for variance

<table>
<thead>
<tr>
<th>Section K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronology of actions/discussions/meeting arrangements progress</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section L</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Conference</td>
</tr>
<tr>
<td>Date</td>
</tr>
<tr>
<td>Outcome</td>
</tr>
</tbody>
</table>
Audit

**Practice Standard 5.** The timescale from the strategy discussion/meeting to an Initial Adult Safeguarding Conference is within 28 calendar days.

Met

Not Met

Reason for variance

**The Adult at Risk or their Representative attended the Adult Safeguarding Conference.**

Met

Not Met

Reason for variance
## Section M
### Case Review

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome</td>
</tr>
</tbody>
</table>

### Audit

**Practice Standard 6.** The timeliness of the completion of the enquiry and the provision of a full assessment report that includes a sound analysis of the adult’s needs, risks and strengths is 42 calendar days or 6 weeks.

<table>
<thead>
<tr>
<th>Met</th>
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<tbody>
<tr>
<td>Not Met</td>
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</table>

**Reason for variance**

**The Adult at Risk or their Representative attended the Adult Safeguarding Conference (REVIEW).**

<table>
<thead>
<tr>
<th>Met</th>
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<tbody>
<tr>
<td>Not Met</td>
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</tbody>
</table>


## Section N
**Outcome of Other Process (include process used)**

<table>
<thead>
<tr>
<th>Reason for variance</th>
</tr>
</thead>
</table>

## Section O
**Views of Adult at Risk. Were their desired outcomes met?**

<table>
<thead>
<tr>
<th>Audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Adult at Risk views or their Representative desired outcomes met or partly met.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not met</td>
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</tbody>
</table>

**Reason for variance**
Appendix 5 – Clutter Scale

Clutter Image Rating Scale – Kitchen

Please select the photo that most accurately reflects the amount of clutter in the room.
| Property, structure, services & garden | • Assess the access to all entrances and exits of the property  
• Note the impact on any communal entrances/exits  
• Include access to attics, lofts, roof spaces, roof voids etc  
• Does the property have a smoke alarm/smoke alarms & location(s)  
• Non-professional visual assessment of the condition of services i.e. plumbing, gas, electrics. This will help inform your future actions.  
• Are the services connected?  
• Assess garden size, access and condition. |
| --- | --- |
| Household functions | • Assess the functionality of all rooms and safety for their proposed/intended use e.g. can the kitchen be safely used for cooking or does the level of clutter prevent it  
• Select the appropriate rating on the 'clutter scale’  
• Estimate the %age of floor space covered in clutter  
• Estimate the height of clutter in each room |
| Health and Safety | • Assess the sanitary condition of each room in the property  
• Are the floors clean? Are kitchen work surfaces clean?  
• Any odours in the property - what from/where from/what of?  
• Any rotting food?  
• Any evidence of candles, naked flames, cigarettes usage?  
• Any higher than expected number of flies?  
• Does an occupant/do occupant struggle with personal care/hygiene?  
• Any random or chaotic writing/graffiti on the walls?  
• Any unreasonable quantities of prescribed/over counter medications?  
• Does resident show any awareness of fire risk posed by clutter? |
| Safeguarding children / family members | • Do any rooms rate at 7 or above on the Clutter Rating Scale?  
• Are there any children or young persons within the household? |
| Animals and pests | • Any pets at the property? Well cared for or do you have concerns?  
• Is there evidence of any infestation? e.g. bugs, rats, mice etc.  
• Are animals being hoarded at the property?  
• Are outside areas seen by the resident as a wildlife area?  
• Does the resident leave food out for foxes, badgers etc.? |
| Personal protective equipment (PPE) | • Do you recommend PPE on the event of future visits?  
• Do you recommend the resident is visited in pairs? Please detail: |
| **Level 1: Clutter Image Scale 1 - 3** | **Household environment is considered standard**  
No specialised assistance is needed. If the resident requests assistance with general housework or feels they are declining towards a higher clutter scale, appropriate referrals can be made subject to age and circumstances |
|---------------------------------------|--------------------------------------------------------------------------------------------------|
| **Property, structure, services & garden** | - All entrances, exits, stairways, roof space and windows accessible  
- Smoke alarms fitted and functional or referrals made to fire service to visit and install  
- All services functional and maintained in good working order  
- Garden is accessible, tidy and maintained |
| **Household functions** | - No excessive clutter, all rooms can be safely used for intended their purpose  
- All rooms are rated 0 – 3 on the Clutter Rating Scale  
- No additional unused household appliances appear in unusual locations around the property  
- Property is maintained within terms of any tenancy/lease agreement  
- Property is not at risk of action by Public Health & Protection team |
| **Health and Safety** | - Property is clean with no odours (pets or other odours)  
- No rotting food  
- No concerning use of candles, nakes flames, cigarette usage  
- No concern over flies  
- Residents managing personal care/hygiene  
- No writing/graffiti on walls  
- Quantities of medications are within appropriate limits, in date and stored appropriately |
| **Safeguarding children / family members** | - No concerns for household members |
| **Animals and pests** | - Pets are well cared for  
- Pets/animals in acceptable numbers  
- No apparent pests or infestations at the property |
| **Personal protective equipment (PPE)** | - No PPE required  
- No visits in pairs required |

<table>
<thead>
<tr>
<th><strong>Level 1</strong></th>
<th><strong>Actions</strong></th>
</tr>
</thead>
</table>
| **Referring agency** | - Discuss any concerns with resident  
- Raise a request for Fire & Rescue Service to provide fire safety advice  
- Refer for Support Assessment if appropriate  
- Refer to GP if appropriate |
| **Housing Landlord** | - Provide details on debt advice if appropriate  
- Refer to GP if appropriate  
- Refer for Support Assessment if appropriate  
- Provide details of support open to the resident via charities, voluntary sector & self help group, if appropriate  
- Ensure resident is maintaining all tenancy conditions |
| Public Health & Protection Team | No action |
| All practitioners | • Complete hoarding assessment  
| | • Make appropriate referrals for support  
| | • Refer to social housing landlord if the client is a social housing tenant or, leaseholder |
| Emergency services | • Ensure information is shared with statutory agencies & feedback is provided to referring agency on completion of home visits |
| Animal Welfare | • No action unless advice is requested |
| Safeguarding Adults / Children | • No action unless other concerns are noted |

| Level 2: Clutter  
Image Scale 4 - 6 | Household environment requires professional assistance to resolve the clutter and the maintenance issues in the property |
| Property, structure, services & garden | • Only one major exit is blocked  
| | • Only one of the major services is not functional  
| | • Concern that services are not well maintained  
| | • Smoke alarms are not installed or not functioning  
| | • Garden is not accessible due to clutter or is not maintained  
| | • Evidence of indoor items stored outside  
| | • Evidence of light structural damage or damp  
| | • Interior doors missing or blocked open |
| Household functions | • Clutter is causing congestion in the living spaces and is impacting on the use of the rooms for their intended purpose  
| | • Clutter is causing congestions between the rooms and entrances  
| | • Rooms score between 4 and 6 on the Clutter Rating Scale  
| | • Inconsistent levels of housekeeping throughout the property  
| | • Some household appliances are not functioning properly and there are additional units in unusual locations around the property  
| | • Property is not maintained within terms of any tenancy/lease agreement  
| | • Evidence of outdoor items being stored inside |
| Health and Safety | • Kitchen and bathroom not kept clean  
| | • Offensive odour(s) within the property (describe)  
| | • Residents trying to manage personal care/hygiene but struggling  
| | • No rotting food  
| | • No writing/graffiti on walls  
| | • No concerning use of candles, nakes flames, cigarette usage  
| | • No concern over flies  
| | • Some concern with the quantities of medications or its storage or expiry dates |
| Safeguarding children / family members | • Hoarding on Clutter Scale 4 – 7 doesn’t automatically constitute a Safeguarding Alert |
- Note all additional concerns
- Properties with children or vulnerable residents with additional support needs may trigger a Safeguarding Alert under a different risk

### Animals and pests
- Pets at the property are not well cared for
- Resident is not able to control the animals
- Animals living area is not maintained and smells
- Animal appears under nourished or over fed
- Rodent droppings observed
- Spiders web within the property
- Light insect infestation observed (fleas, ants, cockroaches etc)

### Personal protective equipment (PPE)
- PPE required

### Level 2
<table>
<thead>
<tr>
<th>Actions</th>
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</thead>
<tbody>
<tr>
<td><strong>In addition to actions listed below these cases need to be monitored regularly in the future due to RISK OF ESCALATION or REOCURRENCE</strong></td>
</tr>
</tbody>
</table>

#### Referring agency
- Refer to social housing landlord if the resident is a social housing tenant / leaseholder
- Refer to Public Health & Protection team if the resident is a freeholder
- Refer to Fire & Rescue Service for the provision of fire prevention advice
- Provide details of garden services
- Refer for Support assessment
- Refer to GP
- Refer to RSPCA if there are animals present
- Ensure information sharing with all agencies involved to ensure a collaborative approach and a sustainable resolution

#### Social Housing Landlord
- Visit the resident. Inspect property and assess support needs.
- Refer to and housing related support which might be available
- Ensure resident is maintaining all tenancy conditions
- Consider enforcing tenancy conditions relative to tenants responsibilities
- Ensure information sharing with all agencies involved to ensure a collaborative approach and a sustainable resolution

#### Public Health & Protection
- Refer to Public Health & Protection’s team with details of resident, landlord (if relevant) referrer’s details and overview of the issues
- Environmental Protection Officer determines an appropriate course of action
- Consider serving notices under Environmental Protection Act 1990, Prevention of Damage By Pests Act 1949 or Housing Act 2004
- Consider options if notices not complied with by occupier
| **All practitioners** | • Ensure information sharing with all agencies involved to ensure a collaborative approach and a sustainable resolution |
| **Emergency services** | • Ensure information sharing with all agencies involved to ensure a collaborative approach and a sustainable resolution  
• Provide feedback to referring agency on completion of any home visits |
| **Animal Welfare** | • Visit property. Undertake a wellbeing check on animals at the property.  
• Educate client regarding animal welfare if appropriate  
• Provide advice / assistance with re-homing animals |
| **Safeguarding Adults / Children** | • No action unless other concerns of abuse are noted.  
• If other concerns of abuse are of concern or have been reported, progression to safeguarding referral and investigation may be necessary. |

**Level 3: Clutter Image Scale 7 - 9**  
Household environment will require intervention with a collaborative multi agency approach with the involvement from a wide range of professionals. This level of hoarding constitutes a Safeguarding alert due to the significant risk to health of the householders, surrounding properties and residents. Residents are often unaware of the implication of their hoarding actions and oblivious to the risk it poses.

| **Property structure, services & garden area** | • Limited access to the property due to extreme clutter  
• Evidence may be seen of extreme clutter seen at windows  
• Evidence may be seen of extreme clutter outside the property  
• Garden not accessible and extensively overgrown  
• Services not connected or not functioning properly  
• Smoke alarms not fitted or not functioning  
• Property lacks ventilation due to clutter  
• Evidence of structural damage or outstanding repairs including damp  
• Interior doors missing or blocked open  
• Evidence of indoor items stored outside |
| **Household Functions** | • Clutter is obstructing the living spaces and is preventing the use of the rooms for their intended purpose.  
• Room(s) scores 7 - 9 on the clutter image scale  
• Rooms not used for intended purposes or very limited  
• Beds inaccessible or unusable due to clutter or infestation  
• Entrances, hallways and stairs blocked or difficult to pass  
• Toilets, sinks not functioning or not in use  
• Resident at risk due to living environment  
• Household appliances are not functioning or inaccessible  
• Resident has no safe cooking environment  
• Resident is using candles  
• Evidence of outdoor clutter being stored indoors.  
• No evidence of housekeeping being undertaken  
• Broken household items not discarded e.g. broken glass or plates  
• Concern for declining mental health |
- Property is not maintained within terms of lease or tenancy agreement where applicable
- Property is at risk of notice being served by Environmental Health

**Health and Safety**
- Human urine and or excrement may be present
- Excessive odour in the property, may also be evident from the outside
- Rotting food may be present
- Evidence may be seen of unclean, unused and or buried plates & dishes.
- Broken household items not discarded e.g. broken glass or plates
- Inappropriate quantities or storage of medication.
- Pungent odour can be smelt inside the property and possibly from outside.
- Concern with the integrity of the electrics
- Inappropriate use of electrical extension cords or evidence of unqualified work to the electrics.
- Concern for declining mental health

**Safeguarding Adults / Children**
- Hoarding on clutter scale 7-9 constitutes a Safeguarding Alert.
- Please note all additional concerns for householders

**Animals and Pests**
- Animals at the property at risk due the level of clutter in the property
- Resident may not able to control the animals at the property
- Animal’s living area is not maintained and smells
- Animals appear to be under nourished or over fed
- Hoarding of animals at the property
- Heavy insect infestation (bed bugs, lice, fleas, cockroaches, ants, silverfish, etc.)
- Visible rodent infestation

**Personal Protective Equipment (PPE)**
- Latex Gloves, boots or needle stick safe shoes, face mask, hand sanitizer, insect repellent.
- Visit in pairs required

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**Level 3**

**Referring Agency**
- **Raise Safeguarding Alert within 24 hours**
- **Raise a request to the Fire Brigade within 24 hours to provide fire prevention advice.**

**Public Health & Protection**
- Refer to Environmental Protection with details of client, landlord (if relevant) referrer’s details and overview of issues
- At time of inspection, EPO decides on appropriate course of action
- Consider serving notices under Environmental Protection Act 1990, Prevention of Damage By Pests Act 1949 or Housing Act 2004
- Consider options if notices not complied with by occupier
**Social housing landlord**
- Visit resident to inspect the property & assess support needs
- Attend multi-agency Safeguarding meeting
- Enforce tenancy conditions relating to residents responsibilities
- If resident refuses to engage serve Notice of Seeking Possession under Ground 13 to Schedule 2 of the Housing Act 1988

**All practitioners**
- Ensure information sharing with all agencies involved to ensure a collaborative approach and a sustainable resolution.

**Emergency Services**
- Attend Safeguarding multi-agency meetings on request
- Ensure information sharing with all agencies involved to ensure a collaborative approach and a sustainable resolution.
- Provide feedback to referring agency on completion of home visits.

**Animal Welfare**
- Visit property to undertake a wellbeing check on animals at the property.
- Remove animals to a safe environment
- Educate client regarding animal welfare if appropriate
- Take legal action for animal cruelty if appropriate
- Provide advice / assistance with re-homing animals

**Safeguarding Adults / Children**
- Safeguarding alert should progress to referral for multi-agency approach and further investigation of any concerns of abuse.

Listed below are examples of questions to ask where you are concerned about someone’s safety in their own home, where you suspect a risk of self- neglect and hoarding.

The information gained from these questions will inform a Hoarding Assessment see appendix and provide the information needed to alert other agencies.

Most clients with a hoarding problem will be embarrassed about their surroundings so adapt the question to suit your customers.

- How do you get in and out of your property, do you feel safe living here?
- Have you ever had an accident, slipped, tripped up or fallen? How did it happen?
- How have you made your home safer to prevent this (above) from happening again?
- How do move safely around your home (where the floor is uneven or covered, or there are exposed wires, damp, rot, or other hazards)
- Has a fire ever started by accident?
• How do you get hot water, lighting, heating in here? Do these services work properly? Have they ever been tested/when were they last tested?

• Do you ever use candles or an open flame to heat and light here or cook with camping gas?

• How do you manage to keep yourself warm? Especially in winter?

• When did you last go out in your garden? Do you feel safe to go out there?

• Are you worried about other people getting in to your garden to try and break-in? Has this ever happened?

• Are you worried about mice, rats or foxes, or other pests? Do you leave food out for them?

• Have you ever seen mice or rats in your home? Have they eaten any of your food? Or got upstairs and be nesting anywhere?

• Can you prepare food, cook and wash up in your kitchen?

• Do you use your fridge? Can I have look in it? How do you keep things cold in the hot weather?

• How do you keep yourself clean? Can I see your bathroom? Are you able to use your bathroom and use the toilet ok? Have a wash, bath? Shower?

• Can you show me where you sleep and let me see your upstairs rooms? Are the stairs safe to walk up? (if there are any)

• What do you do with your dirty washing?

• Where do you sleep? Are you able to change your bed linen regularly? When did you last change them?

• How do you keep yourself warm at night? Have you got extra coverings to put on your bed if you are cold?

• Are there any broken windows in your home? Any repairs that need to be done?

• Because of the number of possessions you have, do you find it difficult to use some of your rooms? If so which ones?

• Do you struggle with discarding things or to what extent do you have difficulty discarding (or recycling, selling, giving away) ordinary things that other people would get rid of?
Hoardling Insight characteristics

- Use this guide as a baseline to describe the client’s attitude towards their hoarding.
- Provide additional information in your referrals and reports to enable a tailored approach that is relevant to your client.

**Good or fair insight:**

The client recognises that hoarding-related beliefs and behaviours (relating to difficulty discarding items, clutter or excessive acquisition) are problematic. The client recognises these behaviours in themselves.

**Poor insight**

The client is mostly convinced that hoarding-related beliefs and behaviours (relating to difficulty discarding items, clutter or excessive acquisition) are not problematic despite evidence to the contrary. The Client might recognise a storage problem but has little self-recognition or acceptance of their own hoarding behaviour.

**Absent (delusional) insight**

The client is convinced that hoarding-related beliefs and behaviours (relating to difficulty discarding items, clutter or excessive acquisition) are not problematic despite evidence to the contrary. The client is completely excepting of their living environment despite it being hoarded and possibly a risk to health.

**Detached with assigned blame**

The client has been away from their property for an extended period. The client has formed a detachment from the hoarded property and is now convinced a 3rd party is to blame for the condition of the property. For example a burglary has taken place, squatters or other household members.
Appendix 6 – Agenda for the first multi-agency / multi-professional/ multi-disciplinary meeting

- Introductions
- Up to date background information on the person causing concern (including medical advice where included)
- Clarification on concerns that have prompted the multi-agency meeting
- Results of formal mental capacity assessment (including “executive capacity” i.e. the ability of the individual to implement their decision)
- Multi-agency risk assessment completed or instigated
- Does the situation come under safeguarding adult’s procedures?
- Are any children at risk?
- Are any animals at risk – do the RSPCA need to be informed?
- Identify ‘challenges’ to agency policy, procedure
- Relevant legal/Statutory power to be identified
- Will legal/statutory powers be applied or used as a contingency? (Refer to appendix 2)
- Information sharing protocol to be agreed
- Communication plan to be agreed
- Action plan and named lead officers
- Financial considerations – How will the Council recover the costs after the event? Does the individual have the means or ability to pay the cost incurred for removal of waste?
- Date of next meeting where required – frequency to be decided by the multi-agency group.
Appendix 7 – Waste Management Policy

1. Current waste service

Cornwall Council, as a Unitary Authority, has a duty to collect and dispose of waste generated by its residents (household waste). This is required under law provided through legislation called the Environmental Protection Act (EPA) 1990.

The Council currently discharges its duty for waste collection and disposal through two contractors. The collection of waste from householders is through Biffa Environmental Municipal Services (who have a contract until 2020), whilst the disposal of waste is through Suez (who have a contract until 2039).

2. Routes for waste

The Council’s statutory duty is collection and disposal service for household waste. The Council’s policy enables this through:

Kerbside collection: The Council’s household waste collection service delivered through an external contractor, waste is collected from residents’ properties, at the kerbside, and on a weekly basis, with recycling collected once a fortnight. Recycling alternates every other week with a subscription based garden waste service. This service is only provided for household non-recyclable and non-hazardous waste, which can fit into a standard plastic rubbish sack. All waste placed out for collection must be contained in disposal bags, which are tied up and protected from seagull or animal attack. Collections begin from 7am.

Clinical waste: A designated service which is free to residents through Biffa. Collection is arranged through the Council.

Disposal sites: The waste and recycling are taken to a disposal site (managed by SUEZ). Disposal of the waste is through landfill which will change to an incinerator in late 2016 early 2017.

Household Waste Recycling Centres (HWRC): Residents can also take their waste and recyclable material to 13 HWRCs. These sites will accept all household waste, including bulky items such wood, metal, electronic waste, batteries and green waste, and also charge for some items such as building rubble, asbestos, plasterboard and tyres. The Council also operates a vehicle permit system to
prevent the illegal disposal of commercial or industrial waste entering in certain vehicles. The permit allows a householder, when using a vehicle that requires a permit, a maximum of 12 visits a year. Charities are only allowed on site if they are a charity shop disposing of re-sell items that have come from a domestic property. HWRC sites are not designed to handle or deal with large quantities of waste arriving, even if it is household waste.

Bulky waste collections: This is a chargeable service provided for household items that are too large to be collected in the general rubbish collection, or for people who cannot transport them to the household waste recycling centres themselves. Bulky items include tables, mattresses, sofas, fridges etc.

3. Legislation

Overarching: Waste is classified, primarily, by the premises from which it is produced. This is set out in primary legislation called the Environmental Protection Act 1990. The classification of controlled waste, as it is termed, is defined within Sect. 75 EPA 1990. Further details on the different classifications are set out within legislation, flowing from the EPA, called the Controlled Waste Regulations (CWR) 2012.

Within the CWR 2012 waste generated from a domestic property is classified as household or domestic waste. Waste from this type of property is normally dealt with by either the householder placing the waste out for kerbside collection, taking it to a HWRC site or paying for it to be removed and disposed of by a commercial waste company (or using Council services such as Suez Bulky Waste collection).

Hoarder waste: Waste generated by a hoarder is still classed as household waste (it is generated from a domestic property). However, if the waste is collected, taken (transferred) and dealt with by a different individual or by a third party organisation such as volunteers or a charity, it has to fit into the Council’s criteria for charities (see section HWRC, above). This can cause issues for HWRCs as hoarder’s waste is likely to be disposed of in large quantities, in a vehicle such as large van/small lorry/skip which aren’t authorised onto the site and could include offensive, hazardous or clinical waste.
Sect. 34 of the EPA 1990 sets out the requirement for a ‘duty of care’ for waste. The duty of care applies to anyone who imports, produces, carries, keeps, treats, disposes of, or are a dealer or broker that has control of, controlled waste. Householders have a limited duty of care because most household waste is disposed of through the local authority waste collection services.

The duty of care also requires a waste carrier to have a Waste Transfer Note to take the waste away. If using a commercial provider the householder/waste producer would need to be a registered waste carrier and have a Waste Carriers Licence (register with the Environment Agency) to take away and dispose of the waste legally.

4. Options Considered

There are a few options available for the collection and disposal of hoarder’s waste. These are set out briefly below. However, it is the considered view of the Council’s Waste Management Team that the preferred route is Option 3, both from an environmental, financial and safety perspective and if Option 1 cannot be undertaken or is not compliant with the Council’s HWRC permitting system and policy.

Option 1: Individual hoarder or family member takes the waste generated by the hoarder to a HWRC site, in amounts consisting of types of material able to allow entry onto the site, which comply with the Council’s permit system (correct vehicle and a maximum of 12 visits for permitted vehicles) and chargeable waste scheme. **CC waste assessment: acceptable.**

Option 2: Volunteer(s) takes the waste generated by the hoarder to a HWRC site, in a van, in large quantities. **CC waste assessment: not acceptable.**

Option 3: CC uses a professional house clearance/cleansing company, who is a registered waste carrier (Waste Carriers Licence), trained and legally able to take the waste away, collected using vehicles or skips with registered waste carrier. They will then take the waste away to a registered waste disposal site – Refuse Transfer Station (RTS), but not a HWRC site. This will require prior arrangement with Suez (disposal contractor for the Council) as this is a commercial arrangement. **CC waste assessment: acceptable.**
5. Requirements for waste collection/disposal

There are a number of key requirements for undertaking collection and disposal of waste from a hoarder's property. They are:

- Disclaimer for access onto premises,
- Uniform and PPE,
- Undertake a full Risk Assessment and have a Safe Systems of Work in place,
- Knowledge of the type of waste (to inform collection and disposal),
- Budget (one specifically identified and cost centre),
- Training (to understand the issues and sensitivities involved with hoarding, along with the specialist house clearance and waste removal requirements),
- Prior assessment of property beforehand (not by waste/house clearance contractor),
- Identify a lead person (not contractor) to negotiate/discuss with property owner or family,
- Accompaniment onto the hoarder’s premises i.e. by fire service, family or a social worker.

6. Variables to service

There are additional points to consider before finalising waste collection/disposal. These variables may affect how the service may operate and are specific to each hoarder case:

1. Prior assessment of property (not by waste/house clearance contractor), to identify the following:

   a) Type of property – is it a flat?
   b) Access – route for removal blocked?
   c) Waste type:
      - Residual waste/food waste,
      - Dry recyclables: paper, newspapers, cardboard, plastic bottles, plastic pots, tubs and trays, glass bottles, cans,
      - Large plastic items – garden furniture, toys etc.,
      - Metal,
• Wood,
• Electrical items (small) – kettle, toaster; electrical items (large)- TVs,
• Bulky items – furniture, fridges, sofas, beds,
• Hazardous waste – tyres, asbestos, paint, chemicals, medicines, gas bottles, human waste/faeces, animal waste/faeces,
• Clinical waste,
• Clothing, textiles,
• Bric-a-brac, ornaments,
• Carpets.

d) Is the waste already contaminated?

e) Can the waste be kept separate?

f) Does the contractor need to be accompanied?

2. Identify a lead person (not contractor) to negotiate/discuss with property owner or family,

3. Wearing non-branded clothing (but still need PPE),

4. Communications – needs to be varied dependence on the person/situation/circumstance,

5. Equipment required,

6. Containment required,

7. Emergency response – i.e. if service is required immediately,

8. Time of day when clearance occurs – i.e. operational hours only,

7. Safeguarding - Providers

Cornwall Council takes safeguarding of Children, Young people and vulnerable adults seriously and any organisations commissioned by Cornwall Council are expected to be fully conversant with safeguarding procedures.

Any commissioned service (provider) will have a child protection policy in place which is consistent with Cornwall and Isles of Scilly Local Safeguarding Children Board (CIOS LSCB) Policy and the south west safeguarding and child protection procedures, (www.swcpp.org.uk). This will have been regularly reviewed and staff will have undertaken training to understand the context and content of the policy.
Issues of safer recruitment, training, including induction, the management of allegations, restraint and whistle blowing will be evidenced within the child protection policy or within a set of safeguarding policies.

**Safeguarding Adults:**

A provider will have a safeguarding adult’s policy in place consistent with Cornwall and Isles of Scilly Safeguarding Adults Board (CIOS SAB) Multi-Agency Policy. This will have been regularly reviewed and staff will have undertaken training to understand the context and content of the policy.

Issues of safer recruitment, training, including induction, making safeguarding adults alerts and whistle-blowing will be evidenced within the safeguarding adult’s policy or within a set of safeguarding policies.

For further information please see the detailed information at:–

[http://cornwallcouncilintranet.cc.cornwallonline.net/media/4126/safeguarding-guidelines-for-providers.pdf](http://cornwallcouncilintranet.cc.cornwallonline.net/media/4126/safeguarding-guidelines-for-providers.pdf)