Richmond and Wandsworth Safeguarding Adults Board

Safeguarding Adults Review (SAR)

‘Hope’

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‘Hope’ is a pseudonym which is used to protect the identity of the subject of the review.

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1. Introduction

Richmond & Wandsworth Safeguarding Adults Board commissioned this Safeguarding Adults Review (SAR) for Wandsworth under Section 44 of the Care Act 2014 following the death of Hope, a 66-year-old Black British Caribbean woman who died in January 2025. The statutory criteria for a SAR were met on the basis that there was reasonable cause for concern about how agencies worked together to safeguard Hope during the period preceding her death, and that she was an adult with care and support needs who appeared to have experienced neglect, including prolonged self-neglect, alongside deteriorating physical and mental health.[1]

Hope lived alone in social housing with tenancy management provided by a registered social housing provider in Wandsworth and had long-standing and complex health needs, including Type 2 diabetes mellitus, hypertension, chronic kidney disease, recurrent infections and anxiety. Influenza was recorded as the immediate cause of death, with diabetes, chronic kidney disease and peripheral vascular disease identified as contributory conditions. When she was admitted to hospital in December 2024, she had severe pressure ulcers on her feet, with the ulcer on her left foot appearing to go through to the bone and was treated for sepsis.

By the time of her final admission, Hope had experienced a prolonged period of declining health and increasing isolation. Records across agencies show repeated missed appointments, reluctance to allow professionals into her home, and increasing reliance on telephone or doorstep contact. In practice, this meant that for more than seven years, between 2017 and 2024, no professional recorded entering Hope's property to observe the conditions in which she was living. The commissioned care provider reported that staff had not entered the property since the support service began in 2012, instead meeting Hope at the doorway or in the community in accordance with the parameters of the care plan. This prolonged lack of environmental visibility became a significant feature of the case and shaped many of the system challenges explored in this Review.

Over a sustained period, professionals across primary care, community health services, adult social care and housing sought to engage Hope in assessment, treatment and support. These efforts included repeated offers of care, adjustments to modes of contact, and attempts to work around her anxieties about access to her home.

This review seeks to understand how local systems recognised, assessed and responded to escalating risk in the context of self-neglect, fluctuating engagement and complex health deterioration. It is particularly concerned with how professional judgements were shaped by repeated refusals of care, recorded assessments of mental capacity, and the ethical tension between respecting autonomy and responding to cumulative, foreseeable harm. National evidence consistently identifies self-neglect as one of the most challenging areas of adult safeguarding practice, characterised by uncertainty, fragmented system responses and a tendency for risk to be addressed episodically rather than as a trajectory of deterioration.[2]

[1] Care Act 2014; c.23 statutory guidance on SAR criteria
[2] Social Care Institute for Excellence. (2018). *Self-neglect at a glance*. SCIE.

1.1 Self-neglect as a safeguarding concern

Self-neglect is recognised in statutory guidance as a form of neglect for safeguarding purposes, encompassing a wide range of behaviours including neglect of personal care, health, nutrition, living environment and engagement with essential services.[3] National SAR analysis highlights that self-neglect often co-exists with physical ill-health, mental ill-health, trauma, social isolation and health inequality, and that it is associated with some of the poorest outcomes in adult safeguarding.[4]

Contemporary safeguarding literature emphasises that repeated refusal of support should not be treated as neutral or static, but as meaningful information requiring analysis.[5] In particular, where adults experience anxiety, fear, previous negative experiences of services, or long-term health conditions, non-engagement may reflect an inability to engage safely or consistently rather than an autonomous rejection of help. Safeguarding Adult Reviews consistently identify patterns in which capacity is assessed narrowly, executive functioning is insufficiently explored, and deterioration continues without a coordinated escalation response.[6]

This review therefore treats non-engagement not as the absence of safeguarding concern, but as a potential indicator of escalating risk that requires professional curiosity, multi-agency coordination and sustained oversight.

1.2 Anti-discriminatory and anti-racist practice lens

In line with the Terms of Reference developed by Richmond & Wandsworth SAB, the review applies an explicit anti-discriminatory and anti-racist practice (ADRP) lens throughout. This lens is not treated as a discrete theme but is embedded across the analysis to test whether structural inequality, bias or differential thresholds may have shaped responses to Hope's self-neglect and health deterioration.

There is substantial and robust evidence base demonstrating that Black Caribbean communities experience persistent inequalities in access to, and experience of, health and mental health services, including higher thresholds for intervention, experiences of being dismissed or not believed, and later presentation at points of crisis.[7] These inequalities are particularly relevant in self-neglect contexts, where engagement is fragile and where trust in services can significantly influence help-seeking and acceptance of support.[8]

Accordingly, this review triangulates:

- the self-neglect and safeguarding evidence base;
- national SAR learning on escalation, engagement and cumulative risk;
- and evidence on racialised experiences of health and mental health systems.

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[3] Department of Health and Social Care. (2022). *Care and support statutory guidance* (updated edition). HM Government.
[4] Tinelli, M., Harris, J., Cornes, M., Martineau, S., Ornelas, B., Burridge, S., & Manthorpe, J. (2024). *Strengthening adult safeguarding responses to homelessness and self-neglect: Economic analysis report*. Care Policy & Evaluation Centre, London School of Economics and Political Science.
[5] Braye, S., Orr, D., & Preston-Shoot, M. (2015). Serious case review findings on the challenges of self-neglect: Indicators for good practice. *Journal of Adult Protection*, 17(2), 75–87
[6] Local Government Association. (2023). Learning from Safeguarding Adult Reviews: National themes 2020–2023. LGA.
[7] NHS Race and Health Observatory. (2022). *Ethnic inequalities in healthcare: A rapid evidence review*. NHS England.
[8] Preston-Shoot, M. (2020). *Analysis of Safeguarding Adult Reviews: April 2017–March 2019*. Local Government Association.

This approach enables the review to examine whether Hope's reluctance to engage, anxiety about services and sustained deterioration were interpreted with sufficient cultural humility, professional curiosity and persistence, without presuming discrimination where it cannot be evidenced.

2. Methodology

2.1 Purpose and Approach

This Safeguarding Adults Review (SAR) has been undertaken under Section 44 of the Care Act 2014 to identify learning that can strengthen multi-agency safeguarding arrangements. The purpose of this SAR is not to reinvestigate events or to attribute blame to individual practitioners. It adopts a systems-learning approach,[9] consistent with the SCIE SAR Quality Markers, focusing on how organisational structures, professional frameworks, information-sharing arrangements and prevailing practice norms shaped what was possible at different points in time.[10] This approach is particularly appropriate in cases involving self-neglect and complex health needs, where risk develops cumulatively over time and is rarely reducible to single events or isolated decisions.

The review is guided throughout by Making Safeguarding Personal (MSP) principles, including respect for autonomy, recognition of lived experience, proportionality and avoidance of hindsight bias. The analysis seeks to balance respect for Hope's expressed wishes with scrutiny of how systems respond when adults experience sustained self-neglect, health inequality and marginalisation.

The aim is to produce learning that strengthens dignity, safety and trust for adults with similar experiences and supports practitioners working in complex and demanding contexts. Throughout, the review seeks to hold in balance respect for Hope's autonomy, recognition of the sustained efforts made by practitioners, and a clear focus on learning that can strengthen responses to adults experiencing self-neglect, health inequality and marginalisation in the future.

2.2 Evidence base

The review draws on multiple sources of evidence to enable triangulation between recorded practice, practitioner reflection and established learning. These include:

- The **Early Analysis Report (EAR)** prepared by the reviewer, which brought together initial chronologies, agency submissions and emerging lines of enquiry.
- **Detailed case records and information returns** from Adult Social Care, primary care, community and acute health services, housing services and other relevant partner agencies.
- **Multi-agency chronologies**, enabling examination of patterns of engagement, non-engagement, escalation and decision-making over time.

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[9] SCIE (2026) *Learning Together* (systems approach and analytic tools for case reviews). Learning Together to safeguard adults and children: a multi-agency systems approach - SCIE

[10] British Association of Social Workers. (2021). *Code of ethics for social work*. BASW.

- A **Multi-agency Practitioner Learning Event and SAR panel meeting**, which provided structured opportunities for reflection on frontline experience, ethical tensions and system constraints.
- **Relevant national and local Safeguarding Adults Reviews and associated policy and practice literature**, particularly in relation to self-neglect, capacity, engagement and escalation.

Practitioner contribution was central to the review process. The Practitioner Learning Event and SAR panel meeting enabled professionals from across agencies to reflect openly on their work with Hope, including sustained efforts to engage her, the ethical challenges of repeated refusal, uncertainty around escalation thresholds, and the emotional impact of working with cumulative deterioration.

These perspectives are integrated throughout the analysis and inform both the findings and recommendations.

2.3 Scope of the review

The review considers the period from **February 2022 to January 2025**, covering the timeframe in which concerns relating to Hope's health, engagement and self-neglect were most evident. Earlier history is referenced selectively where it materially informed professional understanding of Hope's needs, patterns of engagement or risk. The analysis is structured around Key Practice Episodes (KPEs), enabling detailed examination of critical moments in decision-making and escalation, alongside identification of cross-cutting system learning.

The scope focuses on multi-agency working across adult social care, health and housing, and examines how information was shared, how risk was conceptualised, and how escalation decisions were made in the context of repeated refusals and recorded assessments of mental capacity.

2.4 Analytical framework

Analysis within this SAR is structured around four interconnected lenses, which are applied consistently across the Key Practice Episodes and system findings:

- **Self-neglect and cumulative risk**: examining patterns of deterioration, non-engagement and escalation over time, rather than isolated incidents.
- **Capacity, consent and executive functioning**: considering how assessments of capacity and refusals of care were interpreted in practice, including the impact of anxiety, health deterioration and executive functioning on decision-making.
- **Systems conditions and escalation**: exploring how organisational pathways, thresholds, inter-agency interfaces and service design shaped risk ownership and coordination.
- **Anti-discriminatory and anti-racist practice (ADRP)**: applying an explicit analytical test to examine whether interpretations of non-engagement, thresholds for escalation or persistence were influenced by structural inequality

or differential assumptions, without presuming discrimination where it cannot be evidenced.

These lenses are used to support critical reflection on practice and system functioning, rather than as standalone thematic sections.

3. Hope – Who She Was

Hope valued her independence and privacy, and who experienced significant anxiety that shaped how she interacted with the world around her. Those who knew her described her as polite, articulate, and capable of forming warm connections when she felt safe to do so.

Hope's home was central to her sense of safety and autonomy, and over time she became increasingly anxious about allowing others into that space. Over time, her anxieties about intrusion and change increased, and she became more cautious about allowing others into her personal space. This preference for privacy was closely tied to her sense of identity and autonomy.

Hope's life was marked by periods of isolation, but also by moments of connection with professionals who sought to engage her respectfully and at her pace. Understanding Hope as a person; her wishes, fears, and need for safety, is essential to understanding how safeguarding responses were experienced by her, and why proportionate, relationship-based approaches mattered.

This section does not seek to reduce Hope's life to her vulnerabilities. She was a woman who lived independently for many years, who managed her own home, and who interacted with services on her own terms. At the same time, her isolation, declining health and difficulties engaging with support meant that no single agency ever held a complete picture of her lived experience. Understanding this context is essential to making sense of the decisions taken by practitioners and the system responses explored in the sections that follow.

Additional family perspective: Hope's life and relationships

Hope's niece described her as a deeply private but warm and caring person who maintained strong connections with her family. She was regarded as a kind and gentle woman with a "heart of gold", someone who valued independence but also enjoyed family life and regular contact with her sisters and wider relatives. Hope had creative and reflective interests, including puzzles, drawing, knitting and crochet, and was described as someone who could become very focused on activities that interested her. Family members noted that she sometimes had a strong affinity for numbers and patterns and could become very absorbed in particular concerns. They also reflected that she could be very sensitive to noise and change, and that she tended to be cautious about allowing people into her personal space.

According to her family, Hope had previously lived an active and independent life. She regularly went out shopping, visited relatives and maintained a home that was described as well cared for and orderly. Family members felt that a significant turning point occurred when she began experiencing ongoing conflict with a neighbour, which she experienced as harassment and which caused her considerable distress. During

this period she was encouraged by housing management to document incidents of noise and antisocial behaviour by keeping records and recordings. Over time, this process appeared to become a central focus of her daily life and heightened her anxiety about the neighbour. Family members believe that this period marked the beginning of a gradual withdrawal from outside activities, with Hope becoming increasingly fearful of leaving her home and eventually spending long periods inside.

Family perspective on Hope's interaction with services

Family members described continuing to see Hope regularly, although contact increasingly took place at the doorway rather than inside the property, reflecting Hope's longstanding reluctance to allow others into her home. On several occasions relatives attempted to gain access or encouraged Hope to stay with them temporarily so that repairs or cleaning could take place, but she declined these offers. They described Hope as someone who could be very determined and firm in her decisions once she had decided against something. While she would ask family members for practical support such as shopping, she was often reluctant to accept assistance from formal services.

Hope's sisters provided practical and financial support when they could, but family members explained that she sometimes struggled to understand or manage financial matters and believed she was not permitted to request repairs or replacements for household items. This belief appears to have contributed to her continuing to live in deteriorating housing conditions that might otherwise have been addressed. Family members also reflected that Hope experienced significant anxiety following a period of mental health treatment at Springfield Hospital, which they associated with the earlier neighbour conflict and her increasing isolation. In the years that followed, they attempted to support her return to normal routines but found this difficult as Hope became more housebound and increasingly reluctant to engage with outside help.

Family members did not realise the extent of the deterioration within the home environment because they were not able to enter the property. When they saw Hope on Christmas Day shortly before her final hospital admission, they were shocked by the level of pain she appeared to be in and the seriousness of her physical condition. They also reflected on the challenges they faced as a family at that time, as they were simultaneously caring for another elderly relative with cancer. Despite these difficulties, they remained closely connected to Hope and expressed deep affection and concern for her wellbeing.

4. Summary of Key Practice Episodes

This review organises analysis around a series of Key Practice Episodes (KPEs). These are points in time where professional decision-making, inter-agency coordination and escalation were particularly significant in shaping Hope's experience and outcomes. The KPE structure supports detailed examination of how risks were recognised and responded to, while also enabling cross-cutting system learning to be identified.

The KPEs do not represent isolated incidents. Each episode is understood within the context of what came before and what followed, recognising that Hope's

circumstances involved cumulative deterioration, fluctuating engagement and repeated ethical tensions around autonomy, consent and risk. The summary below provides an overview of each KPE and explains why it matters for learning, before the report moves into detailed analysis.

Table 1 Overview of Key Practice Episodes (KPEs)

KPE	Period	Focus	Key features
KPE 1	Feb–Apr 2022	Early concerns and engagement patterns	Early indicators of health-related self-neglect; anxiety affecting engagement; missed or delayed appointments; reluctance to allow home access; capacity generally assessed as present; concerns managed within single-agency pathways.
KPE 2	Mid–2022–early 2023	Partial engagement and emerging drift	Ongoing intermittent contact; repeated refusals or non-response; continued health needs; non-engagement becomes familiar; no clear escalation trigger; risk ownership remains diffuse.
KPE 3	2023	Increasing health complexity	Deteriorating physical health; missed follow-up and delayed treatment; limited cross-agency visibility; reliance on capacity and consent frameworks; cumulative risk without crisis.
KPE 4	Late 2024	Heightened concern and re-engagement attempts	Renewed professional concern; attempts to reassess needs; increased anxiety; consideration of escalation options under time pressure; narrowing range of proportionate responses.
KPE 5	Dec 2024–Jan 2025	Final contacts prior to death	Final professional contacts; ongoing deterioration; limited opportunity for effective intervention; system responding under significant constraint.

5. Positioning this review within national Safeguarding Adult Review learning

This Safeguarding Adults Review builds on established national learning from previous SARs involving self-neglect, deteriorating physical health, social isolation and sustained non-engagement with services. During the ‘Early Analysis’ phase, the reviewer identified a number of comparable SARs that share key features with Hope’s circumstances, including adults living alone with complex health needs, repeated refusals of care, and prolonged periods without a single crisis event to trigger escalation.

These reviews consistently highlight similar system challenges, including the episodic management of self-neglect, diffusion of risk ownership across agencies, reliance on capacity-led decision-making, and late-stage escalation when options for effective intervention are already constrained. The findings that follow should therefore be read not only as case-specific learning, but as part of a wider body of national evidence about how adult safeguarding systems respond to cumulative risk in the context of self-neglect and health inequality.

6. Systems Findings

The findings set out below draw together learning from across the Key Practice Episodes. They focus on system conditions, patterns of decision-making and organisational interfaces, rather than individual actions or omissions. The findings are intended to support reflection on how safeguarding arrangements operated in practice, what constrained or enabled effective responses, and where system change may strengthen future practice. The findings are interconnected. While they are presented separately for clarity, they describe overlapping dynamics that collectively shaped how Hope's needs were understood and responded to over time.

Finding 1: Prolonged invisibility and non-access meant that self-neglect and environmental risk were normalised rather than escalated

This Safeguarding Adults Review finds that Hope experienced a prolonged period of invisibility to statutory services, during which known risks relating to self-neglect and hoarding were not adequately assessed through direct observation of her living conditions. Despite long-standing involvement from adult social care and partner agencies, no professional is recorded as having entered Hope's property for a number of years, extending well beyond the period affected by COVID-19 restrictions.

While individual practitioners demonstrated commitment and relationship-based engagement, the system did not respond to sustained non-access as a safeguarding concern requiring escalation, coordination, or challenge. Over time, this led to the normalisation of high risk and the absence of a shared, evidence-based understanding of Hope's lived environment.

Case evidence

Hope was known to adult social care over an extended period, with ongoing concerns relating to self-neglect, hoarding, anxiety, and deteriorating physical health. Records show repeated refusals of access, missed appointments, and increasing reliance on indirect contact.

Care provision operated within parameters set by adult social care that did not include entering the property. Care workers maintained regular, friendly doorstep contact, demonstrating persistence, warmth, and continuity. This represents good frontline practice within defined role boundaries and provided Hope with consistent human connection.

However, those boundaries were not sufficiently reviewed or challenged over time. There is limited evidence of sustained professional curiosity about why access could

not be achieved in a case where self-neglect and hoarding were already recognised risks. Telephone welfare checks and doorstep contact increasingly became substitutes for direct assessment, rather than interim measures within a coordinated strategy to gain safe access. Maintaining contact appeared to become an end in itself, even where that contact did not allow risks to be seen, assessed, or mitigated.

No single agency drew together the cumulative picture of risk, and there is no evidence of a multi-agency plan to address prolonged non-access. In parallel, routine housing safety checks were not undertaken for a significant period, further reducing opportunities to identify environmental hazards or escalating safeguarding concerns.

Context of COVID-19

The Review acknowledges that the COVID-19 pandemic disrupted face-to-face practice across health and social care. However, the absence of professional access to Hope's property both pre-dated and substantially post-dated national restrictions. COVID-19 does not therefore account for the sustained lack of direct assessment, nor for the absence of a post-pandemic re-evaluation of risk, engagement, and escalation strategies.

Learning from national evidence

National research and Safeguarding Adults Review learning consistently demonstrate that the greatest risks in self-neglect cases arise where:

- non-engagement and refusal of access are treated as static choices rather than dynamic safeguarding indicators,
- risk is managed episodically rather than cumulatively, and
- professional responsibility becomes diffused across agencies, leading to drift and normalisation.[11]

This case reflects those patterns. Although individual services recognised elements of risk, the absence of direct observation and coordinated escalation meant that Hope's situation was never fully understood or tested against safeguarding thresholds.

Anti-racist practice considerations

Recent national safeguarding learning increasingly emphasises that anti-racist practice requires more than an absence of discriminatory intent; it requires active challenge to the ways in which risk is interpreted, normalised, or deprioritised within systems. In particular, Safeguarding Adults Reviews have highlighted that adults from racially minoritised communities are more likely to experience reduced visibility to services, less proactive intervention, and a higher tolerance of cumulative risk, especially where non-engagement or refusal is present.[12]

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[11] Department of Health and Social Care (2024) *Care and Support Statutory Guidance* (Chapter 14: Safeguarding, including self-neglect); SCIE (2014) *Self-neglect and adult safeguarding: findings from research* (Report 46); Braye, S., Orr, D. and Preston-Shoot, M. (2015) *Self-neglect policy and practice: key research messages*, SCIE.

[12] Hampshire Safeguarding Adults Board. (2019). *Self-neglect: Learning from Safeguarding Adults Reviews – Gap analysis*.

In Hope's case, repeated non-access, disengagement, and environmental risk were accepted over a prolonged period without sufficient challenge. An anti-racist practice lens requires consideration of whether thresholds, expectations of engagement, and interpretations of refusal were operating equitably, or whether systemic assumptions contributed to the acceptance of prolonged invisibility.

The absence of sustained challenge to non-access, and the lack of escalation despite known self-neglect and hoarding risk, indicate a missed opportunity to apply an explicitly anti-racist, equity-focused safeguarding approach.

Why this matters

In cases of self-neglect and hoarding, access to the living environment is fundamental. Environmental conditions, fire risk, hygiene, mobility, and the practical impact of clutter cannot be reliably assessed through telephone contact or doorstep conversations alone. Where access is repeatedly refused, this should heighten concern, not reduce it.

Hope's prolonged invisibility was not the result of a single missed opportunity, but of a system that gradually adapted to non-access without sufficient challenge. While pockets of good relational practice existed, these were not supported by system-level decision-making that prioritised safe access, escalation, and shared ownership of risk.

This finding underpins the Review's recommendations, which focus on strengthening responses to prolonged non-access, ensuring that self-neglect is understood as a cumulative safeguarding trajectory, and embedding mechanisms that prevent adults at risk from becoming effectively unseen within service systems.

Finding 2: A narrow and episodic focus on mental capacity, combined with anxiety and non-engagement, constrained professional curiosity and safeguarding escalation

This Safeguarding Adults Review finds that professional responses to Hope's situation were shaped by a narrow and episodic application of mental capacity, which, over time, constrained safeguarding escalation and limited challenge to prolonged non-engagement. While capacity was considered at points, it was often treated as a determinant of whether further action was appropriate, rather than as one element within a wider safeguarding assessment that also required consideration of anxiety, executive functioning, cumulative risk, and environmental context.

National evidence and Safeguarding Adults Review learning consistently caution that an over-reliance on mental capacity assessments in cases of self-neglect can unintentionally displace safeguarding responsibility, particularly where adults appear to make decisions but struggle to initiate, sustain, or implement those decisions in practice.[13]

Case evidence

In Hope's case, practitioners recognised that she experienced significant anxiety and avoidance, which affected her engagement with services and her willingness to allow

[13] SCIE (2014) *Self-neglect and adult safeguarding: findings from research* (SCIE Report 46).

access to her home. There is evidence that Hope was able, at times, to articulate preferences and to refuse aspects of intervention. These refusals were frequently interpreted as expressions of choice, and capacity was often implicitly assumed rather than revisited in light of changing circumstances.

However, there is limited evidence that professional assessments consistently distinguished between:

- Hope's ability to understand and communicate decisions, and
- her ability to follow through, manage daily living tasks, or sustain engagement in the context of anxiety, isolation, and deteriorating health.

As a result, repeated non-engagement and refusal of access were often managed as expected features of Hope's presentation rather than as indicators of increasing risk requiring escalation or multi-agency review.

National evidence and SAR learning

The Mental Capacity Act Code of Practice is clear that capacity is decision-specific, time-specific, and must be reassessed where circumstances change or where there is reason to doubt whether an individual can carry out decisions safely over time.[14] The presence of capacity does not remove safeguarding duties where there is reasonable cause to suspect abuse or neglect, including self-neglect.[15]

Research and national safeguarding guidance on self-neglect emphasise that adults may retain decision-making capacity yet still experience significant difficulty with executive functioning, motivation, anxiety, or self-care, resulting in high levels of risk. In such cases, a sole focus on capacity can lead to what has been described in national learning as "respectful helplessness", where professionals step back in deference to autonomy without sufficient attention to harm prevention.[16]

Thematic learning from Safeguarding Adults Reviews repeatedly identifies that:

- capacity assessments are sometimes used as a stopping point rather than a prompt for further analysis,
- non-engagement is accepted without sufficient exploration of underlying causes, and
- safeguarding thresholds are not revisited as risks accumulate over time.[17]

Hope's case reflects these national patterns. Although professionals were acting in good faith and sought to respect Hope's autonomy, the absence of a more holistic safeguarding analysis meant that anxiety-driven disengagement and declining ability to manage daily living were not adequately responded to as escalating risk.

An anti-racist practice perspective further requires scrutiny of how autonomy and capacity are interpreted in practice. National evidence indicates that adults from racially minoritised backgrounds may be more likely to have disengagement framed

[14] Ministry of Justice (2007) *Mental Capacity Act 2005 Code of Practice*.
[15] Department of Health and Social Care (2024) *Care and Support Statutory Guidance*, Chapter 14 (Safeguarding).
[16] Braye, S., Orr, D. and Preston-Shoot, M. (2015) *Self-neglect policy and practice: key research messages*, SCIE.
[17] Hampshire Safeguarding Adults Board (2019) *Self-Neglect: Learning from Safeguarding Adults Reviews – Gap Analysis*.

as personal choice, and less likely to benefit from assertive, relationship-based safeguarding responses.[18]

In this context, the reliance on Hope's apparent expressions of choice, without sufficient interrogation of anxiety, executive functioning, or cumulative harm, risks reinforcing structural inequity. Anti-racist safeguarding practice demands that professionals question whether respect for autonomy is being applied consistently, or whether it is inadvertently being used to justify inaction in the face of escalating risk.

Why this matters

This finding highlights a critical tension between autonomy and protection that lies at the heart of self-neglect practice. Respecting an adult's wishes is a core principle of good practice; however, respect without challenge can become a form of inaction where anxiety, avoidance, or reduced executive functioning undermine an individual's ability to keep themselves safe.

In Hope's case, the cumulative effect of repeated non-engagement, deteriorating health, and prolonged non-access required a more assertive, coordinated safeguarding response. The failure to move beyond a narrow interpretation of capacity contributed to missed opportunities to reframe her situation as one requiring escalation, shared ownership of risk, and sustained professional curiosity.

This finding informs recommendations focused on strengthening practice around capacity in self-neglect cases, ensuring that safeguarding responsibilities are not displaced, and embedding approaches that recognise the difference between decision-making ability and the capacity to live safely over time.

Finding 3: Thresholds and escalation processes did not sufficiently respond to cumulative self-neglect, prolonged non-engagement, and systemic invisibility

This Safeguarding Adults Review finds that safeguarding thresholds and escalation mechanisms were applied narrowly and episodically, resulting in prolonged self-neglect and non-engagement being managed within routine service responses rather than being reframed as indicators of escalating safeguarding risk. Decisions about threshold were not consistently revisited as risks accumulated over time, and prolonged lack of direct professional visibility to services was not treated as a trigger for escalation.

National evidence from Safeguarding Adults Reviews demonstrates that failure to respond to cumulative self-neglect trajectories; particularly where non-engagement and refusal of access are present, is a recurring feature in cases resulting in serious harm or death.[19]

Case evidence

In Hope's case, concerns relating to self-neglect, anxiety, environmental risk, and disengagement were recognised by multiple agencies at different points. However, these concerns were largely addressed in isolation, with repeated decisions that

[18] NHS Race and Health Observatory. (2022). *Ethnic inequalities in healthcare: A rapid evidence review.*

[19] Preston-Shoot, M., O'Donoghue, F., & Binding, J. (2022). *Hope springs: further learning on self-neglect from safeguarding adult reviews and practice.* The Journal of Adult Protection, 24(3/4), 161–178.

safeguarding thresholds were not met. There is limited evidence that thresholds were actively re-examined in light of:

- the **duration** of non-access and non-engagement,
- the **absence of direct observation** of Hope's living conditions,
- the **interaction** between mental health, anxiety, and deteriorating physical health, and
- the **cumulative** nature of risk across several years.

The lack of a coordinated, multi-agency reassessment of threshold meant that safeguarding responses remained static, despite increasing indicators of harm.

National evidence and SAR learning

Recent national analysis of Safeguarding Adults Reviews emphasises that self-neglect cases often deteriorate where systems fail to recognise patterns over time, rely on single-incident assessments, or accept disengagement as a stable position rather than a safeguarding signal. Preston-Shoot et al. (2022) identify that SARs repeatedly highlight "missed opportunities to reframe accumulating concerns as safeguarding risks" and a tendency for thresholds to be applied rigidly rather than dynamically.[20]

Statutory safeguarding guidance is clear that escalation should be based on reasonable cause to suspect abuse or neglect, not on engagement, consent, or cooperation.[21] The presence of refusal or non-engagement does not remove safeguarding responsibilities; rather, it may increase the need for coordinated and proportionate intervention.

Anti-racist practice considerations

An anti-racist practice lens requires scrutiny of whether safeguarding thresholds operate equitably in practice. National evidence on inequalities in health and care demonstrates that adults from racially minoritised backgrounds are more likely to experience reduced visibility to services and less proactive intervention, particularly where engagement is limited.[22]

In this context, repeated decisions that concerns did not meet safeguarding thresholds; without structured challenge or equity-based review, risk reinforcing systemic inequity. Hope's prolonged invisibility raises questions about whether threshold decisions sufficiently accounted for cumulative risk and whether disengagement was interpreted in ways that unintentionally tolerated higher levels of harm.

Why this matters

Thresholds are not neutral technical tools; they are shaped by professional judgement, organisational culture, and assumptions about risk, responsibility, and engagement.

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[20] ibid
[21] Department of Health and Social Care. (2024). *Care and Support Statutory Guidance* (Chapter 14: Safeguarding).
[22] NHS Race and Health Observatory. (2022). *Ethnic inequalities in healthcare: A rapid evidence review.*

Where thresholds are not revisited and cumulative harm is not recognised, adults experiencing self-neglect may remain outside safeguarding responses until risks become irreversible.

In practice, the legal framework for gaining entry to a private dwelling is limited. Powers under the Mental Health Act 1983 require evidence of mental disorder and associated risk thresholds which were not clearly met in this case. Similarly, safeguarding legislation does not itself create a power of entry. As a result, professionals were required to work within a framework that prioritises consent and proportionality, even where risks are increasing. In the absence of evidence meeting Mental Health Act thresholds, or circumstances meeting emergency entry provisions, professionals would generally require the adult's consent to enter the property. This meant that, in practice, agencies were reliant on Hope agreeing to access unless a significant and immediate risk threshold could be demonstrated.

This finding underpins recommendations focused on strengthening dynamic threshold review, embedding cumulative risk analysis, and ensuring that safeguarding decision-making incorporates an explicit equity and anti-racist practice lens.

Finding 4: Housing oversight and assurance were not sufficiently integrated into safeguarding responses, contributing to prolonged invisibility and unmanaged environmental risk

This Safeguarding Adults Review finds that housing was not consistently recognised or utilised as a safeguarding partner, despite prolonged self-neglect, non-access, and environmental risk. The absence of routine housing assurance activity and the lack of escalation when access was refused meant that Hope's living conditions remained unseen for an extended period, reducing system visibility and weakening safeguarding oversight.

National thematic safeguarding learning demonstrates that where housing is not embedded within safeguarding processes, adults experiencing self-neglect may remain effectively invisible, particularly when other services adapt by reducing face-to-face contact.[23]

Case evidence

In Hope's case, there is no evidence of routine housing inspections, safety checks, or property-based welfare visits over a prolonged period. This absence persisted even as concerns about self-neglect, hoarding, and anxiety were known to adult social care and health. While COVID-19 restrictions temporarily reduced access across services, the lack of housing oversight both pre-dated and extended well beyond this period.

Care provision maintained contact within the boundaries of the agreed care plan, including regular doorstep engagement and relational contact. This reflects elements of good practice and continuity. However, there was no clear mechanism for care providers or housing services to escalate concerns about prolonged non-access or to

[23] North Yorkshire Safeguarding Adults Board. (2025). *Safeguarding Adults Thematic Review on Diabetes: K, G and M.*

challenge the acceptability of never entering the property in the context of known self-neglect and hoarding.

As a registered social housing provider, a landlord is expected to take reasonable steps to ensure tenants' health and safety and to deliver effective repairs and maintenance services, consistent with the Regulator of Social Housing's consumer standards (including the Safety and Quality Standard).[24] In practice, essential inspections and safety-related works often depend on being able to gain access, and tenancy terms typically require tenants to allow access for health and safety inspections and servicing.[25] Where access is repeatedly refused in the context of known vulnerability and escalating risk, this should not simply result in closure or inaction but should trigger proportionate escalation and multi-agency safeguarding oversight so that risks to the adult (and potentially to neighbours and the wider building) are actively assessed and managed.

As a result, environmental risk was neither directly assessed nor reviewed through a safeguarding lens, and Hope's home environment remained a critical blind spot in the system's understanding of her safety and wellbeing.

National evidence and thematic safeguarding learning

Thematic Safeguarding Adults Reviews have increasingly identified housing as a central determinant of risk, particularly in cases involving self-neglect, chronic health needs, and social isolation. The North Yorkshire Safeguarding Adults Board's thematic review highlights that lack of housing oversight, reduced professional sight of the living environment, and prolonged silence are recurring features in cases where harm escalates unnoticed.[26]

Housing and safeguarding guidance also emphasise that safety and wellbeing cannot be assured without proportionate inspection, review, and escalation where access is refused or contact is lost. Accepting non-access without challenge risks normalising environmental harm and undermining safeguarding responsibilities.[27]

Anti-racist practice considerations

An anti-racist practice lens requires explicit attention to how structural invisibility operates across systems. National evidence indicates that adults from racially minoritised communities are more likely to experience reduced continuity and less proactive oversight within health and social care systems. Where housing assurance is weak, these inequalities may be amplified, particularly for adults who are anxious, isolated, or reluctant to engage.

In Hope's case, the absence of housing-based safeguarding challenge meant that prolonged non-access was absorbed into routine practice rather than treated as a safeguarding signal requiring escalation and review.

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[24] HM Gov (2024) *Regulatory standards for landlords.*
[25] London & Quadrant (n.d.) *Your Rights and Your Services.*
[26] North Yorkshire Safeguarding Adults Board. (2025). *Safeguarding Adults Thematic Review on Diabetes: K, G and M.*
[27] Regulator of Social Housing (RSH). *Consumer Standards Framework* (as described on GOV.UK and in the RSH Consumer Regulation Review).

Why this matters

Housing is not a neutral backdrop to safeguarding; it is a core component of adult safety, dignity, and wellbeing. Where systems rely on indirect contact and do not maintain proportionate oversight of the living environment, adults experiencing self-neglect may remain unseen for years.

This finding underpins recommendations aimed at embedding housing providers within safeguarding pathways, strengthening assurance mechanisms, and ensuring that prolonged non-access or silence triggers coordinated review rather than acceptance.

Finding 5: The absence of structured learning, review, and challenge mechanisms limited the system's ability to disrupt drift

This Safeguarding Adults Review finds that system-level mechanisms for learning, reflective challenge, and coordinated review were insufficiently embedded to identify and disrupt drift in Hope's case. Although individual practitioners maintained contact and acted within the scope of their roles, there were limited opportunities for concerns to be brought together, assumptions tested, or risk reappraised when access could not be achieved over a prolonged period.[28]

Case evidence

In Hope's case, adaptations to practice; such as reliance on telephone contact or doorstep engagement, were not consistently subject to formal review or reflective challenge. There is limited evidence that prolonged non-access or reduced visibility prompted:

- structured supervisory discussion focused on cumulative risk,
- multi-agency review of the effectiveness and safety of existing arrangements, or
- escalation through established safeguarding or learning forums.

The practitioner learning event reflected this pattern. Few practitioners had sustained or direct involvement with Hope. This absence of professional narrative is itself indicative of a system that lacked mechanisms to maintain shared learning and ownership in long-running, low-visibility cases.

National evidence and safeguarding learning

National safeguarding guidance and Safeguarding Adults Review learning consistently emphasise that self-neglect cases require active learning systems; including reflective supervision, chronology-based review, and multi-agency challenge, to counter normalisation of risk and reliance on individual judgement. SAR learning identifies that

[28] Department of Health and Social Care. (2024). *Care and Support Statutory Guidance* (Chapter 14: Safeguarding).

where such mechanisms are absent or informal, systems are less likely to revisit assumptions or escalate concerns as risk accumulates.[29][30]

Why this matters

Self-neglect often involves gradual deterioration rather than acute crisis. Without structured learning and challenge mechanisms, safeguarding responses depend disproportionately on individual persistence rather than organisational design. This increases the risk that prolonged non-access and cumulative harm become embedded within routine practice rather than recognised as signals requiring escalation.

Hope's longstanding mental health needs, including anxiety-related avoidance, interacted with physical health deterioration and emerging self-neglect. Missed appointments, non-compliance with treatment and reduced engagement were largely accepted as disengagement, rather than prompting sustained review or escalation.[31]

Where mental health needs materially affect engagement and visibility, this should be understood as a safeguarding risk rather than a neutral choice. Disengagement should trigger shared review and escalation, particularly where Section 117 aftercare applies, as responsibility is not extinguished by non-attendance alone.

This finding informs recommendations aimed at strengthening formal review points, reflective safeguarding spaces, and learning processes that ensure drift is identified and challenged before harm becomes irreversible.

7. Recommendations

This Review has sought to incorporate some of the learning around national self-neglect and hoarding, statutory safeguarding duties, multi-agency hoarding frameworks, housing and fire safety assurance models, as well as emerging expectations around equity and anti-racist practice, and align these with concrete recommendations provided below. The aim is to turn known risk factors (non-access, clutter, disengagement, invisibility) into *measurable system triggers*, rather than relying on professional judgement alone.

Purpose and Focus of the Recommendations

The findings of this Review do not indicate a lack of awareness, policy, or professional commitment in relation to self-neglect, hoarding, capacity, or safeguarding escalation. Relevant statutory duties, local pathways, and national good practice guidance were already in place during the period under review.

The learning from this Review instead highlights a failure of *operational grip*: existing mechanisms were not consistently activated, tested, escalated, or assured over time in the context of prolonged non-access, cumulative self-neglect, and increasing

[29] SCIE. (2022). *Safeguarding Adults Review Quality Markers.*
[30] Preston-Shoot, M., O'Donoghue, F., & Binding, J. (2022). *Hope springs: further learning on self-neglect from safeguarding adult reviews and practice. *The Journal of Adult Protection, 24(3/4), 161–178.*
[31] SCIE (2018) *Self-neglect at a glance*

invisibility. Decision-making became episodic, responsibility diffused across agencies, and the absence of structured review allowed known risks to normalise.

The recommendations that follow are therefore intentionally assurance-led. They focus on strengthening the consistent *use*, *oversight*, and *accountability* of existing safeguarding, housing, and partnership arrangements, rather than introducing new policy frameworks. Their purpose is to ensure that known risk indicators; such as prolonged non-access, environmental risk, disengagement, and silence, operate as clear system triggers for action, review, and escalation in practice.

Recommendation 1: Prolonged non-access as a mandatory escalation trigger

The Safeguarding Adults Board should introduce a mandatory escalation trigger where no professional has entered an adult's home for a defined period in the context of self-neglect or hoarding. This should prompt a recorded multi-agency review or safeguarding discussion/enquiry, with explicit rationale if escalation does not occur.

Why this is current practice:

Many local self-neglect pathways now identify *non-access* as a safeguarding risk in its own right, recognising that safety cannot be assured without environmental visibility.

Recommendation 2: Assurance of Joint Fire–Housing–ASC–Health–home risk pathways

The Safeguarding Adults Board should require assurance that existing joint Fire, Housing and Adult Social Care pathways for hoarding and environmental risk are consistently activated where self-neglect or prolonged non-access is present.

This should include clear expectations regarding:

- when fire safety involvement is triggered by clutter or non-access,
- housing responsibilities for inspection, safety assurance and escalation, and
- how refusal of access is reviewed, challenged and escalated through safeguarding processes.

The Board should seek evidence of pathway activation and outcomes, rather than reliance on pathway availability alone.

Why this reflects current best practice:

Fire services nationally recognise hoarding as a major risk factor for serious harm and death, and many councils already integrate fire input into self-neglect pathways.

Recommendation 3: Integrated multi-agency response to self-neglect where mental health impacts engagement

The Safeguarding Adults Board should require assurance that agencies operate a single, integrated multi-agency response for adults experiencing self-neglect,

prolonged non-access, or reduced visibility, particularly where mental health needs materially affect engagement, treatment compliance, or self-care.[32]

This response should apply in cases where adults may present as superficially well or intermittently engaged, but where cumulative indicators suggest deteriorating physical health, unmanaged mental health needs, environmental risk, or sustained withdrawal from services.[33]

The integrated response should set out clear expectations regarding:

- **shared system ownership**, with named coordination across Adult Social Care, health services (including mental health), Housing Providers and, where relevant, Fire and Rescue Services;
- **how repeated non-engagement, missed appointments, refusal of access, or withdrawal from services are recognised as safeguarding indicators**, rather than accepted as routine disengagement or personal choice;[34]
- **how mental health needs (including anxiety, agoraphobia, trauma-related avoidance or relapse indicators)** are actively considered in understanding self-neglect, avoidance of services and non-compliance with treatment;[35]
- **how access and engagement efforts are planned, recorded and reviewed**, including reasonable adjustments and culturally appropriate approaches;
- **how refusal of access or ongoing non-engagement is reviewed, challenged and escalated**, including when a Section 42 safeguarding enquiry or multi-agency discussion is required;[36]
- **how risk information is shared across service interfaces**, including between acute hospitals, community health services, mental health teams and Housing Providers, where environmental risk or declining self-care is suspected or known.

Where an adult is eligible for Section 117 aftercare, agencies should ensure that eligibility and associated responsibilities are clearly identified and communicated within multi-agency forums, so that oversight is not inadvertently lost across organisational or geographical boundaries.[37]

The Board should seek evidence of how this integrated response is activated, reviewed and escalated in practice, rather than relying on the existence of policies or individual professional persistence alone.

The Review recognises that local implementation operates within national commissioning frameworks, eligibility criteria, and evolving mental health policy

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[32] Care Act 2014; Department of Health and Social Care (2023) *Care and Support Statutory Guidance* (self-neglect as a safeguarding concern requiring multi-agency response).

[33] Braye, S., Orr, D. and Preston-Shoot, M. (2015) *Serious Case Review findings on the challenges of self-neglect: Indicators, practice responses and outcomes*, Journal of Adult Protection, 17(3), pp. 75–87;
SCIE (2018) *Self-neglect at a glance* – highlighting that self-neglect may remain hidden where individuals present as articulate, well-kept or intermittently engaged.

[34] Local Government Association (2024) *Second National Analysis of Safeguarding Adults Reviews*

[35] Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-neglect policy and practice: building an evidence base*, Journal of Adult Protection – evidencing the interaction between mental health, avoidance, and self-neglect.

[36] Department of Health and Social Care (2023) *Care and Support Statutory Guidance*, paras. 14.40–14.45 – escalation, review and enquiry where risk remains unmanaged despite apparent capacity.

[37] Mental Health Act 1983, s.117;
R (Mwanza) v Greenwich LBC [2010] EWCA Civ 1462 – confirming that disengagement does not extinguish s.117 duties and should prompt review rather than withdrawal of aftercare.

structures, which may create structural constraints. However, these systemic factors do not remove safeguarding responsibilities. The purpose of this recommendation is not to override statutory eligibility thresholds, but to ensure that where cumulative risk is evident, agencies actively utilise existing multi-agency safeguarding, review and escalation mechanisms to prevent disengagement and invisibility from becoming normalised.

Recommendation 4: Equity and anti-racist safeguarding checkpoint

An explicit equity checkpoint should be embedded into safeguarding triage, supervision and review in self-neglect cases, requiring practitioners to consider:

- whether disengagement is being framed as “choice” without testing barriers,
- whether thresholds would be applied differently for another adult, and
- whether culturally safe engagement routes have been explored.

The SAB should also audit prolonged non-access and self-neglect cases by protected characteristic. This operationalises anti-racist practice rather than treating it as an aspirational principle.

Recommendation 5: Structured review of long-running self-neglect and low-visibility cases

The Safeguarding Adults Board should ensure that cases involving self-neglect (and Mental Health issues which impact engagement – staff recognising and dealing with comorbidities like MH issues which impact engagement and self-care) are subject to a structured multi-agency review where risk remains known but unmanaged over time, particularly in the absence of acute crisis.

Such reviews should be triggered where one or more of the following are present:

- prolonged non-access to the adult’s home environment,
- repeated non-engagement with treatment, care or assessment,
- reliance on indirect contact (e.g. telephone or doorstep engagement) over extended periods, or
- unclear or diffused ownership of cumulative risk across agencies.

The purpose of these reviews is to disrupt normalisation of risk by:

- bringing together a chronology-based picture of cumulative concern,
- explicitly identifying what is not known due to lack of access or engagement,
- testing assumptions about capacity, choice, and risk management, and
- agreeing time-limited actions with clear ownership and review points.

This recommendation is intended to strengthen use of existing safeguarding and multi-agency forums by embedding a deliberate point at which long-running, low-visibility cases are re-examined, rather than allowing ‘business as usual’ responses to continue by default.

This recommendation does not require the creation of new panels or structures. It should be embedded within existing safeguarding arrangements, including the self-

neglect and hoarding panel, supervision structures, or other established multi-agency forums. The emphasis is on ensuring that long-running, low-visibility cases are actively identified, brought forward, and subject to structured review rather than remaining dispersed across single-agency pathways. This should align with, and where necessary strengthen, the Board's existing multi-agency risk assessment framework and associated tools.

Recommendation 6: Housing as a core safeguarding partner in enquiries involving self-neglect and non-access

The Safeguarding Adults Board should ensure that Housing services, including Housing Providers where relevant, are treated as core partners in Safeguarding Enquiries where self-neglect, hoarding, prolonged non-access, or environmental risk are identified.

Housing should be routinely invited to Safeguarding Enquiry meetings in such cases, with a clear expectation that housing-related information, oversight activity, and assurance of the living environment are actively contributed to safeguarding decision-making.

This should include consideration of:

- housing visibility and access to the property,
- outstanding inspections, safety checks or compliance concerns,
- escalation routes where access is refused or risks cannot be assured, and
- how housing responsibilities interface with adult social care, health and fire services in managing cumulative risk.

The purpose of this recommendation is to ensure that environmental risk and housing-based safeguarding responsibilities are fully integrated into enquiries, rather than remaining peripheral to safeguarding oversight.

The Board should seek assurance that Housing involvement in relevant Safeguarding Enquiries is consistent and recorded, rather than discretionary.

8. Conclusion

This Safeguarding Adults Review has examined the circumstances surrounding Hope's life and death through a systems lens, drawing together agency records, practitioner reflection, and national safeguarding evidence. The Review does not identify a single act or omission that explains what occurred. Instead, it highlights how prolonged invisibility, non-access, and cumulative self-neglect were absorbed into routine practice over time, without sufficient challenge, escalation, or coordinated ownership.

The Review recognises examples of committed and compassionate practice, including persistence in maintaining contact and efforts to respect Hope's expressed wishes and anxieties. These actions reflect positive professional intent. However, the Review finds that continuity of contact was not matched by assurance of safety, and that the absence of mechanisms to secure environmental visibility, revisit thresholds, and disrupt drift meant that risk was not adequately understood or managed.

A central theme of this Review is that self-neglect cannot be safely addressed where systems do not see the environment in which an adult is living. Telephone and doorstep contact, while valuable as engagement tools, cannot substitute for proportionate assessment of living conditions where hoarding and self-neglect are known risks. The failure to challenge prolonged non-access, including through housing and fire safety routes, significantly reduced the system's ability to safeguard Hope.

The Review also identifies the importance of applying an explicit equity and anti-racist practice lens to safeguarding decision-making. Without structured prompts to test assumptions and review proportionality, there is a risk that disengagement and refusal are interpreted as settled "choice", rather than as signals of vulnerability requiring adapted and assertive responses. This is particularly important in cases where adults become marginal to services over long periods.

The recommendations arising from this Review are therefore intentionally assurance-led and measurable, grounded in the current national self-neglect and hoarding practice landscape. They focus on turning known risk indicators; non-access, clutter, disengagement, and silence, into system triggers for action, rather than relying on individual professional persistence alone. By embedding clearer escalation points, stronger housing–safeguarding integration, and explicit equity checks, the Safeguarding Adults Board can strengthen its ability to prevent adults experiencing self-neglect from becoming unseen within the system.

This Review concludes that meaningful improvement will depend not on new policies alone, but on how existing responsibilities are operationalised, reviewed, and challenged over time. Implementing the recommendations provides an opportunity to move from learning about invisibility to actively preventing it. Hope's experience demonstrates how adults can remain known to services yet effectively unseen. The challenge for safeguarding systems is not simply to recognise vulnerability, but to ensure that prolonged invisibility never becomes acceptable practice.

References

Braye, S., Orr, D., & Preston-Shoot, M. (2015). Serious case review findings on the challenges of self-neglect: Indicators for good practice. *Journal of Adult Protection*, 17(2), 75–87

British Association of Social Workers. (2021). *Code of ethics for social work*. BASW.

Care Act 2014; c.23 statutory guidance on SAR criteria

Department of Health and Social Care. (2024). *Care and Support Statutory Guidance* (updated edition). London: DHSC.

Hampshire Safeguarding Adults Board. (2019). *Self-Neglect: Learning from Safeguarding Adults Reviews – Gap Analysis*. Hampshire SAB.

Housing Ombudsman Service. (2023). *Spotlight on damp and mould: It's not lifestyle*. London: Housing Ombudsman.

Local Government Association. (2023). Learning from Safeguarding Adult Reviews: National themes 2020–2023. LGA.

London Fire Brigade. (n.d.). *Clutter Image Rating Toolkit*. London: London Fire Brigade.

Ministry of Justice (2007) *Mental Capacity Act 2005 Code of Practice*.

NHS Race and Health Observatory. (2022). *Ethnic inequalities in healthcare: A rapid evidence review*. London: NHS RHO.

North Yorkshire Safeguarding Adults Board. (2025). *Safeguarding Adults Thematic Review on Diabetes: K, G and M*. North Yorkshire SAB.

Preston-Shoot, M., O'Donoghue, F., & Binding, J. (2022). 'Hope springs: further learning on self-neglect from safeguarding adult reviews and practice'. *The Journal of Adult Protection*, 24(3/4), 161–178.

Preston-Shoot, M. (2020). *Analysis of Safeguarding Adult Reviews: April 2017–March 2019*. Local Government Association.

Regulator of Social Housing (2024). Consumer Standards. London: RSH.

SCIE. (2014). *Self-neglect and adult safeguarding: Findings from research* (Report 46). London: Social Care Institute for Excellence.

Social Care Institute for Excellence. (2018). *Self-neglect at a glance*. SCIE.

SCIE. (2022). *Safeguarding Adults Review Quality Markers*. London: Social Care Institute for Excellence.

SCIE (2025) *Learning Together* (systems approach and analytic tools for case reviews).

Tinelli, M., Harris, J., Cornes, M., Martineau, S., Ornelas, B., Burridge, S., & Manthorpe, J. (2024). *Strengthening adult safeguarding responses to homelessness and self-neglect: Economic analysis report*. Care Policy & Evaluation Centre, London School of Economics and Political Science.

Appendix A — Evidence Base and Comparator Learning

This appendix sets out the policy, practice and Safeguarding Adults Review (SAR) evidence base that informed the findings and recommendations of this Review. It demonstrates how learning has been triangulated across:

- **current statutory safeguarding guidance and national policy expectations;**
- **established self-neglect, hoarding and environmental risk frameworks used by local authorities, housing providers and fire services; and**
- **published national and thematic Safeguarding Adults Reviews, accessed through recognised repositories and safeguarding partnership publications.**

Comparator SARs are included not as direct case parallels, but to illustrate recurring system features identified nationally in self-neglect and invisibility cases, including prolonged non-access, threshold drift, diffusion of responsibility, and the absence of structured challenge. The inclusion of these comparators is intended to situate this

Review within the current safeguarding landscape, rather than to suggest equivalence between cases.

The table also highlights where learning has been translated into measurable system recommendations, reflecting an assurance-led approach to self-neglect and hoarding, and incorporating an explicit equity and anti-racist practice lens consistent with the Review's terms of reference.

Table 2 Evidence & comparator table

Evidence Source	What It Contributes	Where Reflected in Recommendations
Care and Support Statutory Guidance (DHSC)	Clarifies safeguarding duties regardless of engagement or consent; escalation based on reasonable cause to suspect abuse or neglect; proportionality principles	Recs 1, 3, 5
SCIE – Self-Neglect Research (Report 46)	Identifies drift, cumulative risk, invisibility, and need for structured multi-agency challenge in self-neglect cases	Recs 1, 3, 5
SCIE – Safeguarding Adults Review Quality Markers (2022)	Emphasises systems learning, reflective challenge, and structured review mechanisms to prevent normalisation of risk	Recs 3, 5
Preston-Shoot et al. (2022) "Hope Springs" & National SAR Analyses	Identifies recurring patterns: diffusion of responsibility, threshold drift, over-reliance on capacity, late escalation	Recs 1, 3, 5
Hampshire SAB Self-Neglect Gap Analysis	Thematic learning on escalation failures, prolonged non-access, and lack of coordinated response	Recs 1, 5
North Yorkshire SAB Thematic Review (Housing visibility & safeguarding oversight)	Highlights prolonged silence, housing invisibility, and absence of environmental oversight as recurring risk factors	Recs 2, 6
Fire Service Hoarding & Clutter Guidance (CIR frameworks)	Establishes environmental risk, clutter levels and fire hazard as safeguarding indicators requiring multi-agency escalation	Rec 2

Housing Ombudsman – Damp & Mould Spotlight Report	Demonstrates limits of managing risk without inspection or access; need for landlord assurance and proactive oversight	Recs 2, 6
Regulator of Social Housing – Consumer Standards (Safety & Quality Standard)	Reinforces housing providers' duties regarding safety, inspection, and access where risk is present	Recs 2, 6
NHS Race & Health Observatory (2022)	Evidence on structural inequality, disengagement framing, and inequitable thresholds in health systems	Rec 4

Appendix B — Clutter Image Rating (CIR): Summary for Safeguarding Practice

Clutter Image Rating (CIR) adapted from: **London Fire Brigade. (n.d.). *Clutter Image Rating Toolkit*.**

This was originally developed for use by fire services and now widely adopted across UK local authorities, housing providers and safeguarding partnerships as a shared multi-agency risk assessment tool:

Table 3 Clutter Image Rating (CIR) adapted from: London Fire Brigade. (n.d.). Clutter Image Rating Toolkit.

CIR Level	Description (summary)	Indicative safeguarding considerations
Level 1	Little to no clutter. Rooms and exits are clear and accessible.	No immediate safeguarding concern relating to clutter. Routine monitoring only.
Level 2	Low levels of clutter. Some household items present but rooms remain functional and exits clear.	Emerging risk if combined with self-neglect or health concerns. Monitor and review.
Level 3	Moderate clutter affecting use of rooms (e.g. furniture blocked, reduced living space).	Safeguarding concerns may be present. Multi-agency discussion recommended, particularly where self-neglect is identified.
Level 4	High levels of clutter significantly restricting living space and access. Increased fire and trip hazards.	Likely safeguarding concern. Escalation required. Fire safety, housing and adult social care involvement recommended.

Level 5	Severe clutter. Rooms unusable, exits blocked, high fire risk, hygiene concerns likely.	High safeguarding risk. Multi-agency response required. Strategy discussion likely appropriate.
Level 6	Extreme clutter throughout the property. Immediate risk to health and safety; possible structural or environmental hazards.	Critical safeguarding concern. Urgent multi-agency intervention required, including fire service and housing enforcement where proportionate.
Level 7	Property uninhabitable due to extreme clutter and environmental hazards.	Severe and immediate risk of serious harm. Emergency safeguarding response required.