HILLINGDON
LONDON

RESPONSE TO REGULATION 28
CORONER'S REPORT TO PREVENT FUTURE DEATHS

[redacted]
Touching the death of Jacqueline Elizabeth Smith

1	**THIS RESPONSE IS MADE ON BEHALF OF**: London Borough of Hillingdon
2	**REGULATION 28 REPORT RESPONSE**: This response is in answer to the report made to the London Borough of Hillingdon on 21 August 2023 by Mrs. Lydia Brown, the Acting Senior Coroner for West London, under paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION AND INQUEST**: On 16 August 2022, the Coroner commenced investigation into the death of Mrs Jacqueline Elizabeth Smith. The investigation concluded at the end of the inquest, which took place on 10 August 2023. The conclusion of the inquest was suicide. The coroner concluded that the cause of death was: 1a Respiratory depression 1b [redacted] overdose, exacerbated by the concomitant use of [redacted].
4	**CIRCUMSTANCES OF DEATH**: *[Quoted directly from the Coroner's Report]* Took her own life by an overdose of prescribed medication at home and died in Hillingdon Hospital on 12 August 2022. At the time, she was in poor physical health and experiencing considerable anxiety as she was trying, with assistance from the Council, to clear her home of numerous hoarded possessions. She spoke with the single point of access (SPA) crisis telephone service during the evening of 10 August 2022 to ask for help, but no mental health assessment was performed, and she was not called back by the team as promised. Her neighbour requested a welfare check be performed the next day when she was found collapsed and taken to hospital.
5	**CORONER'S CONCERNS**: The matters of concern set out by the Coroner in her report are as follows: *[Quoted directly from the Coroner's Report]*

	Mrs Smith was recognised to be a hoarder and her council property was dangerously full of items blocking all access, impeding stair access and impacting on her ability to access the kitchen or bathroom. The gas supply had been cut off as she did not allow access for the annual inspection. Mrs Smith recognised she had a problem and asked the council for assistance. The offered solution only moved some of her belongings into a local "void" property that she did not have access to with no plan for how to resolve this temporary situation, creating considerable anxiety and stress for Mrs Smith who then took her own life by overdosing with her prescribed medication. (1) The inquest identified that there was insufficient staff training to deal with complex hoarder cases. (2) Other safety assessments such as a fire assessment and/or environmental health assessment were not requested despite there being a clear need. (3) The council "flow chart" was clearly not fit for purpose to assist staff in progressing hoarder support and assistance and was focussed on enforcement procedures rather than tenant support. The inquest was advised that the council's approach was not enforcement, but their documentation did not support this. (4) It was entirely unclear what options were available (if any) when the first plan of assistance completely failed, leaving the vulnerable tenant excluded from her property with no forward plan.
6	**RESPONSE TO CONCERNS (1)-(4)** **ACTION TAKEN / TO BE TAKEN & TIMESCALES**:
	We are deeply saddened by the death of Mrs Jacqueline Smith and offer our sincere condolences to Mrs Smith's family on behalf of the London Borough of Hillingdon.
	<u>Concern (1): insufficient staff training to deal with complex hoarder cases.</u> The London Borough of Hillingdon holds a Housing Management Hoarding Panel, which specifically focuses on hoarding cases in Council properties. As a landlord, the London Borough of Hillingdon recognises the responsibilities it has to its vulnerable residents that may be affected by hoarding. The Terms of Reference for the Panel include the need to deliver training on hoarding to all Officers within Housing Management. These Terms of Reference are at Appendix 1 of this response. Training aims to: • Provide Officers with information and practical guidance on how to effectively manage cases of hoarding.

	• Develop a closer joint approach to dealing with cases of hoarding, ensuring referrals are made to the Council's Adult Social Care (ASC), Environmental Health, the London Fire Brigade (LFB), the resident's General Practitioner (GP) and, where appropriate, a multi-agency risk assessment conference (MARAC). • Document and provide guidance, support and sharing of best practice. • Provide a framework for more robust casework management and monitoring. • Develop an understanding of the psychological reasons why a person hoards. • Ensure that staff understand when a case presents an unacceptable risk and how they must respond. • Highlight when a case is a safeguarding concern due to unwise decisions and lack of capacity. • Identify a range of support measures in the first instance and when to instigate enforcement measures to help staff in determining the most appropriate and effective response. Although training has previously been delivered to Housing Management staff by Hoarding UK, further training will be delivered to all Officers within Housing Management by the end of November 2023 as part of mandatory annual refresher training across the Service.
	<u>Concern (2): Other safety assessments such as a fire assessment and/or environmental health assessment were not requested despite their being a clear need.</u> A series of flow charts has previously been submitted to the Coroner as part of the London Borough of Hillingdon's report for the inquest. The London Borough of Hillingdon has considered the concerns the Coroner has raised and has reviewed the flow charts and amalgamated them into one flow chart for all Officers. This action was completed at the end of September 2023. This single flow chart now ensures that all Officers are prompted to make referrals to the LFB and ASC as well as Environmental Health and the resident's GP where appropriate, and this step becomes protocol for all cases of hoarding in management. The London Borough of Hillingdon is keenly aware of the fact that hoarding can pose a range of health and safety hazards and the need to assess these formally and mitigate presenting risks. The Service is committed to a multi-agency approach bringing together different skills, perspectives and resources which support the Tenancy

	Management Officer role. Cases can be referred to the daily High Risk meetings, MARAC and ASC. Please see Appendix 2 for the updated flow chart.
	Concern (3): The council "flow chart" was clearly not fit for purpose to assist staff in progressing hoarder support and assistance and was focussed on enforcement procedures rather than tenant support. The inquest was advised that the council's approach was not enforcement, but their documentation did not support this. In the London Borough of Hillingdon's report previously submitted to the coroner for the inquest, a series of four flow charts were appended, each with a different purpose. As set out above in response to item (2) of the Coroner's concerns, the London Borough of Hillingdon has reviewed the flow charts and amalgamated them to create one flow chart and removed reference to enforcement given that it is rarely an option when dealing with vulnerable residents where a range of circumstances may have contributed to hoarding behaviour. This action was completed at the end of September 2023. The revised flow chart will ensure that there is a more consistent approach by Officers when dealing with cases of hoarding. The London Borough of Hillingdon is committed to supporting its tenants to maintain their tenancies as far as possible and will act in the best interests of the resident. The London Borough of Hillingdon also recognises that there is a need to be flexible as each case is unique. The flow chart serves primarily as a guide / base for Housing Management staff. Enforcement action and court orders are pursued only in exceptional circumstances – for example, where enforcement is warranted due to the tenant hoarding for commercial gain in breach of their tenancy agreement. The flow chart addresses the concerns raised by the Coroner by giving a clear focus to staff on the detection / suspicion of someone hoarding, checking their status with other partners / professionals, establishing the severity via a risk assessment, and then referring on for a capacity assessment to ASC / enquiring about health before an action plan is developed. Within this process, there is clear reference to assessing presenting hazards and mitigating presenting risks via appropriate referrals. The flow chart will form part of an Operational Guidance Note for staff which will provide further clarity on key stages of casework progression such as flagging hoarding cases in management by the Panel on the Housing Management data base (NEC Software Solutions) and referencing the case on the tenancy management file within Civica workflow to ensure any staff member working on the same tenancy is aware of the vulnerability and plan associated with live hoarding casework. This will also support management oversight of live casework.

	The updated Operational Guidance Note for staff will form a key feature of the mandatory training for Housing Management staff in November 2023.
	<u>Concern (4): It was entirely unclear what options were available (if any) when the first plan of assistance completely failed, leaving the vulnerable tenant excluded from her property with no forward plan</u> Hillingdon Council aims to facilitate positive and sustainable outcomes for residents who are the subject of any form of tenancy intervention casework, including hoarding behaviours and self-neglect. In part, this is achieved by involving them in the process of managing their behaviour at all key stages. The Council is committed to promoting choice and control to an individual over how they can best be supported. Residents can change their minds or other contributory factors may require changes to the plan. This approach will be fully reflected in the updated Operational Guidance for staff. Several options were presented to Mrs Smith and she was given time to consider each one. The first plan was to use garages on the same estate that were rented by a resident that had recently passed way. It soon became clear that it would be some time before these garages would become available. Specialist lifting equipment would need to be brought in to remove heavy engines which were being stored in the garages. The second option was to secure any garages nearby, but unfortunately none were forthcoming. A third option was presented to Mrs Smith relating to use of a one-bedroom property nearby in a sheltered scheme. The plan was to allow her a month to deal with her belongings in her own home whilst staying in the sheltered flat. However, Mrs Smith felt anxious about leaving her possessions and did not view the property, so the option did not progress further. The fourth option was to clear the hallway and staircase and place items in a void flat in the same building, which was just opposite her own property. Once better access was secured, it would be possible to clear the rooms on the upper floors creating space for the return of Mrs Smith's possessions from the void property. However, nearer the time of the decluttering, Mrs Smith expressed that she only wanted the clearance to be done in the kitchen and hallway. This prevented a room from being cleared and made available for the return of items that had been stored in the void property. In summary terms, the plan and options put forward continued to evolve over the episode of support. The need to keep plans under review and bring forward new options as part of a tailored approach will be fully reflected in the updated Operational Guidance for staff. After the declutter for Mrs Smith, the Welfare Reform & Tenancy Support Manager arranged a follow-up visit before she was due to go on annual leave. Unfortunately, Mrs Smith cancelled this appointment as she was unwell and

	the Welfare Reform & Tenancy Support Manager did not see her before she went on leave. The London Borough of Hillingdon recognises the importance of aftercare following the decluttering of a home. The Welfare Reform & Tenancy Support Manager was the Lead Officer dealing with the case. She was due to go on leave in the aftercare period and it is recognised that a better handover should have taken place before she commenced her period of annual leave. It is standard practice in the London Borough of Hillingdon for every Officer to complete a handover to their manager just before they go on annual leave. With immediate effect, the London Borough of Hillingdon has made sure that this standard practice is extended to include handovers by managers who themselves carry a caseload. Handover arrangements generally will be specifically covered in the Operational Guidance Note for staff and covered during the training for all Housing Management staff in November 2023. It is accepted that leaving Mrs Smith's possessions in the void property caused her distress and, in future, the London Borough of Hillingdon will ensure that suitable storage is arranged at the outset of the declutter and referenced in the tailored action plan and Operational Guidance Note.
7	**DATE OF RESPONSE**: 12 October 2023
8	**THIS RESPONSE WAS PREPARED BY**: [redacted] Welfare Reform & Tenancy Support Manager, London Borough of Hillingdon [redacted] **AND APPROVED BY**: [redacted] Head of Housing Management, London Borough of Hillingdon [redacted] [redacted] Corporate Director of Resources, London Borough of Hillingdon [redacted]

APPENDIX 1

Housing Management Hoarding Panel

Terms of Reference

Purpose

The Housing Management Hoarding Panel forms part of the framework to support Hillingdon Council tenants that are known to hoard.

The panel will consider hoarding cases that affect Hillingdon Council tenants;

- To document all hoarding cases and ensure appropriate support is offered to residents that engage with the service.
- To ensure a co-ordinated response to hoarding cases by departments in Housing Management and internal and external partners.
- Review Hoarding cases regularly and ensure actions agreed have been completed by relevant officers.
- Review the resident's housing need and provide support where appropriate to move to suitable accommodation ie Downsize/Sheltered/TA
- Make a Safeguarding Referral where appropriate.
- Refer complex cases to MARAC and wherever possible avoid enforcement action
- Ensure all officers within Directorate of Place receive training to better recognise and support residents that hoard.
- Ensure cases where there is a Fire/Environmental Risk that these are shared with LFB and EH.

Membership/Representative

Tenancy Management Team

Housing Management Services Team

Welfare Reform & Tenancy Support Team

Sheltered Housing Team Leader

Adult Social Care representative

Repairs and Gas Compliance – optional

LFB – Fire Service

Referrals

The Hoarding Panel Referral form to be completed and sent to the housingsupportworkerteam@hillingdon.gov.uk

Referrals should be submitted 15 days prior to the Panel meeting. All referrals will be reviewed to ensure it meets the criteria for the panel.

Meetings

Chair WRTS Manager and minutes to be circulated. Meetings to be held quarterly. Via Microsoft Teams.

Hoarders spreadsheet

Owned by WRTS and shared with relevant teams.

APPENDIX 2

Housing Management Hoarding Process