Safeguarding ENFIELD

Enfield Safeguarding Adults Board

ANNUAL REPORT 2025-26



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NHS North Central London Integrated Care Board

METROPOLITAN POLICE

ENFIELD Council



Please talk to us

As someone who might live, work or study in Enfield you have a vital role in safeguarding adults. If you are worried about someone or yourself, **please talk to us.** You can find help in several different places and there are links and telephone numbers on page 25.



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Vision statement

Our vision is for:

"An Enfield community where we can all live free from abuse and harm; a place that does not tolerate abuse; where we all work together to stop abuse happening at all, and where we all know what to do if it does take place."

Chair's Introduction

I am pleased to introduce the Enfield Safeguarding Adults Board Annual Report for 2025/26. It is a year marked by challenge and by progress as our partnership has continued to adapt to the very many pressures on our people and resources.

Our focus, however, remains both constant and clear: we want Enfield to be a place where abuse of our vulnerable residents is not accepted, where people know what to do if they are worried about abuse and where partners work together to prevent it. Our partnership has openness and learning at its heart.

2025/26 saw a further increase in the number of contacts and concerns we received and whilst this may reflect a greater level of awareness and complexity of issues that people are facing in our community, I have asked that we explore in more detail the underlying reasons for the year-on-year increases that we are seeing. This work is ongoing and will be a standing item on our board agenda for the year ahead.

Oversight of Safeguarding Adult Reviews is a key function of the board and in previous years it has taken us too long to bring many of them to a conclusion. We have delivered improvements in this area, not only in terms of timeliness, but also in the way we have shared learning to drive real changes in our practice across the partnership.

Concerns about exploitation linked to street sex work and the need for clearer communication and escalation when risks come to our attention have been one of the key features of our learning from the year and how we work with our more vulnerable residents to manage risks in their lives.

None of this would be possible without the dedication and professionalism of our front-line colleagues. They do amazing work every day to help keep people safe, many of them as volunteers, and my heartfelt thanks go to them all. Their dedication, compassion and expertise are the foundation of our safeguarding system, and their efforts make a real difference every day.

Our priorities for the year ahead continue to be the prevention of abuse, protecting vulnerable people and learning from every case that comes to us. We will build on what has worked, improve where we should do better and make sure that the voice of residents at risk and their families are heard.

My thanks to all of our Board members, partners and staff who make our work possible and impactful.

Doug Wilson
Chair of Enfield Safeguarding Adults Board and Director of Adult Social Care, London Borough of Enfield

We welcome reader's comments and suggestions: you can email us at:
EnfieldSAB@enfield.gov.uk

Key Facts for the Year (2025/26)

3,860
safeguarding concerns

12
High Risk Advisory Panel meetings

833
Section 42 enquiries

28
complex case partnership discussions at the High Risk Panel

86%
of concluded cases had risk reduced or removed entirely

13
training sessions delivered

- The Safeguarding Information Panel (SIP) improved the quality and timeliness of feedback to care providers, with 52% of providers reporting improved feedback on safeguarding processes within the previous six months.
- Published the Ms C Safeguarding Adults Review and strengthened the way SAR learning is turned into action through impact surveys/audits, action plans, training and quality assurance.
- Launched and embedded new High Risk Advisory Panel processes, supporting partners to discuss complex high-risk cases and identify when legal safeguards may be needed.
- Used Safeguarding Information Panel intelligence to support borough-wide preventative work, including fire safety activity across supported living services and planned hot weather checks in care homes.
- Planned hot weather checks in 80 care homes
- Strengthened practice improvement through multi-agency work on pressure care, mental health safeguarding, safeguarding where an adult has died before a concern is received, and guidance for care providers.
- Delivered a broad training programme, including SAR learning, Self Neglect and What I Wish You Knew sessions, helping practitioners build confidence in recognising risk and working together.
- Enhanced use of safeguarding data and targeted audits helped identify and address emerging issues, such as the rise in self-neglect cases and inappropriate referrals, leading to more focused support and training.

The Enfield Safeguarding Adults Board

The Safeguarding Adults Board (SAB) brings local organisations together to make sure safeguarding arrangements in Enfield work well and improve when new learning is identified. The SAB also supports prevention by raising awareness of how to recognise and report abuse. Abuse can affect anyone, in different places and in different ways. We all have a role in preventing abuse and protecting people when it happens.

The Board in Enfield is made up of the following partners:

- Enfield Council
- NHS North London Foundation Trust
- Metropolitan Police
- Enfield Carers Centre
- HealthWatch Enfield
- Enfield Lay member
- Age UK (Enfield)
- One-to-One Enfield
- Department of Work and Pensions
- London Ambulance Service
- London Fire Brigade
- NHS North Central London Integrated Care Board
- Enfield Probation Service
- Royal Free London NHS Foundation Trust

The North West London and North Central London Integrated Care Boards formally merged to created the NHS West and North London ICB in April 2026.

Story of Impact – Terry

Terry is a 39-year-old Polish-speaking man with a history of street homelessness, alcohol dependency, recurrent seizures and self-neglect, whose circumstances presented significant safeguarding and public health concerns. His case required sustained multi-agency working involving MASH, homelessness services, hospital teams, GP services, outreach workers, police, prison services, supported accommodation providers and interpreter support.

Concerns escalated through repeated hospital admissions, self-discharge, head injuries, suspected cuckooing, unstable housing and non-engagement with treatment. Professionals responded through multi-agency discussions, safeguarding referrals, risk management meetings and coordinated attempts to locate and engage him when urgent health concerns arose.

Although Terry initially struggled to trust services, agencies maintained regular communication, shared risk information and adapted their approach to balance safeguarding, health needs and housing support. Following a period in custody, where he was diagnosed with tuberculosis, partner agencies worked together to plan for release and secure supported accommodation with a more structured package of care. This coordinated response improved consistency and enabled stronger risk management. Over time, as Terry came to trust professionals more, he completed TB treatment, and his housing situation stabilised.

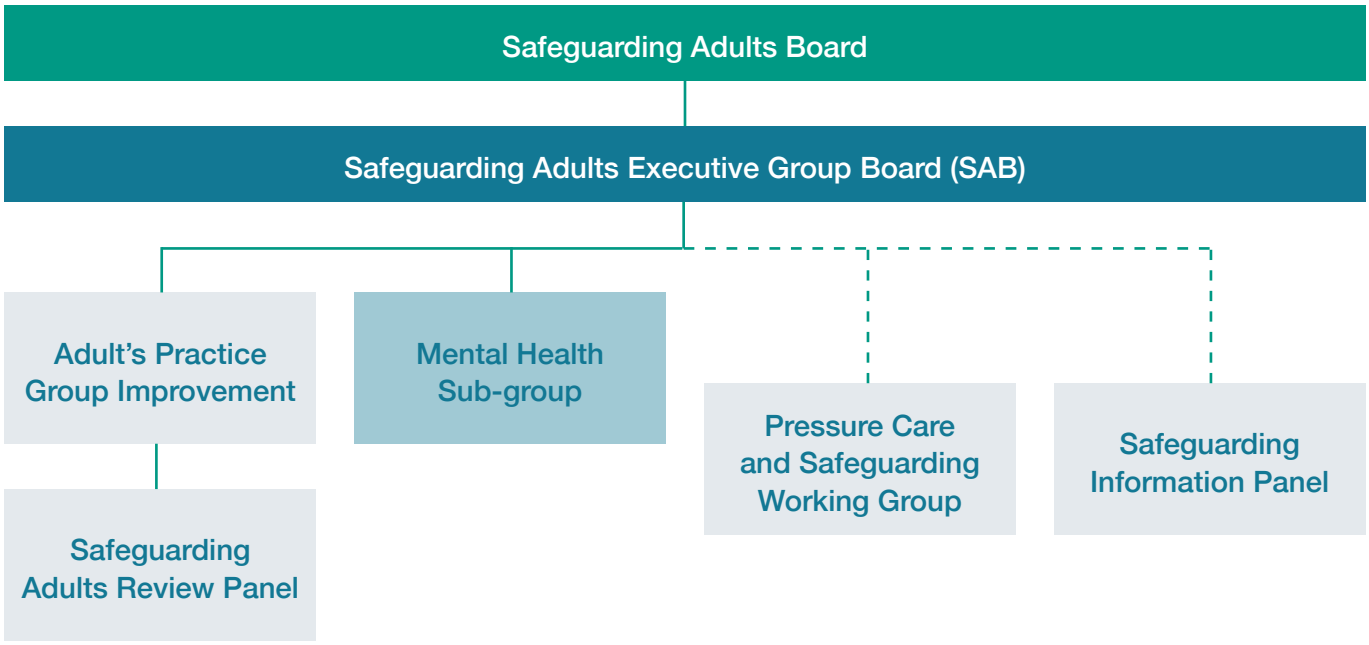
The work with Terry over time really shows the value of persistent, person-centred, multi-agency work in reducing risks.

Enfield's Safeguarding Adults Board structure

The SAB works with other local partnerships to improve people's quality of life, reduce inequalities and keep people safe in Enfield.

Health and Wellbeing Board	**Safeguarding Adults Board**	Safeguarding Children Partnership	Safer and Strong Communities Board

In Enfield, the work of our Safeguarding Adults Board is undertaken by a number of groups and meetings. The meetings bring together partners around a specific area of focus for the SAB:



Safeguarding Adults Board

The Safeguarding Adults Board met 4 times in 2025-2026 (in June 25, July 25, October 25 and February 26) with a focus on driving forward learning from Safeguarding Adults Reviews (also known as SARs) as well as working on the Safeguarding Adults Board Strategy 2023-2028.

Over 2025-26, these meetings, alongside the SAB Executive Group, were chaired by our Chair, Doug Wilson.

During the year, the Board discussed changes across partner organisations, staffing changes and safeguarding trends. The Board also discussed:

- Launching the new High Risk Advisory Panel processes and protocol.
- Hearing from the Safeguarding Improvement Panel and the trends in provider pressures.
- Discussing partner assurances around Mental Capacity practice across partners and launching tools to support with this.
- Monitoring the continued impact of Right Care, Right Person and,
- Discussing learning from SARs and how this can be disseminated to all partners, amongst other topics.

There were many changes across the Safeguarding Adults Partnership during the year. For example, the North London Foundation Trust restructured and the Integrated Care Boards merged, leading to staffing changes. Despite this, attendance and contributions to the Board remained strong.

This helped the Board keep a clear focus on safeguarding adults during a time of organisational change. Partners continued to work together on shared priorities.



In February 2026, the Board agreed the priorities for the next financial year:

1. **Workforce Support**
   A focus on workforce support, with particular emphasis on the impact of vicarious trauma on practitioners across the system and on trauma informed practice.

2. **Risk Identification and Escalation**
   Strengthening how we identify and escalate risk, including clearer arrangements for monitoring risk that is not progressing or resolving, and ensuring appropriate professional curiosity and challenge.

3. **Domestic Abuse**
   Continued focus on domestic abuse, particularly in light of concerns regarding the reduction in the percentage of safeguarding concerns being recorded. The Board will seek assurance that risk is being appropriately identified and responded to.

These priorities are based on Board discussions, safeguarding data, SAR learning and partner assurance from 2025/26. This helps the Board focus on the areas where it can have the greatest impact on safeguarding practice and outcomes for adults at risk.

How we involve the community in our Board

Enfield SAB is lucky to have Gill Hawken, a lay member who is very experienced around both work in the community and Safeguarding Adults, as part of our Board. Gill regularly attends the Board and gives contributions to the Board documents which are insightful and valuable.

The Safeguarding Community Engagement Group ceased meeting in 2025, this was due to availability of partners – instead, the Enfield SAB has invited VCS partners to attend the Board directly (and to attend the What I Wish You Knew or other training events).

Amongst our regular attendees are representatives from:

- One-to-One Enfield
- Age UK Enfield
- Women's Aid
- The Enfield LGBT Network
- Enfield Carer's Centre and several other groups.

As well as this, the Board manager presents regularly at the Enfield Voluntary Sector Strategy Group to make sure that the VCS community is both informed and has an opportunity to feed into the work of the Board.

These conversations are always very useful. This strengthens the link between the Board and local community organisations, helping to ensure that voluntary and community sector insight informs Board discussions and that safeguarding messages reach a more diverse range of people and groups.

SAB Executive Group

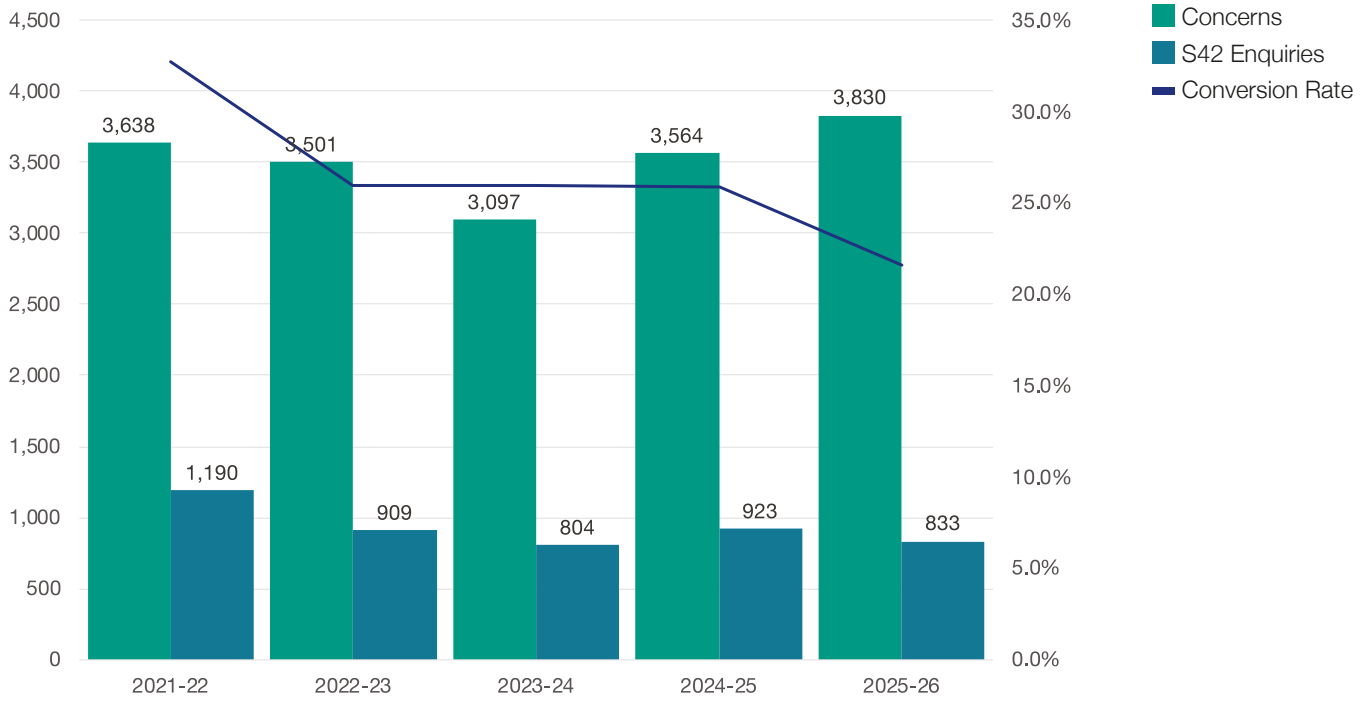
The SAB Executive Group is convened on a quarterly basis to agree the programme for the next SAB and review the Board's Risk Register (which monitors delivery of the Board's Strategic priorities and areas of concern) and Safeguarding Adults Review (SAR) Action Tracker.

In March 2026, the group met and decided that, to avoid repetition and demands on the time of attendees, the Executive Group would be paused for 2026/27 – although members can call an extraordinary meeting if needed.

Key Trends and Data – Section 42 Data for 2025/26

The SAB regularly reviews data around Section 42 enquiries and partners discuss how to support with changing trends and needs.

Number of concerns/enquiries



The Board has noted a drop in the conversion rate (which is the percentage of Concerns that turn into full Safeguarding Adults Enquiries). This also corresponds to reports from Adult Social Care staff that the number of inappropriate referrals (which do not meet the legal criteria) has increased.

In response to this, Adult Social Care initiated a number of targeted audits over 2026/27 into referrals from partner agencies and reporting regularly to the Board on the results of this. Where learning is identified for partners around their referrals, agencies will work together. The Board will receive regular assurance on findings and actions from this work.

The guidance that the Board has published into Making Safeguarding Adults Referrals will also be reviewed. The planned audits will help the Board understand whether concerns are being raised appropriately and whether partners need further guidance or support. This will support more consistent decision-making and help ensure that safeguarding resources are focused on adults who meet the statutory criteria for enquiry.

The London Borough of Enfield has a Section 75 agreement with the North London Foundation Trust – this means that there are seconded Enfield Council staff working within the Trust to provide Care Act (2014) services to adults with Mental Health difficulties. There have been some issues with the data reporting from the Mental Health Trust due to some changes in systems – this has affected the data reporting for this year.

Types of Abuse for Enquiries

As you can see, the proportion of Enquiries around Domestic Abuse continues to fluctuate – this is one reason for the Safeguarding Adults Board's focus on this in 2026/27, to ensure all are trained in recognising Domestic Abuse and that responses and recording are appropriate.

Type of abuse	2021/22	2022/23	2023/24	2024/25	2025/26
Physical Abuse	14.3%	9.8%	13.7%	14.7%	12%
Sexual Abuse	3.6%	3.0%	2.7%	1.5%	2%
Psychological Abuse	12.6%	22.6%	14.3%	12.2%	11%
Financial or Material Abuse	12.4%	10.9%	15.3%	12.4%	12%
Discriminatory Abuse	0.6%	2.4%	0.5%	0.6%	1%
Organisational Abuse	3.8%	1.3%	4.7%	3.4%	3%
Neglect and Acts of Omission	29.5%	32.4%	27.9%	39.0%	35%
Domestic Abuse	10.5%	6.2%	10.2%	7.2%	7%
Sexual Exploitation	1.6%	0.3%	0.7%	0.6%	1%
Modern Slavery	0.6%	1.8%	0.6%	0.4%	1%
Self-Neglect	10.3%	9.4%	9.3%	8.0%	14%

**An enquiry can have more than one type of abuse identified.*

Between 2023-26, the Safeguarding Adults Board had a focus on Self-Neglect, partly as a result of Safeguarding Adults Reviews, and facilitated training, events and guidance around this. There were improvements in partnership working identified through the Board's own Task and Finish group and the High Risk Advisory Panel (HRAP). This may have contributed to the rise in Self Neglect being recognised and reported as safeguarding in Enfield.

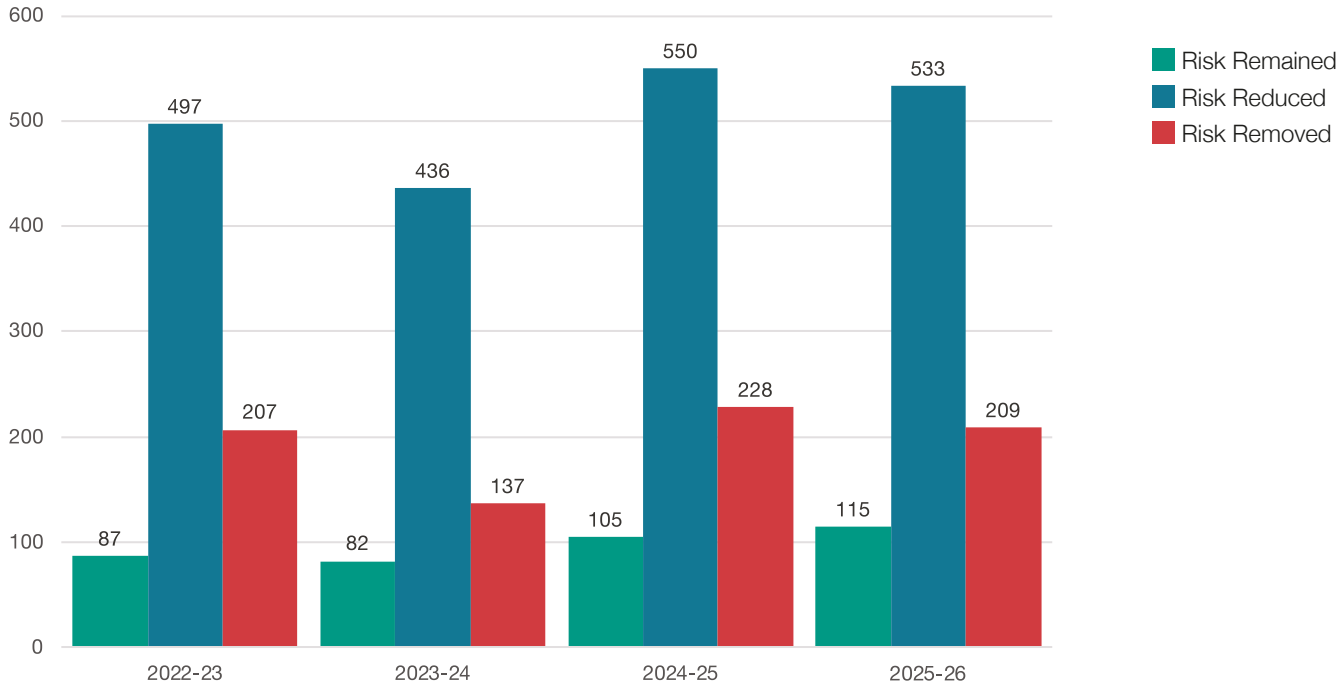
The increase in self-neglect being recognised and reported suggests that practitioners are more confident in identifying complex risk and using multi-agency routes for support. This means that adults experiencing self-neglect are more likely to be seen, discussed and supported through coordinated safeguarding responses.

The High Risk Advisory Panel and Adult Social Care will continue to monitor trends in this area and report to the Enfield SAB.

In 2025/26, approximately 9 out of 10 cases involved support from an advocate, family member or friend. This shows that adults are usually supported by someone who can help them express their views and wishes during safeguarding work, strengthening the Board's commitment to Making Safeguarding Personal.

Risk Outcomes

Where a risk was identified, what was the outcome when the case was concluded?



In the vast majority of cases, safeguarding interventions reduce or remove risk. However, in some cases the risk might remain – this could be because the adult themselves didn't agree with suggested measures. For example, an adult might choose to remain friends with someone who is suspected of financially abusing them. Another example might be not accepting support to declutter if the concern was around self-neglect in the home.



The work of the Safeguarding Adults Board Sub-groups

Practice Improvement Group

In 2025/26, the group met four times and there was good attendance from all partners.

Key activities were:

- Developing the impact surveys which are self-audits for partners to help the SAB to assure practice and learning particularly in relation to Safeguarding Adults Reviews.
- Consulting on and feeding back into the November 2025 review of the London Wide Safeguarding Adults Policies and Procedures.
- Helping develop Local Authority processes for managing safeguarding concerns received after an adult has died, ensuring a clearer process for staff and better support for bereaved relatives.
- Sharing learning from the Children's Safeguarding Partnership around the importance of a Think Family approach.
- Developing the SAB training programme.
- Developing Guidance around Medication Errors and Safeguarding for care providers.
- Ensuring that actions arising from Safeguarding Adults Review recommendations were completed and quality assured.

Sharon Burgess (Head of Quality Monitoring for Enfield Adult Social Care), who chairs the Practice Improvement Group, says: "As Chair of the Practice Improvement Group, I am encouraged by how partners have used the forum to move beyond discussion into practical improvement. Over the past year, the group has strengthened how we learn from Safeguarding Adults Reviews and, importantly, how that learning is applied in practice – through clearer guidance, more consistent approaches for staff and providers, and a stronger focus on assurance and constructive challenge across the partnership.

"There has been a continued emphasis on keeping adults' lived experience central. The group's work reflects a collective willingness to reflect on what has happened and use that insight to inform more effective pathways, stronger oversight and safer practice for Enfield residents."

The group has helped turn learning into practical action, giving partners a clearer route to test whether guidance, training and SAR recommendations are improving day-to-day safeguarding practice.

The Mental Health Safeguarding Sub-group

This group, also chaired by Doug Wilson, began meeting in December 2025 after changes in the recording of safeguarding work within the Mental Health Trust identified some gaps in recording and practice.

The Enfield Local Authority has a Section 75 agreement with the North London Foundation Trust which means that the Trust (with seconded Local Authority staff) conduct Care Act duties (including Section 42 safeguarding enquiries) where they relate to adults known because of mental illness. The Local Authority and the Mental Health Trust have been meeting together to quality assure, act on learning identified, and improve practice over time.

There has been some great partnership working displayed and audits have shown real evidence of improvement and good practice over the period that the sub-group has been meeting.

The sub-group has created a focused space for Adult Social Care and mental health partners to review practice together, address recording issues and strengthen assurance around safeguarding work with adults experiencing mental ill-health.

Doug Wilson has said: "The partnership working through this subgroup has been really productive and is on-going. It has been driven with a real recognition of the importance of robust safeguarding systems for every adult with care and support needs in Enfield – and the strength of strong partnership working between the Local Authority and NHS colleagues."

Pressure Care Working Group

Adult Social Care audits and feedback from providers showed that Safeguarding Concerns were often being raised around pressure care for information purposes rather than because abuse or neglect was suspected. This group is chaired by Elspeth Smith, Safeguarding Adults Practice Lead for the London Borough of Enfield.

The group includes representation from:

- Royal Free London Hospitals Trust
- North Central London Integrated Care Board
- Enfield Public Health
- Enfield Adult Social Care

In 2025/26, the group has:

- Monitored implementation of pressure care guidance previously established by the group.
- Developed stronger links between the Community Healthcare Safeguarding Leads and the Adult Social Care MASH.
- Analysed data around pressure care to identify any patterns.

The group has helped partners distinguish more clearly between quality-of-care issues, clinical pressure care concerns and safeguarding concerns. This supports more appropriate referrals, better use of safeguarding resources and stronger working relationships between health and social care colleagues.

Partners report fewer inappropriate pressure care Safeguarding Concerns are being made and that the panel is working well.

The Safeguarding Information Panel (SIP)

The Safeguarding Information Panel (SIP) is a regular meeting of statutory organisations who have a role in ensuring care providers deliver high quality and safe services. The SIP meets every six weeks, bringing together statutory partners – including CQC, NHS Integrated Care Board, London Fire Brigade – and representatives from Enfield Council care teams, Safeguarding Managers, and practice leads.

SIP meetings provide a forum to share intelligence, assess risks, and coordinate multi-agency actions to support care providers in delivering safe, high-quality services.

Story of Impact

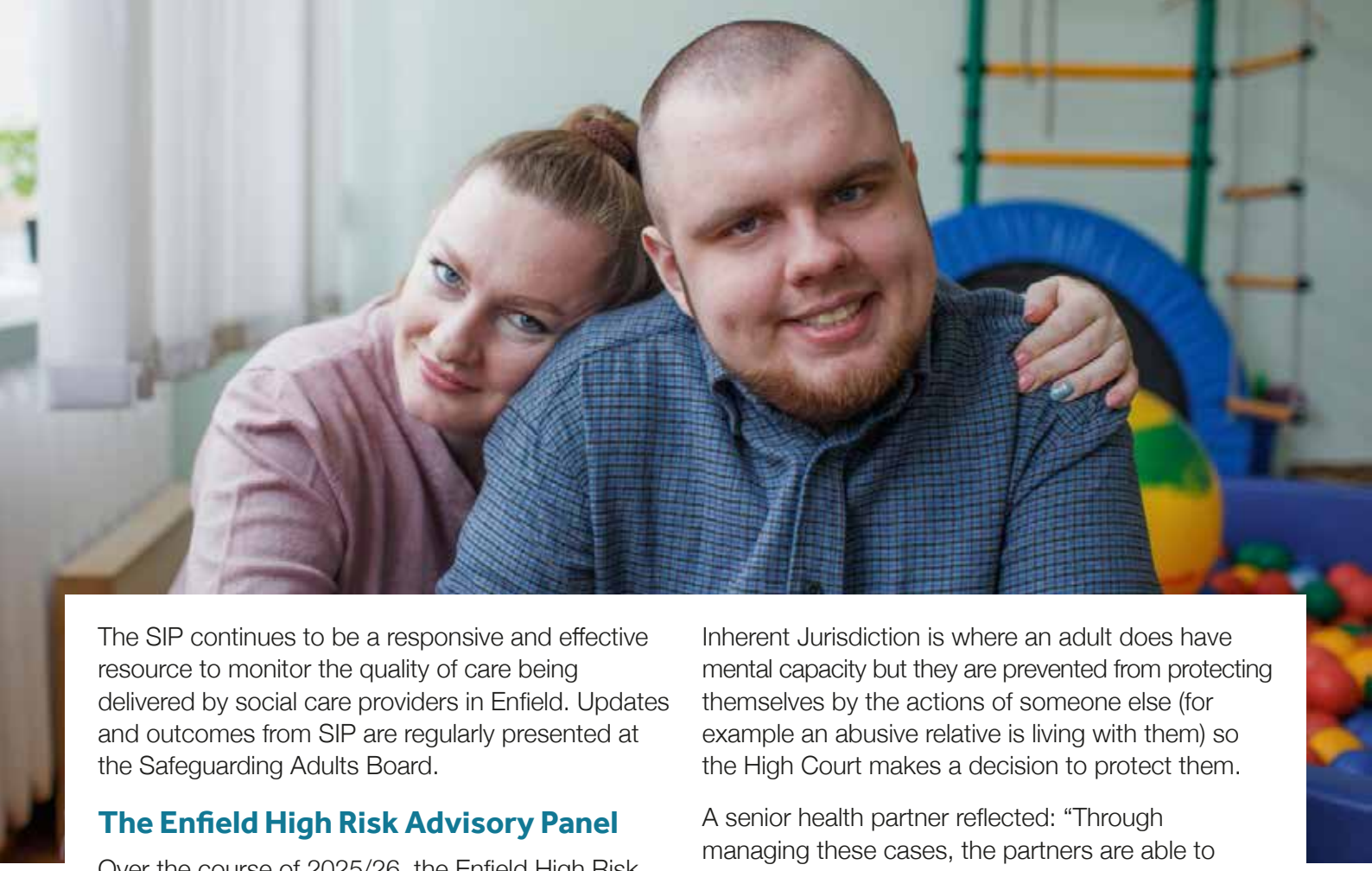
A significant outcome from the SIP came about where a safeguarding concern involving a fire at a supported living scheme was discussed and – due to the risks identified from this – a Fire Safety working group was set up. This working group developed and implemented a plan to review fire safety measures at all known supported living care providers in the borough. Fire safety visits from the London Fire Brigade supported care providers with advice and guidance to improve fire safety measures where required and serious fire safety breaches were escalated for formal support from the London Fire Brigade Fire Safety team.

This demonstrates how the SIP can turn intelligence about an individual safeguarding concern into borough-wide preventative action, reducing fire risk across supported living services and improving provider awareness of fire safety responsibilities.

Adults in supported tenancies throughout Enfield are now safer – the London Fire Brigade described this work as intensive but really valuable and they are considered similar work in other areas.

Another key outcome from the SIP is a planned programme of spot checks at 80 care homes to ensure hot weather protocols are in place and residents are protected during periods of extreme heat. This planned work will provide assurance that care homes are prepared for periods of extreme heat and that residents who may be particularly vulnerable are protected through practical, preventative planning.

The Board recognises the importance of partners and providers receiving clear feedback from safeguarding activity so that learning can be applied quickly. The SIP consulted private care providers about how feedback on safeguarding activity is shared. In April 2025, 52% of respondents reported an improvement in the quality and timeliness of feedback over the previous six months. The SAB Board Manager presented and discussed these findings at the Provider Forums run by the Local Authority.



The SIP continues to be a responsive and effective resource to monitor the quality of care being delivered by social care providers in Enfield. Updates and outcomes from SIP are regularly presented at the Safeguarding Adults Board.

The Enfield High Risk Advisory Panel

Over the course of 2025/26, the Enfield High Risk Advisory Panel met twelve times and featured 28 separate case discussions (around 15 separate high risk individuals – some coming back on multiple occasions).

Through managing these cases, the partners are able to ensure that the person's situation is looked at in a holistic way, the panel uses professional curiosity to interrogate the circumstances and bring ideas for making the individual and those around them safer, and preventing further harm. We support social workers and other professionals such as nurses and midwives, GPs, outreach workers, and housing support workers with a multi-agency approach, achieving the best possible outcome for the people that they are working with.

The panel provides a structured route for partners to share information, test options and agree next steps in the most complex cases. The use of the Court of Protection and Inherent Jurisdiction routes shows that the panel is helping partners identify when legal safeguards may be needed to protect adults at high risk.

The Court of Protection is a court which can agree restrictions or protective measures for adults who lack mental capacity to protect themselves - for example, they might order that someone has to live in a specific safe environment.

Inherent Jurisdiction is where an adult does have mental capacity but they are prevented from protecting themselves by the actions of someone else (for example an abusive relative is living with them) so the High Court makes a decision to protect them.

A senior health partner reflected: "Through managing these cases, the partners are able to ensure that the person's situation is looked at in a holistic way, the panel uses professional curiosity to interrogate the circumstances and bring ideas for making the individual and those around them safer, and preventing further harm. We support social workers and other professionals such as nurses and midwives, GPs, outreach workers, and housing support workers with a multi agency approach, achieving the best possible outcome for the people that they are working with."

David Williams, the outgoing Principal Social Worker for Adults in Enfield, said: "Chairing the High Risk Advisory Panel has been one of the highlights of my role as Principal Social Worker in Enfield. It gives me the chance to see how the local health and social care system is working to support residents in the most difficult circumstances. Whilst the circumstances are often hard to hear about, the willingness of colleagues to discuss and think together, to share information appropriately and accept challenge has been heartening to see. There are many colleagues who support the panel who I would like to thank, and all attendees who prioritise this meeting as part of their busy workloads. I have no doubt it has improved the outcomes for people in the most difficult of circumstances in the Borough."

David Williams is leaving Enfield in July 2026. Natalie Irish, the new Principal Social Worker, will take over as Chair of the panel.

Story of Impact

Charlotte is a woman in her 40s with a variety of health issues – including renal disease. She was struggling to attend vital health treatment and maintain her home. The case was referred to the High Risk Advisory Panel – professionals were really worried about her health and potentially that people were trying to take over her home.

Working together, Police, Adult Social Care, Health Professionals at the Hospital, Enable Addictions services and Housing Officers, were able to speak with Charlotte – establish she had capacity to understand the risks around missing appointments and around her home. Once this was known, they could work with her to improve her situation.

Charlotte now has a small package of care in place to make sure she can keep up with her health appointments and help her with her home. She is attending more regularly and can raise issues when she needs to.

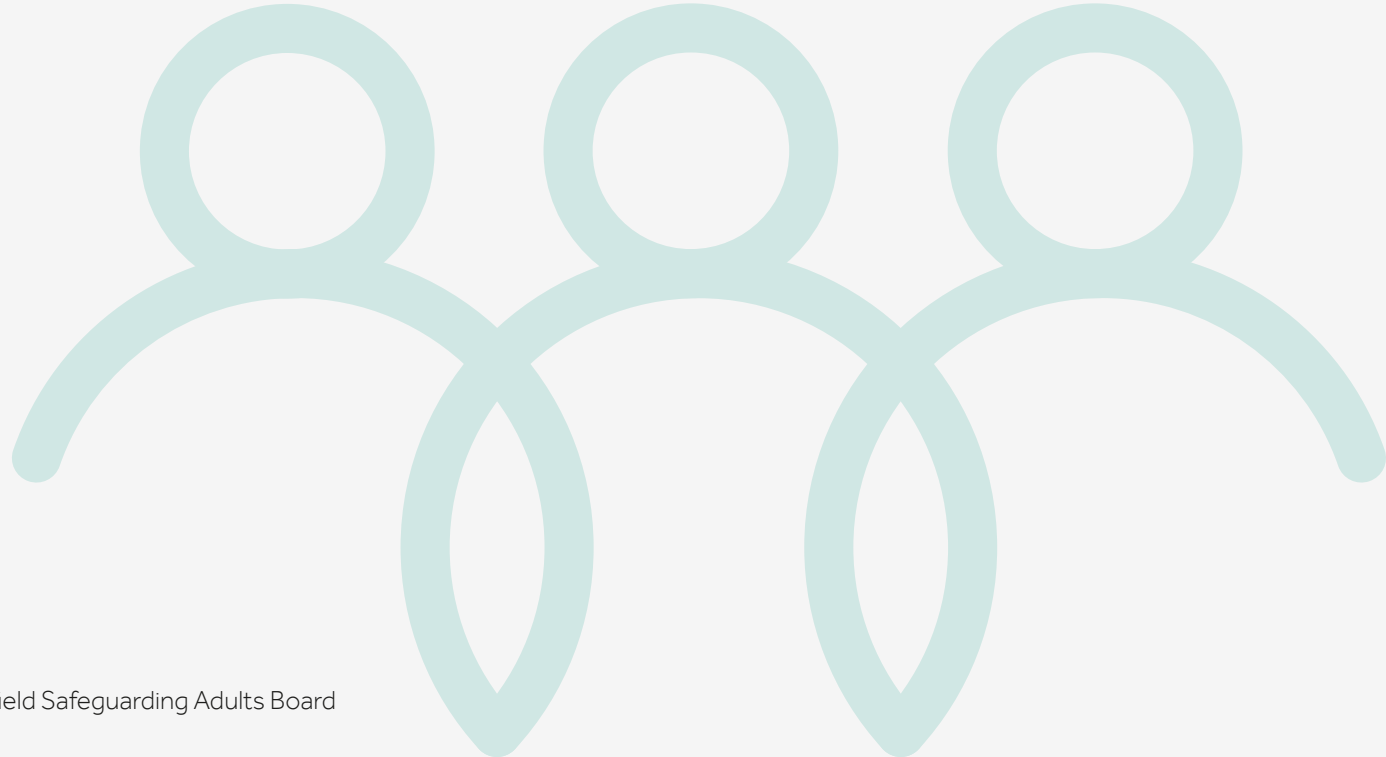
She is considering if supported accommodation might help her in the future – but this will be her decision.

Story of Impact

Luka is a 65 year old man who was sleeping in the communal hallway of his block of flats due to clutter in his property. There were a number of concerns about his Concerns his health and lack of access to hygiene facilities; but there were also concerns about fire risk to others in the block of flats as he was blocking a fire exit and running extension cords across the floor.

Following discussion at the High Risk Advisory Panel, a coordinated approach was put in place to engage with Luka and assess his capacity to understand the risks and implications of sleeping in the communal hallway. Over a period of engagement and rapport building by the social worker and others, he was supported by a hoarding and decluttering service to declutter his flat and get him back into his flat and off the communal hallway.

The London Fire Brigade monitored him through this period also to ensure risks to himself and others were cleared.



Safeguarding Adults Reviews

Published – 1st April 2025 to 31st March 2026

Section 44 of the Care Act 2014 places a statutory responsibility on the Safeguarding Adult Board (SAB) to conduct Safeguarding Adults Reviews (SAR) under certain circumstances.

The SAB is required to arrange a Safeguarding Adults Review (SAR) where there is reasonable cause for concern about how the SAB, and its members or some other person with relevant functions, worked together and the adult at risk died or experienced serious harm or neglect potentially resulting from this.

SABs may arrange for a SAR in any other situation involving an adult in its area with care and support needs, whether they are being met by the Local Authority or not. The SAB may also commission a SAR in other circumstances where it feels it would be useful, including learning from 'near misses'.

SARs are not intended to assign blame but are crucial tools to identify learning for the partnership (both as a partnership and as individual agencies) to prevent future harm.

The Ms C SAR – Published September 2025

Ms C was a woman from Northern Ireland, living in Enfield, who died in October 2022 from heart disease, with Type 2 Diabetes as a secondary cause. She received gender-affirming care in the 1990s and 2000s and identified as transgender. She had a diagnosis of Emotionally Unstable Personality Disorder – as well as several physical health issues.

There were significant concerns about hoarding and self-neglect. She declined many offers of support from professionals (whilst sometimes also requesting more support). Although her death was from natural causes, her health conditions were such that they should have been manageable. This SAR was published in September 2025 and you can find the SAR executive summary here.



The action plan focuses on:

- Support for professionals to work with adults with personality disorders.
- Support for professionals to work with transgender adults.
- Communication between professionals particularly when cases are closed.
- Improvements around Risk Assessment.

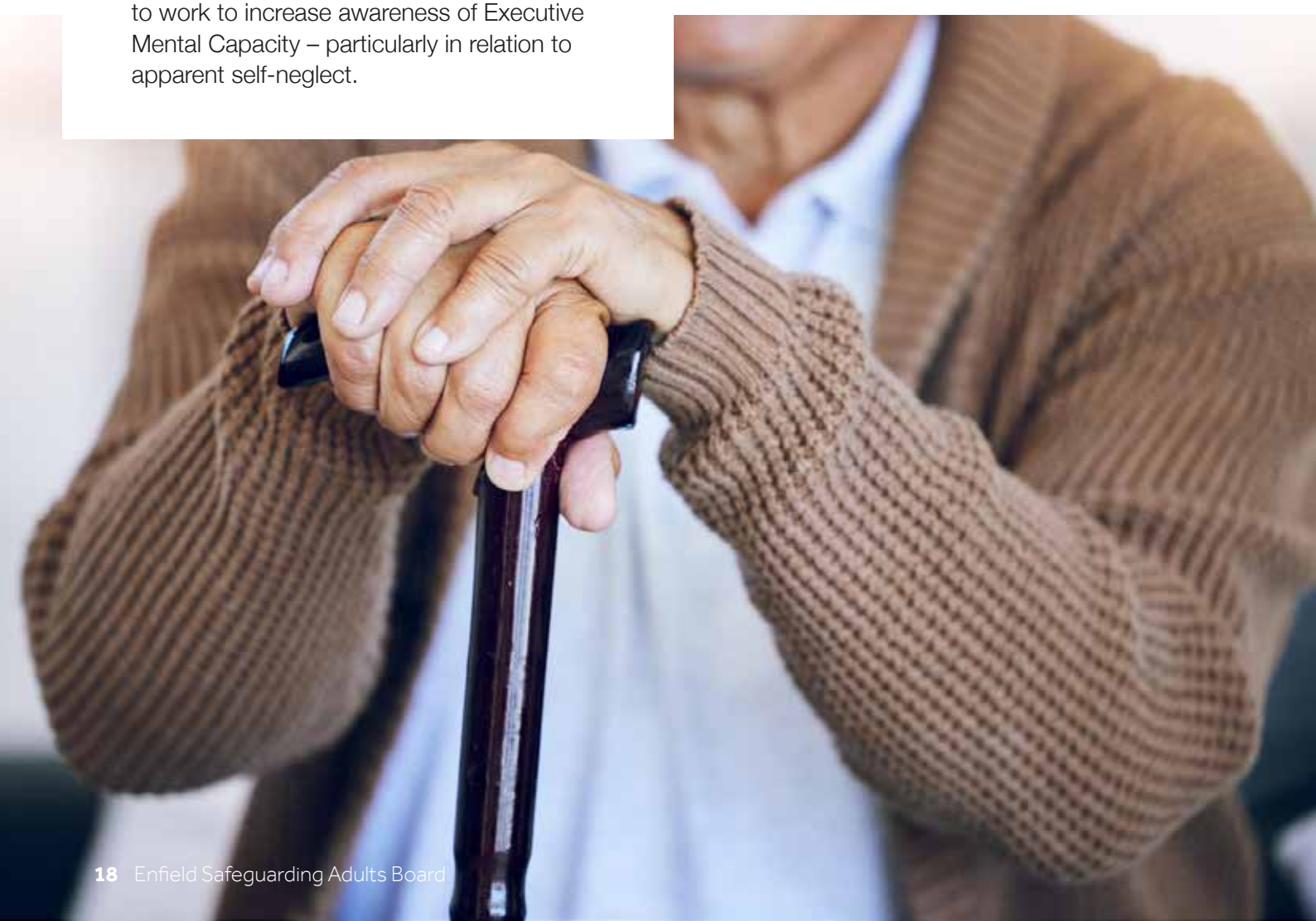
Further work around learning from SARs completed in the previous financial year

The SAB has ensured there is a system-wide action plan for each Safeguarding Adults Review published in 2024/25 (the Elly SAR, the Carers SAR and the Ruth SAR). There are themes that are recurring. Some of the steps we've taken to address these are:

- Reviewed guidance and training on Mental Capacity, particularly where executive capacity may be in question and care is refused, including a SAR learning event in June 2025 focused on this topic.
- Enfield Safeguarding Adults Board and partners to work to increase awareness of Executive Mental Capacity – particularly in relation to apparent self-neglect.

The review will look at responses to concerns about suicidal ideation, how the voice of young adults can be prioritised in assessment processes and how partners understand and respond to online harm. The SAR was agreed in September 2025. An independent reviewer has been identified and commissioned and the Board is working with her to complete this SAR.

- Raising awareness of the importance of a multi-disciplinary approach in cases of apparent self-neglect and specifically the tools that ESAB has already developed to support this.
- Reviewing information sharing amongst partners and how this could be enhanced.
- A new SAR protocol and commissioning procedures were put in place to ensure more timely responses to Safeguarding Adults Review referrals. This has strengthened governance around SAR decision-making and commissioning, helping the Board respond more promptly when a referral is made and ensuring clearer expectations for partners.



Safeguarding Adults Reviews in progress

Enfield SAB is currently working on three Safeguarding Adults Reviews in 2026/27. These are:

A

A case involving a young adult who was attending college in the Borough. He was diagnosed with autism (though was not known to the Integrated Learning Disabilities Services). He went missing in January 2025 and his death by suicide was confirmed in the Summer (there was a delay in confirming the need for a SAR as the Inquest and other processes were on-going).

The review will look at responses to concerns about suicidal ideation, how the voice of young adults can be prioritised in assessment processes and how partners understand and respond to online harm. The SAR was agreed in October 2025. An independent reviewer has been identified and commissioned and the Board is working with her to complete this SAR.

B

This case involves a 50-year-old woman who died from natural causes related to aspiration pneumonia and seizure activity. This woman was living in temporary accommodation which she was on the verge of losing and had a history of street homelessness. There are a number of concerns around how partner agencies worked together in the last years of her life to support her in addressing her health, housing and social care needs. This is a complex review which ties into a lot of on-going work to support exploited women in the Borough.

The SAR was agreed in October 2025. Two independent reviewers have been identified and commissioned and the Board is working with them to complete this SAR.

C

This case involves a 78-year-old man who was living alone in Enfield and passed away following declining care after a hospital discharge. There were concerns (at the time of his discharge) about his mental capacity to make decisions about his care and support and these do not seem to have been taken into account when considering how to respond to the lack of contact.

The review will focus on how agencies responded to his lack of contact, discharge processes and how learning from this and other SARs can be most effectively embedded.

A decision was made to complete a SAR in December 2025. There were some delays in the commissioning process for this review but an independent reviewer has now been appointed and begun work.

The Enfield SAB Training Programme

The Board ran 13 training sessions over 2025/26.

Learning from Safeguarding Adults Reviews Sessions

In June 2025, a learning event was held focusing on learning from both the Elly SAR and the Ms C SAR (which at the time was being finished). This event was attended by around 40 staff from across the partnership and focused on 'When People Refuse Help'.

As the title suggests, this event helped translate SAR learning into practice by bringing partners together to consider how to respond when adults refuse support, how to apply the Mental Capacity Act in complex situations and how to use multi-agency discussion to manage risk more effectively.

We had presentations and facilitated discussions from:

- Dr J Heffernan (Enable Addiction Services) and David Williams, Principal Social Worker for Adults Enfield, around 'the Mental Capacity Act v. the Mental Capacity Act'.
- Elspeth Smith and Androulla Economou, Adult Social Care, on 'The Benefits of the High Risk Advisory Panel'.
- Guided discussions on case studies identified by Enfield's Community Social Work Team.
- Theo Baron from the North Middlesex Hospital spoke around Mental Capacity Assessments around health with a particular focus on learning from the Jacqueline Maguire case and the 'Get Me to the Hospital' guidance for adults with Learning Disabilities.
- Police partners presented on their Section 136 powers and when they might use them.

One participant said:
"It was great to have a day away from my desk to really learn about what all the different partners do in such difficult circumstances."

Another said:
"I just wish it had been a longer day!"

What I Wish You Knew sessions

The Enfield SAB arrange monthly 'lunch-and-learn' online sessions where a particular team or service explains their role and highlights 'What I Wish You Knew…' about what they do and how to collaborate with them. This helps us to ensure that we are connected as a partnership and gives an opportunity to really spotlight key areas.

These sessions have been well received – with between 12 and 60 attendees each time from across the Safeguarding Partnership. The resources from the sessions are also put on the SAB Training webpage so that they can be referred back to when staff are unable to attend.

The sessions are improving partnership knowledge by giving practitioners direct access to specialist teams and services. Making resources available afterwards also helps learning reach staff who cannot attend live sessions.

Feedback from these sessions has been enthusiastic and speakers are often requested again or asked to come to other partnership forums.

"Thank you so much, I really enjoyed learning about what you do and your passion for supporting people really came through"

"Please thank the speaker for us. I know my team members got a lot from the session"

"Fascinating"

There were eight sessions in 2025/26 – with one much longer session bringing in multiple partners on the topic of hoarding:

- **April 2025** – What I Wish You Knew about Street Homelessness – information about how to support adults sleeping rough in Enfield.
- **May 2025** – What I Wish You Knew about Fire Safety in Enfield from our London Fire Brigade colleagues.
- **July 2025** – What I Wish You Knew about working with Neurodiverse Adults from One-to-One, a charity which works with Neurodiverse adults throughout Enfield.
- **August 2025** – What I Wish You Knew about Financial Crimes from the Metropolitan Police.
- **December 2025** – a longer multi-disciplinary session around Hoarding was delivered with contributions from Adult Social Care, Environmental Health and Council Housing partners – this was completed rather than separate What I Wish You Knew sessions in order to give a broader view of how to work with these complex cases. This reflects both learning that partners had requested and learning from the Ms C SAR.
- **January 2026** – What I Wish You Knew about PIPOT, Enfield's Principal Social Worker for Adults spoke about allegations involving Persons In A Position of Trust (PIPOT).
- **February 2026** – What I Wish You Knew about Learning from the Ms C SAR and other serious cases, a briefing from the SAR author on this case.
- **March 2026** – What I Wish You Knew about the Court of Protection, Enfield Adult Social Care Legal Services.

These sessions will continue in 2026/27, with sessions planned around Non-Fatal Strangulation in Domestic Abuse Cases, supporting the Gypsy, Roma, Traveller, Showman and Boatman Communities and Prevent amongst others.

These sessions often give rise to fascinating discussions and help to build our safeguarding networks in Enfield. If you want any more information about these sessions, or have ideas for future sessions, please get in touch with the Safeguarding Adults Board at: SafeguardingEnfield@enfield.gov.uk.



Self-Neglect Training sessions

The Self Neglect Task and Finish Group finished meeting in July 2025 – having reviewed Practice Guidance and the High-Risk Advisory Panel framework. The Practice Improvement Group is carrying forward the further development of Hoarding and Self-Neglect frameworks for the Board.

As part of the work of this group, a short training course was developed for the partnership which was facilitated by David Pennington, Director of Safeguarding, NCL ICB and Elspeth Smith, Safeguarding Adults Practice Lead for Enfield ASC.

These 3-hour sessions ran 4 times between July and September 2025 and were open to all partners. Between 15-30 staff came to each session to learn about:

- Signs of Self Neglect
- The importance of assessment and safeguarding adults in such cases
- Case examples of positive multi-disciplinary working
- The Mental Capacity Act (2005) and
- The Enfield High Risk Advisory Panel

One Nurse described the course as ‘eye-opening’ and participants gave examples of how this will affect their practice going forward. Feedback indicates that the training increased practitioner understanding of self-neglect, mental capacity and multi-agency working. This supports earlier identification of risk and more confident use of the High-Risk Advisory Panel and other partnership routes.

Story of Impact – Suzanne

Suzanne, a woman in her 30s living in supported living, has a history of heart conditions, managed epilepsy and learning disabilities. While physically stable, she experiences significant communication difficulties, including unclear speech, stuttering and hearing impairment, and can become emotionally overwhelmed, particularly when routines change or when discussing distressing experiences.

During the safeguarding process, practitioners recognised the need for a sensitive, person-centred and multi-agency response to ensure she remained supported and able to participate in decisions.

She was clear that what mattered most was feeling safe in her home, protected from distressing interactions with another resident, and reassured by the people supporting her. When discussions became overwhelming, she chose to involve her mother and consented for her to advocate on her behalf, helping to keep her voice central throughout. Professionals worked collaboratively with Suzanne and her mother to explore options, including a possible move, but it became evident that her preferred outcome was to remain where she was if risks could be reduced.

A proportionate plan was therefore agreed across the network around her, including supported living staff, safeguarding practitioners, her mother and the professional network supporting the other resident, whose move to alternative accommodation was progressed. Actions included tailored safeguarding discussions, daily wellbeing checks, strengthened risk management, staff support around communication and de-escalation, and ongoing review.

As a result, Suzanne remained in a familiar environment and avoided the distress of an unnecessary move. She reported feeling safer and more reassured. This case demonstrates Making Safeguarding Personal in practice, with agencies working together to reduce risk whilst improving her sense of safety and control.

Other work of the Safeguarding Adults Board

Working with exploited women

In partnership with Public Health, Police, The Community Safety Partnership and the London Borough of Haringey.

In June 2025, Police colleagues highlighted a number of concerns about the vulnerabilities of women working (or being coerced to work) in the street sex trade in Enfield. Led by Public Health, Housing, Police and the Community Safety Partnership, partners have strengthened joint working in this area, with activity coordinated through relevant partnership boards. The London Borough of Haringey is now co-ordinating a regular multi-disciplinary panel to discuss and support exploited women in the region and a number of SAB partners contribute to this.

The Enfield SAB will continue to contribute to and support this work wherever possible.

Regional Work

Following learning from cases highlighted at the Practice Improvement Group, Enfield SAB has instigated a regional piece of work with NCL SAB partners around developing a regional Missing Person's Framework – it is hoped that this will be published in 2026 – improving our response to missing adults and supporting partners who work across the region.

Protocol and Policy developments

- Terms of Reference and SAR Protocols – these important documents were reviewed to support better practice around Safeguarding Adults Reviews.
- Further High-Risk Advisory Panel guidance – this guidance continues to be reviewed and enhanced regularly; with the Board developing a webpage to support this.
- Work where adults have passed away prior to safeguarding adults concerns being received – the Board supported the development of this Adult Social Care guidance.

The following policies are expected to be published in 2026/27:

- Hoarding Framework.
- Self-Neglect Framework
- Guidance for Providers around Medication errors and Safeguarding Adults.
- A Missing Person's Protocol developed across NCL SAB Partners.

Responding to the CQC Local Authority Assessment

The CQC Local Authority Assessment, published in May 2025, rated Enfield's safeguarding quality statement as 2, meaning that evidence showed some shortfalls. The Board has taken this seriously.

During 2025/26, the SAB has used the CQC findings to support work around:

- Improving timeliness of SARs by reviewing processes and documentation in this area. This included reviewing how we identify and commission authors and firmer processes around panel meetings to ensure that timescales do not drift.
- Worked through the SIP, and with the Enfield Local Authority Quality Assurance Team, to speak with Providers to monitor the quality of feedback that they receive and picked up with specific VCS partners when this is raised through discussion.
- Developed self-assessment impact audits for partners around our SARs and topic areas such as Mental Capacity.
- Received feedback from Adult Social Care around their specific improvement actions.
- Continued to support the High Risk Advisory Panel as a forum for multi-agency discussion of high risk cases.
- Worked specifically around providing additional training and guidance around Hoarding for staff and the public.

Glossary of acronyms and key terms

This glossary explains acronyms and key terms used in this annual report.

Acronym or term	Meaning
ASC	Adult Social Care.
CQC	Care Quality Commission, the independent regulator of health and social care services in England.
ESAB	Enfield Safeguarding Adults Board.
GP	General Practitioner, usually a family doctor or local doctor.
HRAP	High Risk Advisory Panel, a multi-agency meeting where partners discuss complex high-risk situations and agree next steps.
ICB	Integrated Care Board, the NHS organisation responsible for planning health services for a local area.
LA	Local Authority, such as the London Borough of Enfield.
MASH	Multi-Agency Safeguarding Hub, where agencies share information and decide how to respond to safeguarding concerns.
MCA	Mental Capacity Act 2005, the law that supports and protects people who may be unable to make particular decisions for themselves.
NCL	North Central London.
NHS	National Health Service.
PIPOT	Person in a Position of Trust, used when there is an allegation or concern about someone who works with adults with care and support needs.

Acronym or term	Meaning
SAB	Safeguarding Adults Board, a statutory partnership that helps local organisations work together to safeguard adults.
SAR	Safeguarding Adults Review, a review used to identify learning when an adult with care and support needs has died or experienced serious harm and there are concerns about how agencies worked together.
Section 42 enquiry	A safeguarding enquiry under Section 42 of the Care Act 2014, where the Local Authority must make, or cause others to make, enquiries when an adult may be at risk of abuse or neglect.
Section 44	The section of the Care Act 2014 that sets out when Safeguarding Adults Boards must arrange Safeguarding Adults Reviews.
Section 75 agreement	An agreement that allows NHS bodies and Local Authorities to work together through shared or delegated arrangements.
Section 136	A police power under the Mental Health Act that allows police to take someone from a public place to a place of safety in specific mental health circumstances.
SIP	Safeguarding Information Panel, a multi-agency meeting that shares intelligence about care providers and coordinates action to support safe, high-quality care.
VCS	Voluntary and Community Sector.

How to raise concerns or get help for vulnerable people in Enfield

Adults

If you or the person you are concerned about is over 18 (an adult at risk) and you think they are being abused or neglected (including self-neglect) you can report this online here.

You can report anonymously if you feel you need to. Remember, telling us about a concern is sharing a worry so that the adult (and sometimes those caring for them) can get the right support. It really does help people – don't assume someone else will raise it.

Or you can call: **020 8379 5212** (Textphone: **18001 020 8379 5212**).

In an emergency, always call **999**.

There is also helpful information on the MyLife Enfield website. Go to: About Safeguarding Adults

If you think an adult might need more care and support from the Local Authority then please visit the website here to see the different ways to refer and services available.

Children and young people

If you or the person you are concerned about is under 18 (a child or young person):

- Call the Children Multi-Agency Safeguarding Hub (MASH) Team on **020 8379 5555**, Monday to Friday 9am-5pm.
- Call the emergency duty team on **020 8379 1000** (at night and weekends) and tell them what is happening.
- For people who work with children and young people, please make your referral using the Children Portal: www.enfield.gov.uk/childrensportal
- You can email at: ChildrensMash@enfield.gov.uk
- In an emergency – such as when someone is being hurt or shut out of their home – ring the police on **999**.

You can also ring **ChildLine** on **0800 1111** or visit the ChildLine website: www.childline.org.uk

If you don't want to talk to someone you don't know, you can ask an adult that you trust, like a teacher or youth worker or even a friend, to make the phone call for you. When people are working with children they have to follow set procedures, but they will explain to you what they will do and should be able to support you through the process.

ChildLine

ChildLine have launched the **'For Me'** app – the app provides counselling for young people via smartphone and other mobile devices. For more information and to download the app for free, go to: www.childline.org.uk/toolbox/for-me

For all Enfield residents

Domestic Abuse Support

If you have experienced or are currently experiencing being made to feel unsafe by someone close to you, this is domestic abuse. Domestic abuse is not okay and is a crime. Anyone can be affected by domestic abuse and there is help available.

Solace Women's Aid Advice Service offers support for domestic and sexual violence. Phone the advice line on **020 3795 5068**.

You can also find more resources to support anyone experiencing domestic abuse at: www.enfield.gov.uk/services/community-safety/domestic-abuse#how-to-get-help-with-abuse

Modern Slavery Helpline

Modern Slavery is a crime that is hidden from plain sight but, occurs everywhere around us. Modern slavery is happening right here in Enfield and it needs to be stopped. An advice line is available to provide information and support for those that have any concerns or general questions regarding modern slavery. If you would like to discuss your concerns, please contact us on **020 3821 1763** (Monday-Friday, 10am-2pm), or you can email us at: ModernSlavery@enfield.gov.uk

Safeguarding ENFIELD

Website
Safeguarding Adults Board

Email
EnfieldSAB@enfield.gov.uk

Enfield Safeguarding Adults Board

September 2025

ENFIELD Council