Safeguarding Adults Review (SAR)

Following the death of

'Jan'

to explore how HSAB partners can better support adults experiencing multiple disadvantage secure suitable care and accommodation

Commissioned by

Haringey Safeguarding Adult Board

Reviewer: Fiona Bateman

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Contents

Glossary

ASC	Adult Social Care
AMHP	Approved Mental Health Professional
BEH	Barnet, Enfield and Haringey NHS Mental Health Trust
CMHT	Community Mental Health Team
CQC	Care Quality Commission
DHSC	Department for Health and Social Care
ECHR	European Convention on Human Rights
EDT	Emergency out of hours social care
FRT	First Response Team
HSAB	Haringey Safeguarding Adults Board
ICTT	Integrated Community Therapy Team (Haringey)
KLOE	Key Lines of Enquiry
KPI	Key Performance Indicators
LAS	London Ambulance Service
LBE	London Borough of Enfield
LBH	London Borough of Haringey
MACCT	Haringey Multi-agency Care and Coordination Team
MASP	Multi- agency Solutions Panel
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983, as amended
NLP	North London Partnership NHS Mental health Trust
SAR	Safeguarding Adult Review
SAT	Safeguarding Adults Team
Supported accommodation placement	Denotes a place provided by ASC (including from temporary, general needs stock) to ensure care and support can be provided
Supported housing	Denotes a place (including within specified accommodation) provided through housing need/ homelessness pathways where residents receive additional support (funded through housing benefits) to help them live independently.

1. Introduction

1.1. In January 2025 'Jan[1]' was found deceased in accommodation provided by Haringey Council's Adult Social Care [ASC] department. At the time of his death Jan was 64. His ethnicity is recorded as white Eastern European. He had separated from his wife prior to moving to the UK in 2007. He reported he had children and grandchildren abroad but was not in regular contact. Since 2007 he had experienced periods of homelessness, including rough sleeping.

1.2. Prior to his death Jan was known to several statutory agencies and third sector providers to be at high risk due to poor physical health, mental ill-health and reduced cognitive ability possibly linked to dementia. In 2022 he was provided with supported housing within a low needs setting operated by 'provider A'. Shortly after this he exhibited presentations of delusional infestation (aka delusional parasitosis)[2], paranoid ideation towards other tenants and general delusional thinking. His keyworker reported he struggled, due to mental ill-health, to manage his finances, health needs and was socially isolated. Various referrals were made by provider A throughout 2022-2024 to explore statutory routes for additional support. In February 2024, his case was referred to Haringey's Multi Agency Solutions Panel [MASP] who noted he had additional mobility issues, risks regarding financial exploitation and fire safety risks arising from misuse of chemicals to address parasites he believed were in his room[3]. Jan died from acute chronic cardiac failure, caused by secondary hypertension, asthma, and obesity.

1.3. There was no inquest or any other parallel criminal investigation undertaken as his death was reported to be from natural causes. However, provider A and Haringey Council's Adult Social Care department [ASC] expressed concerns that agencies may have worked more effectively to reduce risks so jointly referred the circumstances to Haringey Safeguarding Adults Board [HSAB]. In June 2025 HSAB agreed to commission a mandatory safeguarding adults review to better understand what more could be done to support multi-agency risk management for adults with care and support needs, experiencing multiple disadvantage secure timely assessment and support to access suitable accommodation and support to address health and care needs.

2. Scope of Review

2.1. This review used a hybrid methodology to produce system learning. The purpose of undertaking a Safeguarding Adult Review [SAR] is to establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults, review the effectiveness of procedures (both multi agency and those of individual organisations) and inform and improve local interagency practice by acting on learning. The final report is systems focused, providing clear recommendations that can be translated by HSAB organisations into a 'SMART'[4] action plan.

2.2. HSAB have proposed the SAR will focus on the care and support that Jan received from September 2022, when he was first referred to Haringey Council, until his death in January 2025. Reference is also made to significant events outside of the scope of the review where necessary for context.

2.3. The reviewer is grateful for contributions from practitioners and senior managers involved in the case, HSAB's SAR panel and detailed feedback from NCL ICB's Inclusion Health lead. The information in this report is drawn from case files, minutes and chronologies provided by the SAR panel and the following organisations:

- Haringey Council's Adult Social Care and Housing Demand departments
- The Supported Housing provider

[1] Throughout this report the pseudonym 'Jan' is used in the report to protect the identity of the individual involved. It has been chosen to reflect his cultural heritage.
[2] A rare disorder where the suffer believes, despite a lack of objective evidence of infestation, that they have been infected by parasites. More information is available in Waykar V, Wourms K, Tang M, Joseph V. Delusional infestation: an interface with psychiatry. *BJPsych Advances*. 2021;27(5):343-348. doi:10.1192/bja.2020.69. accessed on 22.08.25 at: https://www.cambridge.org/core/journals/bjpsych-advances/article/delusional-infestation-an-interface-with-psychiatry/E93B281BE85B2D1CB4286DA1549D8CB7
[3] Initially this was within a third sector provider shared supported living environment, but following eviction in June 2024, he was accommodated by the Council in temporary accommodation in line with powers under s19(5) Care Act, pending a care act assessment. This accommodation consisted of general needs accommodation. He had access to a shared bathroom next to his room, but the kitchen was a floor below and he was required to climb stairs to access his room.
[4] That is actions that are specific, measurable, achievable, relevant and time-bound.

- North London Partnership [NLP] NHS Foundation Trust[5]
- GP Practice
- Whittington Health
- London Fire Brigade

2.4. It is understood that, during this period, Jan was not in contact with family members. Following his death efforts were made by the Council to contact his family but it was not possible to trace them. Where possible, we have drawn information to reflect his voice from case materials and from speaking with practitioners who knew him.

2.5. To better understand the learning for HSAB partners to improve cooperation (including with the adult at risk) to ensure health, social care and housing needs are appropriately managed and taking into account local context and previous learning from SARs, the HSAB have requested the following themes are explored:

I. Was full consideration given to wider legal frameworks to address suitability of his accommodation given risks associated with Jan's care needs?

II. What, if any, barriers or challenges make it more difficult to complete holistic need assessments and interim plans for adults experiencing multiple disadvantage? What would support frontline practice comply with duties under Mental Health Act 1983, NHS Act 2006, Care Act 2014 and the Housing Act (as amended) for adults at high risk because of multiple disadvantage?

III. What, if any, improvements have been made to multi-agency assessment processes and practices since Jan's death? How is the impact of those improvements measured by HSAB partners?

3. Local and National context

3.1. A full chronology of Jan's experiences is set out in appendix A of this report and referenced throughout section 4 below. Jan had several significant physical health conditions[6]. In addition, his poor mental health and deteriorating cognition impacted on his ability to understand risks posed to his health if he wasn't concordant with necessary medication and treatment. This, coupled with possible cultural factors, meant he didn't articulate his needs during statutory assessments, though his keyworker (employed by provider A) shared their assessment of his level of need and risks posed by his behaviours linked to his delusional disorder. Despite this, and for the reasons set out below, he wasn't offered holistic care. Sadly, his experiences are not unique as demonstrated within the thematic homelessness SAR[7] completed in 2021 by HSAB.

3.2. Research into safeguarding practice around homelessness, self-neglect and multiple disadvantage has underlined the need for a holistic whole-systems approach for people with intersecting needs and to utilise statutory powers so interventions prevent harm or needs escalating to levels where statutory eligibility criterion require urgent action. This harmonises with the Care Act's wellbeing principle,[8] prevention duties (s2 Care Act) and safeguarding obligations (s42 Care Act) ensuring duties to adults with care and support needs extend beyond the issue of mental capacity as defined by the Mental Capacity Act 2005. The Care and Support Guidance, which accompanies the Care Act, also prescribes early responses to emerging harm to prevent needs escalating. It clarifies local authorities and relevant partners have duties when the adult's needs for care and support are due to a physical or mental impairment or illness and that not caused by other circumstantial factors. This includes '*physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury. The authority should base their judgement on the assessment of the adult and a formal*

[5] During the review period responsibility for assessment sat with Barnet, Enfield and Haringey [BEH] Mental Health NHS Trust though this has since merged with another trust to form NLP

[6] Namely an underactive thyroid, diabetes, high blood pressure, high cholesterol, itchy skin condition, bilateral hip osteoarthritis and mechanical hip, joint and back pain, polyps of the colon, hypertension and cobalamin deficiency. He was required to take numerous medications daily.

[7] Available at: https://haringey.gov.uk/sites/default/files/2024-10/thematic_sar_homelessness_report_2021.pdf

[8] Since April 2015, s1 Care Act requires local authorities to promote an individual's wellbeing whenever it is carrying out any care and support function. Section 2 obligates local authorities and relevant partners to provide services or take other steps it considers will prevent or delay the development of care and support needs by adults in its area.S.6-7 obligates relevant partners (police, NHS, district or county councils, prison, probation, department of work and pensions and providers of health or social care services) to cooperate in the delivery of respective functions to adults with care and support needs and their carers.

diagnosis of the condition should not be required.'[9] Section 11(2b) Care Act enshrines a duty to offer an assessment if adults with needs are experiencing, or at risk of, abuse or neglect.

3.3. Academic and SARs research acknowledge widespread uncertainty as to whether people experiencing multiple disadvantage fall under the 'umbrella' of social care and adult safeguarding (Harris et al, 2022). Whilst ASC assessments must consider legislative restrictions intended to give primacy within the statutory framework to obligations under the Housing Act 1996 (to meet housing need[10]) and under the NHS Act 2006 (to meet health needs[11]), statutory guidance[12] strongly advocates for holistic assessments, including with health and housing colleagues (ch6.75), Occupational Therapy [OT] and other relevant experts (ch6.27). Statutory guidance and case law also sets out how public bodies should apply each relevant statutory duty; all require practitioners to have regard to overriding duties to protect life and prevent inhuman or degrading treatment (article 2 & 3 of the European Convention on Human Rights).

3.4. It is also common for SARs to find that narratives of 'lifestyle choice' and mental capacity sometimes derail responses to adult safeguarding concerns (Preston-Shoot, 2021). The second SAR national analysis[13] argues a need to reshape attitudes of professionals and the structures that enable successful multi-disciplinary support for adults who are at risk from self-neglect but who may appear not to fall easily into established definitions and categories. The Fulfilling Lives programme, (which worked between 2014 and 2021 in twelve areas of the country) provides a solid evidence base for effective practice with people living with multiple disadvantage. Their evaluation report[14] made clear effective work with people living with the effects of multiple disadvantage, trauma and co-occurring conditions requires the following foundations:

- Removing arbitrary barriers to accessing support services, including by co-producing new and changed services with the people who use them
- Improving the training and learning opportunities available for frontline practitioners, and giving them the flexibility to use it in their practice
- Improving access to mental health services and the continuity of care between services and settings

3.5. It is important also to recognise the reality for public sector support during this review period as this impacts on how equipped organisations and practitioners are to respond to adults at risk. In common with many areas across the UK, Haringey Council services have been subject to significant competing resource pressures for many years, including prior and during the review period. In 2022 10% of Haringey residents were recorded as living with disability, 4,500 had a serious disability. In 2024 there were 2,675 homeless households living in temporary accommodation[15]. Similar pressures for the Council's ASC department are detailed in the Eleanor SAR[16] and summarised in response to the third key line of enquiry [KLOE] below.

4. Analysis of agencies involvement

KLOE 1: Duty to provide suitable accommodation

Was full consideration given to wider legal frameworks to address suitability of his accommodation given risks associated with Jan's care needs?

4.1. Jan was initially accommodated within Haringey's borders by Enfield Council [LBE] who had accepted he was in priority need so owed a duty to be accommodated (under part 7, Housing Act 1996). To

[9] Paragraph 6.104 Care and Support guidance, DHSC
[10] S23 Care Act 2014, though this will not apply if the person lacks capacity to make an application or manage a tenancy.
[11] S22 Care Act, though this does not apply if health needs are 'of a nature the local authority could be expected to provide and doing so would be merely incidental and ancillary' s22(1) Care Act, but see also National Framework for Continuing Healthcare
[12] Including Care and Support guidance, Homelessness Code of Guidance and the National Framework for NHS continuing healthcare.
[13] Second National Analysis of Safeguarding adults Reviews (2024) Preston-Shoot et al, available at: https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2019-march-2023-executive-summary.
[14] https://www.tnlcommunityfund.org.uk/media/insights/documents/Summary-of-programme-achievements-evaluation-findings-learning-and-resources-2022.pdf?mtime=20221128143121&focal=none
[15] Taken from Haringey Council's housing strategy, available at: https://haringey.gov.uk/sites/default/files/2024-05/haringey_housing_strategy_2024_-_2029.pdf
[16] Available at: https://haringey.gov.uk/sites/default/files/2025-03/eleanor-sar-report-2025.pdf

meet this duty, he was housed temporarily through a pathway most frequently employed to support those at risk of rough sleeping. London Borough of Haringey's [LBH] rough sleeper outreach team demonstrated continued good practice by supporting and advocating on Jan's behalf directly with LBE by seeking to keep his application active so he would be accommodated by LBE into more suitable long-term accommodation. LBH's outreach team confirmed they had notified provider A of the outstanding active legal duty owed by LBE, but this information was not shared with his keyworker. Jan also does not appear to have notified his keyworker or LBH's housing teams, though this could be explained by concerns about his cognitive dysfunction as early as September 2022.

4.2. Jan's keyworker, unaware of LBE's active legal duty and in recognition of Jan's vulnerabilities, rightly referred for an assessment and support directly to LBH's housing and ASC departments. LBH's housing need worker ensured Jan was supported by his keyworker during their assessment and provided notification of their likely findings within a reasonable time. This concluded he was not in priority need so (contrary to LBE's assessment and the view of LBH's outreach team) did not accept a duty to offer more than temporary respite (for up to 56 days) via LBH's homelessness relief duty. They took steps to refer Jan to alternative providers, again via the homeless pathway.

4.3. ASC assessment in May 2023, having adopted a strength-based approach to his ability to manage activities of daily living, also concluded he was not eligible for social care.[17] This is considered in more detailed below in response to KLOE 2, but learning from Inclusion Health initiatives demonstrates the importance of taking a rights-based, balanced approach to strength-based practice. Crucially, assessors must understand cultural context and adopt trauma-informed perspectives so that due regard is given to whether chronic trauma, cognitive decline and mistrust of services may limit a person's ability to self-protect. The decision he was ineligible was immediately disputed by his keyworker, but the decision not overturned. There is evidence of communication between LBH's ASC and housing department as ASC adopted housing's assessment that he was 'in low need' as rationale for refusing his request to move to older person's supported living. Despite recognition Jan should utilise the homeless/rough sleeping pathway, no checks were done by either ASC or the housing needs team with LBH's rough sleeper outreach team to triangulate whether they shared similar concerns to provider A's keyworker. Had this been undertaken, his local connection to LBE and their outstanding legal duty owed to identify suitable housing would have been discovered.

4.4. His keyworker was misinformed that Jan must be street homeless to be considered further for alternative accommodation. Provider A therefore served a Notice to Quit [NTQ] but agreed not to enforce this following the decision by LBH that he was not in priority need as they feared he would be evicted to the street. This was good practice by the provider. For the avoidance of doubt, though homelessness/rough sleeper pathways are focused on supporting those who are actively rough sleeping, these services sit alongside and are meant to complement statutory duties to provide suitable accommodation, either within supported housing or a supported living placement (ASC). Please see Appendix B for more detail. As was made clear during the subsequent MASP meeting and during learning events for this review, ASC brokerage team have available accommodation for adults who require additional support, even those still able to manage many activities of daily living, if this will prevent their health and wellbeing deteriorating. Many community schemes are available for those aged 50 and over provided they have both housing and support needs[18]. Extra-care facilities are also available for adults over 55.

4.5. It is notable that provider A was identified as suitable temporary supported housing initially by an intermediate body. They are not commissioned (or working with) LBH's ASC or Housing needs departments and so not assessed against LBH's supported housing quality assurance framework[19]. Provider A can still accept direct referrals (including from LBH's housing and ASC staff) for out of

[17] It is notable that, during this period, his application for PiP was also refused, suggesting LBH's decisions were not unreasonable in the legal sense.
[18] LBH confirmed that, whilst there is a large waiting list (approximately over 500) allocation is done by need rather than direct bidding so those with high risk and in urgent need can be accommodated quickly.
[19] Since this review period, provider A has discontinued its operations in Haringey. This decision followed steps taken by LBH to review quality assurance of services providing supported housing funded through housing benefit. More information is available at: https://www.gov.uk/government/publications/housing-benefit-guidance-for-supported-housing-claims/housing-benefit-guidance-for-supported-housing-claims. Provider A reported they felt the review process had not offered adequate formal processes for consultation. They continue to operate, including through nomination agreements with other local authorities across north Central London.'

borough arrangements but, as a provider of low-needs supported housing, is not expected to be regulated by CQC. Many involved in the learning events were unaware supported housing providers were not required to be regulated and therefore usually prohibited by law from providing personal care and support. Whilst (given Jan's history) it was reasonable for LBE to use this pathway as a temporary solution in 2022; this disconnection from LBH's usual mechanisms to support joint working would also have undermined the parity given to provider A's assessment of need and made it harder for them to have a relational support from LBH, e.g. regular information on changes to local pathways for support. This may explain why their referrals in November 2022 to Homeless Health and East London Mental Health NHS Foundation Trust [ELFT], who offer important services but not to adults in Jan's circumstances at that time, were unsuccessful.

4.6. Predictably Jan's needs increased, and consequently his keyworker made further referrals and escalated their concerns resulting in MASP considering the matter in February 2024. There was widespread agreement at that meeting that his poor mental health meant he would be at high risk if made street homeless and that he was not getting the support needed within provider A. Prior to the meeting, provider A had raised concerns that Jan was mixing noxious chemicals in his room to try to treat the perceived infestation. LFB expressed serious concerns regarding the fire and safety risk this posed to him and other residents as it was foreseeable the gases could ignite, given gas was used in the property for heating and cooking. A senior manager from the ASC commissioning team explained they did not believe sheltered accommodation could meet Jan's needs as he required more specialist supported accommodation with 24-hour support, because of the potential fire safety risk and the presence of other vulnerable residents within such settings. He advised current pathways for supported living available to LBH ASC only provide support between 9-5 on weekdays and to access 24 hour support he would need a support plan already in place. Nevertheless this was significantly more than the 3-hour weekly support offered by provider A. This should have triggered attendees at that meeting to make immediate arrangements for a holistic assessment of his needs involving LBH's ASC, Mental Health services, LBH's outreach team, Jan, his keyworker and GP with advice from LFB about how best to mitigate fire safety issues. If this had occurred it is probable (particularly given his GP had referred him for additional OT support and a specialised dementia assessment) that his cognitive decline and delusional behaviours would have been recognised and enabled suitable supported accommodation be made available in line with ASC responsibilities and powers (s2 and s8 Care Act, even if ASC remained of the view that the s18 duty wasn't applicable)[20].

4.7. Practitioners and senior managers involved in this review recognised the siloed way in which statutory assessments were conducted and the complexity of different statutory and non-statutory pathways for accessing supported housing or accommodation increased the likelihood that critical information might be overlooked. They also accepted that, whilst there was an overreliance on provider A's keyworker to manage Jan's needs, too little weight was given to their concerns or representations regarding his inability to keep himself safe or the risks, when his behaviours escalated, he posed to others. There was agreement that MASP processes needed to be more robust so that all HSAB agencies, (who had signed up to MASP as a way to reduce risk), actively attended, were accountable for decisions and followed up on actions. Without this, the tendency for agencies to identify that risk or needs should be met by other agencies or practitioners (often those absent from discussions) will continue, undermining the systems approach that was the whole purpose of a MASP.

4.8. A joint visit between ASC and the Early Intervention Service [EIS] in March 2024 should also have provided an opportunity for holistic needs assessment that considered whether his current home was 'suitable' applying caselaw detailed in Appendix B. During the visit Jan made threats to pour petrol over the property if he was not moved. This should have prompted an urgent joint risk assessment undertaken with the provider, LFB, ASC and the NLP NHS Trust staff and a plan to mitigate risk should have been implemented. This did not happen. During learning events, attendees spoke of additional complexities posed by adults with care and support needs who pose a fire risk. Panel members also recognised current poor practice to highlight fire risks. They believed referrals are often

[20] It is worth noting that this did not would likely have been cost neutral for ASC budget as the cost off accommodation would be met, as it was in provider A accommodation, through housing benefit.

silent on fire safety risks for fear that the person would then be deemed ineligible. If true, this practice is deeply flawed as such practice increases risks to public safety and organisational reputational risks.

4.9. A review of the paperwork completed by ASC in Jan's case records demonstrates action was taken (following the learning from the Ms Taylor SAR in 2019[21]) to ensure assessment and brokerage request forms prompt practitioners to identify fire risks. However, despite obvious and clearly articulated risks these were not recorded. Practitioners did not, therefore, apply learning from previous fire safety SARs[22], nor is there evidence that tools developed by the National Fire Chief Council[23] were employed by practitioners to identify the heightened risks of a fatality.

4.10. Understandably, given the wider public safety duties (including to other residents) many providers are reluctant (or could even be prevented by insurance policies) from offering to accommodate people with a known fire risk, unless there are clear actions taken to mitigate these. The LFB representative explained their community support teams will work with anyone at high-risk to educate carers or supported housing/accommodation providers and can advise on equipment which could reduce the risk. They do not, however, have enforcement powers so rely on HSAB partners and providers to notify them and explore practical solutions to ensure fire safety is considered as part of any offer of support to residents. They also welcome involvement in holistic planning, not least so they can place a marker on properties where fire risks are higher and where the person may need a personalised emergency evacuation plan[24] in the event of a fire. LFB were present at both the MASP and case conference meetings, but disclosed to this review they were unable to find any case notes relating to Jan within their records. It is understood that current practice regarding case recording and flagging of high-risk matters is determined at neighbourhood level. LFB representatives involved in this review accepted it would be useful to have a standardised regional approach to high-risk panels and cross agency risk management to better enable their service to fulfil their functions. Recommendations 2 and 3 are intended to address this concern.

4.11. Jan was subsequently diagnosed with delusional parasitosis, prescribed anti-psychotic medication and referred to BEH's a longer-term Community Mental Health Team [CMHT]. Their waiting list meant that his GP was asked to monitor physical and mental health needs until such a time as CMHT determined a care and treatment plan. Unhelpfully, ASC and his keyworker were advised '*there was no treatment for delusional beliefs*' in apparent contradiction to the decision to prescribe anti-psychotics. Again, no consideration was given to how provider A could be supported to comply with their duties as a landlord by mitigating obvious safety risks to Jan and other residents. Understandingly therefore, provider A reluctantly took the decision to serve Jan with another NTQ which was due to expire in May 2024.

4.12. It was good practice that, having made this decision, they notified ASC and EIS and supported him to reapply to LBH's housing need team. Again, that assessment was conducted in line with expected practice, though the outcome (that he lacked capacity to manage a tenancy and so was ineligible for support under Housing Act 1996) wasn't communicated until June 2024. Provider A continued to accommodate him, despite the NTQ expiration and to advocate to LBH that he should not be re-housed in a temporary unsupported (B&B) property due to the level of his needs and the fire safety risk. Despite the agreement reached at MASP in February there was still no forward plan to prevent street homelessness. It is commendable therefore that in May 2024 his keyworker convened an urgent case conference and highly regrettable that ASC did not attend.[25] The meeting concluded BEH would urgently allocate a care coordinator but that it would be for ASC to identify a suitable placement. ASC's absence meant that the practicalities of how this would be achieved were not explored, nor was there any agreed mechanism for escalation if a suitable placement wasn't found in a timely way. It also meant that LBH's allocated social worker wrongly believed his care coordinator would be

[21] Available at: https://haringey.gov.uk/sites/default/files/2024-10/sar_report_ms_taylor_2019_pdf_549kb.pdf

[22] A search of the national SAR library (undertaken in June 2025 in preparation for this review) referenced 698 cases where fire was the cause of harm, 328 cases identified issues regarding fire safety checks contributed to death or serious harm.

[23] See tools and guidance produced by the National Fire Chiefs Council and available at: https://nfcc.org.uk/our-services/position-statements/fire-safety-risk-assessment-guidance/

[24] In line with Fire Safety (Residential Evacuation Plans) (England) Regulations 2025, for more information please read: https://www.gov.uk/government/publications/residential-personal-emergency-evacuation-plans-residential-peeps

[25] This was attended by BEH's deputy manager east core team, LFB, housing needs worker, GP, provider A's housing support manger and his keyworker.

responsible for identifying suitable accommodation. CMHT has no access to supported accommodation pathways as this is managed, via a s75 agreement between LBH and NLP, through LBH ASC's Care Act responsibilities.

4.13. Jan was evicted on 14.06.24. He was supported by his keyworker to attend the LBH's offices to apply for emergency accommodation. As he had already been assessed as ineligible under the Housing Act 1996 due to incapacity, he was placed into a general needs unsupported (B&B) property (under s19(5) Care Act) pending a full care act assessment by a duty social worker without previous knowledge of Jan's case. The request for urgent assistance from ASC's brokerage team did not identify the fire risk he posed, despite this being a specific query within the relevant form. Following this placement, his keyworker continued to raise concerns that the accommodation was unsuitable due to Jan's mobility issues, that he could not manage his medication or health needs independently (an assessment that was supported by the GP practice nurse) and that there was an absence of coordination between adult social care, mental health and housing services to meet those ongoing risks both to Jan and the public. They also highlighted that families with young children resided at the accommodation so the ongoing fire safety risks should have been addressed. They were advised '*there is nothing else available'*.

4.14. Whilst there is evidence of joint visits undertaken by BEH's care coordinator (allocated in June 2024) with ASC's social worker during the remaining review period and communication between BEH, his GP and the practice's social prescriber, there was no clear plan to ensure he was provided with suitable, safe accommodation throughout the remainder of the review period.

Finding: Whilst separately interventions, reviewed (as they were undertaken) in silo addressed the immediate pressing need, there was no consideration of how collectively agencies should work together to mitigate foreseeable risk or inevitable escalating needs. Consideration of expectations under the Care and Support Guidance and Homelessness Code of Guidance to combine assessments and plan support holistically were not met, meaning Jan's needs were not addressed. Practitioners within ASC and NLP responsible for addressing his welfare needs were not aware of how LBH's decision that he lacked capacity for a tenancy fundamentally changed their legal duties to consider needs in the context of accommodation-based support. Consequently, their focus was incorrectly directed to whether he was coping well enough within the temporary placements. This had already been identified (in February 2024) as unsuitable to safely meet his needs. As such all decisions which followed in respect of Care Act and CPA obligations were unreasonable in the legal sense. This also created an unacceptable risk to the public as agencies were aware of the foreseeable risk that his behaviours could cause a fire or poisonous gases to escape. Recommendations 1,2, 3, 5, 6 and 7 are intended to address these concerns.

KLOE 2: Holistic assessments for adults experiencing multiple disadvantage

This section will explore what makes it more difficult to complete holistic assessments and agree interim plans for adults experiencing multiple disadvantage. What, if any, learning is there for local agencies to improve how agencies work together and with the adult at risk to ensure health, social care and accommodation needs are appropriately managed?

4.15. There is evidence within the case notes that practitioners and clinicians raised concerns and sought to offer solutions to Jan so he could self-manage his co-occurring conditions, for example:

- In the May 2023 response to his diagnosis of diabetes and an extraordinary high blood pressure reading (alongside confirmation from Jan that he didn't remember to take his medication reliably), his GP ordered (in August 2023) a dossette box and blood pressure reader. His keyworker also supported him to access advice (e.g. perhaps help him to remember by getting him an alarm) and ongoing support from the pharmacist to load his medication into a dossette box.

- In August 2023 LBH's OT assessed Jan to be able to mobilise but ordered a walking stick and a shower chair to reduce risk of falls, reporting their input and assessment to his GP.

- Jan was also referred in August 2023 for a neurological assessment. They reported the outcome of an MRI scan confirmed he had '*no acute brain lesions but mild changes of chronic small vessel disease are noted in the brain… this should be assessed with relevant clinical symptoms'*[26]. The MRI findings of mild chronic small-vessel disease are consistent with vascular cognitive impairment, a progressive form of acquired brain injury (ABI) arising from chronic cerebrovascular damage rather than trauma. Such changes can markedly affect executive function, insight, and emotional regulation, leading to behaviours that appear as self-neglect, avoidance, or agitation.

- The GP nurse practitioner raised concerns the following year (June 2024) that, despite interventions he was not adequately managing his medication as '*if he were his health wouldn't still be deteriorating- e.g. leg ulcers were still weeping, blood pressure was dangerously high, and his diabetes had deteriorated requiring a doubling of his metformin*'.[27]

4.16. Cognisant that Jan transferred between three GP practices during the review period, the review explored if this may have impacted on continuity of care but found practice was consistent with NHS guidance, including when he was removed from a practice's patient list for abusive behaviours.

4.17. There is also evidence practitioners considered the prevention duty and referred for early intervention support to connected communities frequently. This was done by his keyworker (in September 2002), the ASC safeguarding social worker (in March 2023) and OT (in October 2023). In October 2023 that service offered to allocate a worker to meet with Jan and invited him to weekly social activities. He was also referred to the GP practice's social prescriber. Jan did not take up these services, relying instead on the trusted relationship he had with his keyworker (employed by provider A). In addition, following the decision to close the safeguarding enquiry, the ASC worker suggested Jan may benefit from Haringey's Reach and Connect service for over 50s. However, in very few interactions did professionals actively consider whether objectively Jan could manage his own health and social care needs or make use of early intervention support. This was despite information provided by his keyworker that contradicted Jan's assertions he would do so, provided he was re-housed. For example, the keyworker reported to the pharmacist and Jan's GP practice when he had not taken his medication, but this didn't prompt a review of his mental capacity or treatment plan or multi-agency consideration as to whether a more interventionalist approach was now required.

4.18. During the learning events, practitioners and senior managers spoke eloquently about the importance of dynamic risk assessment and the flexibility within systems to review outside of planned timeframes if an adult's needs escalated. However, they accepted this did not occur in Jan's case, but couldn't explain why. Case notes imply that practitioners were either overly optimistic that Jan would manage or believed unmet needs would be met by other agencies. Referrals were therefore closed with no accountable organisation considering a long-term plan. Even when he had allocated workers from statutory care agencies services (between June 2024- January 2025 when both BEH and ASC appointed named workers) both wrongly assumed the other agency would arrange appropriate accommodation-based care. This should have been agreed during the joint visit. Practitioners pondered whether Jan was overlooked as he had never been in an obvious crisis.

4.19. All those involved in the review recognised the challenges for frontline practitioners responding in isolation to intersecting needs. They agreed more should have been done to pull together an understanding of how his poor physical health impacted on his mental health and what this might mean to his ability to keep himself safe in the short, medium and longer-term. Whilst they recognised a plan should have been in place and coordinated across primary health care, BEH and ASC to manage risk and needs at each stage, they did not feel there was current capacity within the system to achieve this or a clear way for senior leaders within organisations or across HSAB partnership to have oversight of this gap in current practice.

4.20. Senior managers involved in this review accepted frontline staff (particularly his keyworker and the GP nurse practitioner) had identified that Jan likely lacked executive functioning to meet his medical needs independently and the risks this posed. But they accepted there was no evidence that weight

[26] Taken from the GP records made available for this review
[27] Taken from case records and reported in an email on the 13.06.24 made available to this review.

was given to their views. They explained, by way of an example, inadequate support to monitor and manage his diabetes was likely to have increased his behavioural presentations, so expressed concern there was no agreement (within MASP or the case conference) about how best to monitor his physical health. There was evidence the district nursing service was mentioned as a possible source of support on 11.06.24, but it doesn't appear they were ever involved. It is also notable that he was not referred by the GP practice, ASC or BEH for a discussion at the Haringey Multi-agency Care and Coordination Team [MACCT] or Haringey's Integrated Community Therapy Team [ICTT].[28] The GP's response to Jan's keyworker (when asked to assist with challenging the care act and capacity assessments) stating they '*cannot get involved with social services*'[29] suggests they were unaware of the MACCT, ICTT and other high risk forums (such as MASP). These forums empower them to work collaboratively with HSAB partners to address unmet health needs and prevent additional adverse impact for adults at foreseeable risks of health deterioration arising from cognitive decline. Further, his care coordinator did not refer to BEH's unmanaged risk forum or complex care panel, suggesting they were unaware of these forums or wrongly judged Jan's needs and risks as met.

4.21. The Inclusion Health specialist highlighted the failure to recognise vascular small-vessel disease as a potential neurological driver of self-neglect as an important learning point. Brain injuries, including those from vascular causes, can produce cognitive, behavioural, and emotional difficulties that seriously hinder daily functioning and the ability to maintain housing. Importantly, an ABI does not have to be traumatic; it may result from chronic small-vessel disease, hypertension, diabetes, infections, substance use, or hypoxia. Recognising this link is essential for safeguarding and Inclusion-Health practice. So, the absence of structured follow-up or neurocognitive assessment represented a missed opportunity to connect physical brain changes with Jan's functional presentation. Local Inclusion Health initiatives have been developed in recognition it requires specialist assessment, integrated health and social-care responses, and workforce training to identify potential acquired brain injury early and adapt engagement approaches. Embedding this understanding within local pathways would improve case management and reduce stigma associated with perceived "non-compliance." As such, future safeguarding responses could recommend routine consideration of acquired or vascular brain-injury screening in adults showing fluctuating capacity, chronic self-neglect, or cognitive decline - especially where homelessness[30], hypertension, diabetes, or substance use are present. Recommendation 7 is intended to address this urgent need for practice change.

4.22. It is commendable that his keyworker stayed involved and advocated for Jan throughout the review period including after he had left their property. It is worrying, however, that they were frequently provided with contradictory advice about how to access clinical and social care support to address needs arising from his mental ill-health. It is also alarming there was very little evidence that practitioners responsible for screening referrals or completing assessments within BEH considered Jan's executive functioning to manage his health and stay safe despite objective evidence this could be impaired.

4.23. For clarity, by August 2023 there was reasonable cause to believe Jan lacked executive capacity and that, without assistance to manage his physical and mental health condition, he would be at risk of harm but also pose risks to others. An MRI scan provided objective evidence to back up his keyworker's assertions confirming his brain showed signs of damage consistent with possible vascular cognitive impairment or executive dysfunction, explaining fluctuating capacity, poor self-management, and mistrust or agitation toward services. It also confirmed he was at high risk of future stroke and dementia. Securing that support from statutory services requires an assessment, but both Jan and his keyworker were ping-ponged across the health system (at some cost to the system) trying to secure the assessment as follows:

[28] More information re MACCT is available at: https://www.whittington.nhs.uk/default.asp?c=36180 and for ICTT at: https://www.whittington.nhs.uk/default.asp?c=10851

[29] Taken from Provider A's case notes.

[30] Research indicates that a significant proportion of people experiencing homelessness have sustained a brain injury, often unrecognised. Consequences such as impaired judgment, poor impulse control, and memory problems can compound self-neglect and complicate engagement with services. Exposure to violence and trauma further elevates risk.

- In response to chasing for an update on the mental health assessment which had been due to take place in November 2023, his keyworker was advised by BEH the GP hadn't requested this, but that they could make a direct referral. They notified BEH's older person's mental health team of their concerns but were told, in direct contradiction to the email advice, that referrals must be made via the GP and to see if a primary care mental health practitioner could meet with him.

- The keyworker was then informed the following month that the referral was on BEH's screening waiting list and that his could take 28 days. ASC separately responded that, if the keyworker felt Jan needed urgent assistance, to request an emergency MHA assessment but not how to do so.

- Shortly before the MASP in February 2024 the referral was screened and referred to EIS[31] who subsequently informed MASP they were reluctant to see him as his mental health could be attributed to dementia. The acute NHS trust's designated safeguarding lead advised (during the MASP discussion) Jan could present at A&E to be assessed by the mental health liaison team. It does not appear this recommendation was recorded within the acute trusts electronic case records as, when he did present (in June 2024), he was discharged without a referral to that team.

- In February 2024 EIS suggest his presentations may indicate dementia, but meet with Jan in March 2024, first stating this was likely a physical issue but subsequently diagnosing delusional parasitosis. He was then referred to BEH's CMHT as his symptoms had persisted for over three years (so outside their service criteria). He remained on CMHT's waiting list, despite notification to the team that his needs had increased as he was not taking his mediation in April 2024.

- Following the case conference organised by his keyworker on 05.06.24, a care coordinator was allocated and met with Jan on the 19.06.24 but this only resulted in a further referral (in line with the s75 agreement between LBH and BEH) for ASC to complete a care act assessment. The subsequent care act assessment concluded he had no eligible needs as ASC's assessor incorrectly (and irrationally) concluded his housing issues were addressed.

4.24. The review also found grounds for concern about inter-departmental communication between BEH (now NLP) teams and/or the quality of screening and triage when cases are moved between teams. For example, in March 2024 EIS had diagnosed a mental health condition which is understood to be difficult for clinicians to identify. They were aware Jan was also showing signs of cognitive decline meaning it would likely be more difficult to comply with necessary treatment (the anti-psychotic medication). BEH's senior leader in attendance at the case conference in June was unaware of the diagnosis. Nor were they aware that BEH and the GP had been advised he had ceased to take this medication in April.

4.25. There is no evidence that his GP acted on the keyworkers concerns despite having been tasked by EIS (via a letter rather than through an MDT discussion) of monitoring his physical and mental health needs whilst he was waiting for allocation for support from CMHT. Staff within the GP practice also raised concerns that his physical health required more assertive input as he was unable to manage his treatment plan. He was seen regularly by the practice nurse for treatment to manage weeping leg ulcers, poor diabetes management and dangerously high blood pressure. His death, likely as a result of those unmanaged conditions, could therefore have been delayed if not prevented if better care was available within a suitable setting. Provider A had highlighted their concerns to his GP but felt these were dismissed, so resolved to work instead with allied health professionals within the surgery, including the nurse and social prescriber. Again, this demonstrates the risks (and additional costs in resource) to the system that not creating parity of esteem between staff who work directly with adults experiencing multiple disadvantage and are trusted by them. Many people on this pathway have similar life experiences to Jan. Often, like Jan, they are estranged from family and socially isolated. Language or cultural norms can also create barriers. A trauma-informed approach which many agencies involved in this review were seeking to embed, should openly encourage parity for

[31] Again without the direct intervention of his keyworker it is likely that the referral would otherwise have been closed as Jan did not respond to a phone and 'opt-in letter' (in line with NLP policy) despite evidence being available that he was likely delusional and suffering memory problems. It isn't clear, from the documents made available to this review, what reasonable adjustments were made by the Trust to ensure Jan understood (given English was not his first language) or (given his presentations) have executive capacity to act on the content of the letter.

practitioners who know the person though regular contact. For some people, a trusted keyworker or carer can replicate family and so their voices should be heard within statutory assessments and treatment reviews.

4.26. For GPs outside specialist homeless pathway settings there remains little structured guidance on managing chronic self-neglect, leaving practitioners uncertain about when to re-refer, escalate concerns or question multi-agency decisions. This can generate significant professional and ethical dilemmas, with limited advice available from medical-defence bodies. As noted above, (4.20) the multi-agency risk management fora were not used. Recommendation 4 should ensure there are clear escalation pathways for GPs when risk persists despite "threshold not met" outcomes. ICB, working with the Borough Partnership, should also ensure guidance on diagnostic pathways and multi-agency risk management is widely disseminated and supported by training for primary-care teams on recognising and documenting self-neglect and fluctuating capacity.

4.27. Too often, despite the keyworker's continued advocacy, Jan's need was judged not to be acute (even whilst in the B&B temporary ASC placement) to warrant assertive action in line with statutory powers and duties. From ASC's perspective this was because they did not believe he needed support with personal care. This is not the only criteria that should have been considered. Likewise, BEH workers felt assured he was managing his mental health as he had not disengaged nor suffered an acute crisis requiring MHA assessment and use of compulsory treatment powers. Again, these should not be the thresholds for proactive secondary mental health support. His GP did not feel able to challenge a lack of input from other partners, despite concerns raised by their own practice staff and clear evidence of health deterioration. The lack of a care and support plan to enable him to access therapeutic or medical support to treat the manifestations of his delusional disorder and dementia contradicted the views expressed during the MASP and case conference meetings where attendees had already agreed his needs and risks to others were such that coordinated care was required. ASC commissioners had also warned they were likely beyond those that could be safely managed in sheltered accommodation. The case exemplifies the intersection of homelessness, chronic ill-health, and cognitive decline. Embedding Inclusion Health principles within safeguarding and Care Act practice would promote earlier identification of risk and more coordinated case management across health, housing, and social care. Linking this learning to ongoing regional work in NCL (e.g., Homeless Health Outreach Service[32], FOCUS, Rough-Sleeping Mental Health initiatives) would strengthen system alignment and sustainability of improvement actions.

4.28. Attendees at learning events reflected it was unlikely that the strength-based approach adopted by his care coordinator and ASC's duty and safeguarding social workers took proper account of likely needs if current accommodation fell away. It remains of serious concern that practitioners could not confirm, after he had left provider A's supported housing, whether his behaviours of mixing dangerous chemicals and threats to pour petrol had ceased. They were also unaware if this risk had been shared with the B&B provider. Prior to this move, provider A had put in place steps to monitor Jan's use of chemicals and undertaken very frequent welfare checks on him and the other residents to mitigate harm and meet their duty of care. They also escalated their concerns (via assessment pathways and safeguarding). That any mitigation to foreseeable risk ceased to occur once he was moved into a statutory pathway for support should urgently be addressed by HSAB partners providing assurance steps have been taken to review risk management oversight for those residing in temporary placements either via ASC or housing duties. Recommendations 2 and 4 should address this issue, however, if partners are unable to offer this assurance the risk should be escalated by HSAB to the Health and Wellbeing Board.

Finding: The evidence base for necessary improvements to ensure more effective use of public sector resources to meet important statutory wellbeing and safeguarding functions forms the foundation of national policy to address rough sleeping, the NHS 10-year plan and local housing, integrated health and public health

[32] The service's operating hours are Monday to Friday, 8am to 8pm and will be working across NCL wide boroughs (Barnet, Camden, Enfield, Haringey & Islington), offering direct engagement, advocacy, and pathways into housing, health, and social care services. Referrals are welcome from professionals across statutory and voluntary sectors. There is also free training available for all staff to improve access to services for clients experiencing multiple disadvantage and co-occurring conditions.

strategies. There is also agreement from local political and strategic leaders across the HSAB partnership to work cooperatively to achieve coordinated care for adults experiencing multiple disadvantage, but Jan's experience demonstrates practical guidance for frontline staff and oversight of the operational reality remains weak. Notwithstanding objective evidence that Jan likely lacked executive capacity, too little regard was given to statutory expectations to bringing together frontline practitioners from relevant partner agencies. Instead frequent handoffs between departments (e.g. across BEH and LBH) and between relevant partners (e.g. between BEH and primary care) actively increased the risk Jan would experience harm and that he may inadvertently cause this to other vulnerable adults and children residing alongside him. Agencies did not use existing multi-agency forums effectively or processes (including under the London Safeguarding Adults Multi-agency Policy) to agree a safe way to ensure continuity of care and support for Jan to stay well whilst on waiting lists for secondary mental health input. Recommendations 1, 2, 4, 5, 6 and 7 are intended to support improvement to address these concerns.

KLOE 3: Moving to a system-wide approach from treatment to prevention

This section explores what, if any, improvements have been made to multi-agency assessment processes and practices since Jan's death? How is the impact of those improvements measured by HSAB partners?

4.29. National reports[33] have documented the exceptional pressures faced by statutory agencies seeking to support adults with care and support needs. They also recognise the adverse impact of critical staff shortages (11.6% vacancy rates) and high staff turnover (20%) across the sector placing significant pressure on ASC staff to meet their statutory duties to assess and provide safe care in a timely way. As set out within the Eleanor SAR, LBH reported they were experiencing many of the same national pressures for much of this review period. Alongside pressures to manage demand for adult social care and health services, the national housing crisis is well documented and understood to hold additional risks for areas of high deprivation[34] and population density, such as Haringey.

4.30. During the review period LBH's ASC reviewed operational structures, moving to a localities model and increasing staff within those teams by 25%. Improvements to practice expectations were introduced to support adoption of a strengths-based practice model.[35] The impact of these changes has been monitored through a Key Performance Indicators [KPI] dashboard and monthly meetings between the performance team, heads of service, service managers and team managers to oversee progress, with any exceptions discussed at departmental management team meetings. ASC reported that findings from case file audits are also discussed at these sessions to ensure there is a loop of learning and improving. CQC's assessment report identified this change was reported by staff to enable a more integrated approach and faster access to OT and care act assessment, but CQC also recognised the transformational impact would need time to embed. It is notable, given concerns identified (within KLOE 2, especially 4.20) that CQC recommended more is needed to improve communication and timelines of referrals to support those requiring mental health support and to enable '*more proactive planning and professional meetings so clear actions could be agreed within set timeframes with responsible parties outlined. This included care providers and other agencies such as housing*'.[36]

4.31. In recognition that signposting to connected communities did not work for adults at risk without executive capacity, ASC are working more closely with third sector organisations and inclusion health projects to redesign how they support adults waiting for social care assessments to ensure there is a clear offer of early intervention support. The new pathway is expected to 'go live' in November 2025 and will be directly linked and overseen by ASC senior leadership team.

[33] CQC's State of care report available at: https://www.cqc.org.uk/publications/major-report/state-care/2023-2024/access/asc.
[34] Haringey's population has an Index of Multiple Deprivation score of 9 (1 is the least deprived, 10 is the most deprived) meaning it is one of the most deprived local authorities in England.
[35] This model was coproduced with practitioners (supported by Research in Practice as a critical friend) based on 11 strengths-based standards that practitioners are expected to demonstrate in all of their interventions with adults and carers. This has been adopted as a borough partnership model and is used by health, children and community colleagues.
[36] CQC report was published in February 2025 but covered practice during the review period and available at: https://www.cqc.org.uk/care-services/local-authority-assessment-reports/haringey-0225/summary

4.32. The need for a regional approach is demonstrated within Jan's case as agencies' failings in February 2023 to check with LBH's assertive outreach team, who have access to a regional multi-agency database (CHAIN[37]). CHAIN is designed to support people with a history of rough sleeping. It provides a shared understanding of need and up to date information about how those needs are being supported and by which agencies. Had this been utilised, LBH would have been quickly able to liaise with LBE colleagues to ensure they complied with legal duties under the Housing Act 1996 to find him suitable housing. This could then have been the extent of LBH's involvement, as Jan had already articulated he did not wish to live in the area.

4.33. Jan may also have come to the attention of the Camden Health Improvement Practice service prior to the review period (2018-20). It is not unusual for adults experiencing homelessness to move across local authority boundaries and therefore receive specialist input from multiple services. Whilst there are some mechanisms to support continuity of care for adults known on the CHAIN database, this should also prompt HSAB partners (possibly working with the London SAB Network) to explore clearer information-sharing protocols between outreach, primary-care, and social-care teams to prevent fragmentation of care and memory loss across systems.

4.34. Since 2016/17 housing needs workers are co-located within some partner agencies, including at local job centres and at St Ann's to enable joint working with EIS. Co-location of practitioners from different disciplines has been shown to have a positive impact as it enables relational practice to develop and a greater understanding of the powers and duties each agency can employ to support adults with care needs access statutory pathways and stay safe. This is particularly important given the rise in the complexity of needs for people referred through the homelessness pathway, most of whom have experienced multiple disadvantage. In conversation with the reviewer, senior strategic commissioners explained they had learned from local mortality reviews[38] that to improve the parity of esteem between specialist third sector providers and statutory services, they will need to ensure the homelessness pathways are integrated with statutory routes rather than running alongside. Panel members also cautiously welcomed changes introduced regionally to remove a verification process (that someone has a sustained period of rough sleeping) but rather adopt a 'no wrong door approach' provided that in practice this continues to champion the expertise of specialist outreach providers at assessing risk for those currently or with histories of rough sleeping.

4.35. In addition, strategic housing leads reported that they are also exploring opportunities to work with health colleagues to build in an ethical process to introduce digital tools. These will support practitioners from all disciplines to recognise when statutory duties may apply across specialisms, organisational and geographical responsibilities. In October 2025 LBH hosted a 'rough sleeper' summit. This bought together a wide range of stakeholders, including political leaders, commissioners and practitioners from statutory services, third sector partners, and individuals with lived experience to consider how best to respond to needs of the 'hidden homeless' population including people (like Jan) in unsafe accommodation or who may avoid or be unable to access services due to past trauma and multiple disadvantage. The emphasis was on adapting the safeguarding lens to better identify and support individuals. Such events are welcomed, but to operationalise strategic ambitions for preventative, multi-agency practice that addresses inequality, GP staff will need to be encouraged to use clinical time to secure agreed treatment plans. Viewing treatment through a safeguarding lens does not make this an administrative task, it is fundamental to safe care.

4.36. In recognition that more must be done to change the narrative that ASC does not provide accommodation, and to challenge normalisation of risk for people on the homelessness and rough sleeping pathways, LBH confirmed they hope to strengthen the trusted assessor model already used to support safer, speedier hospital discharge. LBH ASC and Housing Needs senior leaders also intend, in December 2025, to host all team managers across both service areas to explore at a practical level assimilation of eligibility criteria and practice in response to findings from this review.

[37] More information is available at: https://homeless.org.uk/what-we-do/streetlink-and-chain/chain/

[38] LBH is one of the few local authorities to have routinely undertaken learning reviews in respect of each adult who dies whilst on the homelessness pathway. This learning has been used to help shape local public health, housing and inclusion health strategies. It has also been recognised nationally and regionally as best practice. HSAB receive an annual report regarding the impact of support to adults on the homelessness pathway. In 2024 this also included information on learning from the mortality reviews.

This review should act as a catalyst for staff working within statutory pathways to embrace the expertise of practitioners (including those working in the third sector or provider services). This should address the capacity issues reported by ASC, by enabling holistic assessments without endless signposting. It should support better engagement and improved results for co-produced care and treatment plans.

4.37. Since the review period, BEH has merged to become part of the larger sub-regional North London Partnership NHS Trust. As part of this, the Trust invested £25million to transform community mental health support, including improving pathways for older adults and those (like Jan) still of working age but already experiencing frailty and cognitive decline as a consequence of the effects of homelessness and multiple disadvantage. However, senior leaders and practitioners understood that, despite agreement his needs required the input of a care coordinator (under the Care Programme Approach), there remained a lack of ownership across the statutory partners. NLP colleagues explained the role of care coordinator had changed in line with organisational policy to one similar to a keyworker. They accepted that may have caused confusion with partners, as the title hadn't been amended, so other agencies continued to rely on Jan's care coordinator to lead on ensuring all aspects (including duties to meet his physical health, safeguarding and suitable accommodation needs) were met.

4.38. Though the care coordinator was a qualified community psychiatric nurse, they lacked organisational support or community links to ensure critical tasks to safeguard Jan were completed. This includes not having legal authority to complete a care act assessment on behalf of the local authority, leaving them feeling powerless as they are reliant on other professionals to implement interim plans who will likely have competing demands for time and resources. NLP reported there were clear organisational policies on escalating risk and that their staff can refer to multi-agency panel or call case conferences. NLP also confirmed staff are supported to manage complex cases through regular supervision, access to specialist safeguarding support from a dedicated team, regular training and through the option to refer to a complex care panel. However, the care coordinator (satisfied Jan was not in mental health crisis) did not employ any of these mechanisms to escalate his deteriorating physical health, understand if further cognitive decline may be impacting on his executive function (and so secure further input from older adults/ dementia services) or manage the continued fire safety risk posed by his delusional disorder. On the contrary, ASC reported they had understood from communications with his coordinator that Jan was functioning well. Whilst greater professional curiosity could have been employed to ensure this was the case, given provider A's continued advocacy, NLP recognised there remains significant work to empower staff and to ensure strategic oversight of case work that more clearly demonstrates interventions are having a positive impact on service users' wellbeing and safety. Recommendations 5-7 are intended to support HSAB partners secure assurance improvement action plans are having a positive impact in practice.

4.39. Over the review period and since Jan's death, North Central London Integrated Care Board [NCL ICB] has invested significant resource into inclusion health projects to achieve better health equality for people experiencing multiple disadvantage. The positive impact of those projects is reported both to local borough partnerships and overseen at local authority level by the Health and Wellbeing Boards. The improvements made are welcomed and, given existing research findings by the London School of Economics[39], likely to result in significant cost efficiencies systemwide. As noted above, ICB and LBH strategic leads already recognise the needs to more closely integrate the green shoots of positive practice emerging from inclusion health projects into mainstream services. However, it was difficult within this review to ascertain how the impact of local strategies and new service models are evaluated or reported more widely. This report is being written at a time of considerable structural reform of local NHS quality assurance and safeguarding processes[40]. How these reforms and funding cuts will impact on the sustainability of recent practice improvements will need to be carefully considered by HSAB partners and local Health and Wellbeing Board. Recommendation 8 should assist these discussions.

[39] For example see: https://essenceproject.uk/keyword/safeguarding/

[40] Proposals to reform quality assurance processes were put forward via national reports (see for example, https://www.england.nhs.uk/long-read/working-together-in-2025-26-to-lay-the-foundations-for-reform/).

Finding: Much of the learning from Jan's case emulates findings within HSAB's thematic review into homelessness published in 2021 and the regional Yi SAR[41] completed in 2019. Practitioners and senior leaders involved in the review spoke of changes that had been introduced to address the gaps identified, but the sense of frustration that findings within this review were already well understood was palpable. There is a strong commitment at both frontline and strategic level to seek to rectify this. But this cannot necessarily be achieved solely at a local level and without reference to national policy changes, including continued pressures on public sector organisations to reduce costs. Future strategic improvement priorities to reduce health inequalities will require a firm understanding of the adult safeguarding duties that are owed across all relevant partners and the role played by a wide range of good quality supported housing or accommodation options and coordinated community-based health and social care.

5. Conclusion and recommendations

5.1. The impact of unsuitable housing and ill health has on wellbeing is well understood. Jan's experience demonstrates this, as he died of preventable conditions which had already been identified as requiring care and support at a much higher level than available in the temporary accommodation provided to him. The absence of follow-up neurocognitive assessment was a missed opportunity to integrate physical and mental-health evidence into safeguarding planning. It was also luck, not good judgement, that meant Jan's behaviours (which escalated due to the lack of necessary support) did not cause serious harm or death to others.

5.2. The recommendations below are written to reflect existing workstreams already in place and complement learning from relevant previous reviews undertaken by HSAB.

Recommendation 1: Building on the work done following Eleanor SAR to support improved understanding within primary care of statutory housing duties to respond if health needs mean accommodation may no longer be suitable for residents, HSAB partners should invest resource to support HSAB produce 'grab guides' for staff across different disciplines to better understand how homelessness pathways and inclusion health initiatives intersect with statutory duties so frontline staff, including those working in third sector and provider organisations can work collegiately across organisations, disciplines and geographical boundaries. These should support wider understanding that a public health approach to the growing complexity of people's needs will require early intervention and universal services to support adults, wherever possible, maintain their health. The guides should also provide links to tools or practice guidance on assessing executive capacity and local routes for escalation to statutory pathways where unmet needs will likely lead to foreseeable harm if left unmanaged.

Recommendation 2: Whilst fire safety prompts are included as a standard within LBH ASC needs assessment, practice needs to be audited across health, housing and social care to ascertain if this is being used to identify and reduce fire safety risks. To enhance a preventative approach to fire safety, LBH and NLP should provide clear guidance on their webpages of how to refer to the LFB for a home fire safety visit[42], what fire safety equipment or assistive technology is available to reduce risk and which agencies are responsible for the different types of preventative support/adaptations/assistive technology. This should also detail how to apply for that support.

Recommendation 3: In light of learning from this SAR and regional SARs involving fire deaths, LFB should provide data to HSAB on which partner agencies submit referrals and whether there are gaps in providing details e.g. how to access the property. HSAB could then seek assurance from agencies with low referrals rates of the steps those agencies are taking to increase fire safety awareness within their workforce. Such data enables the partnership, as part of their usual business to '*hold partners to account and gain assurance of the effectiveness of its arrangements*'[43] by demonstrating positive practice change in response to this SAR.

Recommendation 4: MASP terms of reference were previously revised by HSAB partner agencies, but these could be made more accessible to frontline practice and should reference the role of other multi-agency forums, including NLP unmanaged risk and complex care panels, Whittington NHS Trust's ICCT and MACCT to prevent duplication of effort. Partners should sign a memorandum of understanding with clear commitments for ensuring internal legal and managerial advice has been provided by the referring

[41] Available at: https://nationalnetwork.org.uk/2019/SAR%20Yi%20Publishing%20version%20with%20Cover%20page.pdf
[42] More information is available at: https://www.london-fire.gov.uk/safety/the-home/home-fire-safety/home-fire-safety-checker-hfsc/
[43] Pg 14.139 Care and Support Guidance

organisation prior to a referral, as well as agreed standards for representative's attendance and seniority. The funding arrangements for administration of MASP should also be agreed so actions are tracked and agencies accountable. There should also be agreed KPI measures (including outcomes for adults) and reporting lines to both HSAB and partner agencies. Consideration could be given to whether an independent chair of MASP could provide a mechanism for dispute resolution and assurance to HSAB that the process addresses system barriers to holistic care.

Recommendation 5: NLP should review their decision to change the purpose and role of a care coordinator and provide assurance to HSAB and NCL ICB that current practice meets the statutory expectations under the Care Programme Approach.

Recommendation 6: To support the development of a trusted assessor model within the homelessness and mental health pathways, NCL ICB and LBH should consider making available training to third sector and provider staff, allied health professionals within GP practice and triage staff. HSAB should receive data on the source of s42 concerns as a measure of the impact of that training.

Recommendation 7: NCL ICB working with their inclusion health specialists, LBH Housing Needs commissioners and ASC Safeguarding Head of Service should provide guidance for primary and secondary care partners to embed practice that enables early assessment and diagnosis of acquired brain injury including from vascular causes. This should be written into HSAB's self-neglect guidance.

Recommendation 8: Given the proposed structural and funding reforms to safeguarding and quality assurance required in line with recent policy[44], regional NHSE leads and ICBs should consult with HSAB partners and LBH's Health and Wellbeing Board to minimise risks that proposed funding cuts will impact on the sustainability of recent practice improvements designed to promote wellbeing for adults with care and support needs.

[44] Proposals to reform quality assurance processes were put forward via national reports (see for example, https://www.england.nhs.uk/long-read/working-together-in-2025-26-to-lay-the-foundations-for-reform/ and https://www.england.nhs.uk/long-read/update-on-the-draft-model-icb-blueprint-and-progress-on-the-future-nhs-operating-model/).

Appendix A: Jan's lived experience relevant to the review period

Important contextual information prior to the review period:

1) Initially, prior to the review period, Jan had been rough sleeping in Enfield. He was supported by LBH's assertive outreach rough sleeper team[45] to apply to Enfield Council for housing support, who accepted he was in priority need and provided housing. Unfortunately, he was evicted from that property due to arrears as Jan had not made an application for housing benefit support. He returned to rough sleeping, but the assertive outreach team continued to advocate to get him access long-term housing through Enfield Council. In September 2022, to meet their interim duties (s188 Housing Act 1996) Enfield Council, with support from an intermediary third sector organisation, secured Jan supported housing within a low support unit managed by provider A in Haringey. This was understood to be temporary until more suitable accommodation was available as Jan wished to live in another borough. The supported housing was intended for people with low to medium housing support needs. A support worker visited for weekly meetings to support with budgeting, to monitor physical and mental health and, usually, to support move on into fully independent private rented accommodation.[46]

2) At this time, Jan was understood to have numerous health conditions, namely an underactive thyroid, diabetes, high blood pressure, high cholesterol, itchy skin condition, bilateral hip osteoarthritis and mechanical hip, joint and back pain, polyps of the colon, hypertension and cobalamin deficiency. He was required to take medication regularly[47]. Case files (from GP and provider A) suggest he was unable to comply without assistance in taking his medication resulting in a deterioration in his health. In March 2022 he was concerned about lymphoma, but this was investigated and found to be of no concern.[48] The supported housing provider confirmed, during this review, they were unaware Enfield Council had accepted a duty to re-house Jan into more suitable accommodation; they also confirmed that initially they had very limited information about the nature of his vulnerabilities and health needs. Provider A's keyworker however met with Jan to understand his needs. Initially Jan was focused on his physical health conditions and his need to secure identification and proof of eligibility for housing benefit. Delays in obtaining this and passing it to Enfield Council meant that the relevant department within Enfield Council [LBE] kept closing his housing application[49]. LBH's assertive rough sleeper outreach team continued to advocate on his behalf and confirmed to the reviewer that, as far as they were aware, Enfield Council confirmed as recently as June 2022 that he remained eligible for housing support in line with their duties under Part 7 Housing Act 1996.

The review period:

3) Provider A's case records document weekly meetings between Jan and his keyworker noting, as early as November 2022, that Jan exhibited paranoid behaviours towards other residents and the government. The keyworker also reported Jan neglected his health (not attending medical appointments, despite requesting that they help him to make these appointments). His keyworker also made referrals to Haringey Council's [LBH] Adult Social Care [ASC] department for an assessment of his social care needs (in September 2022) and in November 2022 to Homeless Health[50], connected communities and ELFT. Provider A reported not getting feedback from those services to confirm if Jan had secured input at that time.

4) Around this time, Jan raised concerns the room/his mattress was infested with bugs. On 21.11.22, in response to Jan dismantling his bed, his room was inspected by pest control who confirmed no infestation, but Jan continued to raise concerns throughout the time he remained in the property. His keyworker continued to record concerns regarding his mental ill health and delusional behaviours but

[45] Based at Mulberry Junction, more information available at: https://homeless.org.uk/homeless-england/service/mulberry-junction/

[46] On average they offer service users 3 hours of weekly support, however provider A reported Jan required and received many more hours than they had been set up to provide.

[47] including Antihistamine (as needed), Levothyroxine 50mg, Amiodipine 5mg, Fexofenadine 180mg, Atorvastatin 20mg and Mometason Furoate 100g.

[48] Jan reported moles on his forehead and right shoulder impacted on his wellbeing and that he would like them removed from cosmetic reasons. He was referred by his GP for a consultation in March 2024 (despite cosmetic concerns usually indicating non-eligibility for NHS treatment) but did not attend the appointment. He was re-referred by his GP in August 2024.

[49] As the supported accommodation was in Haringey, Haringey Council's revenue department would have been responsible for making payments of any eligible housing benefit to cover rent costs but this was a separate legal entitlement to the ongoing duty to find suitable accommodation Enfield Council continued to owe to Jan.

[50] A service operated by BEH Mental Health Trust, this was refused as Jan was no currently rough sleeping.

noted that when asked Jan would confirm his mental health was fine. In January 2023 the keyworker chased LBH's ASC requesting the outcome of their referral in September and followed this up by email to LBH ASC's first response team.

5) During the review period Jan made two applications to LBH's housing teams for support to find more permanent, suitable housing. This was on advice from his keyworker as he appeared not to remember he had an outstanding application with LBE and the keyworker was unaware of this. The first application was made in February 2023 to LBH's housing options team via the online referral and was responded to that day to confirm they would contact him for an assessment within the week. This was completed by telephone with support from his keyworker on the 13.02.23, following which Jan was asked to provide evidence that he had a local connection to Haringey. He was also advised that, as he hadn't lived in Haringey for over 3 years, he would be refused for older people housing. It was noted in provider A's case files he had been served a Notice to Quit [NTQ] which would expire on the 10.03.23 as, prior to this, his keyworker told he could only be re-housed if he were street homeless. Jan's keyworker helped him to provide further evidence requested by LBH's housing needs team, but also took the opportunity to set out in writing their concerns and views of his vulnerability proposing it would not be appropriate (because Jan's level of needs) to refer him to private rented, independent move-on accommodation options. Medical evidence was submitted to Now Medical (LBH's Housing Registration team's external provider) for an opinion on his priority need status. Now Medical confirmed on the 21/03/23 that Jan did not have a priority need.

6) In March 2023 his keyworker raised a safeguarding concern to LBH ASC detailing his symptoms of psychosis- Jan's fixated belief that there were parasites on his skin and in his accommodation, as well as paranoia towards other residents. They also raised concerns regarding his financial management. This was closed in May 2023 after a care act assessment concluded he did not have eligible care and support needs and that he had capacity[51] to manage his finances. The closure summary noted Jan *'would not meet the eligibility criteria for care and support. He manages quite well and has his own daily routine. He can prepare his own breakfast, he can dress and undress, he can mobilise with a walking stick and do his own shopping often, is able to take care of his personal hygiene, struggles slightly with cleaning his home but he has spoken to his landlord regarding this, able to do his own laundry and able to attend appointments with his support worker, manages his own medication and overall is able to do these things with relative ease and no issues…."*[52] The safeguarding enquiry summary noted he wished to move accommodation to older person's supported living accommodation, preferably in another area. Jan was advised he would not meet criteria as he was assessed as low priority for re-housing by LBH's housing needs team. He was referred to connected communities and provider A's keyworker was advised to contact his GP if a referral for mental health support was needed. The safeguarding officer also contacted Jan's GP to request a medication review and for an assessment his mental health.

7) His keyworker sought to challenge the capacity and needs assessments, citing memory issues and ongoing paranoia with infestations of bed bugs, explaining repeated pest control visits to the property had confirmed there was no objective evidence of an infestation. The safeguarding social worker reaffirmed their position and advised his keyworker to work with his GP and an interpreter to reduce the risks that Jan may get confused. Provider A's keyworker also raised these concerns with Jan's GP throughout appointments in March and April 2023. The GP gave advice re hip pain and noted he was already on the waiting list for physiotherapy. They agreed to refer to the ASC for an OT assessment and to refer to the surgery's mental health clinic in April 2023. However, shortly after this, he was '*discharged from the surgery due to a volatile outburst'* after Jan had angrily accused surgery staff of discrimination and made adverse references to their presumed ethnicity and cultural backgrounds. The surgery wrote to explain their decision and provided details of alternative surgeries he could receive ongoing NHS care from.

8) In April 2023 his allocated LBH's housing need worker made contact and completed their vulnerability assessment over the phone, thereafter (on the 19.04.23) his housing need worker issued a personalised housing plan and letter advising of their preliminary findings he would unlikely be found in priority need.

[51] Although the LBH social worker confirmed they had completed an assessment of his needs under the care act and assessed his capacity, they confirmed both these assessments were unable to be accessed for this review as they had not migrated when LBH ASC changed their electronic recording system in 2024.
[52] Taken from the email dated 16.05.23 from Muhummad Illya to Joanna made available to the review

On the 21.04.23 his housing needs worker referred him to St Ignatius (supported housing) and Hope Worldwide (a charity working with single homeless people) and his case was closed on the 17.08.23 as the relief period[53] had ended. Notification of this was sent to him alongside the formal non-priority decision. He did not exercise his right to appeal this decision.

9) Jan's claim for a Personal Independence Payment was also denied on the 15.05.23 as his daily needs and physical needs were too low to receive payments. He did not ask for support to appeal the decision until one week before the deadline, so his keyworker wrote on his behalf to appeal (setting out their views on his level of need) but also requested via an extension to gather further evidence. During a subsequent telephone call with the DWP, the support worker raised concerns that Jan may be struggling with dementia, but it is unclear if this had been reported to his GP until an email in late June raised this (alongside asking for support to challenge ASC's decision that Jan did not have eligible care needs). His keyworker also wrote the following day to request the GP put in place measures to ensure Jan was seen with his keyworker and interpreter at face-to-face appointments.

10) Around this time, Jan was diagnosed with diabetes, prescribed metformin and was referred by his GP for specialist dementia assessment and an OT assessment. In early August, following concerns regarding extraordinary high blood pressure readings, Jan confirmed he didn't always remember to take his medication. The keyworker and GP then discussed previous decisions by ASC that Jan did not have eligible care needs. The GP explained they '*cannot get involved with social services*' instead they offered to request a dosette box to assist him. The nurse confirmed they believed Jan to understand his medical needs but noted he was '*likely to forget'*. Provider A's case notes report the keyworker felt the GP was dismissive of their concerns and inconsiderate, so they decided they would work with nurses at the surgery instead. A request was also made to ASC's first response team for an urgent reassessment as '*to date his case has been pushed back but he is now presenting as serious risk to himself*',[54] namely that his inability to take his blood pressure medication reliably was likely to be impacting on his memory and puts him at high risk of stroke and death. The risk was subsequently set out in a detailed email to the first response team and copied also to previous safeguarding social worker who had completed the capacity and needs assessment in May 2023. A dosette box and blood pressure reader was provided by the GP on the 18.08.23. From this date his pharmacy loaded the dosette box to enable him to take the correct medication. There is evidence on provider A's case notes of them monitoring whether he had taken his medication correctly at their weekly keywork sessions and that they reported to the GP practice and pharmacist when he hadn't.

11) On 24.08.23 the OT appointment (face to face) was undertaken. The OT assessed Jan to be able to mobilise but recognised he would require a more reliable walking stick and a shower chair. Both these items were ordered quickly and the keyworker informed. The OT also made referral to connected communities in October 2023 who offered to allocate a worker to meet with Jan and invited him to weekly social activities. The OT reported their input and assessment to his GP. His GP also made referrals to Neurology and to the General Surgery's lumps and bumps service. On the 31.08.23, 'In Health ltd' reported the outcome of an MRI scan confirming he had '*no acute brain lesions but mild changes of chronic small vessel disease are noted in the brain… this should be assessed with relevant clinical symptoms'*[55]. The GP reviewed the information in mid-September but it isn't clear what, if any, action was taken to evaluate the impact on his daily living.

12) Provider A's case notes report Jan's GP was scheduled to conduct a mental health assessment on the 21.11.23. His keyworker chased for an outcome of the mental health assessment on the 22.12.23 and was advised by the mental health trust that the GP had not referred but that they would accept a direct referral. An email referral was submitted that day. At the same time, his keyworker emailed Haringey SAB to raise concerns that they had referred and made complaints to ASC, GP, mental health and housing solutions but were getting nowhere, citing '*clear signs of self-neglect, financial abuse, serious mental health issues and lack of cognitive functioning*'. They explained they could not meet his high needs within their provision and requesting advice. The SAB team confirmed this email was forwarded

[53] Under s.189B(1) Housing Act 1996 as inserted by s.5(2) Homelessness Reduction Act 2017.
[54] Taken from Provider A's case notes which included a copy of the email sent.
[55] Taken from the GP records made available for this review

to the safeguarding adults duty inbox and that relevant senior managers were copied into the email. Jan's keyworker also set out concerns to the mental health older people's team and were advised, contrary to the email advice during the telephone call, that it was for the GP to refer so they were told to raise this with the GP or ascertain if the primary care mental health practitioner could meet with Jan.

13) In early January 2024 his keyworker made a further referral to the mental health trust; this was placed on the screening waiting list (at the time the Trust had a 28-day window to screen referrals). His keyworker also again contacted ASC's safeguarding team (including the relevant Head of Service and Director of Adult Social Service [DASS]). They received an email response explaining why it would be necessary to ensure care needs were addressed via the correct referral pathways (including if emergency mental health crisis responses were needed for MHA assessment). His keyworker replied explaining they had escalated their concerns to the DASS as they felt earlier referrals were not taken seriously. They were advised a referral to Multi Agency Safeguarding Panel [MASP] may be appropriate[56]. A further assessment by ASC confirmed Jan did have capacity, but also mental health problems. The safeguarding concern was closed on the 23.01.24 after the social worker had made a referral to Jan's GP for a referral to mental health and suggested Jan may benefit from Haringey's Reach and Connect service for over 50s[57]. They also put forward the case to MASP.

14) On the 01.02.24 the mental health trust tried to contact Jan by phone and on the 14.02.24 sent a 'opt-in' letter and text, asking him to contact by the 20.02.24 to access their service. His keyworker responded on his behalf and provided collateral information to the screener who then referred the matter for discussion within the Trust's Multi-Disciplinary Team [MDT] who agreed to send the referral to the Early Intervention Service [EIS].

15) On the 26.02.24 LBH's MASP met to discuss Jan's circumstances. This meeting was chaired by LBH ASC's Safeguarding Head of Service, during which the safeguarding social worker confirmed they believed Jan had mental health concerns, but that these were not '*safeguarding related*'. St Ann's hospital's mental health team (responsible for the EIS service) explained they believed his poor mental health could be attributed to dementia rather than psychosis and so were '*hesitant to see him*' but were due to discuss his case later that month and would revert. All in attendance accepted he was at high risk if made street homeless due to his additional vulnerabilities, but there wasn't agreement on how that should be prevented. Homes for Haringey's manager advised that they did *'not feel sheltered housing would be appropriate as it does not provide the needed level of care required. He requires specialist supported accommodation*'. In part this was due to the lack of clarity about whether his needs arose from a neurological or mental health condition. Whilst those in attendance recognised that '*whilst this debate is ongoing [Jan] is not getting the support and is declining*'.[58] The proposal put forward by the Chair was for provider A to write again to request a needs assessment. London Fire Brigade representative offered to add weight to any letter requesting a further needs assessment due to high risks arising from Jan's misuse of hazardous chemicals within his accommodation which could cause a fire or poisonous gases to escape posing an immediate risk to himself and others at the property but did not offer a home safety fire visit. The proposed interim protection plan was for Jan to present to A&E for an assessment of his mental health needs as it appeared to the safeguarding lead from Whittington that he may be in crisis.

16) In early March, concerned about the lack of progress, his keyworker contacted ASC's Safeguarding Head of Service. The MH Trust's early intervention service [EIS] arranged to meet Jan at a face-to-face meeting on the 06.03.24 where he was assessed (accompanied by his keyworker). The following day Jan attended St Ann's and showed staff photographs of bites on his arms and buttocks. He explained he felt frustrated as wasn't believed by his keyworker and wanted to move house. He was offered reassurance by Trust staff. The staff subsequently advised that they did not share his keyworker's concerns regards to his mental health or psychosis and felt '*Jan does indeed have bites from bed bugs*' so suggested a move to another property. They confirmed they had arranged a home visit for March. This took place on the 18.03.24, following this he met with their psychiatrist who diagnosed delusional

[56] More information is available at: https://www.haringey.gov.uk/sites/default/files/2024-11/masp_faqs.pdf and Safeguarding adults policy and procedures | Haringey Council
[57] More information is available at: https://reachandconnect.net
[58] Taken from the minutes of the meeting made available to this review.

parasitosis and prescribed anti-psychotic medication. It was noted Jan had made threats to pour petrol on the house if he was not moved and this was noted as an ongoing fire risk- though no fire safety plan was discussed or agreed between the services. He was referred to the CMHT, East Core team (BEH NHS Trust) as he had been expressing fixed delusions for over 3 years so outside EIS service criteria who are commissioned to respond to the first episode psychosis. Both ASC and provider A's case notes report his keyworker was informed by '*there was no treatment for delusional beliefs*'. His GP was informed of the diagnosis and the referral to the Core team, in the interim the GP was asked to monitor his physical and mental health. His keyworker agreed to assist with contacting the GP to discuss next steps. He was screened by the east core team in late March 2024.

17) On the 08.03.14 he was also served with a NTQ (terminating his tenancy on the 03.05.24) as he posed an arson risk. ASC and the EIS were advised of this. He was also assisted to make an application to LBH's housing needs team. He was assessed by LBH's housing needs team on the 22.04.24 with support from his keyworker. LBH's housing need team also completed a face-to-face vulnerability assessment on the 13.06.24 to ascertain his understanding of his housing needs and what he could do independently. Following input from a senior housing manager, the assessments concluded (on 13.06.24) that he lacked capacity to manage a tenancy. ASC agreed that he couldn't manage independently based on the medical documents from his support worker and St Ann's diagnosis as he was preoccupied by the symptoms of his delusional disorder.

18) On 08.04.24 his keyworker noted he had stopped taking his medication as this was making him dizzy. The keyworker reports telling the CMHT's east core team but was subsequently advised (on the 17.04.24) his case was still awaiting allocation of a care coordinator. On the 20.05.24 his GP made a referral for an ultrasound and to urology as Jan had raised concerns that scarring was causing him difficulty accurately passing urine.

19) By late May, Jan was showing notable distress regarding his likely eviction, given there was no forward plan to prevent street homelessness despite the agreement reached at the MASP in February. As such, an urgent case conference was called by his keyworker and held on the 05.06.24. This was attended by BEH's CMHT deputy manager of the east core team, LFB, housing needs worker, GP, provider A's housing support manager and his keyworker. LBH ASC were not in attendance. LFB advised the risk of fire extremely high due to gas cooking facilities and the presence of mixing bleach and acid which could ignite. Also noted inhalation was also potentially fatal so posed risk to Jan, other tenants and the public. It was again agreed he should not be made street homeless via the eviction as his needs made him very vulnerable and the Trust's chronology notes that it was reported he was not managing his medication well. The minutes incorrectly state '*he has not got a specific diagnosis and it is difficult to engage him with the right service'.* Provider A's case notes reported discussion focused on '*putting pressure on ASC to find suitable alternative supported accommodation'*.[59] It was agreed a care coordinator would need to be allocated[60] and would then assess his needs, with ASC providing support to complete a care act assessment if needed. It was noted this wouldn't be done urgently as both assessments could take up to 28 days. His keyworker was advised to take him to A&E if his crisis persists as could be assessed by the on-site liaison team.

20) On the 09.06.24 Whittington NHS Trust confirmed Jan attended their Emergency Department (ED) confirming he had an issue with a bed bug infestation in home[61]. He explained he had reported this to his landlord but needed to obtain a letter regarding the bed bugs. He was provided with antihistamine for skin rash advice to speak with his GP to obtain the letter and for a referral to dermatology and discharged with a letter sent to his GP. On the 10.06.24 he was assigned a care coordinator. The following day he attended a GP appointment with his keyworker; his general health was monitored and concerns discussed. He was offered a personalised care plan, and it is noted he was already working with the surgery's social prescriber.

[59] Taken from Provider A's case notes p268/300 MH assessments
[60] According to NLP NHS Trust's chronology, staffing issues in the team delayed allocation for 6 days.
[61] It was also noted within Whittington NHS trusts chronology he had complained about cellulitis, bumps on face that need cutting down. Also complained of a closed penis head- he wanted to cut to foreskin by 5cm due to pain and having young girlfriends.

21) Jan was evicted on 14.06.24. He was supported by his keyworker to attend the Council's offices to apply for emergency accommodation. Previously, provider A had negotiated with ASC they would continue to accommodate him beyond the final date of the NTQ to enable suitable accommodation to be identified as they did not believe it would be safe for Jan or other residents if he was accommodated in general needs temporary accommodation. Despite this, earlier agreement between ASC and housing needs that Jan lacked capacity to manage a tenancy and recognition within the MASP meeting that he would need specialist accommodation, nothing had been identified. He was accommodated therefore by the Council's ASC department in line with their duties under s19(5) Care Act pending a full care act assessment into general needs (B&B) accommodation.

22) A review of the paperwork completed by ASC in Jan's case records demonstrates action was taken (following the learning from the Ms Taylor SAR in 2019) to ensure assessment and brokerage request forms prompt practitioners to identify fire risks. However, despite obvious and clearly articulated risks these were not recorded on the request for urgent assistance from ASC's brokerage team. So that team was unaware when arranging accommodation of the fire risk he posed. His keyworker continued to raise concerns that the accommodation was unsuitable due to Jan's mobility issues, that he could not manage his medication independently and that there was an absence of coordination between adult social care, mental health and housing services to meet those ongoing risks. The keyworker also highlighted that families with young children resided within the B&B so the ongoing fire safety risks should have been addressed. The keyworker was advised '*there is nothing else available'*.

23) BEH CMHT's chronology indicated that a risk assessment and crisis plan was completed on the 12.06.24 and on 19.06.24 Jan met with his care coordinator. The care coordinator also submitted a referral to ASC for a care act assessment to be completed. In an email to the GP social prescriber, his keyworker reported they had attended the care act assessment on the 19.06.24 but that during this Jan had '*denied the need of some essential support… denied having mental health issues*'.[62] Within this email the social prescriber was ask to alert the GP to the need to monitor his glucose as the keyworker had been advised this was a matter for the GP and not social care. The prescriber forwarded the email to the surgery asking for GP input. A physical health check undertaken on the 26.06.24 and a consultant medical review was also booked for the 16.07.24. His care coordinator also met with him then, noting his mental health was settled but that he had informed them he was struggling to cope in the new accommodation. He was advised this would be addressed within the Care Act assessment and suitable accommodation met through his social worker. Previously the care coordinator had advised provider A they couldn't access any alternative accommodation options as BEH was only expected to support someone address their mental health.

24) Jan contacted his care coordinator on the 07.07.24 and 08.07.25 expressing that he couldn't cope without a care package. His previous keyworker had also contacted the care coordinator that week to alert them to his high level of need, the fire risk his behaviours posed and previous decisions that he lacked capacity to manage a tenancy. The NHS Trust's chronology noted his care coordinator '*reassured him that he will chase up with the allocated social worker*'. His mental health was reviewed in mid-July and he was noted to be responding well to medication, so the plan was to conduct a further medical review in 6 months. Joint home visits (attended by the allocated care coordinator and social worker) to complete the care act assessment were undertaken in mid-July. CMHT's case notes recorded '*social worker to consider relocating [Jan] to a suitable accommodation*'[63].

25) Provider A's keyworker raised a subsequent safeguarding concern in respect of the decision that Jan did not have eligible care needs. This was not recorded as a fresh safeguarding concern (as there was an existing enquiry open from the referral in January 2024). On 01.08.24 Jan was again assessed as being '*able to attend to personal care, nutrition, goes to food bank regularly for food although in receipt of benefits, uses public transport, can access community. Does not like to cook and describes self as "lazy", mobilises well. Multiple physical health issues. Accommodation appears to be the main problem. Mental health stable and is engaging with care coordinator*.'[64] ASC IMR then notes discussions between his care coordinator and social worker about 'general housing issues'. LBH's case records suggest a

[62] Taken from the email contained within his GP records
[63] Taken from NLP NHS Trust's chronology prepared for this review.
[64] Taken from ASC IMR prepared for this review.

safeguarding enquiry into self-neglect was undertaken between 08.01.24 and concluding on the 18.11.24, on the basis that '*no enquiries were made as [Jan] was visited by the allocated worker in person and did not appear to be self-neglect significantly*'[65]. The outcomes (that Jan wished to be able to manage his personal care) were noted as 'not met'. Concerns and high risks already noted within the earlier MASP or case conference were not considered.

26) For the remainder of the review period, Jan remained in the temporary B&B accommodation without any input for his physical health or social care needs but supported by care coordinator to oversee mental health issues. Contacts in late July were to assist him arrange physical health appointments, he was also assisted in October with his PiP assessment outcome and during monitoring contacts in October and December was reported to '*sound relatively settled in his mental state*'[66]. On 7th January 2025, following no answer to a second phone call from Jan's mental health care coordinator, a doorstep visit was made, and Jan was found deceased. His cause of death was recorded as acute chronic cardiac failure, with secondary causes being hypertension, asthma, and obesity.

Appendix B: Interface between Care Act 2014 and Housing Act 1996 duties to accommodate.

As needs for care and support can be met '*in a care home or in premises of some other type*' [s8 Care Act] staff will need to differentiate between accommodation options available to the Council and the impact this has for the adult's financial circumstances. Learning from HSAB's thematic SAR and this review demonstrates the importance proper application of legal principles in providing clarity on when it is lawful, reasonable and fair to give primacy to obligations under the Housing Act 1996 (to meet housing need[67]) or the NHS Act 2006 (to meet health needs[68]).

Statutory guidance[69] strongly advocates for holistic assessments, including with health and housing colleagues (ch6.75), OT and other relevant experts (ch6.27). Working in partnership enables us to comply with overriding duties to protect life and prevent harm (in line with a human rights-based approach), LBH's prevention duties (s2 Care Act), the enduring duty to assess (s11(b) Care Act) and safeguarding obligations (s42 Care Act).

Take time to understand if the person's need for accommodation and care could be provided via:

- **emergency or short-stay specialist homeless beds** are accessed via specialist teams to enable an immediate safe placement so an adult at risk of rough sleeping can assess assessment, reconnection and move on options. This is funded via Rough Sleeper Initiative not via housing benefit or ASC funds.
- **commissioned supported housing** exists to provide structured housing-related support to help the adult develop independent living skills and manage tenancies. This is commissioned through the Council's housing need teams. It is funded through rent and a service charge, though the adult can apply for housing benefit. This is not funded via adult social care pathways as the support offered is not intended to meet care and support needs.
- **exempted supported housing** is accessed via a self-referral or partner agencies (such as probation, VCFS organisations) and offers 'more than minimal support and supervision'. This is not commissioned by the Council, but some landlord may be subject to CQC or the Social Housing Regulator. This is funded through higher housing benefit to meet the cost of rent and support, not LBH commissioned.

Where an adult living in accommodation types listed above requires personal care, first consider if the accommodation remains 'suitable'. If so, domiciliary care should be offered and the adult assessed for care

[65] Taken from the s42 Enquiry report record made available to this review
[66] Taken from NLP NHS Trust's chronology prepared for this review.
[67] S23 Care Act 2014, though this will not apply if the person lacks capacity to make an application or manage a tenancy.
[68] S22 Care Act, though this does not apply if health needs are 'of a nature the local authority could be expected to provide and doing so would be merely incidental and ancillary' s22(1) Care Act, but see also National Framework for Continuing Healthcare
[69] Including Care and Support guidance, Homelessness Code of Guidance and the National Framework for NHS continuing healthcare.

charges as set out below. Alternatively, they may require support within **'specified accommodation'** as defined by the **Choice of Accommodation regulations 2014,** namely:

- **supported living, extra-care or sheltered accommodation** differs from supported housing as has been specifically designed for adults with care and support needs so that personal care is available if required. The personal care may be provided by someone other than the landlord (in which case the landlord does not require CQC registration). Usually, the adult will be responsible for rent (and can apply for housing benefit) but the care costs may be subject to charges and so the procedure for financial assessment (set out below) should be followed.
- **shared lives** accommodation is provided for an adult in the home of a shared lives carer who has been approved to provide personal care to the adult if required.
- **residential care, including within a nursing home** is provided within CQC registered premises and, like domiciliary care services which are provided in the adult's own home are subject to charges.

Where an adult requires 'specified accommodation' it is ASC, (not the Council's housing needs team) who are responsible for commissioning the accommodation as part of the care plan. The person's ordinary residence may remain with LBH even if the placement is out of borough, but again take time to carefully consider this as you may owe additional continuity of care duties (s37 Care Act) if a move to supported accommodation is outside of the borough and changes the adult's ordinary residence.

An LBH ASC financial assessment form must be completed for anyone accessing specified accommodation to calculate liability for care charges. They should also be supported to maximise their income as they may be eligible for Housing Benefit to help meet the cost of rent.

It will also be important for staff to ensure adults and their representatives understand that they can exercise a choice of accommodation provided their preferred placement is of the same type as specified in their care and support plan, suitable to their needs, available and the provider will agree to the Council's terms. If the adult's preferred specified accommodation is more expensive than the Council's identified offer, then it will be important to explain their option is to 'top-up' any additional cost. You will also need to secure a financial assessment from the third party to evidence they can meet the costs [s4.2.2 top-up policy] and a top-up agreement to facilitate the placement. The adult (or their rep.) must be made aware that failure to pay the top-up would likely result in debt recovery processes and a review of the placement.