A Safeguarding Adults Review Overview Report

Concerning 'Robert'

November 1983 - January 2016

28 July 2017

Contents Page

1 SECTION ONE: INTRODUCTION

1.1 The circumstances that led to this review

Robert[1] was diagnosed with Foetal Alcohol Syndrome (FAS) and there were references to Robert having a learning disability[2]. He lived with his father in a two-bedroom property owned by Haringey Council but managed by Homes for Haringey. Robert's father was the sole tenant of the property having exercised succession rights following the death of his wife (Robert's mother). Robert was the registered carer for his father. In July 2015 Robert's father passed away and as a result Robert was reported to be suffering from low mood and depression and was on anti-depressants. On receipt of the notification of the death of Robert's father, Homes for Haringey (HfH) advised that whilst Robert could not succeed to a tenancy of the family home, he could apply for a grant of tenancy to a smaller property. In December 2015, the HfH Decision Panel turned down the application for the Grant of a Tenancy because of lack of evidence of exceptional reasons. Robert was asked to leave the property. At the time of the Panel's decision, there had been no completed assessment of his vulnerability or his care and support needs. On 6th January 2016, Robert was served a Notice to Quit the property. Later that same day, Robert was found hanged. He was aged 32 years at the time of his death.

1.2 On 11th February 2016, through the Safeguarding Adults Review Sub Group, the Haringey Safeguarding Adults Board (HSAB) decided to commission a safeguarding adult review into the circumstances that led to Robert's death. The HSAB was of the view that, on the information presented at the time, the threshold for safeguarding adult review under Section 44 of the Care Act 2014[3] was met.

1.2.1 A Safeguarding Adults Review (SAR) Panel was set up and an independent reviewer commissioned. The final report was approved at an Extraordinary Meeting of the Board on 15th November 2016 with delegation to the SAR Sub-group to further amend the report with information from a meeting with Robert's family on December 2nd 2016, and the outcome of the Inquest.

[1] This is a fictitious name to ensure the anonymity required by Haringey SAB

[2] 'Learning disability' is a: significantly reduced ability to understand new or complex information, to learn new skills; reduced ability to cope independently which starts before adulthood with lasting effects on development. *Department of Health. Valuing People: A New Strategy for Learning Disability for the 21st Century. 2001*

[3] Under Section 44 Care Act 2014, Safeguarding Adults Board must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. The Care and Support Statutory Guidance 2015 at Paragraph 14.17 list neglect and acts of omission as including "emotional or physical care needs, failure to provide access to appropriate health, care and support services".

1.2.2 An inquest hearing into Robert's death took place at North London Coroner's Court on 29th March 2017 which recorded an open verdict, with the cause of death asphyxiation by strangulation; further recording that Robert was full of sorrow about the death of his father and full of worry about his future.

1.4 This SAR is based on information in Individual Management Reviews (IMRs) from: Adult Social Care (including the Safeguarding Adults Team, Haringey Learning Disability Partnership), Homes for Haringey, Metropolitan Police, North Middlesex University Hospital NHS Trust, Key Support/One Housing Group. The Vulnerable Adults Team was not asked to provide an IMR but email responses were provided to questions asked by the reviewer. Notes were obtained from Robert's GP and these were followed up by a phone conversation with the reviewer. The SAB Chair and Manager and the SAR Panel Chair met with Robert's sister, her husband and a family friend on 2nd December 2016. Their feedback has been incorporated into this report in footnotes and 4.14 below.

1.5 **Terms of reference**

1. What did each agency know about Robert's history and at what stage? Was Robert known as a vulnerable adult with learning disabilities?
2. How did each agency assess and understand Robert's needs and vulnerabilities and what did they do about it?
3. What was agencies understanding of Robert's experience following the death of each of his parents? How was communication between agencies, with Robert and his family about his needs and vulnerabilities?
4. Bearing in mind agencies' knowledge about Robert, were appropriate risks and needs assessments completed and acted on?
5. What guidance, policies and procedures were in place to support staff and what was the expectation of how these would be implemented at the time?
6. What impact did the implementation of the October 2015 allocations policy have on 'Robert's' behaviour and ultimate death? Could the policy have been interpreted and implemented differently? Should the policy be changed?
7. How did agencies define and interpret 'independent living', in particular the phrase 'capable of independent living?' How did this definition affect entitlement to service?
8. Were senior managers involved at points in the case where they should have been? What impact did management involvement have?
9. Were there any organisational difficulties being experienced within or between agencies?
10. Were there any specific issues arising from the interface between safeguarding duties and responsibilities and housing duties and responsibilities?

Supplementary questions were asked of Homes for Haringey:

11. Do your procedures and practices encourage and enable face to face meetings with vulnerable applicants or their representatives to discuss tenancy application?
12. Is information available to applicants on the criteria used by the Decision Panel?
13. What explanation and/or demonstration of supported housing were Robert and his sister given?
14. Was a capacity assessment (under the Mental Capacity Act 2005) made or requested regarding Robert and his application for Grant of Tenancy?

1.6 Methodology

All agencies were asked on 5th April 2016 to provide Individual Management Reviews (IMRs) by 27th May 2016 covering the period 6th January 2015 to 6th January 2016, addressing the questions set out in the Terms of Reference, and were asked to give a summary of any involvement with Robert which fell outside the scope of the review, identifying significant events. It was an oversight that the VAT was not asked to submit an IMR, although subsequent questions put by the reviewer have been answered promptly.

1.7 Glossary[4]

FAS	Foetal Alcohol Syndrome is the most severe form of foetal alcohol spectrum disorders which are a group of conditions that can occur in a person whose mother drank alcohol during pregnancy. Problems may include an abnormal appearance, short height, low body weight, small head size, poor coordination, low intelligence, behaviour problems, and problems with hearing or seeing. Those affected are more likely to have trouble in school, legal problems, participate in high-risk behaviours, and have trouble with alcohol or other drugs[5].
Decision Panel	A Homes for Haringey Panel, with delegated authority under the Haringey Council Allocations Policy to grant tenancies in exceptional circumstances. The five Panel members are: Tenancy Management Team Leader, Lettings Team Leader, Hearthstone Manager (domestic abuse services), Housing Advice and Options Team Leader and Vulnerable Adults Team Leader.
Housing Options	In Homes for Haringey, the team reviews housing options for those at risk of losing their tenancy, public or private.
HfH	Homes for Haringey - the arm's length Management Organisation (ALMO) for Haringey Council's housing stock.
HLDP	Haringey Learning Disability Partnership provides health and social care to people with a diagnosis of Global Learning Disabilities (GLD) and their carers.
Key Support	Key Support is a service commissioned and contracted by Haringey Council with One Housing to provide housing related support under the Housing Related Support (Supporting People) programme.
SAT	Safeguarding Adults Team – the team dealing with all adult Safeguarding referrals to Adult Social Services.

[4] Fuller explanations of agencies in bold are given in Section 3
[5] http://fasaware.co.uk/documents/

TMO Tenancy Management Officer – responsible for tenancy enforcement, dealing with anti-social behaviour, interviewing service users, dealing with complaints and enquiries.

VAT Vulnerable Adults Team is commissioned and contracted by Haringey Council, part of the Housing Demand Directorate within Homes for Haringey (previously the Council's Community Housing Service). The VAT assesses and refers vulnerable adults, regardless of tenure, who are homeless or at risk of homelessness, or who may qualify for housing related support on the basis of vulnerability to a range of accommodation based and floating support services.

1.8 **Review panel members**

Independent Chair And Reviewer (from 13.09.16)	Mike Wilson, Director Public Voice (Haringey Healthwatch)
Independent Reviewer from 08.03.16 to 13.09.16	Imogen Parry
Clinical Commissioning Group	Hazel Ashworth, Safeguarding Adults Lead
North Middlesex University Hospital	Eve McGrath, Safeguarding Adults Lead
Metropolitan Police	Allison Hamer, Detective Sergeant, Specialist Crime Review Group Pam Chisholm, Detective Sergeant, Specialist Crime Review Group
LBH Adult Social Care	Beverly Tarka, Director of Adult Services
Housing	Astrid Kjellberg-Obst, Executive Director of Operations, Homes for Haringey
Housing Related Support	Claire Drummond, Commissioning Manager
Legal Advisor to the Board	Stephen Lawrence-Orumwense, Assistant Head of Legal Services, LBH
Haringey Safeguarding Adults Board	Patricia Durr, Business Manager, HSAB

2 SECTION TWO: THE FACTS

2.1 Family

Robert: DoB: 7.11.1983 Died: 6.1.2016

Father: DoB: 1937 Died: 17.7.2015

Mother: not known Died: 1989

Sister: DoB: 1966

The family lived in a two bed council property in the Wood Green area from 1985. The sister has married and now lives in Edgware. Following the mother's death in 1989 the father succeeded the tenancy and looked after Robert (when he was a child and then due to his learning difficulties resulting from the FAS, became responsible for his finance and housing)[6]. From approximately 2010 the father started treatment for cancer and then Robert became the father's carer, receiving Carer's Allowance.

2.2 Chronology

Prior to January 2015: little is known about Robert and his life up until the time of his father's death in July 2015. The information that follows is a bare outline:	
1983	Robert was born on 7 November, 6 weeks premature[7] and subsequently diagnosed with Foetal Alcohol Syndrome (FAS) due to mother's alcoholism.
1985	Robert's parents commenced tenancy of a two bedroom council property in Wood Green
1986	Robert's name was placed on Haringey's then Child Protection Register following a multi-agency child protection conference in November, due to concerns about his mother's health and ability to care for him. There were also concerns about his sight, speech and growth. In November he was admitted to NMUH for 'investigations of short stature. Mother alcoholic. Child has FAS and short stature. Intellectually normal. Spoke only at three years of age, otherwise developmentally normal'.[8]
1989	Robert's mother died and the tenancy passed to father

[6] Information supplied by GP
[7] NMUH IMR
[8] NMUH IMR

1990	Robert is removed from the Child Protection Register. His development and progress is noted as within normal range: school reports that Robert needs lots of help.
1997	Children's Services case note references a contact with the North Tottenham Duty Team and the completion of an overview assessment. On the basis of the information available to this review, there is no evidence that Robert was further supported by Haringey Children's Services.

2.2.2

2001 to 2015: Robert came to the attention of the police intermittently, from the age of 18, on eleven occasions: eight of these related to drug possession (cannabis), others related to possession of offensive weapons, civil disputes and witnessing a crime.[9]	
2014	The family were visited at home by a HfH Tenancy Management Officer in relation to the father who had bone cancer and an Integrated Access Team (IAT) referral was made requesting a wet room.[10]-Robert was recorded by HfH as his father's carer and receiving carers allowance and this was the basis of his eligibility to live in the property as a single adult. Robert was invited by Adult Social Services to attend an Occupational Therapy Assessment; there is no evidence to indicate he attended.
From January 2015	
17 July 2015	Robert found his father's body which was collapsed on the stairs. The police and an ambulance were called. His death was caused by cardiac arrest, following prostate and bone cancer.11
10-24 August 2015	Robert visited his GP three times regarding the death of his father, requested sleeping tablets and awaiting bereavement counselling. He was prescribed anti-depressants.
1September to 24 November 2015	Robert visited his GP eight times, seeking support for housing situation, poor sleep, poor eating and low mood. On 24 November, he was reported to be attending bereavement counselling, having good support with no thoughts of harm and not noted to be suicidal[12]
16 September 2015	The Tenancy Management Officer (TMO) emailed Robert's sister regarding her phone call to the call centre on 14 September which had notified HfH of the death of her father. The email explained that Robert cannot succeed tenancy in law (as there can only be one succession

[9] Police IMR
[10] HfH IMR
[11] Police IMR
[12] Note from GP

	per tenancy[13]) but Robert could apply for tenancy to be granted to him[14]
21 September 2015	Robert's sister emailed the TMO with some of the evidence required and explained that 'my brother has problems dealing with anything or anyone so I am dealing with everything on his behalf. At present he is under doctor for severe depression with loss of my dad. He is registered disabled with Alcohol Foetal Syndrome'.
22 September 2015	The TMO emailed sister requesting that she provide confirmation from GP of his medical conditions.
23 September 2015	Robert's GP phoned the Safeguarding Adults Team (SAT). GP spoke to a social worker (who has since left Haringey Council and cannot be traced) who concluded that the referral was not a safeguarding concern. The GP was asked to follow up the call with a referral letter. The GP was told on the phone that the referral letter (which arrived with the social worker on the same day) would be referred onwards to Haringey Learning Disability Partnership (HLDP). The letter stated that Robert 'had a history of learning disabilities as a result of foetal alcohol syndrome, was bereaved, tearful, on anti-depressants, finding it difficult to cope with day to day living, was able to shop and cook for himself but was finding financial and accommodation issues overwhelming....would appreciate help with supporting this gentleman'. The Social Worker said that the GP did not report any safeguarding issues. The letter was not uploaded until 22 October 2015.[15]
24 September 2015	Robert's sister emailed the TMO expressing concern that Robert was receiving red rent arrears letters and requesting a temporary tenancy until his benefits were sorted out.
28 September 2015	The TMO emailed Robert's sister to advise that the Income Collection Team had been informed that Robert was in the process of applying to be granted the tenancy. The email stated that 'Robert had to explain this to Housing Benefit and continue to pay rent. A temporary tenancy

[13] 1985 Housing Act, Section 88

[14] Haringey's Housing Allocations Policy, September 2015, para 15.25.9 and internet information at http://www.homesforharingey.org/almo/information_for_tenants/tenancy/yourtenancy.htm#grants (accessed 28 June 2016)

[15] HLDP IMR

	could not be set up. All the requested documents needed to be sent asap'.[16]
30 September 2015	Robert's sister emailed the TMO stating she was in contact with the benefits office and would send the missing documents, asking the TMO to let her know if this would be sufficient to do the report to the Decision Panel.
1 October 2015	The TMO emailed Robert's sister requesting confirmation that Robert was his father's official carer. The sister emailed confirmation that day.
5 October 2015	Robert's GP emailed the TMO with information about Robert, stating she (GP) was waiting for HLDP assessment (unaware of delayed processing of her referral).
5, 7 October 2015	The TMO emailed Robert's sister chasing documentation.
22 October 2015	The GP's email to the SAT was finally uploaded and sent to HLDP, one month after it was received.
23 October 2015	The TMO's report was finalised. The report recommended a grant of tenancy for a suitable one bedroom flat and advised that Robert has learning difficulties and suffers from depression and foetal alcohol syndrome. It also stated that Robert is awaiting a review from the Learning Disabilities Team about Robert's support with daily living and signed by the TMO Manager
12 November 2015	A decision by the Decision Panel on Robert's application for Grant of Tenancy was deferred: *TMO to refer to Learning Disabilities team for assessment of Robert's independent living skills*.
12 November 2015	Robert self-referred to Key Support; he was assessed and allocated to a support worker on 26 November. (The delay of two weeks was not explained in the IMR, but stated as 'allocated within 24 hours and the first face to face contact with the support worker was made within 4 days).
13 November 2015	Robert's GP was sent a referral form by HLDP because there was insufficient information in her referral (to the SAT) of 23 September and for completion of the attached referral form provided.
16 November	Robert's GP was sent an email reminder by HLDP but there was no response, and this was not followed up.

[16] HfH IMR

19 November 2015	The TMO emailed Robert's sister to inform her of the deferred Panel decision. The TMO requested confirmation that Robert could live independently and asked whether he was registered with HLDP and if so, the name of his support worker. She also asked whether Robert would be interested in moving into 'Supported Housing, which is warden assisted independent living accommodation'.
24 November 2015	The TMO emailed Robert's sister requesting an urgent response to her email of 19 November. Robert's sister replied stating that she would talk to her brother that day and requested that the tenancy be transferred, or if not, 'keep him as near me as you could'. TMO replied that day stating she was unable to say whether the application would be approved.
26 November 2015	Robert was allocated a support worker by Key Support.
1 December 2015	A Key Support worker (hereafter referred to as the 'support worker') met Robert who he was described as being 'in low mood because all attempts (tenancy succession and rehousing) made by his sister to the council failed as well as the referral to HLDP by the GP'[17]. His risk was identified as one of potential homelessness that was being mitigated by liaising with all relevant housing departments.
2 December 2015	The TMO emailed Robert's sister stating that the information was urgently needed, warning that the case was soon to be presented to the Decision Panel and 'if there is insufficient information, they may decide to discharge duty'. Robert's sister emailed the TMO with the details of Robert's support worker (but didn't make it clear what agency they worked for, i.e. not HLDP), and stated that 'Robert can live on his own but I have to phone him each day to remind him to wash and do certain things. He is not happy with the idea of living in warden controlled property'.
3 December 2015	Robert's support worker (Key Support) emailed TMO stating they were making a referral to the Vulnerable Adults Team (and this referral was overlooked until 21 December). The TMO emailed the support worker explaining that Robert had applied to be granted a tenancy following the death of his father requesting confirmation of Robert's independent living skills, and asking whether an assessment had been carried out.

[17] Key Support IMR

4 December 2015	Robert's support worker emailed the TMO explaining that: he had met Robert for the first time on 1 December and would be supporting him for the next six months, *'the main issue is to avoid the risk of becoming homeless, I have no concerns as far as his independent living skills. As an example he promised to call the DWP for the initial interview'*[18] [19]. Robert's support worker emailed VAT and supplied (with two emails): consent form, copy of registered disability card, VAT referral form, VAT support risk assessment form. A VAT officer replied that there was no referral form attached (having only seen the first email).
7 December 2015	The TMO report for the Decisions Panel was finalised with the same recommendation and citing the exceptional circumstances as *'learning difficulties, foetal alcohol syndrome and depression'.* The report did not include an assessment from HLDP but referenced the Key Support support worker statement.
10 December 2015	Robert's support worker was on annual leave 7 to 18 December. A support assistant telephoned Robert in his absence to inform him, offering assistance in the meantime. Robert was reported to have replied that *'the tenancy was on hold until after Christmas'* but it is not known why he said this or whether this was queried by the support assistant. The Decision Panel did not approve Robert's application for Grant of Tenancy as *'applicant has learning difficulties but is ok for independent living'*
17 December 2015	TMO sent letter to Robert stating that his application for a Grant of Tenancy had been turned down because 'you have not provided any evidence of exceptional reasons why your case should be considered' and stating that 'you do not have permission to remain in the property and I am giving you notice to vacate the property. Please make arrangements to clear the property and return the keys..... If you do not return the keys you will be regarded as a trespasser and HfH will instruct legal to apply to the court to seek possession of the property. If you need to talk to somebody about your options for housing you can do so by calling 0208489 1000 or you can email housingadvice@haringey.go.uk'.
21 December 2015	Robert's sister emailed the TMO on behalf of Robert stating that the above letter (received on 19 December) *'telling him to vacate his*

[18] HfH IMR

[19] This 'assessment' and email exchange on 3 and 4 December between the TMO and the support officer were not mentioned in Key Support's IMR

	family home after 31 years has made him almost suicidal... you are making him homeless, he has a disability and left to survive on the streets will not last long at all'. She stated that she was unable to offer him accommodation and asked that he is recommended as a priority for housing in Barnet. She added that she'll be contacting his support worker and his local MP because *'your decision is brutal and inconsiderate at this time, six days before Christmas. Thank you for ruining what was already going to be a very difficult Christmas for us.'*
21 December 2015 to 4 January 2016	The TMO was on leave and no response was made to the sister in the TMO's absence. An out of office message was left on the TMO's email inbox giving an alternative contact during this period of absence.
21 December 2015	Robert's sister disclosed the Decision Panel's decision to the support worker. The officer invited Robert in for a meeting the following day The support worker resent the referral form etc to VAT (which had already been sent on 4 December). He sent another email to the VAT having been advised of the Decision Panel's decision, requesting input as a matter of urgency.
22 December 2015	The support worker met Robert who confirmed the Decision Panel's decision. The support worker 'completed an HB application for Robert to be assisted as an authorised tenant to prevent rent arrears from accumulating'[20].
23 December 2015	The Key Support Support Worker made a referral to HLDP for assessment of Robert's learning disabilities. The covering note to the referral stated that Robert was being supported "in relation to Mental Health, Learning Disabilities and Housing issues" and "would like to take this opportunity to forward the Referral form for an assessment by your services". HLDP screened the referral that day deciding that Robert was not likely to be eligible for its services as: it was unclear whether Robert had Global Learning Disabilities, he held a driving licence and was therefore likely to be high functioning , there was no mention of risk of self-harm or need for acute mental health intervention. He was allocated on 4th February 2016 to a clinical psychologist who made an appointment for additional screening to assist in signposting to more appropriate services on 4 January.
24 December 2015	The VAT officer emailed the support worker stating that Robert had been booked to be assessed by the housing options team on 7 January.

[20] Key Support IMR

	No explanation was given regarding why the referral had not been taken up by the VAT[21].
3 January 2016	Robert failed a breathalyser test following a car accident in which he clipped another vehicle while under-taking, resulting in him hitting a wall. The police accompanied him in an ambulance to North Middlesex Hospital where he was admitted to Accident and Emergency. He was given street bail after considering whether he had awareness and understanding of the process. He was treated as a trauma case and given a follow up outpatient appointment at the fracture clinic for his fractured hand. Whilst in A&E he gave a blood sample related to the alcohol level.
4 January 2016	The TMO (having returned from leave) emailed Robert's sister in response to her email of 21 December, stating that she was unable to override the decision not to grant Robert a tenancy and that if he'd like a housing association tenancy he'd have to approach the housing association of his choice directly[22]. The TMO made no notifications of concern to any other agency or to her manager.
6 January 2016	The legal document Notice to Quit was served on Robert by hand. Robert was found dead in his home. Cause of death recorded as asphyxia and suspension (hanging). Note pinned to front door, retained by the police, stated '*I have hanged myself please don't let my sister find me as I am hanged myself*'. The note also stated *'My Dad I love and need so bad right now I won't do this without you I found you and I saw death can't go on after that 17.7.15 my life was changed forever. I can't cope with this anymore it's just to much for me'*. On the back of this note was a copy of Robert's driving licence.
15 January 2016	The police obtained the result of Robert's blood test which was just below the legal limit for driving. The clinical psychologist from HLDP telephoned Robert to find out more about his concerns and what was needed and left a message.
16 January 2016	Robert's sister emailed the TMO stating that '*you showed no compassion or interest at all in Robert's situation... all you seemed interested in was making him homeless. His last days including Xmas you made an absolute misery. You didn't take him being a vulnerable*

[21] The referral had been passed from VAT to the Housing Options Team because Robert had stated he didn't want to live in 'warden-controlled accommodation' (email from HfH)

[22] This was incorrect as the Decision Panel work instruction (describing the process for referring cases to the Decisions Panel) states that there is a right of review.

	adult or being suicidal as important at all and proceeded with your actions regardless. He is now dead, you pushed him over the edge, he left notes stating this'.
20 January 2016	The clinical psychologist from HLDP telephoned Robert again and on another no response telephoned key Support and Robert's sister

3 SECTION THREE: ORGANISATIONAL CONTEXT

3.1 This section summarises the status, responsibilities and actions of the principal agencies that became involved when, in September 2015, Robert's sister contacted HfH for assistance with Robert's housing situation, following their father's death in July 2015. The Police and North Middlesex University Hospital were only peripherally involved but are included for completeness.

3.2 **Homes for Haringey (HfH**) is not part of Haringey Council, but is a commissioned agency (Arm's Length Management Organisation), set up in 2006 to manage Haringey Council housing stock. Haringey Council owns the homes and takes responsibility for housing policy and strategy, HfH is responsible for the day to day management of council homes. From October 2014, HfH took over additional responsibility from Haringey Council for Community Housing Support this included homelessness, advice & options, VAT, temporary accommodation, allocations & lettings. The commissioning of Housing Related Support services remained with the Council.

3.2.1 Of relevance to the circumstances of this SAR is that a new Allocations Policy was approved by the Council in September2015 (for implementation by HfH) alongside the introduction by HfH of a new Succession Policy and Succession Procedure from June 2015, and a Decisions Panel work instruction at the end of 2015. The Decision Panel 'will consider the exceptional nature of a referral including taking the following into account:

1. The length of time a tenant has been resident
2. If the resident would be someone the Council would otherwise have a statutory duty to assist under the homelessness legislation
3. If it is in the Council's interest to make a Grant of Tenancy
4. Organisational error including wrong advice that has resulted in a detrimental effect on the applicant's housing position
5. Serious mental health or medical issues that would have a severe detrimental effect on their health and well being
6. Where an applicant could have been part of a joint tenancy before the death of a partner/spouse/cohabitee'[23].

3.2.2 The action of HfH can be summarised as:

- Responding to Robert's sister's request for housing assistance following the death of their father by submitting reports requesting a Grant of Tenancy to the Decision Panel in November and December
- Contacting relevant agencies and individuals requesting information for the report to the Decision Panel
- Notifying Robert of the unsuccessful outcome
- Issuing a Notice to Quit the property

[23] HfH Work instruction 'Decisions Panel – to describe the process for referring cases to the decisions panel' (undated)

3.3 **Key Support** is a service commissioned and contracted by Haringey Council with One Housing to provide housing related support under the Housing Related Support (Supporting People) programme. The action of Key Support can be summarised as:

- Casework support
- Responding to a self-referral from Robert
- Contacting HLDP, HfH, VAT

3.4 **The Vulnerable Adults Team (VAT)** is commissioned and contracted by Haringey Council, part of the Housing Demand Directorate within Homes for Haringey (previously the Council's Community Housing Service). The VAT assesses and refers vulnerable adults, regardless of tenure, who are homeless or at risk of homelessness, or who may qualify for housing related support on the basis of vulnerability to a range of accommodation based and floating support services. Staff include a senior manager, four VAT officers, a pathway manager and a move-on officer. A VAT representative is a member of the Decisions Panel.

The action of the VAT is summarised as:

3.4.1
- Passing the referral from Key Support to Housing Options

3.5 **Haringey Learning Disability Partnership (HLDP**) is a community based service which provides health and social care input to people with a diagnosis of Global Learning Disabilities and their carers. The Partnership is an integrated Health and Social Care team and is made up of employees from the Local Authority, Whittington Health, and Barnet Enfield and Haringey Mental Health Trust.

3.5.1 The Partnership consists of a range of professionals, including Social Workers, Nurses, Speech and Language Therapists, Psychologists, Psychiatrists and more. Eligibility for receiving specialist services from HLDP is based on (1) a diagnosis of Global Learning Disabilities or (2) eligibility to receive social care services under The Care Act 2014, which introduces a national eligibility threshold, which consists of three criteria, all of which must be met for a person's needs to be eligible. Prior to the GP referral on 23 September, Robert was not known to HLDP.

The action of HLDP is summarised as:

3.5.2
- Deciding he was unlikely to be eligible for service from the HLDP, following referral from Key Support
- Allocating Robert to a clinical psychologist for screening and signposting

3.6 **The Metropolitan Police Service** involvement was peripheral. Robert failed a breathalyser test following a car accident in which he clipped another vehicle while under-taking, resulting in him hitting a wall. The police accompanied him in an ambulance to North Middlesex Hospital where he was admitted to Accident and Emergency. He was given street bail after considering whether he had awareness and understanding of the process. The police do have a well-developed system for checking "vulnerability" and following the

accident Robert was not identified as “vulnerable” but the Panel acknowledged that this incident may have added to the stress that Robert was experiencing.

3.7 **North Middlesex University Hospital** Accident and Emergency Department is where Robert was admitted following the car accident on the 3rd January. He was treated as a trauma case and given a follow up outpatient appointment at the fracture clinic for his fractured hand which he did not attend because he died before the appointment date.

3.8 **The GP** had most direct involvement with Robert which can be summarised as:

- Seeing Robert in surgery on eleven occasions between August and November
- Phoning the Safeguarding Adults Team in September with concerns about Robert’s welfare.
- Making a written referral to the SAT for them to refer to HDLP
- Emailed the TMO with information about Robert, stating she (GP) was waiting for HLDP assessment (unaware of delayed processing of her referral uploaded on 22nd October).
- Receiving a referral form from HLDP on 13th November because there was insufficient information in her referral (to the SAT) of 23 September 2015 (not uploaded by the SAT until 22nd October)
- Did not complete the form from HDLP and being reminded by HDLP on 16th November 2015 but the form was not completed.

4 SECTION FOUR: ANALYSIS

In deciding to undertake a SAR, the HSAB SAR subgroup considered that agencies may have failed to take into account Robert's vulnerability and whether they could have worked more effectively to seek to protect Robert. The Panel were asked to review the evidence and produce an analysis in relation to a number of Terms of Reference and this analysis is outlined below.

4.1 What did each agency know about Robert's history and at what stage? Was Robert known as a vulnerable adult with learning disabilities?

4.1.1 Haringey's Children Services

4.1.1.1 Robert's name was placed on Haringey's Child Abuse Register following a multi-agency child protection conference in February 1987, due to concerns about his mother's health and ability to care for him. There were also concerns about his sight, speech and growth. In November 1987 he was admitted to NMUH for '*investigations of short stature. Mother alcoholic. Child has FAS and short stature. Intellectually normal. Spoke only at three years of age, otherwise developmentally normal*'.

4.1.1.2 Robert's mother died in 1989 and in 1990 Robert is removed from the Child Protection Register. His development and progress is noted as within normal range: school reports that Robert needs lots of help.

4.1.1.3 In 1997 Children's Services case note references a contact with the North Tottenham Duty Team and the completion of an overview assessment. The Panel has no further information in relation to Social Services involvement with Robert between 1997 and 2015.

4.1.2 North Middlesex University Hospital

4.1.2.1 In November 1987 he was admitted to NMUH for 'investigations of short stature. Mother alcoholic. Child has FAS and short stature. Intellectually normal. Spoke only at three years of age, otherwise developmentally normal'. There is no further recorded information following up this assessment which had suggested that Robert was developmentally normal.

4.1.3 Housing - Homes for Haringey

4.1.3.1 Homes for Haringey appear to have had no recorded detailed knowledge of Robert's history or his vulnerability prior to his sister's first email in September 2015. Robert was not known to Homes for Haringey as a vulnerable adult with learning disabilities. It was recorded that Robert was his father's carer and in receipt of Carers Allowance. There is a record of an Occupational Therapist visit to see Robert's father to help him with his physical needs once he became ill but no mention of Robert's capacity to manage day to day living.

4.1.3.2 Following contact by Robert's sister the TMO did recognise there was an issue of vulnerability. The TMO reports to the Decision Panels in November and December 2015 clearly stated that Robert was "vulnerable" but this was not defined in any detail. It is likely that Robert's circumstances following the death of his father (low mood, poor sleep, prescribed anti-depressants, sister acting on his behalf and advising of his circumstances) would have led Homes for Haringey to form the view that Robert is a vulnerable person.

4.1.4 Housing - Key Support

4.1.4.1 Robert self-referred to Key Support and was allocated a support worker on 26th November. He had a number of interviews with the support worker, the first on 1st December. Key Support did not appear to consider that Robert had a learning disability but did consider that he was vulnerable: '*the main issue is to avoid the risk of becoming homeless, I have no concerns as far as his independent living skills. As an example he promised to call the DWP for the initial interview'*[24] [25]. Reflecting this view Key Support referred Robert to the Vulnerable Adults Team (VAT) and subsequently HLDP.

4.1.5 Haringey Learning Disability Partnership (Haringey Clinical Commissioning Group and Adult Social Services)

4.1.5.1 Robert was not known to Haringey Learning Disability Partnership (HLDP) prior to receiving Dr Patel's (GP) referral in October 2015 via the Council's database. The referral did not appear to be urgent because the GP advised Robert's coping issues related to finances and accommodation and that he was 'able to shop and cook for himself but is finding financial and accommodation issues overwhelming'. HLDP concluded that Robert was receiving appropriate treatment from the GP for his symptoms of reactive depression due to a bereavement.

4.1.5.2 On the 13 November 2015 HLDP screened the GP's referral to determine if it was likely that HLDP was the appropriate service for Robert. HLDP is a specialist service which works with adults who have Global Learning Disabilities with an IQ of below 70. HLDP concluded that more information was needed to inform the screening assessment and emailed the GP, specifying what further information was needed. No further information was provided by the GP in response to this email and HLDP did not follow up on the request.

4.1.5.3 On 23 December 2015 a Support Worker from One Housing (an external provider) emailed HLDP requesting an assessment 'for learning disabilities'. The referral was screened on the same day by HLDP. The referral indicated that the Support Worker was unsure whether or not Robert had Global Learning Disabilities and stated that Robert had a full driving license (it is most unusual for a person with a GLD to be deemed as safe to drive, passing the driving examination and theoretical assessment)[26] The referral did state that Robert had 'severe depression' but no reference was made to him being at risk of self harm, nor did it reference that Robert was being evicted which would have been picked up as a trigger for an urgent response. HLDP IMR acknowledge that *"In hindsight the reference to 'severe depression' by Key Support should have been picked up as a risk when referral first came to the attention of HLDP.{ Key Support} should have been contacted to clarify the risks and to be more specific about what was needed."*

[24] HfH IMR

[25] This 'assessment' and email exchange on 3 and 4 December between the TMO and the support officer were not mentioned in Key Support's IMR

[26] Robert's sister explained that he was very motivated to learn to drive, and passed on his 11th attempt. She indicated that this success did not mean that he was high functioning in other areas of his life and said he still required prompting in many aspects of daily living.

4.1.6 General Practitioner (GP)

4.1.6.1 The GP had knowledge of Robert's medical history and Robert had visited the GP on eleven occasions between 10th August and 24th November 2015. The GP described Robert to the Review as: *"Very capable, but his father had been his carer with responsibility for his finances and housing. No medical concerns, regular blood tests, physically able to do everything. Had a job p/t, may have been voluntary. Disengaged from Learning Disability teams as father did everything. Father had been main carer even when mother (alcoholic) was alive. Reciprocal carer arrangement with father ill – Robert did physical things."*

4.1.6.2 There is no evidence of a comprehensive needs assessment being made at any time after 1986 of Robert's vulnerability or his learning difficulties. Robert was not known as a vulnerable adult with learning disabilities to any of the agencies and there is no evidence that this Panel could find that Robert had a learning disability rather than possibly learning difficulties arising from FAS.

4.1.7 **In summary,** information about Robert's circumstances following the death of his father in July 2015 came to the attention of Homes for Haringey through Robert's sister from September 2015. Homes for Haringey had formed the view based on information received between September and December 2015 that Robert was vulnerable. But there was no assessment of the nature and extent of Robert's vulnerability, the impact on his housing situation and due consideration of the six listed criteria which the Decision Panel should consider in deciding whether to grant a tenancy. HLDP ought to have received (from the SAT) a referral on Robert's circumstances on 23rd September 2015 following the GP referral which refers to a history of learning disabilities. HLDP received a referral on 23rd December 2015 from the Key Support Support Worker. There was a delay by Adult Services (HLDP) of about 3months to consider the referral for an assessment of Robert's needs for care and support (i.e. needs assessment). The question about whether Robert did or did not have learning disabilities was still in question when he died[27].

4.2 How did each agency assess and understand Robert's needs and vulnerabilities and what did they do about it?

4.2.1 **The Met Police h**ad come in to contact with Robert since age 18, on eleven occasions. Eight of these related to drug possession (cannabis), others related to possession of offensive weapons, civil disputes and witnessing a crime. Robert failed a breathalyser test following a car accident in which he clipped another vehicle while under-taking, resulting in him hitting a wall. The police accompanied him in an ambulance to North Middlesex Hospital where he was admitted to Accident and Emergency. He was given street bail after considering whether he had awareness and understanding of the process. The police do have a well-developed system for checking "vulnerability" and following the accident Robert was not identified as "vulnerable" and had not been identified as "vulnerable" on any of the previous occasions.

4.2.2 In November 1987 Robert was admitted to **North Middlesex University Hospital** for *'investigations of short stature. Mother alcoholic. Child has FAS and short stature.*

[27] Robert's sister said that he had received support throughout his schooling and continued, as an adult, to have a high level of dependency due to his level of intelligence and ability. She tried to tell people but felt 'he was invisible' and 'no one took it seriously'.

Intellectually normal. Spoke only at three years of age, otherwise developmentally normal'.[28]When Robert attended NMUH after the car accident on 3rd January 2016 there was no record of him as being vulnerable and at the time he was treated for a fractured wrist and allowed to go home with a follow up appointment at the Fracture Clinic.

4.2.3 Homes for Haringey

4.2.3.1 As noted earlier Robert was recorded on the house / tenancy file as being his father's carer and in receipt of Carers Allowance. HfH became aware that Robert may be vulnerable following correspondence with Robert's sister but there was no clear understanding of the nature and extent of his vulnerability.

4.2.3.2 'Vulnerability' in the housing context is used to determine if a homeless person has a priority need for accommodation as a result of, amongst others, old age, mental illness or learning disability or physical disability or any other special reason. The Homelessness Code of Practice is helpful in the context of how Homes for Haringey Decision Panel dealt with Robert's application for grant of a tenancy and provides at Paragraph 10.16 that for persons with m*ental illness or learning disability or physical disability*:

> *"Housing authorities should have regard to any advice from medical professionals, social services or current providers of care and support. In cases where there is doubt as to the extent of any vulnerability authorities may also consider seeking a clinical opinion. However, the final decision on the question of vulnerability will rest with the housing authority. In considering whether such applicants are vulnerable, authorities will need to take account of all relevant factors including: i) the nature and extent of the illness and/or disability which may render the applicant vulnerable; ii) the relationship between the illness and/or disability and the individual's housing difficulties; and iii) the relationship between the illness and/or disability and other factors such as drug/alcohol misuse, offending behaviour, challenging behaviours, age and personality disorder".*

Also, at Paragraph 10.17

> "*Assessment of vulnerability due to mental health will require close co-operation between housing authorities, social services authorities and mental health agencies. Housing authorities should consider carrying out joint assessments or using a trained mental health practitioner as part of an assessment team..."*

4.2.3.3 The TMO attempted to obtain information on Robert's circumstances and vulnerability for the Decision Panel Report. Information was sought from the GP who had made a referral for an assessment to the Adult Services SAT and was subsequently passed on to the HLDP who had delayed in undertaking the required assessment. But what little information the TMO did receive was confusing and ambiguous.

4.2.3.4 On 12th November 2015, the Decision Panel had rightly deferred its decision on the grant of a tenancy for an assessment of Robert to be undertaken by HLDP. Whilst the Key Support Support Worker became involved and a referral was made to the VAT, the crucial assessment of Robert's vulnerability was still absent as at the time of reconvened Decision Panel meeting

[28] NMUH IMR

on 10th December. The Decision Panel proceeded to make a decision not to grant a tenancy without the benefit of a proper assessment of Robert by HLDP or as to his vulnerability. This appears contrary to the position taken at its 12th November meeting. It is possible that the decision was based on a misunderstanding about the Key Support assessment presented in the report

4.2.3.5 The rationale for the Panel's decision on the grant of a tenancy was on the basis of an assessment from Key Support that Robert had learning difficulties "but is ok for independent living" and lack of evidence of exceptional reasons. The decision should have been informed by a comprehensive assessment of Robert's vulnerability or an assessment by HLDP. The Decision Panel could have been deferred to press for the required assessment.

4.2.3.6 The quality of the report on which the Panel made its decision is a concern as it is not clear how it related to any of the six listed criteria that the Panel should take into account when considering the exceptional nature of the request. The Decision letter did not set out the right to seek a review of the decision. However, we cannot be certain that even if Robert had a comprehensive assessment of his needs and this was included in the Decision Panel Report the decision the Panel reached would have been any different.

4.2.3.7 There was considerable ambiguity relating to Robert's ability to live independently with Key Support stating that Robert was capable of independent living in the report to the Decision Panel but did not clarify what support needs he may have to facilitate this[29].

The term "independent living" was not clearly understood and neither was the term "supported housing" as different levels and types of support could be available to enable someone to live independently; sheltered housing is but one of many options.

4.2.4 Haringey Adult Services

4.2.4.1 As indicated above, SAT and HLDP had delayed in responding to the request by the GP on `23rd September 2015 for an assessment of Robert. There was a subsequent referral by the Key Support Support Worker on 23rd December that HLDP responded to on the same day and decided that Robert was not likely to be eligible for HLDP services but that additional information was required and the case was passed to a clinical psychologist in the team.

The clinical psychologist attempted to contact Robert on the 15th and then 20th January. The HLDP IMR acknowledge that "The Community Mental Health Team may have been more appropriate resources to respond to the referrals made by the GP and Key Support and this decision should have been made sooner by the HLDP, rather than adding Robert to the HLDP waiting list". There should have been a proper and timely person centred needs assessment to inform the decision on eligibility as required by legislation and guidance.

4.2.4.2 The Care Act (CA) 2014 and the Care and Support Statutory Guidance 2016 sets out the framework for an assessment of an adult's needs for care and support. Where it appears to a

[29] Robert's sister said that he could live by himself but needed daily phone calls to remind him to do certain things. This doesn't appear to have been understood to indicate his level of dependency and therefore vulnerability.

local authority that an adult may have need for care and support a care "needs assessment" must be carried out by the local authority[30]. Having carried out that assessment, the local authority must go on to consider whether the assessed person has any eligible needs[31]. If the person assessed has eligible needs, the local authority is under a duty to provide support[32]. If the assessed needs are not eligible needs then the local authority has a power to meet those needs -[33] . Further information about the needs assessment can be found at footnote[34]. The

[30] Section 9 CA 2014

[31] Section 13 CA 2014 and Care and Support (Eligibility Criteria) Regulations 2015/313 (the 'Eligibility Regulations').

[32] Section 18 CA 2014

[33] Section 19 CA 2014

[34] As to the needs assessment, the Care and Support Statutory Guidance provides that

"The purpose of an assessment

6.9 The purpose of an assessment is to identify the person's needs and how these impact on their wellbeing, and the outcomes that the person wishes to achieve in their day-to-day life. The assessment will support the determination of whether needs are eligible for care and support from the local authority, and understanding how the provision of care and support may assist the adult in achieving their desired outcomes. An assessment must be person-centred, involving the individual and any carer that the adult has, or any other person they might want involved. ..

6.10 An assessment must seek to establish the total extent of needs before the local authority considers the person's eligibility for care and support and what types of care and support can help to meet those needs.....

6.11 An individual may be unable to request an assessment or may struggle to express their needs. The local authority must in these situations carry out supported decision making, helping the person to be as involved as possible in the assessment, and must carry out a capacity assessment. The requirements of the Mental Capacity Act and access to an Independent Mental Capacity Advocate apply for all those who may lack capacity.

6.12 Eligibility determinations must be made on the basis of an assessment, and cannot be made without having first carried out an assessment..... The eligibility determination cannot take place until an assessment has been completed, except in cases where the local authority is meeting urgent needs.

Needs assessment

6.13 Local authorities must undertake an assessment for any adult with an appearance of need for care and support, regardless of whether or not the local authority thinks the individual has eligible needs or of their financial situation.

First contact with the authority

6.22 The assessment process starts from when local authorities start to collect information about the person. From their very first contact with the local authority, the person must be given as much information as possible about the assessment process, as early as possible, to ensure a personalised approach to the assessment. This should include detail of what can be expected during the assessment process (such as the format and timescale of assessment, complaints processes and possible access to independent advocacy) and allow them to be as involved in the process as possible...

6.28 Local authorities must ensure that any adult with an appearance of care and support needs, ... receives a proportionate assessment which identifies their level of needs. Where appropriate, an assessment may be carried out over the phone or online. In adopting such approaches, local authorities should consider whether the proposed means of carrying out the assessment poses any challenges or risks for certain groups, particularly when assuring itself that it has fulfilled its duties around safeguarding, independent advocacy, and assessing mental capacity. Where there is concern about a person's capacity to make a decision, for example as a result of a mental impairment such as those with dementia, acquired brain injury, learning disabilities or mental health needs, a face-to-face assessment should be arranged. Local authorities have a duty of care to carry out an assessment in a way that enables them to recognise the needs of those who may not be able to put these into words... 6.29 An assessment should be carried out over an appropriate and reasonable timescale taking into account the urgency of needs and a consideration of any fluctuation in those needs. Local authorities should inform the individual of an indicative timescale over which their assessment will be conducted and keep the person informed throughout the assessment process.

Supporting the person's involvement in the assessment

6.30 Putting the person at the heart of the assessment process is crucial to understanding the person's needs, outcomes and wellbeing, and delivering better care and support. The local authority must involve the person being assessed in the process as they are best placed to judge their own wellbeing. In.... all cases, the authority must also involve any other person requested.

6.31 Where local authorities identify that an adult is unable to engage effectively in the assessment process independently, it should seek to involve somebody who can assist the adult in engaging with the process and helping them to articulate their preferred outcomes and needs as early as possible. This will include some people with mental impairments who will nevertheless have capacity to engage in the assessment alongside the local authority. They may require assistance whereby the local authority provides an assessment, tailored to their circumstances, their needs and their ability to

requirements of the guidance, in particular, on the timescale and the person centred approach were not met.

4.2.5 As noted above the **Key Support** Support Worker considered that Robert's need was to be rehoused following his threatened eviction from the family home. He was considered to be capable of independent living: this statement would be professionally understood to potentially imply that support to sustain independent living may need to be applied. Action was taken to refer Robert to the VAT for housing advice and support.

4.2.6 **The GP w**as aware of Robert's depression following his father's death and apart from prescribing any medication the GP referred Robert for Bereavement Counselling which he was attending.

4.2.7 **In summary,** there is no evidence that any comprehensive assessment of Robert's vulnerability or care and support needs was considered or completed by the principal agencies (i.e. Homes for Haringey Key Support, and Adult Services (SAT and HLDP)) coming into contact with Robert between September 2015 and his death in January 2016.

4.3 What was agencies understanding of Robert's experience following the death of each of his parents? How was communication between agencies, with Robert and his family about his needs and vulnerabilities?

4.3.1 Little is known about Robert's response to the death of his mother as he was so young but the death of his father had a very significant impact on him. Robert was known to have been bereaved and to be depressed or severely depressed by HfH, the GP, Key Support, HLDP,

4.3.2 In August 2015 Robert visited his GP three times regarding the death of his father, requested sleeping tablets and awaiting bereavement counselling. He was prescribed anti-depressants. From September to November 2015 Robert visited his GP eight times, seeking support for housing situation, poor sleep, poor eating and low mood. At the end of November 2015, he was reported to be attending bereavement counselling, having good support with no thoughts of harm and not noted to be suicidal.

4.3.3 Following his death, Police spoke with friends of Robert and they stated that he was devastated by the death of his father and blamed himself. They described how he regretted going out and leaving his father alone, because when he returned he found his father at the bottom of the stairs and his father subsequently passed away. He is also said to have attempted to take his life on a previous occasion, through taking an overdose of tablets. This was not described as a serious attempt on his life but agencies were not aware of it at all.

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engage. They should be supported in understanding the assessment process and assisted to make decisions wherever possible.

Record keeping

6.98 Following their assessment, individuals must be given a record of their needs or carer's assessment. A copy must also be shared with anybody else that the individual requests the local authority to share a copy with.

4.3.4 There were no face to face meetings between HfH and Robert or his sister nor any case conference involving other agencies. It is interesting to note that the only agency we can evidence communicating with Robert's sister is Homes for Haringey. A series of email communications between the TMO and Robert/his sister provided information about Robert's situation and vulnerabilities but this was piecemeal, often produced under time pressure and left a lot to interpretation.

4.3.5 A housing-led case conference would also have clarified the roles of the various agencies involved and provided some clarity about and control over referrals for assessments. Participation in case conferences is included in the TMO job description making it clear who should take the lead in convening the conference and this is being addressed in revised HfH procedures. A face to face meeting with Robert and a housing led case conference would have facilitated an assessment of Robert's:

- capacity to make decisions regarding his tenancy application
- abilities and disabilities
- care and support needs
- safeguarding needs
- knowledge and understanding of independent living/supported housing
- risks associated with remaining in or leaving the tenancy.

4.3.6 The process and criteria of the HfH Decision Panel were not made transparent to Robert or his sister which would have helped to ensure the relevant information was provided to the Panel to meet their criteria. Establishing a personal relationship at an earlier stage may have avoided this.

4.3.7 The failure to establish a personal relationship with Robert may have also contributed to the way the Decision Panel's decision was communicated to Robert just before Christmas. Given the knowledge of Robert's vulnerability and the fact that his sister was communicating with HfH on Robert's behalf sending a notice to quit to Robert outlining the decision without speaking to him directly about it and its consequences was insensitive. The fact that the letter was sent just before Christmas was particularly problematic given the Christmas break. The wording of the letter is drafted to meet the legal requirements relating to the eviction process and could not therefore be changed.

4.3.8 Although there was a delay in Robert receiving bereavement counselling from the original GP referral on 10th August due to the start of a new service, by 24 November Robert was reported to be receiving counselling with good support with no thoughts of harm. Evidently the death of his father was causing him emotional distress and attending counselling was viewed as helpful.

4.3.9 There was no direct communication with Robert and/or his sister about the HLDP consideration of the referrals from the GP and Key Support and any assessment process, other than after his death when the clinical psychologist from HLDP called Robert and then his sister.

4.3.10 **In summary**, the review highlighted a fundamental problem with direct communication with Robert and the need to improve communication between agencies in relation to housing and homelessness and vulnerability.

4.4 Bearing in mind agencies' knowledge about Robert, were appropriate risks and needs assessments completed and acted on?

4.4.1 Assessments of risks and needs should emerge in relation to concern about vulnerability – albeit that the determination of vulnerability is approached differently by agencies depending on the service being offered. Knowledge about Robert's vulnerability only emerged to agencies, other than the GP, during the process to reach a decision on his eligibility for social housing. At that time there was evidence from Robert's sister and GP that he was very depressed and anxious about the future although the GP did not report that he was suicidal.

4.4.2 As noted above in section 4.1 agencies other than HfH, Key Support Housing and the GP were not aware, or of the opinion, that Robert was a vulnerable adult as there was no evidence available to them to suggest this was the case. Adult Services did receive information that suggested vulnerability but at the time of his death there was no completed assessment of the nature or extent of vulnerability and/or care and support needs arising.

4.4.3 **The Homes for Haringey** IMR states that *'it would have been beneficial if a fuller assessment of Robert's needs and the potential risks associated with refusing him a Grant of Tenancy had been sought and provided through .... either the HLDP or the VAT to enable the Decisions Panel to make a more informed decision about his vulnerability and whether the Council would have had a statutory duty to assist under the homelessness legislation or if there were serious mental health or medical issues that would have had a severe detrimental effect on his health and wellbeing';* and further that *'it would have been good practice to request an assessment of his needs, vulnerabilities and risk through the Integrated Assessment Team who could have obtained an assessment from HLDP or VAT*'.

4.4.4 The **Key Support** Support Worker was of the view that Robert was at risk of homelessness and referred his case to the Vulnerable Adults Team which was an appropriate referral.

4.4.5 The GP was aware that Robert was depressed following the death of his father and referred him to bereavement counselling in August which he attended.

4.4.6 **In summary** all agencies had partial knowledge and information about Robert and their decision making in respect of him was affected by this. This did not lead to any assessment of risk and vulnerability or a completed needs assessment.

4.5 What guidance, policies and procedures were in place to support staff in HfH and what was the expectation of how these would be implemented at the time?

4.5.1 There had been new guidance and procedures issued around October 2015 when a revised Allocations Policy had been introduced and the Decisions Panel was a new feature of the process. There were no specific Grant of Tenancy procedure or guidance notes relating to the changes resulting from the new Allocations Policy at that time. The cover report to the policy explained that a revised procedure would be developed and a Decision Panel set up for November 2015 and this was the case[35].

4.5.2 The Decision Panel that Robert's case was referred to was one of the first Panel meetings and all those involved were testing out this new way of working. Similarly, the staff had not all had

training on the new policy and procedures and this may have contributed to the lack of clarity around the content and structure of reports to The Panel; the criteria that The Panel adopted to guide their decisions; and the clarity in reporting the Panel's decisions. The reports are signed off by the line Manager or other Manager before submission. HfH gave no information on these criteria to Robert or his sister. The final version of the Guidance notes on the Decision Panel reflected comments by managers on an earlier draft and were not formally issued to staff until 21st January 2016.

4.5.3 It is worth noting here that the TMO was in error in the January response to Robert's sister that she could not overturn the Decision Panel's decision – there is a right to review of decisions in the guidance. This was a time of transition and both staff and Decision Panel members were becoming familiar with the new arrangements and the TMO should have consulted with her manager.

4.5.4 Policies and procedures for HfH did not spell out the need for face to face meetings with vulnerable adults to discuss tenancy applications although home visits and case conferences are included in the job description. The procedures have now been amended to include home visits and new mobile devices do not allow for cases to be processed unless a home visit has taken place.

4.5.5 **In summary** the review has found that although guidance, policy and procedures were in place, they were in the process of development and not fully embedded in practice.

4.6 What impact did the implementation of the October 2015 allocations policy have on 'Robert's' behaviour and ultimate death? Could the policy have been interpreted and implemented differently? Should the policy be changed?

4.6.1 The October 2015 allocations policy (of the Council) was not the problem (simply enforcing new policy). There is no evidence to suggest that the Allocations Policy should be changed nor that it should be interpreted differently. The issues that need to be addressed relate to the implementation.

4.6.2 In late 2015 no formal and fully signed off procedures were in place for HfH TMOs in relation to the operation of the Decision Panel, nor had any training or briefings been provided. However, team leaders were part of its development and were responsible for signing off reports

4.6.3 Final guidance notes on the Decision Panel were not issued to staff until 21st January 2016. Robert's case was one of the first put before the Decision Panel. It has been speculated that, perhaps due to the unfamiliar process and the lack of guidance, the TMO's reports to the Decision Panel did not include all the relevant information however managers had to sign off the reports and were familiar with procedures. The second report did not make it clear that the HDLP had not provided the assessment of Robert and the information had come from Key Support.

4.6.4 The separation of the Grant of Tenancy process from the assessment of homelessness was a further cause of ambiguity. The decision on homelessness is a separate one but there was no information presented to the Decision Panel in relation to Robert's eligibility for assistance under the homelessness legislation and if that would have just been advice or more direct rehousing support. This is recognised now as the HfH IMR states, 'this would avoid applicants being made homeless following a Decision Panel application and then presenting themselves

as homeless for a further determination'. There is a duty to provide advice and information about homelessness and the prevention of homelessness (Section 179 Housing Act 1996). The Homelessness Code of Guidance for Local Authorities provides that:

> " ***2.11.*** *Many people who face the potential loss of their current home will be seeking practical advice and assistance to help them remain in their accommodation or secure alternative accommodation. Some may be seeking to apply for assistance under the homelessness legislation without being aware of other options that could help them to secure accommodation. Advice services should provide information on the range of housing options that are available in the district. This might include options to enable people to stay in their existing accommodation, delay homelessness for long enough to allow a planned move, or access alternative accommodation in the private or social sectors.*

4.6.5 Once the decision was reached that Robert was not to be granted a tenancy, the focus shifted on securing possession of the property. There should have been more focus on advice and assistance on alternative housing options to prevent Robert becoming homeless.

4.6.6 It seemed that Robert was high functioning; neither the police nor NMUH had identified him as vulnerable and HLDP had indicated that he was above their threshold for support (GLD, IQ 70) but we do not have a formal assessment. Robert was not known to HLDP prior to the first referral in September 2015. The fact that Robert had a driving licence defined him (to HLDP) as 'probably high-functioning' and therefore unlikely to be entitled to service other than signposting by a clinical psychologist[36]. It is possible that the clinical psychologist would have identified Robert's needs at the appointment fixed for January 4th 2016 (which he did not attend) but it was too late.

4.6.7 **In summary,** the impact of the implementation of the October 2015 Allocations Policy on Robert's behaviour and ultimate death is very difficult to assess. One of the key elements which would inform this question is missing i.e. a professional assessment of Robert's vulnerability and needs. We can say that the information provided to the Decision Panel was not as comprehensive as it could have been and there was confusion around the contents of the report to the second meeting and the reasons it was requested, including the depth and origin of the assessment presented therein. However, we cannot say with any certainty that even if the information that had been provided to the Panel meetings had been more comprehensive and focussed that the Panel would have made a different decision. In the absence of a professional assessment of Robert's vulnerability we cannot be certain that, as a single man, the Council would have accepted a duty to rehouse him under the Homelessness legislation[37]. We do not have any direct evidence that Robert's death was linked to the

[36] See above note 26

[37] Under the Housing Act 1996, the housing duties commence when an application is made by someone who appears to be homeless or threatened with homelessness. If that person is eligible for assistance and has a defined priority need, the authority must secure that temporary accommodation is made available while the authority carries out its duties to consider the eligibility of the application for assistance. Where, on completing these inquiries, the authority decides that the applicant is not in fact homeless or threatened with homelessness, or does not in fact have a priority need, or that a homeless applicant with a priority need became homeless intentionally, the duties are limited to giving advice, with a duty to secure temporary accommodation for those applicants who have a priority need. Where a local housing authority decides that an applicant who is homeless has a priority need and did not become homeless intentionally, the authority must secure that temporary accommodation is made available for a period of up to two years unless, in the opinion of the authority, there is sufficient accommodation available in the area suitable to the needs of the applicant. An authority may also refer the application for

Housing Panel decision although it may have been a contributory factor. The review acknowledges that Robert died on the same day as the eviction notice which was the outcome of the Housing Panel decision. He was reported by his friends to have attempted suicide before, but this was not known to agencies until after his death. Robert's note pinned to front door, retained by the police, stated *'I have hanged myself please don't let my sister find me as I am hanged myself'.* Another note stated *'My Dad I love and need so bad right now I won't do this without you I found you and I saw death can't go on after that 17.7.15 my life was changed forever. I can't cope with this anymore it's just too much for me'*. On the back of this note was a copy of Robert's driving licence.

4.7 How did agencies define and interpret 'independent living', in particular the phrase 'capable of independent living?' How did this definition affect entitlement to service?

4.7.1 The Panel considered Robert's case based on criteria 5 as per the guidance below: *Grants of tenancy should be completed as part of the grants of tenancy procedure. The panel will consider the exceptional nature of a referral including taking the following into account:*

1. The length of time a tenant has been resident.

2. If the resident would be someone the Council would otherwise have a statutory duty to assist under the homelessness legislation.

3. If it is in the Council's interest to make a grant of tenancy.

4. Organizational error including wrong advice that has resulted in a detrimental effect on the applicant's housing position.

5. Serious mental health or medical issues that would have a severe detrimental effect on their health and well being.

6. Where an applicant could have been part of a joint tenancy before the death of a partner/spouse/cohabite.

The Panel considered this term of independent living to ascertain whether Robert had serious mental health or medical issues.

4.7.2 There was confusion about the term "independent living" and what this actually meant in the context of Robert's rehousing which resulted in ambiguity about Robert's ability to live independently. This was compounded by the suggestion that "supported housing" with a warden might be suitable for Robert without any clear understanding of what the options were, see chronology 19th November 2015.

4.7.3 The statement by the Key Support Support Worker that '*I have no concerns about his independent living skills*' in the absence of a complete picture of Robert's support needs, on

assistance to another authority if it concludes that the applicant has a connection with that authority. An applicant who wishes to challenge an adverse decision may first seek an administrative review by the local authority and may then appeal against an adverse decision to the county court on a point of law.

4th December appears to have been fundamental to the decision by the Decision Panel not to grant Robert a tenancy. This assessment by the support worker was contradicted in the Key Support referral to HLDP where the question '*does the person have difficulty living independently*' was ticked. HfH had no knowledge of the detail in this form sent to HLDP but should not in any case, have relied solely on the Key Support assessment in its decision making.

4.7.4 The request by the TMO to Key Support and to the sister seeking views about Robert's ability to live independently gave the impression that '*confirmation of his independent living skills*' would assist in his application for a grant of a general needs property. Robert's sister said that '*Robert can live on his own but I have to phone him each day to remind him to wash and do certain things. He is not happy with the idea of living in warden controlled property'*. This was in response to the suggestion that "supported Housing" might be a suitable option, see below.

4.7.5 Neither Robert, nor his sister acting on his behalf, were given an explanation of the supported housing options available and the TMO did not query her (and Robert's) apparent misunderstanding of this type of housing when the sister said that her brother 'is not happy with the idea of living in warden-controlled accommodation'. This out-of-date and highly misleading term[38] revealed a lack of understanding that good practice would have been addressed by arranging for Robert and his sister to visit some suitable supported housing schemes together with explanations of the nature of support that could have been offered to Robert. Since no assessment of Robert's needs was ever made it is hard to gauge whether Robert would have thrived in appropriate supported housing or whether he would have managed, with the support of his sister, in general needs accommodation.

4.7.5 **In summary**, the confusion around what the term "independent living" meant and an understanding that it was not mutually exclusive from housing support may have had implications for the decision on Robert's rehousing. If the report to the Decision Panel had made it clear that Robert was capable of independent living but needed some support (although there was no needs assessment to quantify this) there may have been a different outcome but we cannot be sure.

4.8 Were senior managers involved at points in the case where they should have been? What impact did management involvement have?

4.8.1 The HfH IMR states that the… '*TMO was an experienced officer who would normally be expected to complete casework and requests to panels with minimum supervision*. However as the policies and procedures were changing regarding allocations it would have been good practice for managers to provide additional support and guidance at this time. Management did not appear to provide the level of scrutiny and support needed to identify the lack of a comprehensive needs, risk and vulnerability review and that the request for an assessment from HLDP had not been provided.

4.8.2 That IMR also considered that the TMO's manager should have scrutinised the TMO's first and second Decision Panel reports more carefully. The TMO's manager did countersign the Reports to the Decision Panel but if there had been some challenge and discussion some of the ambiguities in the Reports, particularly the second one, may have been clarified. As noted

[38] See 'Sheltered and retirement housing – a good practice guide', Imogen Parry and Lyn Thompson, CIH 2005

elsewhere the Decision Panel procedures do allow for a review and as the TMO seemed to be unhappy with the decision one might have expected the Manager to suggest a review.

4.8.3 The email from Robert's sister on 21st December raised concerns *('almost suicidal'*) that should have been dealt with in the absence of the TMO and not left until her return from leave in early January. Evidence was provided separately showing that the TMO had an out of office message on advising about alternatives to get in touch. There is no evidence that the sister had done this. It is also critical to note that once the TMO read this e-mail, this case should have become a safeguarding issue and escalated to her manager.

4.8.4 The supervision and support offered within Key Support was also a 'light touch', although it was good practice that the senior covered for the frontline worker during her leave.

4.8.5 The work of the social worker based in the SAT was not apparently supervised as the significant delay of four weeks from 23rd September to 22nd October in loading the GP referral and then referring it to HLDP was not picked up by managers. This was a significant delay.

4.8.6 **In Summary,** management input did not appear to provide the level of scrutiny which would have identified the lack of a risk and vulnerability review and that the request for an assessment from HLDP had not been provided.

4.9 Were there any organisational difficulties being experienced within or between agencies?

4.9.1 The review uncovered confusion about which agencies do what, with resultant confusion amongst both staff and customers. There should have been no confusion about accessing the VAT which sits in HFH but there was confusion about which client groups the VAT deals with. This would have been the obvious team to refer Robert to in the first instance but this referral only happened on the 4th December via Key Support. It should be noted that a VAT representative is on the Decision Panel.

4.9.2 There had been a history of poor communication between the VAT and Key Support and in 2014 measures were taken to deal with this by ensuring that an officer from Key Support (One Housing in 2014) visit the VAT on a regular basis. It is interesting to note that the referral to the VAT was by Key Support and not the TMO. The HRS Manager responsible for Housing Support commented that:

"There should be no impediments to a successful referral and assessment between Tenancy Management and VAT, which are both in Homes for Haringey, or to referrals from Key Support. Previous deficiencies in this regard had been identified to One Housing in HRS service review (within a Quality Assessment Framework) in 2014, and addressed by ensuring that a One Housing support officer spent time working in the VAT team."

4.9.3 **In summary,** there were some difficulties in communication within and between agencies and problems and confusion in understanding agency roles and responsibilities.

4.10 Were there any significant unnecessary delays in communication?

4.10.1 The GP's referral took an unexplained length of time to be logged by the SAT to then to be passed onto HLDP (23 September to 22 October). It took another three weeks before the GPs referral was queried by HLDP for further information (22 October to 13 November). The unanswered query to the GP was not pursued by HLDP after issuing one reminder (16

November). It took a second referral on 23rd December by Key Support Officer for HLDP to consider the request for an assessment.

4.10.2 There was a delay in the response by the VAT to the referral from Key Support (between 4 and 21 December) due to the fact of an initial email being sent by Key Support on 4 December without the referral form attached and a subsequent email sent the same day with the attachment being overlooked by the VAT.

4.10.3 **In summary**, the impact of these delays is difficult to assess but it is likely that if there had not been a delay in referrals to HDLP and the VAT Robert may have had an assessment which could have informed the Decision Panel process. However, we cannot say with any certainty what difference that would have made to the grant of tenancy decision.

4.11 Were there any specific issues arising from the interface between safeguarding duties and responsibilities and housing duties and responsibilities?

4.11.1 Robert's case has shone the spotlight on the workings between Housing Services and Adult Services not only in identifying vulnerable persons and the nature and extent of their vulnerability but also their care and support needs and determining eligibility for services. A common factor in housing and social care is the emphasis on joint and co-ordinated working. The Homelessness Code of Guidance provides that:

> *"Why Joint Working?*
>
> ***5.3.*** *At its best, joint working can result in higher quality and more efficient and cost effective services. Joint working can:*
>
> *• expand the knowledge and expertise of partner agencies;*
> *• help to provide higher quality integrated services to clients with multiple needs;*
> *• help to ensure people who are homeless or at risk of homelessness do not fall through the net because no one agency can meet all their needs;*
> *• reduce wasteful referrals and duplicated work between agencies. For example, common procedures for assessing clients and exchanging information mean homeless people do not have to be repeatedly assessed by different agencies.*

The Code goes on to give examples of joint working and advice on the need to identify cases where there is a need for case specific joint working and to develop protocols with partner agencies:

> ***"TYPES OF JOINT WORKING***
>
> ***5.6.*** *Joint working can take many forms. Examples of types of collaborative working that could help to achieve the objectives of a homelessness strategy might include:*
>
> *• establishment of a multi-agency forum for key practitioners and providers to share knowledge, information, ideas and complementary practices;*
> *• protocols for the referral of clients between services and sharing information between services*
> *• joint consideration of the needs of homeless people by housing and social services authorities under Part 7, the Children Act 1989 and community care legislation;"*

5.7. *When offering housing advice and assistance, housing authorities should consider devising screening procedures that identify at an early stage those cases where there is a need for case-specific joint working. Authorities may also wish to encourage their partner agencies to develop similar procedures. Where there is a need for such an approach, authorities are encouraged to adopt agreed protocols to ensure that appropriate action can be quickly initiated. Early appraisal of all clients who may require multiple assessments, by whichever authority is first approached, with agreed triggers and procedures for further action may help to prevent duplication of enquiries.*

The Care and Support Statutory Guidance in line with the legislative requirements provides for internal cooperation between officers in local authorities responsible for housing and adult care and support:

Ensuring co-operation within local authorities

15.23 ...Local authorities must make arrangements to ensure co-operation between its officers responsible for adult care and support, housing, public health and children's services,....

15.24 .... it is important that local authority officers responsible for housing work in co-operation with adult care and support, given that housing and suitability of living accommodation play a significant role in supporting a person to meet their needs and can help to delay that person's deterioration...

In the context of assessments and joint working, the Guidance provides for:

Integrated assessments

6.75 People may have needs that are met by various bodies. Therefore, a holistic approach to assessment which aims to bring together all of the person's needs may need the input of different professionals such as adult care and support, children's services, housing, experts in the voluntary sector, relevant professionals in the criminal justice system, health or mental health professionals.

6.76 A local authority may carry out a needs assessment jointly with another body carrying out any other assessment in relation to the person concerned, provided that person agrees. In doing so, the authority may integrate or align assessment processes in order to better fit around the needs of the individual. An integrated approach may involve working together with relevant professionals on a single assessment.....

6.77 Where more than one agency is assessing a person, they should all work closely together to prevent that person having to undergo a number of assessments at different times, which can be distressing and confusing.

4.11.2 The review has also flagged the need to strengthen awareness within Housing Services of adult safeguarding and the referral pathways to adult services. During the second half of 2015, HfH staff were guided by an out of date safeguarding policy which did not include any reference to the Care Act, the statutory guidance or to new housing safeguarding responsibilities. Of particular relevance to Robert is the requirement that housing staff are familiar with the six

principles underpinning adult safeguarding (empowerment, prevention, proportionality, protection, partnership, accountability), are trained to recognise the symptoms of abuse and neglect and are vigilant and able to respond to safeguarding concerns. There is no evidence that the TMO or her supervisors/managers considered safeguarding (or applied the principles) in their dealings with Robert and his sister between September 2015 and January 2016. This is despite much safeguarding training, though it is not clear that it has been embedded. [39] There is a need in all general needs housing organisation to 'skill up' their entire workforce in safeguarding, improve supervision creating a 'culture of safeguarding.

4.11.3 An opportunity was missed by HfH to refer Robert to the Safeguarding Adults Team and/or the Community Mental Health Team. As stated in the HfH IMR a '*safeguarding referral should have been made*' following receipt of Robert's sister's email on 21 December stating that he was almost suicidal. The IMR also states that the TMO's eventual response to the sister's email (in early January), *'should have been to raise concerns about Robert apparently being 'almost suicidal' with her line manager, to raise a safeguarding alert and to suspend further action (regarding the eviction) until a risk assessment and a review of the case had taken place'*. Instead the '*TMO was of the opinion that she had followed appropriate procedures and that the concerns raised by the sister (that her brother was 'almost suicidal') did not warrant discussing with her manager'* which is not in line with the TMO job description.

4.11.4 However, there was a subsequent referral by Key Support on 23rd December to HLDP but no mention of being almost suicidal or the pending eviction. As mentioned above, HLDP did not make further enquiries as to the concern of severe depression stated in the referral and decided that Robert did not meet their eligibility criteria. HLDP did not consider passing the referral to the Community Mental Health Team but it had been referred to a clinical psychologist

4.11.5 There has been no evidence of any involvement by the Safeguarding Adults Team in Robert's case, other than the delayed and transferred referral from the GP in September.

4.11.6 **In summary,** there should have been a better and more effective arrangement between housing and adult social care in assessing Robert's vulnerability and care and support needs in the context of the decision on the grant of a tenancy, future housing options and his general wellbeing. There is the need for a joint protocol between HfH and Adult Services in dealing with cases where there are overlapping duties and responsibilities and which should set out clear expectations, outcomes and timescales.

4.13 Was a capacity assessment (under the Mental Capacity Act 2005) made or requested regarding Robert and his application for Grant of Tenancy?

4.13.1 The TMO took at face value the sister's statement that she would '*deal with everything at present on Robert's behalf*' and did not meet directly with him – which was not in line with procedure. There is no record of a mental capacity assessment of Robert by any individual with regard to his application for Grant of Tenancy and therefore, by implication, no legal grounds for his sister's involvement on decision making on his behalf. There is no record that there was a Lasting Power of Attorney in place to enable her to deal with Robert's affairs on

[39] PhD thesis: Not just ticking the box: an investigation into safeguarding adults training transfer in Cornwall by Lindsey Anne Pike https://core.ac.uk/download/files/295/29817210.pdf

his behalf[40]. The GP considered that 'Robert's capacity to deal with his own affairs during the second half of 2015 would have been affected considerably by depression'[41]. It must be emphasised that there is no evidence to suggest that the sister failed to act in Robert's best interests at any point, but the apparent lack of awareness by all agencies coming into contact with Robert of the need to be aware of, to understand and to correctly apply the principles of the Mental Capacity Act[42] (including the need to enquire about a Lasting Power of Attorney) is an issue that needs to be addressed.

4.14 The key messages for the SAR from the meeting with his sister, her husband and a family friend were that:

- 'he was invisible' - all the agencies involved didn't see Robert's vulnerabilities and his high level of dependency, in so far as his father had prompted him to do everything and he needed a lot of daily support to function;
- ' no one took it seriously', despite his sister 'shouting from the rooftops' about his vulnerabilities – the agencies made assumptions about his ability because he could drive, but he had been highly motivated and focused on passing his driving test and only passed after 11 attempts;
- that his sister's insistence that agencies communicate with her directly instead of Robert was an indication of his level of need but was not questioned or explored;
- there was a lot of delay and difficulties in contacting and seeing the right people and yet inadequate time to properly consider his future housing options – the eviction was a terrible shock;
- and finally they would have welcomed a capacity assessment and taken up LPA if this had been mentioned to them, but it never was.

Robert's family members were familiar with Lasting Power of Attorney (LPA) provision, his brother-in-law having undertaken this role for his own elderly mother: they were completely unaware that LPA could have applied to Robert, as they understood that it was only relevant for older people. They said that if anyone had indicated that LPA could apply to Robert, they would have done this, and if they had been aware of the significance of a capacity assessment they would have asked for one to be undertaken. They appreciated that there would be learning from the SAR and welcomed the opportunity to go through the report and express their views, although this was distressing

[40] Robert's sister did not have LPA for Robert because she was unaware that she needed to (see 4.14).

[41] Information supplied by GP

[42] http://www.legislation.gov.uk/ukpga/2005/9/contents

5 SECTION FIVE: CONCLUSIONS AND LEARNING POINTS

A number of issues emerge from the analysis above which need to be addressed by the relevant organisations identified in parentheses.

5.1 The lack of face to face contact with Robert as part of the housing assessment led to poor quality information being provided to the Decision Panel meetings on both occasions. A case conference including Key Support, once they were involved, could have prevented this. **[Homes for Haringey]**

5.2 If personal contact had been made with Robert and his sister it may have resulted in a more thoughtful way of delivering the Decision Panel's determination. There were a number of concerns about the way this was communicated: (1) the timing just before Christmas holiday (2) Direct communication with Robert when all communication had been with Robert's sister (3) The failure to speak to Robert and his sister before the Notice to Quit arrived. **[Homes for Haringey]**

5.3 Neither Independent living nor housing support was adequately defined though this was considered to be fundamental to Robert's case for Grant of Tenancy. This was further confused by a lack of clarity around supported housing options and sheltered housing and poor quality of information to Robert's sister. This confusion would have been avoided by face to face contact and a case conference. **[Homes for Haringey]**

5.4 The key agencies did not assess or understand the nature and extent of Robert's vulnerability, nor his care and support needs as any needs assessment was delayed or deficient. Staff were not clear about the referral pathway for Robert with HfH suggesting in their IMR that it would have been good practice to refer Robert to the IAT for an initial assessment and they would have referred Robert to the HDLP or VAT for a more detailed assessment **[Homes for Haringey / Haringey Council]**

5.5 A new allocations policy had been introduced in October 2015 and a Decision Panel had been introduced into the review process and relevant guidelines, work instructions and staff training were finalised at a later date. The bedding in period may have led to confusion amongst staff and managers and Decision Panel members even though they all were involved in the development of the new procedures. This may have impacted on the quality of the decision making process and the quality of the report and its supporting evidence. However, given the lack of an assessment of Robert's vulnerability we cannot say that the decision not to rehouse Robert was wrong, but as a potentially homeless single man, support to prevent risks of homelessness should have been considered prior to any action being taken. **[Homes for Haringey / Haringey Council]**

5.6 The completion of referral forms by Key Support Housing should be more thorough and consistent to avoid ambiguity when making referrals. **[Key Support / Haringey Council]**

5.7 Staff may not be as familiar with the Mental Capacity Act 2005 as they should be. It was taken for granted that Robert's sister could represent his interests even though the TMO should have written confirmation from Robert that this was the case as per HfH guidance. Had relevant enquiries of mental capacity been made at the outset this would probably have resulted in Robert having an assessment of his needs and vulnerability; the one crucial piece of information that was missing. **[Haringey Council / Homes for Haringey / Key Support]**

5.8 There were some delays in communication between agencies which indicate a lack of management oversight of the referral processes. There is no evidence of active management involvement in relation to supervision or quality control. This was particularly relevant in HfH at the time when policies, procedures and working practices were changing – although both reports to the Decision Panel were counter-signed by the line manager with the purpose of review and quality assurance. The four week delay in uploading the referral from the GP to the SAT for referral to HDLP suggests a lack of system resilience and management oversight**.** There was also a delay in VAT to process the referral from Key Support. **[HfH / Haringey Council / VAT]**

5.9 Staff do not seem to be familiar with the most recent Safeguarding guidelines under the Care Act 2014 and if they have had training it needs to be embedded in practice. There was an opportunity to refer Robert for an assessment when his sister reported that he was suicidal but this was not a consideration – this is clearly a trigger for action in the HfH safeguarding procedure but was not acted upon. **[Homes for Haringey / Key Support Housing]**

5.10 Whilst a number of frontline staff from different organisations were trying to support Robert, there was a lack of co-ordination between them: there were 3 housing support services involved with Robert. Further there was a lack understanding of which services were the most appropriate to support him through these events that were causing him distress. The referral pathways need to be clear to all housing related staff involved in dealing with adults who may be vulnerable **[Homes for Haringey / Haringey Council / Key Support / IAT]**

6 SECTION SIX: RECOMMENDATIONS

The Safeguarding Adults Board should seek the following assurances:

6.1 That a multi-agency protocol is developed between Homes for Haringey, Adult Services and other relevant agencies to enable a better co-ordinated arrangement in assessing and responding to the needs of vulnerable adults threatened with or at risk of homelessness. Homes for Haringey should act as the lead agency in developing the protocol. The protocol should include:

- arrangement for identifying at an early stage those cases where there is the need for joint working;
- the pathways for referrals between and within agencies and guidance for completing referrals;
- arrangement for the referrals between and within agencies for assessments and service provision and sharing information for these purposes;
- the roles and responsibilities of agencies;
- if practicable and with agreement of the vulnerable adult, arrangements for joint or integrated assessments and for aligning the assessment process to fit around the needs of the adult;
- arrangement for the joint or co-ordinated assessment of risk and for managing any risk of harm, abuse or self neglect arising;
- arrangements for case conferences for agencies to share information and co-ordinate assessments and outcome of assessments and to determine support to be provided), agencies responsible and timescale;
- arrangement for communicating with the vulnerable adults (including home visit and face to face meeting) and where necessary undertaking an assessment of mental capacity and decision making on behalf of the vulnerable adult;
- a shared key / lead working / case manager model. (Homes for Haringey have already introduced this change in practice)
- the housing options available for vulnerable;
- arrangement for ensuring that agencies and their staff has a clear understanding of the workings and requirements of the protocol; and
- arrangements for annual review of the protocol and disseminating the outcome of the review to agencies and their staff.

6.2 That Homes for Haringey and any other housing provider in the borough ensure that training and clear guidance are available alongside any change in housing policy so that all relevant staff understand and can explain them to tenants. This information should be included in correspondence with tenants.

6.3 That Homes for Haringey review the workings of their Decision Panel to ensure that they are appropriately taking into account the six listed criteria when making a decision on the grant of a tenancy relating to vulnerable adults. The decision letters include reasons and the right to request a review.

6.4 Homes for Haringey and Housing Support staff have an up to date understanding of adult safeguarding roles and responsibilities, are able to identify adults at risk of harm, abuse and/or neglect and know what to do about it and are well supported to fulfil their role.

6.5 That Homes for Haringey should improve staff awareness and understanding of mental capacity and assessment of mental capacity of vulnerable adults and the requirements for relatives to act and make decisions on their behalf.

6.6 Within Adult Services, referrals and request for assessments relating to vulnerable adults are responded to and completed in a reasonable time and in accordance with the care and support statutory guidance.

7 SECTION SEVEN: ACTIONS ALREADY TAKEN TO ADDRESS LEARNING FROM THIS REVIEW

7.1 This review was commissioned by the Board in March 2016. Agencies involved in the case identified learning for their respective organisations and took action before and during the SAR process which the Panel was made aware of and wishes to acknowledge. Agencies identified learning and actions in the Individual Management Reviews which were requested at the start of the review in addressing its Terms of Reference. The SAR Panel has been responsible for monitoring the implementation of learning and actions within agencies during the course of the Review and following its completion, this will be overseen by the Board's SAR Sub-group, chaired by the Independent Chair of the Board.

7.2 Homes for Haringey and LBH Adult Social Care have been working together to develop a clear and single pathway across housing and homelessness, Housing Related Support commissioning team, Adult Social Care and Children's Services in respect of assessing and responding to the needs of vulnerable adults threatened with or at risk of homelessness. This will form the basis of the multi-agency protocol as set out at *Recommendation 1* of this report and planning for the dissemination of the pathway and protocol across multiagency staff teams is underway.

7.3 Homes for Haringey has reviewed and implemented its revised safeguarding policy and procedure together with a set of training methods to fully implement it across the relevant teams. Homes for Haringey assures that it is has mechanisms in place to keep abreast with any new legislation and best practice to adapt relevant procedures and training accordingly and that its organisational learning department ensures that the relevant reminders and refresher training are kept alive and fully embedded.

7.4 Relevant HfH Staff have been reminded about key aspects of work and expectations, including leading on their case management to ensure solutions including together with other agencies, home visits for all cases under review, making sure consent is obtained by the customer for a third party to act upon their behalf, the importance of quality reports and clarity of source of assessments and about the role of the decision panel, including the opportunity to re-open a case any time new evidence is available.

7.5 Within HfH, specific case work is now driven from our tablet computers with specific workflows and milestones. Progressing a case is no longer possible without a visit as the programme does not allow to move to the next stage without details of a visit. If the visit did not take place, the system books a new visit automatically.

7.6 Homes for Haringey has initiated a review of the Decision Panel process and composition as outlined at *Recommendation 3.*

7.7 A Housing Related Support contract review is taking place with One Housing, and a contemporaneous internal One Housing review informed by the findings of the SAR investigating Robert's case management and the lessons learned including: the timescales of referral and assessment; procedures for handovers and information exchange between staff and management review of cases; the quality of needs and risk assessment and referral information; the HKS key worker role pro-actively supporting access to housing, care and health

services; the quality of communications and relationship management with key stakeholders, and consent for third parties to act on behalf of service users; and practice on incidents reporting.

7.8 The Housing Related Support team has updated policies and procedures on Safeguarding and Incidents reporting with HRS providers in 2015/ 2016 and conducted workshops with the Council Safeguarding lead at the HRS Provider Forum on Safeguarding liaison and practice. All services are cyclically reviewed in relation to the Supporting People Service Review Quality Assessment Framework criteria on: support planning; safeguarding, diversity, health and safety; and client involvement and empowerment.

7.9 A new Housing Related Support Risk Management Framework is planned to be introduced which will include the assessment of the frequency and type of service and contract reviews and checks, with new and revised protocols, policies and procedures identified in consultation with partners, providers and stakeholders.

7.10 In LBH Adult Social Care, improved performance management systems and training for staff is in place involving:

- case file audits overseen by the Principal Social Worker ensures that performance and timeliness of assessments is monitored and training and support needs are identified;
- team management information is scrutinised at monthly performance meetings;
- a business analyst has been employed to support business improvements outcomes through monitoring of recording and response time;
- a refreshed supervision policy has been launched and managers and staff trained on how to use this tool to support improved performance and outcomes for staff and clients;
- Care Act Guidance and training on Care and Support Assessments is ongoing and Principal Social Worker training sessions based on the learning emanating from the SAR is planned.