Lambeth Safeguarding Adults Board

Safeguarding Adults Review G

Lead Reviewer: Lynn Sellwood

Presented to the Lambeth SAB on: 27th July 2021

The Lambeth Safeguarding Adults Board would like to acknowledge the role that the neighbour, who this review refers to as Sheila, played throughout George's life and in particular over the period of this review . She provided a caring watchful eye over the family when they refused services. She saved George's life when she rescued him from the fire. Subsequently she agreed for him in to live in her home whilst other arrangements were being made to support him. She has shown ongoing compassion towards this family and is the unsung hero of this story.

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Introduction

The Lambeth Safeguarding Adults Board (SAB) agreed this case should be reviewed because it met the statutory criteria for a Safeguarding Adults Review (SAR) under section 44 of the Care Act 2014. George was rendered homeless in November 2019 after an arson attack on his home by his brother, Andrew, who was, at the time, his sole carer.

The case highlights the complex issues professionals face when dealing with adults who have learning difficulties, with little or no literacy and who are disadvantaged by additional significant factors which impact their well-being, including refusal of services, leading to neglect and self-neglect, alcohol abuse, violence, and familial coercive control.

The case illustrates the challenges for professionals to engage with “difficult” families and the impact of failing to demonstrate professional curiosity, especially when the adult seems to agree with an intervention to improve the circumstances under which they live only to refuse or rescind at a later date. There is a propensity to assess adults, despite the evidence to the contrary, as having the capacity to make “unwise decisions” without fully understanding why there is a reluctance to engage with services offered. This review illustrates the way that agencies act in silos, do not question what is behind unwise decision-making, fail to share their “bit” of information with other agencies and could be unduly influenced by assumptions surrounding cultural identities.

Executive Summary

On 23 November 2019, George’s brother and sole carer, Andrew, set fire to the family home. A neighbour, Sheila, who had been closely monitoring George, an agreement made when formal care arrangements were refused, went to get George to safety. The damage caused to the property meant that George was unable to return to his home.

George’s medical notes included a reference to having learning difficulties. He could not read or write and was unable to manage his own financial affairs. He had no documentation to access benefits such as a birth certificate, national insurance number (NINO), passport or bank account. He had been entirely dependent on his mother and after her death, his older brother, Michael, for money. He also experienced the symptoms of the panic disorder, agoraphobia, which manifests in a high level of anxiety where he was unable to leave his home. This disorder was never formally diagnosed. There had been many incidents of violence at the family home before Andrew’s eventual prison sentence for the attack on Michael with a hammer in 2013. In 2003 Andrew stabbed George in the back and in 2004, Andrew attacked Michael’s hands with a hammer. George had lived in the local authority 3-bedroom property since 1979 with his mother and two brothers (Michael and Andrew).

George’s mother died in June 2016 after a period of neglect and self-neglect. Michael died in February 2019 due to health complications following excessive alcohol consumption. The night before his death he had a blow to the head, seemingly from a fall in his bedroom. Michael was George's carer before his death. It was at this point that Andrew became George’s carer.

In 2013, Andrew was detained in prison for 5 years after attacking his brother, Michael, with a hammer. During his prison sentence in 2016 he attempted suicide and was placed in a psychiatric setting. He was released from prison on licence on 28th December 2018 subject to conditions of residence. It seems these conditions were disregarded, and he was living at the family home when Michael died. Andrew was assessed as Category 2, level 1 MAPPA and not subject to a multi-disciplinary monitoring meeting. After the death of his brother Andrew continued to live with George and initially was willing to be George's carer.

Adult Social Care were contacted by George's neighbour Sheila, in March 2019. A safeguarding concern was immediately raised about the condition of the property and the state of self-neglect of George. A considerable amount of work was undertaken to support the two brothers (George & Andrew) who were both struggling each in their own way.

The Safeguarding Adults enquiry undertaken following the arson attack found that George was also experiencing financial abuse at the hands of Andrew, who had been using George's benefit payments to buy alcohol and had not been buying food. George's professed wish was to remain with his brother Andrew as his informal carer despite concerns about George and Andrew's ability to do this. It was understood that this wish was borne from both brothers having been placed into children's homes at some time during their childhood. It will be noted that both brothers had been contacted by REDRESS. It was only after the arson incident that George finally admitted he was scared of Andrew and always had been.

A number of organisations were involved or aware of George and his brother. Working with the family was sometimes challenging and they frequently seemed to accept services only to change their minds at a later date. Services, including Mental Health services, General Practitioner, London Borough of Lambeth Housing Services, Metropolitan Police and Probation Services, could have worked more effectively to prevent the abuse of George from occurring.

It is worth noting that Andrew has been returned to prison for breaching his licence. George has been successfully placed in the Shared Lives scheme and is making progress.

A Simple Timeline

December 2018

- Andrew released from prison on licence with a requirement not to visit the family home. Andrew had been convicted as a result of an attack on Michael with a hammer.
- NPS assess Andrew as MAPPA Category 2, level 1

January 2019

- Andrew attends weekly NPS supervision, starts a DWP claim but unknown to anyone but his brothers and neighbour has moved back into the family home, breaching his licence conditions. This is of particular importance to NPS and DWP.

February 2019

- The older brother, Michael, who is George's carer, is found dead in the family home. There is an investigation by Police. Andrew's statement reveals that he lives at the address.

March 2019

- Sheila, the long-standing friend and neighbour contacts Duty Social Worker about George and the state of the property and how the brothers are living.
- Andrew informs NPS of his "change" of address as a result of his brother, Michael's death. NPS retain Andrew as MAPPA Cat 2 level 1 without reference to George's vulnerability.
- Police called to a domestic disturbance at the family home. Andrew makes allegations that George is keeping the mother's pension. There is no investigation into the fact that the mother had died in 2016. Andrew used homophobic and racial abuse at the Police. He was arrested.

April 2019

- Andrew sentenced to 80 hours Community order by Court. No investigation into financial abuse by NPS.
- Housing have the first meeting with the two brothers to discuss succession of tenancy which has been dormant since the death of the mother in 2016. Andrew is deemed capable of being the lead tenant.
- Andrew started a new Benefits claim for Universal Credit since having a new address.
- Andrew attends GP to get a sick note to preclude him from attending community service.
- ASC start to collect information about George, Integrated Disability Service is involved. The neglect of George and the poor state of the property is obvious.
- Clear evidence of Andrew's previous violence towards George is shown. A safeguarding enquiry is opened and is escalated to Housing, DWP and GP.

May 2019

- EPC/DWP start work on the benefits claim for Andrew and George. George has never claimed because he is without any proper documentation to authenticate his identity.
- Andrew is designated as George's appointee. There is no evidence that George's wishes were explored away from Andrew's influence.
- Andrew is designated as the tenant in the property. The property then becomes subject to the "bedroom tax" and council tax.
- GP provides another certificate of sickness for Andrew.
- Andrew admits to DWP staff that he has difficulties with reading and writing
- PCSO's called to a neighbour dispute by Andrew. They deal with the situation but do not take adequate notes or investigate further with any follow-up.

June 2019

- NPS notes that Andrew looks neglected and malnourished. No reference to George.
- EPC/DWP are still working on George's claim. There is a discussion about whether Andrew should be George's appointee or whether there should be a corporate appointee.
- GP issues further certificates of sickness to Andrew but now he is citing carer's stress
- ASC start to chase Housing re repairs to the house.

July 2019

- GP issues two further certificates of sickness
- Andrew and George receive help with the funeral costs for Michael who died in February
- George receives PIP benefits.
- ASC press Housing twice in this month to address mould and damp and other issues in the family home.
- George is referred to Living Well Hub for mental health assessment
- Further home visit by social worker to the home, food vouchers are issued but George has not yet been able to claim any benefits.
- George is still not registered with the GP. There is some confusion about why he was de-registered in the first place.
- George was not accepted as a mental health referral by LWH.

August 2019

- After some discussion there was a visit by CPN to George, a diagnosis was suggested and there were some suggestions and signposting but they were not appropriate for George who was agoraphobic and had a learning disability/difficulty.
- NPS have concern that Andrew is not completing his Community service order because of certificates of sickness issued by the GP.

- DWP organise a home visit to complete George's benefit claim.
- Housing schedule a visit to the property to assess its state.
- GP has reinstated George as a patient and after a home visit organises District Nurses to come and take blood samples. (This doesn't happen and is not followed up)
- CPN signposts George to inappropriate support like befriending and support groups.
- NPS contacts GP about the duration of Andrew's sickness and the prognosis for the future

September 2019

- GP issues further certificates to Andrew for carer stress
- Andrew finds it hard to deal with Council tax claim and PIP enquiries

October 2019

- Andrew engages EPC to help with the demands from Council Tax arrears
- Andrew declares that he can't cope with being George's appointee or carer.
- A Care Package is agreed with George which involves domiciliary care coming to the house. This is refused when the carers turn up.

November 2019

- Sheila, the neighbour, takes over the care of George under Direct Payments
- NPS refer the 80 hour Community Order as unworkable and return it to court
- George receives benefits
- Arson attack on home. Andrew confesses to Police that he was responsible and he is returned to prison in breach of his licence.
- George finally admits that he has always been scared of Andrew, he temporarily moves in with Sheila until he is placed in the Shared Lives scheme.

The principal findings from this review are:

1. There was a failure to consider George's vulnerability given the family history and context. All agencies focussed on Andrew; George was rarely at the forefront of agencies' decision-making.

2. All agencies displayed a general lack of understanding of how George's learning difficulties impacted on his ability to self-advocate which contributed significantly to his vulnerability to abuse

3. Record-keeping and information sharing was inadequate

Recommendations to the Board

1. **The Board should seek urgent assurance from all partner agencies that they have a suitable framework or criteria that is used to identify and manage their vulnerable clients.** Some partners, including the MPS and ASC, already have their own vulnerability framework (see Appendices) and these could be used as a guide for others. Recognition of vulnerability must go beyond obvious visible concerns and should include hidden vulnerabilities including lack of literacy and numeracy skills, digital poverty and mental ill health. This work should be undertaken to enable partner agencies to sufficiently probe the reason why some adults fail to engage with services. It is suggested this is completed and presented to the Board within one year of this report's publication.

2. **The Board must identify the operational barriers that prevent frontline staff from implementing the strategic information sharing agreements that are currently in place.** This report highlights the real danger to people that is presented by incompatible systems and lack of access to relevant data. This work will lead to more robust access to data and appropriate training to analyse and understand information.

3. **The Board should prioritise further multi-agency focus on the issue of adult family violence between siblings and parents as part of its wider approach to reducing the incidence of Domestic Violence.**

   Domestic Violence Policies should be amended in line with the findings of the DHR which reads: "Within the definition of domestic abuse there is a wide range of different abuses including: intimate partner violence and abuse for people of all ages, genders and sexualities; adult family violence and abuse; so-called "honour"-based abuse; forced marriage; child to parent, and adolescent to parent violence and abuse. While all are gendered (most victims and survivors are women and most perpetrators are men) and coercive control is the main feature of the abuse, there are differences, and we need to ensure responses and interventions are tailored and appropriate."

4.The Board should immediately pose the question to itself and its partners 'What does a culture of professional curiosity look and feel like?' this work will ensure that all partners are sufficiently confident that their front line staff display professional curiosity in all interactions with their vulnerable clients.

Individual Agency Recommendations

Probation Services

- The Probation Service Lambeth to provide an assurance report to the board of the findings of any national/divisional audits on the management level of MAPPA eligible clients
- The Probation Service Lambeth to provide an assurance report to the board of how conditions of residence are arrived at for clients on licence where they return to a previous address in line with national Probation guidance. They must demonstrate to the Board that there has been every effort to understand the wishes of other family members to ensure no duress has been applied to their agreement.
- The Probation Service Lambeth must demonstrate that every effort has been made to share information with relevant agencies, including Adult Social Care to ensure the successful return to the family and society at large in respect of a mental health history while in prison.

This assurance should be prepared within six months of the publication of this report and presented to the Board for scrutiny and challenge.

DWP

- The DWP serving Lambeth must undertake a review of its process and procedures in respect of vulnerable people, especially those with learning difficulties to ensure that there is a flexible and responsive service to aid those in need of benefits and support. The Board will need to be assured that the current process and interactions as demonstrated in this report are recognised as inadequate in providing the support needed to provide benefits to vulnerable adults.
- The DWP must assure the Board that it has an internal system to flag and support vulnerable adults which is generated by its own staff and is not reliant on Adult Social Services to enact.

This assurance should be prepared within six months of the publication of this report and presented to the Board for scrutiny and challenge

CCG, LHA and GP Service

- Lambeth Health Authority and the GP service must undertake a review of its processes and procedures in respect of deducting patients from its register to ensure that the patient has been removed for good reason. Those reasons should be clear and transparent and should be open to scrutiny. This practice should be vigilant in respect of vulnerable adults including those with learning disabilities or difficulties.

- The GP Service must undertake a review of how it flags and offers services for those patients who are listed as Learning Disabled**.** This must include a process of making sure that other relevant services are aware of the existence of the patient. The GP practice has the facility to print out a list of vulnerable patients from the EMIS register. Practices should scan the list regularly and make sure that any vulnerable patient who has not been seen for a long time is identified and followed up. In addition, GP practices should make reasonable adjustments for vulnerable patients including the use of easy read letters, texts and information leaflets so that they are able to understand the content of invitations for appointments and understand health advice.

- The CCG must undertake a review into why some vulnerable patients are excluded from good practice MDT services because of postcode and boundary issues. There should be a review into the extent of the problem and solutions offered to the Board to ensure equitable access to services at each GP surgery. At national level there should be a mechanism to ensure that patients who reside in a borough which is outside the borough where their general practice is located can be identified with a view to investigating any concerns about their well-being. This could be equivalent to cross-borough 'huddle' which should include adult social care as they may be the only partner providing services to the patient.

- Practice HCPs should exercise a greater degree of professional curiosity about the daily lives of people with learning difficulties particularly if their quality of life appears poor. This would allow the possibility of offering further assessment and referrals for example to the LD team, where warranted. Practice staff should exercise professional curiosity about the relationship between a carer and the person they care for, particularly where there are factors which indicate that the relationship between the two parties may be difficult.

This assurance should be prepared within six months of the publication of this report and presented to the Board for scrutiny and challenge.

Adult Social Care

- ASC to provide assurance that they have a department wide mechanism to track unallocated cases awaiting assessment.

This assurance should be prepared within six months of the publication of this report and presented to the Board for scrutiny and challenge.

Lambeth Housing Services

- All departments within Lambeth Housing Directorate should read and understand the impact of their decision-making, or lack of it, on the lives of vulnerable residents. The simple fact of failing to address the succession in tenancy after the death of the mother and the subsequent loss of rent to the organisation provides a business case for better communications and engagement with residents. There were many missed opportunities to refer the occupants to other agencies or find out more about why the succession procedure was not actioned.
- Lambeth Housing should review its practices in relation to flagging the vulnerability of its residents, not least in relation to the annual Gas Safety and electrical inspections of each property. This provides an annual opportunity to assess vulnerability provided the people carrying out this operation are sufficiently trained and aware of their responsibilities to vulnerable adults. In this case the residents were deemed to be unauthorised occupants. The current position is that "***Housing do not carry out gas safety checks to properties that are in unauthorised occupation and currently have no plans to do so. If a property is in unauthorised occupation this means the council has no contract with the persons residing there and in law they are trespassers. In the majority of cases of unauthorised occupation legal proceedings to evict them will be either planned or ongoing and it is felt unlikely the council would receive the required access or co-operation to carry out gas servicing.***"

This assurance should be prepared within six months of the publication of this report and presented to the Board for scrutiny and challenge.

Metropolitan Police Service

- **Local Level – Central South Basic Command Unit Senior Leadership Team (AS BCU SLT).** It is recommended that AS BCU SLT debrief the officers involved in the investigation of the sudden death of JC (Merlin 19FOU001745) to remind them of the importance of completion and sharing of Merlin ACN reports with Adult Social Care when vulnerable adults are found living in challenging conditions. The significance of a perpetrator of domestic abuse who was a MAPPA nominal living at the address was not recognised in this case therefore the officers involved should be reminded of the importance of information sharing with the lead agency for management which in this case was the Probation Service.

- **Local Level – Central South Basic Command Unit Senior Leadership Team (AS BCU SLT)** It is recommended that AS BCU SLT debrief the officers who investigated the matters detailed in CRIS 1209073/19 to remind them of the potential of financial

abuse occurring between siblings and the importance of completing DASH risk assessments in these circumstances.

This assurance should be prepared within six months of the publication of this report and presented to the Board for scrutiny and challenge.

SLaM:

- SLaM must provide assurance as to how they respond to barriers to engagement especially where someone is unable to engage due to agoraphobia, literacy issues or communication difficulties.

This assurance should be prepared within six months of the publication of this report and presented to the Board for scrutiny and challenge.

Review Timeframe

It was decided in terms of gaining the most valuable learning, the critical time period to be reviewed was from December 2018 to September 2019 when George was rehoused and Andrew was convicted to serve a prison sentence for arson. During that time period, Michael, the eldest brother, died in the family home.

Terms of Reference

The SAR Panel identified the need to consider and reflect on the following:

1. How effectively did key agencies communicate with one another and is there evidence of joint decision making and responsibility for the case.
2. Was risk identified, assessed and managed effectively? If yes, how? If no, what was missed?
3. How do we support service users who do not, or cannot, engage with services?

Methodology

Statutory guidance requires SARs to be conducted in line with the six safeguarding principles of empowerment, prevention, proportionality, protection, partnership and accountability.

In addition:

- there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice,

- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations being reviewed
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
- Families should be invited to contribute to reviews. they should understand how they are going to be involved and their expectations should be managed appropriately and sensitively (DoH 14:138)

This review draws heavily on the principles and processes of the "Learning Together" case review process developed by social Care Institute of Expertise (SCIE). The process has been stymied somewhat by the COVID 19 pandemic and lockdown guidance.

The SAR process included:

- All agencies completing a chronology which was subsequently merged and available in this report
- The lead reviewer analysed the chronology and sought related documentation or contextual information via phone/video calls
- An online meeting of the agencies to consider the findings and subsequent recommendations
- Telephone conversations and a meeting with the trusted family friend and neighbour of the family
- The Independent Reviewer was unable to meet with George because of COVID protocols in place and was unable to meet with Andrew because of his prison sentence and COVID protocols.

Reviewing Expertise and Independence

The SAR has been led by Lynn Sellwood, M.A. who has no previous involvement with this case or any relationship with Lambeth SAR or partner agencies. Lynn Sellwood was the Chair of Bromley Safeguarding Adults Board from 2017-2020. Prior to that Lynn Sellwood had worked in Education.

Methodological Comment and limitations

- Participation of Professionals. Every professional has willingly and fully engaged with this process.
- Perspective of Family members. This has not been possible because of COVID protocols but the family friend and long-standing neighbour, Sheila, gave a full account of the events from her perspective initially by phone conversation and in person towards the end of the process. It should be noted that Sheila has great sympathy for Andrew, whom she sees as a victim in this story. She asserts that his needs as an abused child, an alcoholic with learning difficulties, who lived with a

violent father and self-neglecting mother was never given the appropriate support to achieve his best life.

Structure of the Report

In addition to the introduction the report has two main sections:

1. A detailed chronology to provide an overview of what happened
2. Findings and recommendations

Pen Pictures

George

George, (dob 1967) was born in Ireland and was brought to England as a baby with his older brother by his mother and father. There was a long history of social and emotional issues within the family which would have increased his vulnerability. His father was a violent alcoholic who died suddenly at home. His mother, in later years, was neglected; she self-neglected and refused services. The home was unkempt and in the last years of her life she did not eat or look after her own well-being and hygiene. She refused care packages and ended her life in hospital suffering from malnutrition. She had three sons, each unable to cope with the nature of the family. Michael, the oldest brother, (DOB 1963), similarly to his father, was an alcoholic, unable to cope with the normal routines of life or with the issues presented by his two brothers. He became the carer for George and had access to benefits. The youngest, Andrew (DOB 1972), also used alcohol to excess and had a history of violence. It has become clear that the brothers were very scared of the younger brother, Andrew.

George was placed in a Care Home in Lambeth during his childhood and recently has been contacted by the REDRESS scheme, the outcome of which is confidential. It has been noted by many agencies that George has learning difficulties, cannot read or write, or take responsibility for himself. Despite many agencies, including his GP, noting his Learning Disability he had never received a formal assessment of his disability until the period in question of this report. He had worked in the past as a painter, but he was attacked in the street in 2002 and as a result became fearful of leaving home leading to undiagnosed agoraphobia. This impacted his life hugely and he quickly became completely dependent on his older brother Michael. He did have a trusting friendship with a neighbour, Sheila, who tried to encourage him to leave the house and accept help. However, it should be noted that all members of the family had a history of engaging with services and seeming to accept help until the person knocked on the door when they would be ignored or chased away.

George was not in receipt of any benefits because of a lack of documentation including a birth certificate, passport, National Insurance number or bank account and was reliant on his brothers for support of the most basic kind. George had been temporarily de-registered with the GP despite the rest of the family being known to the surgery. George had been listed as

Learning Disabled by the surgery in the past. George's younger brother, Andrew, had a history of domestic incidents which often involved arguments about money and access to his mother's pension and benefits. Andrew was violent towards his brothers and was jailed for his attack on Michael with a hammer in 2013. George witnessed this violence on a regular basis and probably lived in fear of Andrew but was never willing to support any prosecution of him. The police have noted five incidents where George was a victim of Andrew's assaults between 2003-2013. It was not until the arson incident that George revealed that he had lived in fear of Andrew for most of his life.

Andrew

Andrew was the youngest sibling and had been in care at a group care home at the same time as George. Andrew was also contacted by REDRESS instituted by Lambeth. According to the neighbour, Sheila, Andrew had been the person who found the father dead in his bed and he frequently referred to that incident as a problem for him. His father was known for alcohol abuse and domestic violence. Andrew also abused alcohol and became aggressive and violent when he had had too much. The neighbour, Sheila, describes him as a lovely man when sober, eager to try and do the right thing. It has been noted by several agencies that Andrew masked his learning difficulties and was semi-literate. He was adept in covering his lack of understanding of what was required when dealing with outside agencies.

There is a familial history of alcohol abuse leading to aggressive, violent and loud anti-social behaviour. This was evident from the father and continued in the behaviour of Michael and Andrew. Andrew has a history of verbal and physical violence, including cruelty to animals in his past. He often used racist and homophobic abuse to potential carers and professionals. It is not possible to ascertain whether any of the family received help or any intervention to control the alcohol abuse. The family history suggests it would have been refused. There is a narrative of the family members seeming to agree to agency interventions in order to get people off their case and then rejecting help when it was provided, especially if it meant anyone going into the house.

On release from prison in 2018, it is evident that Andrew did not observe the licence conditions and moved in to the family home after a few days at the Assessment Centre hostel. The brothers, Michael and George, would not have been able to prevent it because he exercised control over them with his violent behaviour. Michael died at the family home after a fall. This was the second family death where Andrew was present at the discovery of the death.

Andrew has a substantial history of domestic incidents reported to the Police. Prior to 2018 there were 199 domestic incidents at the address which were alcohol related. Often they were disputes about money, particularly the use of the mother's pension. It seems that Andrew exerted a great deal of power within the family. The incidents which caused the police to be called were often about money and who had control of it. There were at least two incidents whereby Andrew accused George of keeping the mother's pension money. The police note that George was seen as a victim of Andrew five times between 2003-13. Andrew attacked his older brother, Michael, with a hammer in 2013 for which he served a five year prison sentence. It is notable that police incidents at the home address were non-existent while Andrew was in prison. It is evident that Andrew exercised coercive control within the family and the fear of him prevented the brothers from supporting any prosecution.

Being in control of money was a source of argument between the brothers. After their mother died it seems there was no succession in tenancy concluded. As a result considerable rent arrears mounted. Andrew was convinced that George was keeping their dead mother's pension. This was never investigated.

Andrew had attempted suicide while in prison in 2016 and was moved from prison to a psychiatric setting. He was clearly violent when he used alcohol and had a traumatic family history of death. He was very concerned about the failure to bury his mother in good time. The neighbour, Sheila, had a good relationship with Andrew and describes him as a good man when sober but easily overwhelmed by demands on him of a bureaucratic sort which would expose his inability to read and understand what was required of him.

Timeline and Merged Chronology

Please note that this is very detailed and demonstrates the weight and frequency of agencies' interventions with both brothers.

December 2018

27/12/18 MPS received information from the Prisoner Intelligence Notification System (PINS) that Andrew would be released on licence from prison on 28/12/2018. This was recorded on a Police intelligence report.

28/12/18 MPS received a further Intelligence report to reflect Andrew's release from HMP BRIXTON following his conviction for GBH on his brother, Michael. A copy of his licence conditions were attached to the report. The licence stated that Andrew must reside at an address approved by his supervising probation officer but this address is not specified on the licence.

Comment: Making a copy of the licence conditions available for all officers to view is good practice as these cannot be replicated in full on the PNC. The address to which Andrew was being released was not recorded on his licence. This is common practice as an offender may change address during the course of the licence period.

28/12/2018 – NPS noted Andrew released from custody subject to licence. Placed in Bed and Breakfast accommodation on day of release prior to placement in Lambeth Assessment Centre. Andrew was assessed as MAPPA Category 2 level 1 which meant he was not subject to inter-agency review or discussion.

Comment: this decision, with hindsight, may well have contributed to the lack of oversight of Andrew and his compliance with the terms of his licence. There is no mention of the Prison Navigator passing on Andrew's mental health history.

January 2019

03/01/19 – NPS notes Andrew attends Stockwell Road for supervision, confirmation that he is living in the assessment centre, has a job centre appointment and has arranged to start

the process for claiming benefits. Discussion about Andrew trying to confirm where his mother is buried as he was not informed about her death whilst in custody.

Comment: It is suggested by the neighbour, Sheila, that Andrew had been informed of his mother's death.

09/01/19 – NPS Andrew attends supervision which focusses on not contacting his family without approval and practical support for his current situation.

15/01/19 – NPS Andrew Attends supervision – focus on support.

21/01/19 NPS Management oversight on the MAPPA assessment to address the information about the family and possible safeguarding concerns regarding contact with the family.

22/01/19 – NPS Attends supervision – no evidence of family contact since release

29/01/19 – NPS Supervision appointment – focus on employment options

February 2019

01/02/19: ASC Social worker attempted to contact George's brother, Michael, and was unable to contact him because his number was unobtainable. However, a message was left on his neighbour Sheila's mobile phone voicemail, asking her to contact duty for an update on the George's condition.

05/02/19: NPS Andrew attends supervision appointment – focus on family history including repeated behaviours such as alcohol use

19/02/19: NPS Supervision appointment. Andrew was seen by another colleague in his own PO's absence – still awaiting his benefits and reliant on foodbank and assessment centre support whilst not working.

26/02/19: DWP: Andrew made a claim to Universal Credit at Stockwell Job Centre, his ID was verified by a biographical appointment on the 28th February 2019. His bank details were verified at the same time with details of his name. Getting personal budgeting support was discussed, and he declined. At the appointment his work coach was informed he had a support worker, and that the phone number being used on the claim was the support worker's as Andrew did not have a phone at this time. The support worker's details were also placed on the claim. Andrew was highlighted on the claim as being vulnerable, especially as Andrew was bereaved and an ex offender, and as his brother had passed away.

26/02/19: Police were called to the property by the London Ambulance Service (LAS) to assist with a report of a person collapsed. This was followed by a second call from LAS at 14:20 hours reporting an unexpected death. A further call was made by the LAS at 16:49 hours requesting an estimated time of arrival (ETA). Due to a high volume of calls officers were assigned at 17:37 but did not arrive at the address unit 18:13.

Comment: It appears the first CAD was closed as there were no units available to attend but with a request for LAS to notify police if the matter related to an unexpected death. The call was graded S[1] which means police should attend within an hour however the due to competing demands police were unable to meet this target. None of these CADs record the name of the deceased person but a MERLIN was created.

Once on scene police spoke with Andrew about what had happened. He explained that Michael, the deceased, had been fine the night before. He said Michael had watched the football match and then went to sleep. Andrew said that Michael and George slept in the same room and at some point during the night George reported Michael had fallen out of bed and hit his head on the fire place to the right of the foot of the bed. It was also recorded that in the days prior to this Michael had been vomiting up blood. It was reported that George helped Michael back into bed.

Andrew said he and George got up as usual the next morning and Andrew left to go to the Job Centre. George remained in the house until Andrew returned home at about 13:30 hours. George told him that Michael had not moved since but Andrew dismissed it and said Michael was sleeping. A short time later they checked Michael over and when they could find no pulse, Andrew ran across the street and to their neighbour, Sheila, and informed her of this. She called for the LAS and Andrew said he started chest compressions but soon realised this would not make a difference as Michael was deceased.

The death was initially thought to be suspicious and detectives from the Criminal Investigations Department (CID) attended and spoke to the brothers. Andrew said Michael had been in hospital about two months before and has had carers but refused their help. Andrew said that over the previous few days Michael kept saying that "his time was up". After a survey of the scene, an examination of Michael's body, gaining witness accounts and the completion of local enquiries, it was determined that Michael's death was unexpected but not suspicious and the scene was closed.

Comment: the MERLIN found report records the enquiries undertaken which led to the decision to determine Michael's death as non-suspicious. The IO included a summary of intelligence concerning Michael and the issues of domestic abuse within the family. The attending officers made comment on the poor state of the premises but there is no indication that they identified either George or Andrew as vulnerable. It does not appear consideration was given to the completion of a MERLIN Adult Coming to Notice (ACN) report to highlight the brothers' living situation to Adult Social Care or the Housing department.

Comment: It appears from Andrew's statement that he was living in the family house contrary to his conditions of release.

28/02/19: DWP the work coach tried to contact Andrew's support worker, with no luck and a voicemail was left.

March 2019

01/03/19**:** ASC - The neighbour, Sheila, contacted duty to report concerns about George and the lack of heating in the property. She also advised that his brother Michael died on Tuesday. George's case was on the waiting list with the Integrated Disabilities Service (IDS) and so IDS agreed to prioritise it.

01/03/19 - 24/04/19**:** ASC - repeated attempts by IDS duty workers to get hold of George, neighbour, and brother. Voice messages left.

01/03/19: DWP the work coach spoke to Andrew's support worker by phone who stated that Andrew was no longer living at the address provided on the claim and didn't understand why he was using it. It was discussed that Andrew may be rough sleeping and using this address as a residence address.

01/03/19: Housing Repairs Manager informs Neighbourhood Housing Officer that Surveyor has reported that the tenant of said property was deceased and two sons with special needs were occupying the property.

04/03/19: NPS Andrew attends the office unplanned to inform his PO that his brother Michael has passed away and he was informed by a neighbour as George does not engage with him. Andrew felt responsible for trying to organise the funeral without support from other family members.

Comment: Andrew was not telling the truth here (see MPS notes 26th February)

04/03/19: NPS Review of MAPPA level to remain as level 1.

Comment: What evidence and verification did NPS use to maintain MAPPA level 1?

14/03/19: DWP Andrew attended Stockwell Jobcentre and insisted he did live at the address held on the Universal Credit System. The work coach called the support worker while Andrew was present. The support worker reiterated that Andrew no longer lived at the address, and that he was offered a room, but Andrew refused it and was very abusive. The support worker explained he kept the room vacant for Andrew for an extra 5 days, but Andrew came back and still refused it. The work coach offered to help Andrew with changes on his Universal Credit account, Andrew was abusive, impatient, and walked out saying he was going to make a claim in another jobcentre.

15/03/19: NPS Andrew attends the Probation Office to inform that he has moved address, his PO was not available so significance of new address being the family home is not recognised. He had continued to reside in the assessment centre until this point.

Comment: NPS believed Andrew that he was living at the Assessment Centre, there is no evidence of verification or enquiry about his address.

19/03/19: NPS Andrew informs PO that he has moved back to the family home due to the death of victim of the index offence, his older brother Michael. Stated that he had moved back to care for George as the tenancy had not been transferred from the mother's name and the local authority were prepared to transfer the tenancy to Andrew who wanted to support his brother.

19/03/19: NPS Management oversight on the case to complete checks with the relevant agencies regarding the care for George.

27/03/19: MPS 22:30 hours - Andrew called police to report that he believed George was keeping his mother's money from him and this had caused a disturbance. Police attended and found Andrew outside in the street. George was spoken to and stated it was just a verbal argument and was not a domestic incident. Officers stated Andrew was agitated and became aggressive. He would not listen to officers when they tried to calm him, he stated he had a knife. He was placed in handcuffs in order for officers to search for the weapon. He continued to shout racial and homophobic abuse at the officers and was arrested on suspicion of committing offences under Section 4A of the Public Order Act. No weapon was found. Officers commented that Andrew repeatedly spat at them and continued to behave in an aggressive manner when he arrived in custody.

29/03/19: NPS Andrew Appears at Camberwell Magistrates Court for the offences of Racially Aggravated Harassment x 2 against Police Officers.

April 2019

01/04/19: MPS Andrew was charged with the offences and remanded to appear at court where he was sentenced to a Community Order with an unpaid work requirement of 80 hours for both offences.

Comment: Officers determined that this matter did not meet the criteria to be recorded as a domestic incident and therefore no DASH[2] risk identification checklist was completed. This may have been a missed opportunity to identify the financial abuse later reported by George. It is noted that had officers completed the required five year intelligence checks in domestic abuse cases they would not have found records of any such incidents within the time period as Andrew had been in prison throughout. It is apparent that Andrew was the predominant cause for such disturbances in the family prior to that.

Comment: there was no check to discover the mother had been dead since 2016.

01/04/19: DWP Andrew's claim was closed.

01/04/19: NPS decision to issue a Head of Service Warning letter, the last warning prior to recall action being taken as Andrew was convicted of Racially Aggravated Harassment and subject to a Standalone Unpaid Work Order (UWP) of 80 hours. Andrew was sentenced to 80 hours Unpaid Work (UPW) for the new offence. Offence linked to George storing the mothers' pension money and not placing the money in a bank or changing it over to the new

notes being circulated. Andrew was angry and phoned the police but was frustrated at the response and abusive towards the officers. Andrew to be referred for counselling regarding the bereavements he has suffered.

Comment: No check to discover reference to mother's pension given that she had been dead since 2016. No enquiry as to whether the brother George was vulnerable to Andrew's violent outbursts.

02/04/19: NPS Andrew attends supervision appointment and discussion about his recent behaviour linked to his brother and the financial situation. Review of his circumstances and checking what coping strategies are in place.

02/04/19: MPS received a PINS notification detailing Andrew's release from prison on 01/04/19: following his conviction for the public order offences. This was recorded as information report for intelligence purposes.

02/04/19 MPS: At 11:20 hours Andrew called police to report that George was keeping his mother's pension. He also asked the call handler if he could have money to go to Thameside prison to collect his property. When offered an appointment for police to attend and take details of his complaint, he declined and said he would go the Brixton police station to report directly.

Checks were made over the next 24 hours and when no record could be found of a corresponding CRIS report, Andrew was contacted by phone. He stated that he did go into the police station but did not have a reference. Andrew claimed the matter had been resolved and did not need police to attend however the call handler stated as the report was a domestic incident a report must be completed. Andrew said he was busy and couldn't attend. There were repeated unsuccessful attempts to contact Andrew to complete the report before the CAD was reviewed by a supervisor who noted the matter was a dispute over money and not a domestic incident. The matter was closed with the comment "*No information to suggest there has been any wrongdoing by the brother taking the mums pension*".

Comment: It does not appear that it was identified that Andrew's mother was deceased and therefore there could have been potential offences if a pension was being fraudulently claimed.

04/04/19: Housing. The two sons George and Andrew meet staff at Streatham Housing Office to apply for succession of the tenancy. Succession authorised by Head of Neighbourhood Housing. As there was no Neighbourhood Housing Manager for Norwood at the time, the Neighbourhood Housing Manager for Clapham was asked to action the succession on the Housing Management System. There was a discussion about which of the two brothers should succeed. It was decided that it had to be Andrew because he was the only one capable of managing a tenancy.

Comment: No check made to discover George's vulnerability and whether he was agreeable to the decision.

08/04/19: DWP Andrew made a reclaim for Universal Credit under the address of his family home, this put him in the Streatham Jobcentre. As this was a reclaim he did not need another Biographical appointment, he needed to attend with evidence of his bank details and a fit note outlining his needs. A hand over with a work coach was completed.

15/04/19: NPS Andrew started to produce medical certificates indicating he was unfit for work and unable to complete his UPW hours or attend his appointments due to chest/lung problems.

15/04/19: NPS MAPPA J form sent to the Job Centre which is used to inform the Job Centre staff of claimants within the MAPPA criteria which may impact on potential employment.

17/4/19: GP Andrew attended GP for an upper respiratory tract infection for which he was given a medical certificate

24/04/19: ASC Duty works to gather background information about George. Spoke to Upper Norwood Surgery and they indicated that George was no longer a patient at the surgery, and they had no access to his medical records.

Comment: There is some confusion as to why George had been de-registered. It has been suggested it was an administrative error and was rectified.

25/04/19: ASC Two practitioners from Integrated Disabilities Service carried out an unannounced welfare visit and met with George and his brother Andrew. State of the property noted as severely neglected and primary concern was about George and Andrew having no access to money. Several immediate actions taken including provision of food vouchers.

25/04/19: ASC Referral made to Every Pound Counts (EPC) Team as allocated social worker noted George had no bank or post office account, was not in receipt of any benefits, had no formal ID, and concerns they were in rental arrears.

25/04/19: ASC Email to Lambeth Housing/Repairs sent requesting urgent follow up to address state of property. Also, to clarify position with name on tenancy.

26/4/19: Andrew attended GP for the same on-going cough symptoms for which his medical certificate was extended.

30/04/19: ASC Feedback from EPC Manager, who had reviewed records and suggested that given Andrew's forensic history including stabbing of George in 2003 (the assault on Michael was with a hammer in 2013) that it was not advisable for him to become the appointee for George. George has no access to funds, no ID, no bank account, no NINO, no history of Housing Benefit. Agreed that a Mental Capacity Assessment for finances needed. It was suggested that a safeguarding enquiry be opened which would enable enquiries to be made with DWP about the brothers. An urgent Universal Credit application was needed, and this could be paid as an exceptional payment in the absence of a bank account.

Comment: George revealed he had been stabbed by Andrew in the past and showed the scar to the EPC staff member on his torso.

30/04/19: ASC Discussion held with Team Manager and agreed that a Safeguarding Enquiry process under self-neglect should be undertaken in response to all the concerns raised.

30/04/19: ASC Contact with DWP to request support to claim Universal Credit and PIP as no known account, NI nor ID. Situation was urgent.

30/04/19: ASC Email sent to Housing Income team to ask them to confirm arrangements to succeed tenancy and status of rent arrears.

May 2019

01/05/19: DWP Received a phone call from Every Pound Counts (EPC) making Work Coach aware of Andrew and his circumstances including his brother George and deceased brother Michael (main carer of both and household before he passed). An explanatory email with the full details was requested.

01/05/19: DWP Andrew attended his appointment with the Work coach, Andrew was pleasant and very grateful for the help he was receiving. The Work Coach explained that this appointment would verify his details and make sure he receives a same day advance and a food bank voucher. Andrew had his own mobile phone and phone number. Andrew then explained the bereavement of his brother Michael on 26/02/2019 and his mother the previous year. He explained that he needed help with funeral costs. Andrew was provided with a funeral fund application and bereavement fund application. He took these forms to go back to Every Pound Counts to ask his support worker to help him fill out the forms and he agreed. Andrew was asked about how he felt about looking after his brother George and if he felt he was able to. Andrew explained that he could look after him emotionally but not financially and needed help with this. He explained the George did not leave the house, which made this easier for him. Andrew also said that George was able to leave the house but only to buy cigarettes. Andrew was asked about where he received the money for this, Andrew said his deceased brother Michael would give them both money and paid the rent. A request to backdate Andrew's claim, with details of why the claim was not started earlier was issued. Andrew then left satisfied and was thankful for the help. Andrew's work responsibilities (commitments) were switched off due to having a fit note and being an unofficial carer for George.

An email was sent to Every Pound Counts to make them aware of the appointment being completed and what help had been provided. EPC replied with thanks but wanted to know how George's claim was progressing.

01/05/19: DWP Andrew went home and spoke to George requesting he make a claim for Universal Credit and Personal Independence Payment. He then spoke to EPC who sent an email to explain that George became agitated when this was proposed to him. EPC requested that Andrew become George's appointee.

Comment: George was unlikely to respond to these demands because of his inability to read and write.

Comment: Why was no link made between Andrew's arrest and conviction for the GBH assault on Michael with his abuse of George and allegations of financial impropriety over mother's pension?

01/05/19: ASC Call to George's brother, Andrew to explore actions needed to access benefits for both himself and George. He claimed no one helped apply for benefits before or after leaving prison. He made an earlier claim for UC at Stockwell Job Centre because when he left prison, he was living in a hostel nearby. He lived there for a few months then moved into family home when brother died. The claim made online in Stockwell Job Centre was closed as he had difficulties providing information. DWP closed the claim and told him he had to start the claim process again. Andrew reported he went to housing office today but was told the officer is off sick hence still unclear what the position is from housing. There is no food or gas in property.

Extensive support and information provided by EPC service around benefits, funeral grant and Housing to Andrew although it was noted that he became easily agitated and agreed he can become angry when things are not resolved quickly.

Comment: Andrew is not telling the truth about his residence on leaving prison

01/05/19: ASC Lambeth Housing Team confirm there is no active rent account in the names of the brothers. The rent account belonging to the deceased mother was closed Aug 2017 which had credit of £60.00.

Confirmed that there was no use and occupation account in any of the brothers' names. A succession document from 2017 on file asking for documents to proceed with succession but was never followed through.

02/05/19: ASC Correspondence with Housing which indicates arrears of £12,080.05 written off. Also, that agreement that Andrew will succeed the tenancy and that someone will be assigned to see how to support them to downsize. Confirmed repairs will be followed up.

02/05/19: Housing actioned the succession to transfer the tenancy to Andrew on the Housing Management System.

03/05/19: DWP sent a referral for Andrew to become George's appointee for a Universal Credit claim, this was so that Andrew could make a claim for George on his behalf. On the same day was sent a referral for a home visit be conducted for a Work Coach to complete a pre claim for George.

03/05/19: Housing informed the Principal Income Officer, that Andrew would be signing to accept the succession that day. PIO asked Every Pound Counts Manager in Adult Social Care for assistance with downsizing the property as the two brothers were under-occupying the three-bedroom property. PIO also advised the Housing Welfare Solutions Team that the brothers may require assistance with bedroom tax due to the under-occupation. EPC asked Lambeth Housing if the succession could be a joint tenancy between Andrew and George because George had an appearance of having a learning disability and/or mental ill health but Adult Social Care had yet to complete a capacity assessment to determine whether he had a learning disability. However, it was noted that succession cannot be a joint tenancy, the tenancy can only be granted to one of the qualified persons who is able to succeed.

15/5/19: GP - Andrew developed a painful lump in his chest. He was given a medical certificate.

21/05/19: ASC - Follow up with DWP regarding the status of benefits.

22/05/19: Housing - EPC advised Housing that Discretionary Housing Payment had been awarded and asked why Andrew had not yet signed to accept the succession. Housing advised that Andrew had failed to attend an appointment at 11.30 on 21 May 2019. Housing

also explained that he had tried calling Andrew and his phone was always busy but he would keep trying. EPC informed Housing that Andrew was keen to assist with getting repairs done but he was aware that there may be difficulties securing the cooperation of George.

23/05/19: Housing: Housing Support Officer in the Housing Welfare Solutions Team informed Housing that he had spoken to Andrew and referred him to the Lambeth Tenancy Support Service contractor, Single Homelessness Project, for floating support to help with claiming Council Tax Support. Housing Support Officer let Housing know that he had asked Andrew to get in touch with them to sign the paperwork, but he was not sure Andrew would as he seemed a bit confused. EPC also informed Housing that she had asked Andrew to contact them as well and would be inviting Andrew to Lambeth Civic Centre to help him claim Personal Independence Payment for George. EPC also shared the impression that Andrew may himself have some learning difficulties as he seemed to have difficulty explaining and understanding more complex information although Andrew did not acknowledge this. EPC explained that staff needed to check Andrew's understanding otherwise he often misunderstands what has been explained and the actions he needs to take. EPC also informed Housing that Andrew was very stressed by the difficulties he is having with George, particularly the challenges George is presenting with regards to him not been willing to engage with Housing or Benefit services.

Comment: Andrew's Learning Difficulties could account for his stress and agitation

23/05/19: ASC Andrew called stating he felt stressed and finding it challenging to support George who refuses to engage with support offered or sort out his own benefits. IDS confirm with Andrew that he is still able to continue to support George until a social worker can visit to do a further assessment.

23/05/19: MPS Andrew called police to report that his neighbour had called him names and told him to cut the grass. He was advised that this was not an offence, but the call handler also noted that Andrew sounded as if he had a learning disability. The CAD was passed for the attention of the Gipsy Hill Safer Neighbourhood Team (SNT). A tasking request was completed for SNT officers to call with Andrew at home to discuss the issue.

Two Police Community Support Officers (PCSOs) called to property the next day but did not get a response. They reported that they spoke with a neighbour and said they would speak to the council. A contact card was left at Andrew's address requesting he contact police. There is no record of him responding to this.

Comment: the PCSOs did not record which neighbour they spoke to or the nature of what they intended to report to the council.

30/05/19: DWP the home visit was conducted, Andrew became George's appointee and with the information gathered for the pre claim, George's claim was able to be made.

June 2019

04/06/19: NPS Andrew attends a supervision appointment looking ill and malnourished and has an appointment with Croydon University Hospital on 19th June 2019. States he has officially been made his brother's carer and in receipt of an independent allowance.

Discussion of family circumstance and no indication of increased risk to George or that of Andrew.

Comment: How was this assessment made? Was any verification sought?

07/06/19: NPS OASys review undertaken, and risk of harm posed reduced to medium meaning that there is still a risk of harm but it is unlikely unless there is a change in circumstance such as increase in alcohol/drug use or loss of employment.

09/06/19 DWP another home referral was made to complete the initial evidence needed for the claim to progress regarding identification evidence for George

11/06/19 DWP Both Andrew and George were referred to the manager Disability Employment adviser, who sent an email to EPC asking if it was appropriate for Andrew to be George's appointee, and if it would not be better that George received a corporate appointee. It was also asked if there was a social worker or GP involved. On the same date EPC explained that Andrew was finding hard to navigate both claims and would need more help, that Andrew left school without getting any academic qualifications and reports he did not really engage with secondary school. EPC said that there was no one else to be George's appointee, and Andrew would have to do it. George did have a social worker.

12/6/19: GP Andrew complained of stress issues especially with regard to caring for his brother. His sick note now reflected this stress instead. He was signposted to mental health NHS contacts.

17/06/19: DWP George's claim was started and was under Stockwell Jobcentre.

18/06/19: ASC Case allocated to a Social Worker who contacts NPS to get background on Andrew before visiting the property alone as a female worker. Probation officer advises she has not been to the property.

19/06/19 Health Authority requested to remove George as he had moved to another Health Authority.

19/06/19: ASC Allocated social worker chases Housing about the repairs work.

19/06/19: ASC Case discussed in supervision. Agreement for a letter to be sent to invite George in for an assessment.

Comment: No evidence that SW was aware of history of George's agoraphobia

24/06/19: ASC Contact with GP surgery who advises George is no longer registered. Allocated social worker raises concern explaining that as he has agoraphobia, this may have been the barrier to him accessing health care. She explained that George's mother and brother who were his carers have also died and he needs to be seen by a GP. Escalates the situation by requesting a discussion be held with the practice manager.

28/06/19: ASC Contact from Andrew very upset and threatening: 'being sent pillar to post' has had enough and stated 'if someone pushes me too much I will seriously hurt someone - do not push my buttons, you do not own me - you are not my mum or dad'. Joint visit arranged with male social worker.

28/06/19: NPS Andrew failed to attend the thinking Skills Programme induction.

July 2019

04/07/19: ASC Email sent to NHS Integrated Commissioner regarding GP situation to request support with the case.

8/7/19: GP Andrew wanted to extend his sick note regarding the stress of caring for his brother.

10/07/19: ASC receive confirmation that a Support Officer from SHP (Tenant Management Organization) was working with both brothers to support with arranging the funeral for their brother

12/07/19: DWP George was awarded Personal Independence Payment

12/07/19: Housing: Social Worker in Lambeth Learning Disabilities Service, advised Housing that repairs to the property were required due to damp, mould and other structural issues.

15/07/19: ASC Referral of George to Living Well Hub (Mental Health Service) to request support with the case

15/07/219: ASC Allocated Social Worker sends 2nd Email to CCG to request update on GP involvement

15/07/19: SLaM Email re- referral to Living Well Hub (LWH) part of Lambeth Alliance, referral made by social worker Lambeth Learning Disabilities Team, Adults & Health. Referral content: Confirmed he was under the care of the LD team and went onto to express concern that he was agoraphobic and not left the house for a number of years. Documented he did not have a GP due to move in GP catchment area. As a consequence, expressed concern he was not getting fit notes to enable him to claim benefit. Home requires repair and may need to move in meantime causing psychological distress. Asked for additional help.

Comment: LWH requested clarity in initial referral. The Living Well Hub was the "front door" to Mental Health Services.

17/07/19: ASC Allocated Social Worker emails Head of Service to request payment to obtain a Birth Certificate for George (as lack of identification is causing issues in obtaining benefits)

18/07/19: ASC Home visit carried out with two social workers. Allocated Social Worker completes a Carer's assessment with Andrew. Issues with George accessing benefits means relying on Andrew's benefits. Food vouchers continue to be provided by ASC. Electricity due to be cut off.

18/07/19: ASC Allocated Social Worker follows up with British Gas and arranges for emergency provision.

18/07/19: SLaM Referral received, and acknowledgement sent to referrer.

19/07/19: ASC Allocated Social Worker Contacts Housing to get an update on repairs situation, to request bedroom tax be waivered and for case to be escalated due to delays.

19/07/19: ASC Follow up email to Lambeth CCG regarding GP situation. Concern raised that GP surgery having discharged George from their care, should have transferred George to an alternative GP practice.

19/07/19: SLaM Referral discussed in screening meeting – acknowledged Andrew known to service briefly in 2018 and discharged. Documented that George states he does go out but not past the front gate. He gets palpitations – goes out into the back garden. Carers views obtained - Documented that his brother Andrew lives with him but he is limited in terms of leaving area for any amount of time as this would leave George without food – Andrew has only recently been released from prison. Diagnosis – no formal mental health diagnosis.

22/07/19: ASC Liaison with Funeral Services and Andrew regarding the payment for funeral and arrangements.

22/07/19: SLaM Email to referrer informing them that the referral be rejected. Reason provided is that LWN is a short term service and as George is open to the Learning Disability Team, he has a social worker who could follow up on the interventions required for instance registering with GP, liaison with council in terms of housing repairs and access to benefits. Email recommends that learning disability follow up on Agoraphobia and social inclusion issues.

Comment: A phone call might have been useful at this point

22/07/19: SLaM telephone call to LWH to state that George had been agoraphobic for 20 years and perhaps would benefit from a mental health assessment and regular support with this condition. Advised her to email back so he and a colleague could consider whether a mental health assessment was required with a mental health clinician.

22/07/19: SLaM Revised referral form emailed back confirming need for Mental Health Assessment for George and that he would be unlikely to leave home to attend appointments. It was pointed out that he would not be eligible for Mental Health Learning Disability Team as he does not have a diagnosis.

Comment: some confusion about what is being requested.

23/07/19: SLaM decision to arrange home visit with social worker in order to ascertain mental health needs and report back to the team.

Comment: Good inter-agency working in terms of joint visit to assess.

25/07/19: GP asked to review George by his social worker in regard to physical and mental health. This was carried out at home with his brother (Andrew) present. The house was run down and unkempt but not cluttered. There were no acute concerns with regards to his mental health though it was understood he suffered from Agoraphobia. There were no acute concerns with his physical health aside from a poor diet and occasional cigarette and alcohol use. It was arranged for routine bloods to be performed. At this point George agreed to attend surgery for this, and Andrew said he would attend with him. It was felt that George had capacity to make decisions with regards to his health and after establishing a rapport with him it was believed that he and his brother intended to come to the surgery for an appointment.

Comment: No awareness of possible coercive control

25/7/19: GP another sick note covering Andrew's stress was given

26/07/19: ASC Social worker spoke with Andrew who confirmed that GP from Upper Norwood Surgery visited the home yesterday and did a health check with George. Left forms to enable registration.

Comment: No check on literacy skills

29/07/19: ASC Initially refusing referral and challenge made by ASC regarding this, Mental Health confirmed they have accepted the referral and a CPN has been allocated to George.

29/07/19: LWH Community Psychiatric Nurse emails Social Worker to request convenient time to undertake a joint home visit for following week

31/07/19: LWH Telephone call between CPN and Social worker to ascertain further information – not been seen by GP since 2003, had two brothers who cared for him at home following death of his mother. One brother died previous year. Now only one brother who is now main carer for him and he had recently been released from prison- home visit arranged for 18.8.19 agreed a more detailed report to be emailed in preparation for visit.

Comment: Good liaison and communication between agencies.

31/07/19: LWH: CPN emailed report stating that George was possibly on the autistic spectrum. George over-estimates his abilities as a defence, particularly in relation to rationale for not leaving the house. He also states he lacks capacity to manage his finances.

Comment: Useful information about possible Autistic spectrum provided but significance of information really does not appear to have been explored.

August 2019

02/08/19: ASC Allocated social worker spoke with Andrew to inform about the appointment with the Living Well Hub (Mental Health Service) on Thursday 8th August, 11am.

05/08/19: ASC EPC Team Manager contacts DWP Local Lead to request a case conference to discuss the issues of the case with the view of identifying best way forward. (This was particularly important given neither George or Andrew could engage in many of DWP's processes.

Comment: the stress of not being able to comprehend the system or having the means to access it, given the two brother's semi-literate status, has been underestimated here.

07/08/19: ASC Probation officer contacted ASC to inform that Andrew is on license and a community order, he has not been complying by not attending appointments and is at risk of being recalled back into prison. PO is aware that Andrew has been caring for his brother, however the courts will not look kindly at this if he continues not to attend. Request for info be sent about his caring role/tasks.

07/08/19: DWP Home referral was conducted, George's identification was verified by a biographical appointment and bank details were under Andrew.

07/08/19: NPS Andrew attended for supervision. Confirmed he continued to reside with George and gave the contact number for George's social worker. NPS and SW discussed the current arrangements with Andrew being a carer for George and supporting his day to day living needs. NPS explained that Andrew was subject to licence and the requirement to complete his UPW hours. Requested that Adult Services provide more support to the family to enable this to happen. A meeting between SW and Andrew/George was planned in the future to discuss a way forward.

07/08/19**:** ASC Social worker sends information to Probation Officer as requested (excerpt below)

Thanks for you call yesterday. As discussed, Andrew has been caring for his brother George who has the following difficulties.

- *Andrew supports his brother by maintaining the tenancy, paying bills and expenses, financial assistance, shopping for Andrew.*
- *His brother George has agoraphobia, therefore has been unable to leave the house for approximately 20 years.*
- *George is completely dependent on Andrew for support him with all his needs outside of the home.*
- *He was supported by their late brother Michael who died in February 2019.*
- *George is unable to use a phone and does not have access to a bank account*
- *George has a learning difficulty and possible learning disability which has not been formally assessed.*
- *Both are care leavers and were under children's services living in group homes.*
- *Social worker supporting George to receive benefits so that he can have access to an income.*
- *George will now be receiving support from the GP and Living Well Hub, along with the Learning Disability Service*
- *Andrew has also been trying to make arrangements for their late brother to have a funeral. Michael died in February 2019*

08/08/19: ASC Housing confirm with ASC that repairs assessment/follow up visit scheduled for 15/08/2019.

08/08/19: SLaM Home visit LWH and SW. George is seen with his brother and a neighbour, Sheila. George is described as quite thin and wearing oversized clothes. George does not know how to use mobile phone or computer. History taken/information obtained – was in care as a child, worked as a painter -decorator then stopped work to care for his mother who died 2 – 3 years earlier. 20 years ago he was attacked and robbed in the street and he has been unable to leave the house since this event. Has not claimed benefit and has no ID. Social worker has been liaising with DWP to get benefits issue resolved – home visit by DWP has occurred. Neighbour, Sheila, has been helping out with food and bills.

It was documented that it was difficult to ascertain his needs and George appeared to have difficulty understanding questions he was asked- he reported hearing his deceased mother and brothers' voices in the house. Wants to go on holiday. Plan: to look at befriender or volunteer.

Comment: Useful to have the neighbour present as an advocate or intermediary but professional curiosity not fully demonstrated in the documented assessment. A fuller account of his mental state and formulation would have been useful. It may have been useful to assess George alone at a future date to avoid any potential for pressure from family member. Carer assessment not covered in the documentation of the assessment. This may well have been offered by Learning Disability team

8/8/19: GP informed by the Social Worker that although agreeing to attend surgery for blood tests, in reality it would be difficult for George and it would be unlikely he would attend. It was arranged for District Nurses to do a home visit to take the blood tests. There was a discussion about George's agoraphobia. The GP was informed that Living Well Hub was helping him in regard to this. The DN referral was made by email but it is not clear why the bloods were not carried out. It is possible George refused blood tests or he wasn't at home when the District Nurse attended is not clear.

Comment: DN's do not provide feedback on failed referrals. As such, this was not highlighted until the patient was in the surgery on 28.11.2019.

12/08/19: DWP- An email was sent to EPC to assist Andrew in reporting his housing costs for the property he lived in. It was important Andrew received the right amount of housing costs because the amount of bedroom tax percentage was incorrect. Andrew only put himself down as living in the accommodation. The house was still under the mother's name and this had to be changed. The house was 3 bedroom, which meant Andrew would have had to pay for 2 spare rooms. It was changed to 1 spare room. This was rectified when Andrew put George down as a non-dependent.

Comment: Andrew would have been unable to fully comprehend the forms given his reading difficulties.

George's Social Worker was asked to send information regarding George's needs because his claim reported his health condition as an appendix and this would not have qualified for a work capability assessment. EPC met with Andrew on 14th August 2020 to complete Andrew's housing change and George's health conditions on that claim with direction from us over email.

13/08/19: LWH: Consent to share information form.

Comment: Obtaining consent - good practice

13/08/19: LWH CPN emails Social Worker to check if referral to SAIL/Age UK (an advocacy service) had been made. It was documented that they would be able to support him in getting out on a longer term basis.

Comment: this seems a rather inadequate solution to a rather complex set of circumstances given the history of refusing services and agoraphobia

14/08/19: LWH Social Worker replies to state he has not been referred to either agency named above.

14/08/19: LWH CPN emails Social worker to confirm she has referred George to SAIL who will be able to provide support with befriending, learning, lunch clubs, group activities, meeting new people and access to transport. Closed to LWH on grounds that no clinical input required and he has refused clinical input.

Comment: No evidence that assessment indicated what clinical input was required or that he was offered any.

23/08/19: NPS information requested from the GP regarding Andrew's health due to the continued production of sick notes that he is unable to work.

23/8/19: GP letter from Probation Officer requesting GP to ascertain duration/prognosis of the reasons for his sick notes

24/8/19: GP letter from surgery to Probation Officer with chronology of events. The surgery was unable to give an idea when his stress symptoms would resolve and therefore uncertain of any prognosis.

September 2019

03/09/19: NPS Information from the GP stating that Andrew's chest/lung issues had been resolved but no time frame for the resolution of the stress symptoms

4/9/19: GP sick note written for Andrew (ongoing carer's stress)

18/9/19: GP reviewed for chesty cough, treatment was given to Andrew

25/09/19: ASC EPC officer follows up Council Tax credit claim

30/9/19: GP sick note written for carer's stress for Andrew who reported support from social worker

October 2019

01/10/19: NPS Andrew completed the pre- group work for the thinking Skills programme.

04/10/19: ASC Allocated social worker speaks with Andrew who was being helped to upload evidence needed for the council tax claim of £400. EPC is looking into this and has put a hold on the claim. Andrew informed that he has received another letter from the rent department stating that there has been a failure to pay the rent and are in £133 arrears. Advised Andrew EPC would be contacted. - Email sent to EPC. Agreed a home visit to see George and Andrew on Wednesday 9th October, 2pm with colleague.

07/10/19: ASC Allocated social worker receives a telephone call from Andrew who feels he can't cope with the benefit application process (upset with regards to having numerous calls

from PIP). He informed that he cannot cope with having lots of calls from different people and he does not want to be a carer for his brother George anymore. Also, he does not want to receive George's payments into his account anymore. Social worker confirms they can explore other arrangements when she visits on Wednesday 9th October.

09/10/19: ASC Allocated social worker carries out visit with a colleague. Notes highlight this was a challenging visit and George was insisting on going back to Ireland.

10/10/19: ASC Contact made by REDRESS Scheme officer to follow up with both brothers given their history in local care homes (*outcome of this is confidential).*

15/10/19: ASC Allocated social worker contacts neighbour Sheila to get an update on how things are going for George and Andrew. She reports George has visited her a few times asking for food. Sheila confirmed Andrew is agreeing for a carer to support George although concerns George will not let them in. Sheila has been trying to take George out shopping in Crystal Palace with her as a way of getting him out.

15/10/19: ASC Adult Social Care Panel agrees funding for George to receive a care package (care workers visiting daily).

18/10/19: NPS Andrew failed to attend UPW on 7 occasions between 18/09/19 and 30/10/19 and was suspended from the project.

28/10/19: ASC Care package commences through a domiciliary care agency

29/10/19: NPS Supervision appointment no evidence of alcohol issues recorded and noted that George is supported by Adult Services.

30/10/19: ASC Record of Supervision Discussion: George chased the domiciliary agency away saying he did not need any help. Agreed social worker would formally ask the neighbour Sheila, if she can take up the role and she could be paid by Direct Payments.

Client Affairs Team (within ASC) to be approached to take over managing George's money as concerns that Andrew is spending George's money on alcohol, not enough food being bought and also Andrew is too stressed with the responsibility.

November 2019

01/11/19: ASC Allocated worker speaks with neighbour Sheila who confirms that care worker has been allowed access by George a couple of times and they've managed to do some cleaning in the house. Neighbour reported Andrew is drinking less and doing the shopping. George will also tell Andrew what he needs, and her daughter does shopping for him. Allocated social worker discusses the option of Sheila becoming the formal carer under direct payments arrangements. She agrees to this.

1/11/19: GP sick note written for carer's stress whilst trying to apply for PIP, Andrew reports already supported by SW and Probation Officer on a monthly basis, with plan to liaise with SW/PO for update about ongoing requests of sick note.

06/11/19: NPS Andrew attends his UPW project with a doctor's note citing he is unable to complete the work due to stress caused by family issues. Decision to return Order to court as unworkable due to his ill health.

07/11/19: ASC Care agency service is cancelled as George refusing the carers and agreed new plan is for Sheila to become the formal carer as George responds to her and she has agreed to this.

13/11/19: ASC Allocated social worker contact Disability Advice Service (DASL) to discuss how to arrange the direct payments for George given he cannot be the 'employer' as lacks capacity around financial management and would not manage this. Options around payroll companies are discussed to identify best way forward.

14/11/19: DWP George was awarded Low Capability Work Related Activities (LCWRA) which meant George would not be required to look for work and was awarded a higher amount of Universal Credit.

20/11/19: ASC - GP contacts allocated social worker regarding George having an LD Health Check. Allocated social worker reminds that this will need to be conducted in his own home given agoraphobia.

20/11/19: DWP- Andrew attended work search reviews with his work coach.

23/11/19: MPS Police report to Social Services out of hours service that there has been an arson attack on the home.

Comment: the investigation and prosecution of the arson offence committed by Andrew was thorough and conducted expeditiously, however, George made reference to the financial abuse and coercive behaviour committed by Andrew in his VRI. He stated he was too frightened to leave the house in general. He said that he was "*petrified of Andrew and always has been*".

Comment: It does not appear that further supporting evidence was sought in order to consider prosecuting Andrew for further offences relating to this domestic abuse. However examination of the case file submitted to the CPS showed that despite cooperating with the VRI process George was unwilling to support the prosecution of the case at court. This was a recurring theme throughout the years when such incidents were reported by all family members.

Comment: A MERLIN ACN was completed to highlight that George was now homeless as the fire had rendered the house unfit for habitation. It was agreed that George would stay with neighbour Sheila for the weekend but would need assistance from housing going forward. The ACN report identified George was a vulnerable adult who was known to the Adult Learning Disabilities service. A referral was also made to GAIA, the domestic abuse service.

25/11/19: ASC Allocated social worker speaks with Sheila who explains Andrew had knocked on the door showing her he had started the fire and had then tried to attack George. Sheila managed to get help get George away from the house to safety. Sheila confirmed George could stay with her as she had a spare room and was able to provide care to him.

25/11/19: GP Social worker made contact with the surgery; social worker in progress to conduct a welfare check, social worker also requested another home visit due to concerns with mental health since incident with Andrew setting fire to the house.

25/11/2019: NPS Andrew recalled to custody for breach of licence due to the commission of the offence against George.

28/11/19: GP George attended surgery for review with his neighbour, Sheila, he is reported to be looking into sheltered accommodation. He also had a physical review.

29/11/19: GP social worker updated by GP, social worker reported search for alternative accommodation was underway.

Findings

Having thoroughly reviewed this case and its many complex interactions it can be concluded that there were professional failings across several agencies and at multiple points in time, all of which led to a failure to safeguard George and exacerbate the violent and controlling behaviour of Andrew.

The principal findings from this review are:

1. **There was a failure to consider George's vulnerability given the family history and context. All agencies focussed on Andrew; George was rarely at the forefront of agencies' decision-making.**

    - DWP systems were not appropriately adapted to meet George's needs despite ASC's 'Every Pound Counts' team proactively pushing for information and solutions to the problems each brother presented in accessing benefits. DWP were at times unable or unwilling to engage with both brothers and failed to understand the impact of a learning difficulty or disability on their ability to engage fully with the process of accessing benefits. The lack of documentation to evidence George's identity proved an insurmountable hurdle and one that George was unable to negotiate without the help of EPC.
    - CCG and GP services were not responsive to George within his family unit. Access to oversight "Huddles" was dependant on postcode. The family address was in LB Lambeth but the GP surgery was in LB Croydon which made it difficult for George to access services. There seems to be no methodical system in place to monitor vulnerable adults in the practice, even those who had been identified as LD.
    - MPS had many opportunities to further investigate vulnerability at the family address. There were missed opportunities to follow up accusations of financial abuse in relation to the mother's pension. There were missed opportunities to refer the premises and its occupants as vulnerable. No Merlin was issued after the death of Michael, which initially presented as suspicious.

- Lambeth Housing had not pursued tenancy succession or rent arrears in respect of the property and did not grasp the vulnerability of George. Gas Safety inspections did not lead to referral of the occupants as vulnerable. Indeed, these inspections refer to 2017 and 2019, with no inspection carried out in 2018. There seem to be too many silos within the Housing department and the opportunity for sharing knowledge related to George were missed.
- National Probation Service did not consider George's vulnerability during their work with Andrew and did not seek his opinion about Andrew's change of address after the death of Michael, the older brother who was the victim of the index crime. There was a great deal of evidence of Andrew's violence within the family going back to 2013, including an attack on George. Andrew's transfer to a North London Mental Health setting after a suicide attempt in HMP Wayland in 2016 was not shared with SLaM or Lambeth ASC. There needs to be greater transparency into how MAPPA decisions are arrived at. If Andrew was made MAPPA level 2 an MDT meeting would have convened, and George's needs may have been considered more central to decision making.
- The whole family had been subject to interventions from various agencies including the brothers as children, the mother's self-neglect, alcohol abuse and domestic violence. No history or context was explored in sufficient detail and how it impacted on George. Much of what was said was accepted at face value and not professionally verified. George was often in the presence of Andrew when agreeing to decisions affecting his life and was at no time offered confidential advocacy. In some sense the brothers were enabled to refuse services because the circumstances of the refusal were never properly investigated.
- The enquiry by MPS into the death of Michael at home may have lacked sufficient understanding of previous forensic history of Andrew and the fact that the terms of his licence precluded him from living at the family address. George was vulnerable to Andrew's abuse, but a Merlin was not raised on this occasion.

2. All agencies displayed a general lack of understanding of how George's learning difficulties impacted on his ability to self-advocate which contributed significantly to his vulnerability to abuse

- ASC provided some assertive duty social worker interventions in respect of George, but George had to wait a long time to get an allocated social worker from the LD team. It is evident that once in place the effort to engage all agencies was purposeful and productive.
- There was no formal referral for a professional advocate for either George or Andrew. The neighbour, Sheila, was a trusted friend and had a key role in referring concerns to ASC. She had been a friend and neighbour to their mother and had extensive knowledge of the family history. She became a useful conduit to explain what was happening to the brothers and to ASC. Despite this positive relationship it seems that all agencies were satisfied to rely substantially on Sheila and did not display any professional curiosity as to the nature of George's learning difficulties.

- Referral systems used by all agencies relied on reading materials, IT access, attending unfamiliar venues and admitting strangers to the house when it was clear that George's literacy and numeracy skills and his comprehension of multiple issues was poor. George additionally struggled with undiagnosed agoraphobia and this compounded his many other needs. George's learning disability was often referred to but never formally diagnosed or explored. this led to regular offers of inappropriate forms of support which caused him to disengage
- Andrew was able to mask his learning difficulties with unpleasant and occasionally violent behaviour. It seems that as a result of this behaviour Andrew's own needs were never professionally explored and therefore, he was not suitably supported to make better decisions for himself and George.

3. Record-keeping and information sharing was inadequate

- There was a failure to verify Andrew's address on leaving prison on licence and allocation of MAPPA status may have been different had the whole history been known or investigated. For example, when Michael had been presented to MARAC in 2013 it was evident that Andrew posed a risk of violence within the family, yet this was not considered when Andrew returned to the family home.
- CCG and GP did not have a robust system to check de-registered patients and there is no evidence of a system to identify vulnerable adults within a surgery patient list. GP suggests that George was put into LD category in 2003 which should have triggered regular heath checks, however there is no evidence that these checks took place. There was a failure to follow up in a meaningful way and it seems George had been de-registered from the surgery. This may have been because George failed to attend the surgery for appointments but there is no evidence that this was checked and his agoraphobia was considered.
- There was some confusion between SLaM and the now defunct Living Well Hub which acted as the front door to Mental Health services which initially led to information not being shared or understood. There seemed to be no knowledge of Andrew's previous mental health history, particularly while in prison. Prisons have their own Mental Health provision and details of a prisoner's mental health however this history is not routinely shared with domestic mental health providers (SLaM), NPS, ASC, MPS or the GP.
- Lambeth Housing had distinct silos in place to deal with housing issues which enabled information to regularly be lost or unknown between departments. There was Tenancy Support which seemed to deal with Council Tax matters, Housing Welfare Solutions which dealt with downsizing and bedroom tax, a surveying and repairs department and a financial affairs section. It took the efforts of the Every Pound Counts section of ASC to push these departments into resolving the housing issues for this family including the tenancy succession, rent arrears and the dilapidated state of the property. In addition, housing departments had limited access

to ASC information regarding what were described as “high level” cases. This disjointed dynamic presented huge issues to both Andrew and George, with inappropriate demands made of them to provide information and communicate regarding issues they did not understand. This caused immense stress and it seems that this may have contributed to Andrew taking his frustration out on George.

Recommendations to the Board

1. **The Board should seek urgent assurance from all partner agencies that they have a suitable framework or criteria that is used to identify and manage their vulnerable clients.** Some partners, including the MPS and ASC, already have their own vulnerability framework (see Appendices) and these could be used as a guide for others. Recognition of vulnerability must go beyond obvious visible concerns and should include hidden vulnerabilities including lack of literacy and numeracy skills, digital poverty and mental ill health. This work should be undertaken to enable partner agencies to sufficiently probe the reason why some adults fail to engage with services. It is suggested this is completed and presented to the Board within one year of this report’s publication.

2. **The Board must identify the operational barriers that prevent frontline staff from implementing the strategic information sharing agreements that are currently in place.** This report highlights the real danger to people that is presented by incompatible systems and lack of access to relevant data. This work will lead to more robust access to data and appropriate training to analyse and understand information.

3. **The Board should prioritise further multi-agency focus on the issue of adult family violence between siblings and parents as part of its wider approach to reducing the incidence of Domestic Violence.** Domestic Violence Policies should be amended in line with the findings of the DHR which reads: “Within the definition of domestic abuse there is a wide range of different abuses including: intimate partner violence and abuse for people of all ages, genders and sexualities; adult family violence and abuse; so-called “honour”-based abuse; forced marriage; child to parent, and adolescent to parent violence and abuse. While all are gendered (most victims and survivors are women and most perpetrators are men) and coercive control is the main feature of the abuse, there are differences and we need to ensure responses and interventions are tailored and appropriate.”

   4.The Board should immediately pose the question to itself and its partners ‘What does a culture of professional curiosity look and feel like?’ this work will ensure that all partners are sufficiently confident that their front line staff display professional curiosity in all interactions with their vulnerable clients.

Individual Agency Recommendations

Probation Services

- The Probation Service Lambeth to provide an assurance report to the board of the findings of any national/divisional audits on the management level of MAPPA eligible clients
- The Probation Service Lambeth to provide an assurance report to the board of how conditions of residence are arrived at for clients on licence where they return to a previous address in line with national Probation guidance. They must demonstrate to the Board that there has been every effort to understand the wishes of other family members to ensure no duress has been applied to their agreement.
- The Probation Service Lambeth must demonstrate that every effort has been made to share information with relevant agencies, including Adult Social Care to ensure the successful return to the family and society at large in respect of a mental health history while in prison.

This assurance should be prepared within six months of the publication of this report and presented to the Board for scrutiny and challenge.

DWP

- The DWP serving Lambeth must undertake a review of its process and procedures in respect of vulnerable people, especially those with learning difficulties to ensure that there is a flexible and responsive service to aid those in need of benefits and support. The Board will need to be assured that the current process and interactions as demonstrated in this report are recognised as inadequate in providing the support needed to provide benefits to vulnerable adults.
- The DWP must assure the Board that it has an internal system to flag and support vulnerable adults which is generated by its own staff and is not reliant on Adult Social Services to escalate.

This assurance should be prepared within six months of the publication of this report and presented to the Board for scrutiny and challenge

CCG and GP Service CCG, LHA and GP Service

- Lambeth Health Authority and the GP service must undertake a review of its processes and procedures in respect of deducting patients from its register to ensure that the patient has been removed for good reason. Those reasons should be clear and transparent and should be open to scrutiny. This practice should be vigilant in respect of vulnerable adults including those with learning disabilities or difficulties.

- The GP Service must undertake a review of how it flags and offers services for those patients who are listed as Learning Disabled. This must include a process of making

sure that other relevant services are aware of the existence of the patient. The GP practice has the facility to print out a list of vulnerable patients from the EMIS register. Practices should scan the list regularly and make sure that any vulnerable patient who has not been seen for a long time is identified and followed up. In addition, GP practices should make reasonable adjustments for vulnerable patients including the use of easy read letters, texts and information leaflets so that they are able to understand the content of invitations for appointments and understand health advice.

- The CCG must undertake a review into why some vulnerable patients are excluded from good practice MDT services because of postcode and boundary issues. There should be a review into the extent of the problem and solutions offered to the Board to ensure equitable access to services at each GP surgery. At national level there should be a mechanism to ensure that patients who reside in a borough which is outside the borough where their general practice is located can be identified with a view to investigating any concerns about their well-being. This could be equivalent to cross-borough 'huddle' which should include adult social care as they may be the only partner providing services to the patient.

- Practice HCPs should exercise a greater degree of professional curiosity about the daily lives of people with learning difficulties particularly if their quality of life appears poor. This would allow the possibility of offering further assessment and referrals for example to the LD team, where warranted. Practice staff should exercise professional curiosity about the relationship between a carer and the person they care for, particularly where there are factors which indicate that the relationship between the two parties may be difficult.

This assurance should be prepared within six months of the publication of this report and presented to the Board for scrutiny and challenge.

Adult Social Care

- ASC to provide assurance that they have a department wide mechanism to track unallocated cases awaiting assessment.

This assurance should be prepared within six months of the publication of this report and presented to the Board for scrutiny and challenge.

Lambeth Housing Services

- All departments within Lambeth Housing Directorate should read and understand the impact of their decision-making, or lack of it, on the lives of vulnerable residents. The simple fact of failing to address the succession in tenancy after the death of the mother and the subsequent loss of rent to the

organisation provides a business case for better communications and engagement with residents. There were many missed opportunities to refer the occupants to other agencies or find out more about why the succession procedure was not actioned.

- Lambeth Housing should review its practices in relation to flagging the vulnerability of its residents, not least in relation to the annual Gas Safety and electrical inspections of each property. This provides an annual opportunity to assess vulnerability provided the people carrying out this operation are sufficiently trained and aware of their responsibilities to vulnerable adults. In this case the residents were deemed to be unauthorised occupants. The current position is that "***Housing do not carry out gas safety checks to properties that are in unauthorised occupation and currently have no plans to do so. If a property is in unauthorised occupation this means the council has no contract with the persons residing there and in law they are trespassers. In the majority of cases of unauthorised occupation legal proceedings to evict them will be either planned or ongoing and it is felt unlikely the council would receive the required access or co-operation to carry out gas servicing*.**"

This assurance should be prepared within six months of the publication of this report and presented to the Board for scrutiny and challenge.

MPS

- **Local Level – Central South Basic Command Unit Senior Leadership Team (AS BCU SLT)**

It is recommended that AS BCU SLT debrief the officers involved in the investigation of the sudden death of JC (Merlin 19FOU001745) to remind them of the importance of completion and sharing of Merlin ACN reports with Adult Social Care when vulnerable adults are found living in challenging conditions. The significance of a perpetrator of domestic abuse who was a MAPPA nominal living at the address was not recognised in this case therefore the officers involved should be reminded of the importance of information sharing with the lead agency for management which in this case was the Probation Service.

- **Local Level – Central South Basic Command Unit Senior Leadership Team (AS BCU SLT)**

It is recommended that AS BCU SLT debrief the officers who investigated the matters detailed in CRIS 1209073/19 to remind them of the potential of financial abuse occurring between siblings and the importance of completing DASH risk assessments in these circumstances.

This assurance should be prepared within six months of the publication of this report and presented to the Board for scrutiny and challenge.

SLaM:

- SLaM must provide assurance as to how they respond to barriers to engagement especially where someone is unable to engage due to agoraphobia, literacy issues or communication difficulties.

This assurance should be prepared within six months of the publication of this report and presented to the Board for scrutiny and challenge.

APPENDIX A: GLOSSARY OF TERMS AND ACRONYMS

Acronym	Full Word
REDRESS	The **Lambeth Redress Scheme** pays compensation to people who were abused or lived in fear of being abused while in Lambeth's care as children. The scheme is for those who lived in or visited a Lambeth children's home (including those at Shirley Oaks) or attended Shirley Oaks Primary School.
PINS	Prisoner Intelligence Notification System
CRIMINT	MPS Intelligence System
SAB	Safeguarding Adults Board
SAR	Safeguarding Adults Review
MAPPA	Multi Agency Public Protection Arrangements
DOH	Department of Health
DWP	Department for Work and Pensions
MERLIN ACN	Adult Come to Notice
HMP	Her Majesty's Prison
EPC – Adult Services	Every Penny Counts
ASC	Adult Social Care
CPS	Crime Prosecution Service
LD	Learning Disability
VRI	Victim Recorded Interview
GBH	Grievous Bodily Harm
PNC	Police National Computer
NPS	National Probation Service
OASys	NPS Risk assessment System
SLaM	South London and Maudsley Trust
CCG	Clinical Commissioning Group
SHP	Tenant Management
GP	General Practitioner
LWH	Living Well Hub (a partnership between SLaM, Lambeth and Voluntary Sector)

CPN	Community Psychiatric Nurse
UPW	Unpaid Work Order
PIP	Personal Independence Payment
SW	Social Worker
PO	Police/Probation Officer
CAD	Computer Aided Dispatch
LAS	London Ambulance Service
IO	Investigating Officer
SAIL	AGE UK Advocacy Services
IDS	Integrated Disability Service
ACN	Adult Coming to Notice
PCSO	Police Community Support Officer
IDS	Integrated Disability Service
TS (Housing)	Tenancy Support (Council Tax)
WS (Housing)	Welfare Solutions (Downsizing)

APPENDIX B: Existing Documentation relating to Vulnerability Indices

Understanding existing definitions of 'vulnerable' or 'vulnerability' related to Adult Safeguarding.pdf (lambethsab.org.uk)

https://www.met.police.uk/SysSiteAssets/foi-media/metropolitan-police/disclosure_2018/october_2018/information-rights-unit---policy-about-vulnerable-victim-of-crime