

# Management review: Balakrishnan case

RESTRICTED REDACTED VERSION: CLASSIFICATION 'OFFICIAL'

Clement Guerin

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London Borough of Lambeth

21/1/2016

## **Executive Summary**

## **Background**

In October 2013, three women fled from a household in Brixton. The household was led by Aravindan Balakrishnan, and was made up of members of his family and of members of a political sect which he led. One of the three who fled the household was Mr Balakrishnan's daughter, whose mother had been a member of the political sect. Mr Balakrishnan had tightly controlled her life for all her 30 years.

In December 2015 Mr Balakrishnan was convicted of falsely imprisoning and mistreating his daughter for more than 30 years, and for raping two followers of the political sect.

Following the conviction, Lambeth Council Services which had contact with the household have undertaken a review of their involvement, separated into this report on services that had contact with the adults in the home and a separate report overseen by Lambeth Safeguarding Childrens Board relating to services that work with children.

This report has contributions from Adult Social Care, Benefits & Customer Services and Housing. Independent scrutiny of this report has been provided by the Chair of Lambeth Safeguarding Adults Board.

## **Summary of findings**

#### **Adult Social Care**

- Adult Social Care had a number of episodes of contact with Mr Balakrishnan's sister-in-law, who was a member of the household and who had care and support needs associated with her disability. She was the tenancy holder, and her benefits income appear to be main or only income for the household.
- These contacts included Adult Social Care staff undertaking a number of assessments of community care needs of Mr Balakrishnan's sister-in-law. During none of these were Adult Social Care told that Mr Balakrishnan and his daughter were members of the household.
- During Adult Social Care's involvement, Mr Balakrishan's daughter would have been over 18, so even if Adult Social Care staff had become aware of her presence it would not have appeared untoward.
- No shortcomings in the work have been identified. No interventions can be identified that should have taken place that would have brought to light what was happening to Mr Balakrishnan's daughter.

#### **Benefits and Customer Services**

- There were Housing Benefits and Council Tax claims relating to Mr Balakrishnan's wife and his sister-in-law. These were errounously put in the name of Mr Balkrishnan's wife in the first instance and later changed over
- No shortcomings in the work have been identified. No interventions can be identified that should have taken place that would have brought to light what was happening to Mr Balakrishnan's daughter.

## **Housing**

- Mr Balakrishnan's wife and her sister were housed in temporary accommodation in 1993 by Lambeth Council. The application said the household consisted of the two of them.
- They lived at a number of temporary addresses until being housed permanently in 2005 in Peckford place, where Mr Balakrishnan's sister-in-law was the tenant.
- The contacts with the household since then have been straightforward, relating to repairs and gas checks.
- The services delivered to the household were appropriate
- There is no indication of any instance where there would have been a missed opportunity to identify anything untoward occurring



# Adult Social Care Management review: Balakrishnan case

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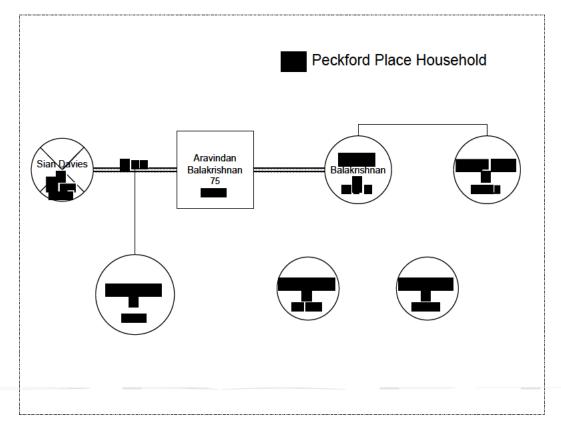
## **Summary**

- The household at Peckford Place consisted of
  - Mr and Mrs Balakrishnan
  - Miss Mrs Balakrishnan's sister. She has a number of disabilities

    , and has been known to Lambeth Adult Social Care
    from time to time, though most of her care was provided by her sister and other
    members of the household
  - who is the daughter of Mr Balakrishnan and Sian Davies who had been a member of the household till her death in 1997
  - o Balakrishnan who were members of the political group led by Mr
- was kept under the control of Mr Balaskrishnan from her birth, and this led to some of his convictions in Court. She never attended school.
- left the household, with the support of a charity, in October 2013.
- Lambeth Adult Social Care's work following those events consisted of
  - o Ensuing Miss needs were met, including a placement in a care home;
  - Undertaking an assessment of the needs of Mr and Mrs Balakrishnan, and supporting them as carers of Miss
  - A safeguarding adults enquiry in to whether anything untoward had happened to
     Miss
  - o A safeguarding adults process to support the police investigation in to events in the household. This work was passed to the Safeguarding Childrens Board in April 2014.
  - Work with Council to ensure the needs of the three people who left the household were being met. Lambeth Adult Social Care funded services for these people for several months.
- The analysis below of the work done by Lambeth Adult Social Care finds that the work done was carried out to a reasonable standard and there are no significant shortcomings in the work.
- A broad-brush lesson is identified in that any potential, though far from certain, difference
  there could have been would most likely come from reflective, analytic practice which would
  support work undertake with healthy scepticism and respectful uncertainty. These are skills
  and practice based issues which are complex to influence.

# People involved

## The Peckford Place household



Name	Role(s)
Aravindan Balakrishnan	Leader of the collective Husband of Balakrishnan Father of Balakrishnan
Balakrishnan	Wife of Aravindan Balakrishnan Sister of Carer of
	Sister of Balakrishnan Intermittent user of adult social care services
Sian Davies	Mother of
	Daughter of Aravindan Balakrishnan and Sian Davies
	Member of the collective Carer of
	Member of the collective Carer of

## Peckford Place household address history

Start	End	Address	Source of information
Unknown	Unknown		LB Lambeth Housing
28/10/1993		Homelessness application made by Miss	LB Lambeth Housing
1996	4/4/2003	which had been used as temporary accommodation	LB Lambeth Housing
26/7/1996		OT report recommends three bedroom ground floor wheelchair accessible property	LB Lambeth Housing
26/3/1997		withdraws nomination because the applicant wants to include other females not included on her housing application.  was not happy to accept the nomination as the property was not suitable to accommodate them.	LB Lambeth Housing
4/4/2003		Evicted from	LB Lambeth Housing
08/04/1998	25/06/2003	recorded as residing a	LB Lambeth Adult Social Care
30/5/2003		Applicants Balakrishnan and accept housing offer	LB Lambeth Housing
25/6/2003	1/8/2005	recorded as residing at	LB Lambeth Adult Social Care
15/07/2005		An offer of a permanent tenancy at 1C Peckford Place is made, and the offer is accepted	LB Lambeth Housing
01/08/2005	27/11/2013	recorded as living at 1C PECKFORD PLACE, BRIXTON, SW97BS	LB Lambeth Adult Social Care

## Adult Social Care involvement with members of the household

Brief summaries are given here of ASC involvement. More detailed chronologies can be found in the appendices

- Appendix A gives a chronology of the involvement with Miss in regards to her care and support needs
- Appendix B gives a chronology of the involvement with Miss and in regards to their possible care and support needs
- Appendix C gives a chronology of the adult safeguarding work following the arrests of Mr and Mrs Balakrishnan in November 2013

## **Key events in ASC involvement with Miss**

Start	End	Summary
February 1999	Unclear	There was a request for an Occupational Therapy (OT) assessment. As this predates the current electronic records, information is limited.
August 2005	October 2006	Ms has moved to Peckford Place. A handrail and other equipment are fitted in the bathroom.
January 2007	February 2007	A GP made a referral as Mrs Balakrishnan had been admitted to hospital and nobody else in the household was able to help Ms have a bath. By the time contact is made to visit to undertake an assessment, Mrs Balakrishnan had returned home and was helping her sister again.
August 2009	October 2009	A GP made a referral  A home visit is undertaken, and Mrs Balakrishnan and Ms dismiss the concerns.
October 2009	Unclear if this admission lasted till March 2010	Ms
March 2010	March 2010	request an OT assessment. Equipment is provided to assist with lifting for personal care.
January 2012	February 2012	Ms in February 2012 with a substantial package of home care services.
May 2012	June 2012	Mrs Balakrishnan asked for the care services to be cancelled

	ensured that Ms was visited at home and a review undertaken to establish her views before the care was cancelled. Ms was spoken to alone as part of this. She said she had recovered so did not need so much help.
October 2013	The police reported that three people who had been involved in providing care to Miss had left the household. They were concerned that this would mean Miss would be left without sufficient care. Care services were arranged.
	In November, after the arrests of Mr and Mrs Balakrishnan and the level of media presence at the house, this became unsustainable and

## ASC care and support involvement with Mr and Mrs Balakrishnan

Assessments of community care needs were undertaken with Mr and Mrs Balakrishnan in December 2013. Neither was found to have needs which were eligible for support from Adult Social Care.

ASC care and support involvement with Miss  The intention of Lambeth Adult Social Care was initially to ask	and Council to undertake an
assessment on its behalf to establish the needs, if any, of the three peop	. •
the extraordinary circumstances, Lambeth bore the costs for the service	provision.
Council began the assessment process on Lambeth's behalf be	
completed responsibility for completing the assessments and funding art to Council.	ny services required shifted

## **ASC safeguarding adults work**

There were two strands to this

- Risks to Miss It was clear that Miss was a person with community care needs and, once concerns around what had happening in the household became clear to Adult Social Care in November 2013, it was appropriate to have a safeguarding adults enquiry. It was established by December 2013 that Miss was reporting that she had not experienced abuse or neglect.
- Risks to the members of the household who left in October 2013:
  - o It was not clear at any point to Lambeth Adult Social Care that any of the three people had community care needs and, if so, what these were.

- Given the extraordinary circumstances of the situation, and in the absence of any other viable option being presented, a safeguarding adults framework was used to help plan the responses to the situation.
- o The safeguarding adults work identified that immediate risks were being managed by the persons being away from the household and receiving support, and that the criminal investigation was the primary means of establishing the facts. The safeguarding adults process was used to coordinate the multi-agency contribution to the police's investigation.
- By April 2014 it was clear that a primary focus of the police investigation and the
  area of outstanding concern for partners were about experiences as a
  child. It was agreed that the management of the response to these issues would sit
  with Lambeth Children's Safeguarding Board and its sub-groups.

## What Adult Social Care knew about the household

The table below has the references to the household extracted from the assessments undertaken by adult social care staff up to an including October 2013. All the assessments were of Miss

It can be seen that information about Mr Balakrishnan and being members of the household was not shared with adult social care staff. There are mentions of two people it can be assumed are Ms and Ms but neither feature to any great extent in any of the assessments. For instance, their names are not recorded at any point and it is not evident that they were spoken to, even though their roles in caring for Ms were known.

Given that Ms was able to give her own account of her situation, it would be reasonable for those undertaking these assessments to be guided by her as to who to talk to as part of the assessment process. It could be said that approaching the situation with greater scepticism and curiosity may have led to asking more questions about these two people. That may have yielded some information about them, but it is not obvious that it would have shed any light on the situation of

Given that it appears no information was shared with any of the assessors about Mr Balakrishnan or despite the number of contacts over a period of years, there are grounds to suspect that the withholding of this information from adult social care staff may have been intentional.

Start date	End date	Event	Information contained about the household
10/3/2006	5/04/2006	OT Assessment of	None
4/9/2009	10/9/2009	Overview assessment of	she stated that her sister makes decisions regarding her care needs and that she has been caring for her over 30 years. Miss further stated that she trusts her sister and believes she would make the right decisions."  "Miss sister/carer was offered domiciliary/carer's support but she declined, stating that she is supported by her two female friends (a group of philanthropists) who have been living with them for many years in their 3 bedroom adapted flat. She stated that they are financially sufficient, and  "Lives with sister/main carer and two female friends, These women assist the main carer and provides sitting service as well assist with activities of daily living."

9/3/2010	9/3/2010	OT Specialist Assessment of	"Client sister has been her main carer for 40 years. Sister and friends live with client and help as required."  "Ms who lives with her sister and friends who are her carers in a 3 bedroom ground floor council flat. Access"  "No formal care package in place. client's sister and friends are her carers."
24/1/2012	25/1/2012	Overview assessment of	"Her sister along with other friends used to provide full care for her and there was no Social Services package in place."  "Ms lives with her elder sister/ main carer."  "Lives with sister/main carer."
19/4/2012	2/5/2012	Review of community care needs of	"Ms lives with her sister/main carer in a three bedroom purpose built ground floor council flat for disabled people with wheelchair dependent."  "Ms sister, is her main carer who supports her with the help of a family friend."
1/6/2012	22/6/2012	Closing summary	"(sister / main carer) has expressed wishes to continue to look after client with the support of their family friends."
4/9/2012	4/9/2012	TOPAZ Review	Section on "other people in household (including children)" is blank  "Ms who is wheelchair bound. Her main carer is her older sister who looks after Ms - full time."
28/10/2013	28/10/2013	Initial Contact Assessment	T/c from called reporting welfare issues. He said they just removed 3 people from s/users flat  ow they have removed these people there is concerns s/user will not cope. There is elderly husband and sister living with her but police are not sure if they are able to look after s/user.

	"T/c to sister Ms Balakishnanr; and informed the above. Sister says these people are long term friends who has been living with them. They were helping s/users as friends

## **Analysis**

## Was the work done well enough at the time?

The key tests to consider are

- Whether the work happened as it should have; and
- Whether anything that should have happened failed to happen.

Episodes or instances that appear to be relevant for consideration are

- •
- The safeguarding adults response to the events of October and November 2013
- Whether visitors to the household could have been reasonably expected to have had concerns

	be spoken to alone.	A social worke	r visited the ho	ome a few days late	er but appears	to
have spoke	en to the sisters together.	Miss	d she was happ	ру		
				"	_	Ì

Analysis: Did the work happen as it should have? Did anything that should have happened fail to happen?

- The social worker should not have needed the prompting from to have spoken to a person on their own when there was a concern this reminder and yet still, as far as ASC records show, appear to have spoken with Miss alongside her sister is a shortcoming of this work.
- The approach to safeguarding adults would have been flawed if the hypothetical situation about came about.

  but local authorities should take a leading role where there are safeguarding adults concerns. As it turned out, Miss was admitted to hospital shortly afterwards and no concerns were raised by the hospital with Lambeth Adult Social Care about any safeguarding adults concerns.

• Even if Miss had been spoken to alone, and even if Adult Social Care had taken a more assertive approach to leading the response to the safeguarding adults concern, it is not obvious that this would have changed the outcome. Miss was then, and has been since, very clear that she wants her sister involved in decision making about her care and treatment, and that she has no concerns that her sister has anything but her best interests at heart.

#### Conclusion

The work done would have been better had Miss had been spoken to alone, and if Adult Social Care had taken a more assertive approach to leading the response to the safeguarding adults concern. However, the work as it was carried out was done to a reasonable standard. As noted above, though this would have improved the practice it is not likely that the outcome would have been different.

### The safeguarding adults response to the events of October and November 2013

Lambeth Adult Social Care were not aware at the time that the three people had left the household, nor was there any reason for it to be. The police made contact with the local authority after they had left, and the reason for them making that contact was the concern that Miss might no longer receive the care and support that she needed.

Lambeth Adult Social Care asked the question of the police whether the people that had left the household were people with community care needs and whether the police had concerns that they had experienced abuse. The police said they did not. Lambeth adult social care services drew the conclusion that these were, therefore, people who fell outside of the "No Secrets" framework, and that the support they were receiving from the police and the services they police had put them in touch with were sufficient.

Once the police released further information in to the public domain, Lambeth Adult Social Care reviewed the position. There were discussions at the time about whether the safeguarding adults framework was the most appropriate, with the most obvious other option being a children's safeguarding framework as by now it had become apparent that a significant concern was what had happened to a child since their birth. However, as there was no realistic prospect of any other process taking up the matter there and then, it remained in the safeguarding adults arena until the decision of April 2014 by the Chair of the Children's and Adult's safeguarding boards.

Analysis: Did the work happen as it should have? Did anything that should have happened fail to happen?

The scope of this review is the actions of Adult Social Care only.

- In October 2013, when the three people left the household, Adult Social Care were told by
  the police that they did not have community care needs and had not experienced abuse or
  neglect, so the decision not to have a safeguarding adults enquiry was reasonable;
- In November 2013 Adult Social Care took the view that, in the light of what had been learned, that at least one of the people may have care and support needs and may have experienced abuse or neglect so the adult safeguarding framework was an option. Had another framework been a viable option at the time, then it might be that the adult safeguarding framework would not have been the main way of structuring the response, but there was no viable alternative at the time, and it was outside of the control of Adult Social Care staff to have changed this. In those circumstances, the decision to frame the work within an adult safeguarding process was a reasonable response, though it made for some complications.

#### Conclusion

The decisions made and actions taken by Lambeth Adult Social Care in regards to safeguarding adults work in October and November 2013 were reasonable.

The observations and actions by Lambeth Adult Social Care visitors to the household

### **Analysis**

- There was some involvement by an Occupational Therapist in 1999, at which time Miss would have been 16 years old, which raises the question whether attention should have been paid to a younger person in the household not in education. However, as the information about this episode is limited we cannot know if the OT involved would have met with or been aware that Miss was part of the household. The information that there is says it was "a request for OT to view property" so there is a reasonable chance there would have been no contact with Miss
- The next involvement came in 2005 by which time Miss would have been 22 years old, so the question of a young person not in education being in the household would not arise.
- All the visits to the home were in connection to the care and support needs of Miss Whilst Social Workers must be skilled at applying respectful uncertainty and healthy scepticism in their work, there also is a right for adults to live their lives in whichever way they see fit, within the bounds of legality. It is not unusual for Social Workers to work with people whose lives are unconventional in one way or another. As a society, and as a matter of government policy, many people with care and support needs are helped in the main by friends and family, so there would have been many features of this household that though unusual would not necessarily have given cause for alarm.

- Though we know now that the bounds of legality were being breached, this was not being done in ways that would necessarily have been obvious to a visitor to the household. And it should be remembered that most members of the household appear to have been content with the arrangements. We should be wary of applying hindsight or are own norms when making judgements about what people visiting the home can reasonably be expected to have been aware of.
- It was established in Court that Mr Balakrishnan was an extraordinarily controlling figure. His control over his daughter was done by psychological and emotional means, and the whole household had some degree of suspicion about the outside world. They were taking steps to keep from people visiting the household what was going on.
- It is unfortunate that it seems Miss decided to cancel care services because of the cost, when it seems that a timely financial assessment would have established that she need not pay for those services. It may be that care workers being in the home more regularly may have identified some of the issues we now know, but we cannot know that this would have been the case.
- The police's enquiries looked in to what people visiting the household saw. There was a consistent pattern that people did not see anything untoward. Mr Balakrishnan, it emerged in Court, was an extraordinarily manipulative person and it seems likely that he would have taken steps to keep people visiting the household from learning about anything untoward, and that he may have had the support of other members of the household in doing this.

#### Conclusion

It is important to ensure we are not applying unreasonable standards due to hindsight. People visiting the household on behalf of Lambeth Adult Social Care were working with Miss who was living in a household of adults, made up of family and friends, who were helping her meet her needs in the way she wanted. There were unacceptable things going on in the household, but these were not apparent to Adult Social Care staff visiting, partly because there were efforts going on to conceal them. The work was carried out to a reasonable standard.

## Would anything be different today if the same circumstances arose again?

## Safeguarding adults work

If the circumstances of were to arise again today, it is likely that Lambeth Adult Social Care would be more proactive in its leadership of the response to those concerns. In 2009, Lambeth had only recently adopted a Safeguarding Adults Policy and Procedure, this meant the culture of local authority leadership in safeguarding adults work was not well established in Lambeth at the time. This has changed, with all safeguarding enquiries having a Safeguarding Adults Manager from the local authority leading the work, and many safeguarding adults enquiries consider issues to do with

The challenges faced in October and November about determining the role of safeguarding adults processes in responding to the issues may well be similar should the same circumstances arise today. Safeguarding Adults work now falls under the Care Act 2014 and its statutory guidance, rather than "No Secrets", but the issues around determining in this instance if any of the three people who left the household were a person with community care needs, as "No Secrets" required would be similar in determining if they were a person with care and support needs who was unable to protect themselves from abuse and neglect.

#### Assessing whole households under the Care Act 2014

The assessments of Miss community care needs were carried out under s47 of the NHS and Community Care Act 1990. A criticism of that legislation was its atomistic approach with a focus only on the individual. The equivalent assessment today would be carried out under s9 of the Care Act 2014, which has a stronger emphasis of understanding a person's needs in context, including that of their household, family and friends. It may be that an assessment carried out today under the Care Act 2014 would give a clearer picture of who the other people in the household were and what the relationships were.

However, even if all this had been captured clearly it is not obvious what difference it would have made. And it is questionable whether there would have been complete cooperation and transparency from everyone in the household.

#### Relationship of safeguarding adults work and safeguarding children work

The primacy of the safeguarding adults framework as the organisation structure for the work may not have been the best one. It was clear from November 2013 that the root cause of the issues was what had happened since the birth of Miss and her treatment in her childhood. Attempts to have this located in the right place floundered until April 2014, with the intervention of the Chair of the local safeguarding boards. This may reflect the difficulties in drawing the boundaries of the role of the local authority and the safeguarding boards

## Lessons to be learned

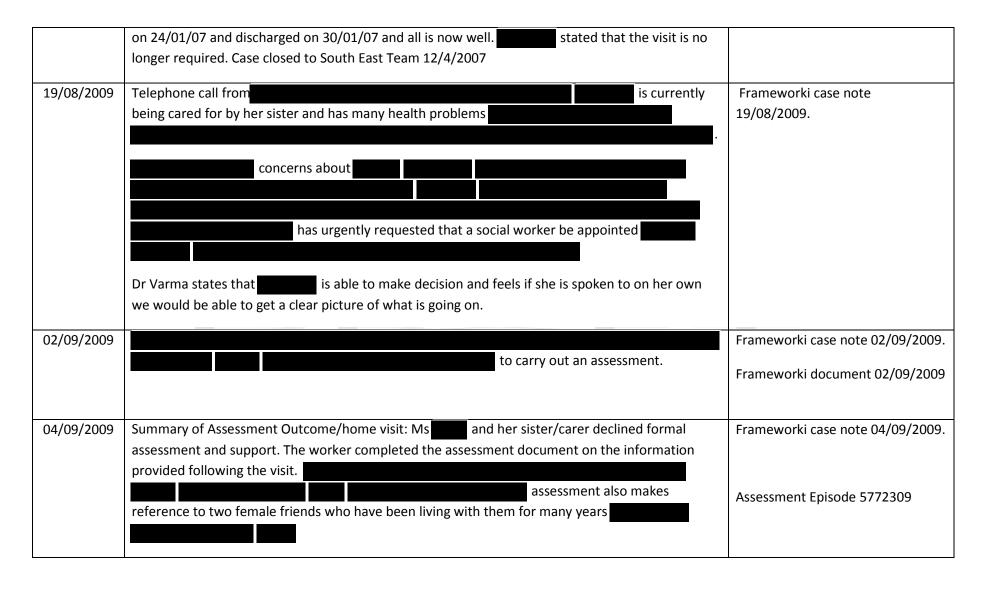
Adult Social Care had involvement in a household where many of the people were content with their unconventional arrangements. There were some things going on that were seriously wrong, and these had been going wrong since Miss was born.

The circumstances were unusual and extraordinary. It is not obvious that Adult Social Care staff could have done something different in their dealings with the household that would have brought the issues to light earlier. But if there is anything that could have been done differently it seems most likely that it would sit in the area of healthy scepticism and respectful uncertainty. That is to say, changes to policies, procedures and systems would not make it more likely that the truth could have been uncovered. That would come from good, reflective, thoughtful practice.

Even then it would be far from certain that these issues would have come to light. But it is important that in the focus on important issues around completing assessments and getting services in place we ensure there is the support for staff meeting people in difficult circumstances to be able to have the chance to spot and explore what may be fleeting glimpses of something deeper than the surface presentation.

# Appendix A: Chronology of care and support work with Ms by Lambeth Adult Social Care

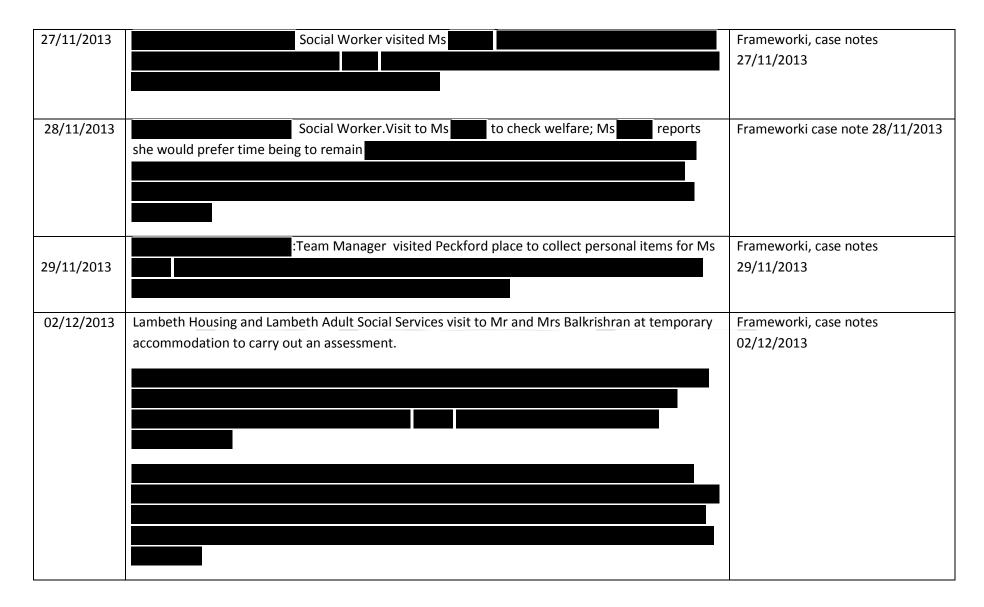
Date	Event	Source
25/02/1999	Request for an Occupational Therapy (OT) assessment.	Frameworki case note, 25/02/1999.
01/08/2005	Referral received from Mrs. Balakrishnan for OT  Peckford Place.	Frameworki case note, 01/08/2005.
10/03/2006	OT Assessment started; completed on the 05/04/2006.	Frameworki episodes 5268422 and 5276919.
27/09/2006	Home visit by OT to review	Frameworki case note.
18/10/2006	Home visit by OT	Frameworki case note.
26/01/2007	Referral received  Lambeth Adult Social Services (South East team), saying that the main carer is in hospital and he has been alerted by neighbours that Ms  is not receiving any care. T/c to neighbour  same flat and at the moment  sister was in hospital.	Frameworki episode, 5383703 and 5383706.  Framework case note 26/01/2007.
06/02/2007	Case allocated for an urgent assessment of need. Telephone call was made to arrange a home visit; and answered who said Ms sister was admitted into hospital	Frameworki case notes 06/02/2007 and 12/4/2007.

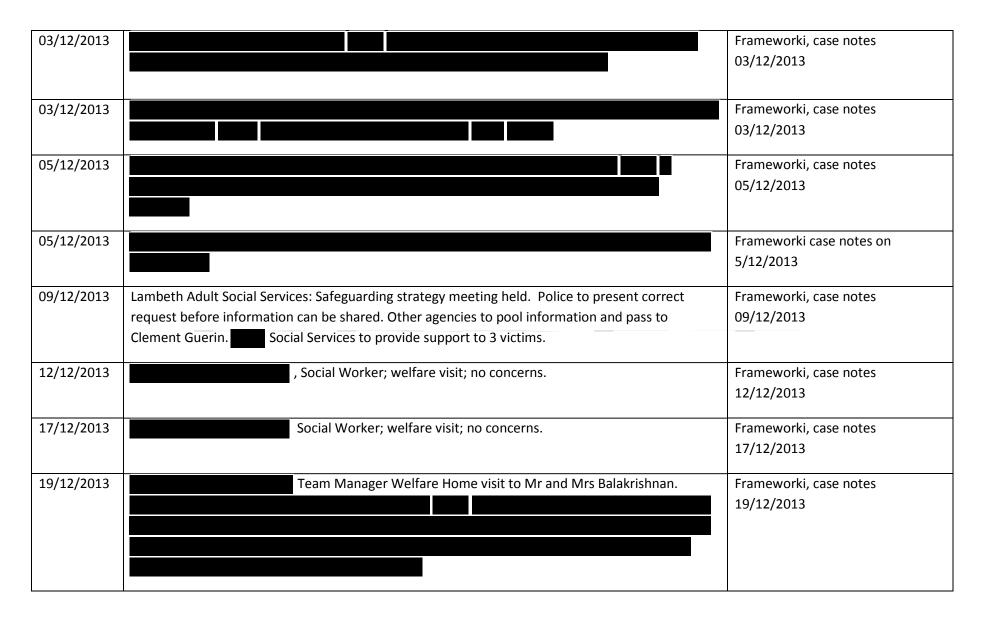


09/09/2009	South East team;	Frameworki case note, 09/09/2009
14/09/2009	South East team; Case dellaocted as Ms appeared to be accepting care.	Frameworki case note,
		14/09/2009.
02/03/2010	Referral for OT assessment	Frameworki case note,
		02/03/2010.
09/03/2010	Lambeth OT home visit. Need identified:	Frameworki case note, 09/03/2010
	Ms sister and friend also	
	present.	
10/01/2012		Frameworki case note, 10/01/2012
	Request by OT to put in a care package.	
25/01/2012	Overview assessment completed	Frameworki document
23/02/2012		Frameworki case note, 23/02/2012
19/04/2012	completes review of care package. Ms requests a small increase in	Frameworki case note, 19/04/2012
	hours to allow	
30/05/2012	informed by that the carer wanted to cancel the service	Frameworki case note, 30/05/2012
	The team manager decides that a social worker needs to visit to discuss this with	
	Miss before the service is cancelled.	
31/5/2012	A social worker visited Miss and spoke with her on her own to discuss the situation with her.	Frameworki case note, 1/6/2012
	Miss was clear that she wanted the services cancelled	

21/06/2012	Lambeth Financial Assessment team: Financial Assessment completed with outcome as nil financial charge.	Frameworki Episode 6300211 and 6300245
04/09/2012	telephone review	Frameworki Episode 6343349
25/10/2013	Initial Contact Team:	Frameworki case note, 25/10/2013
28/10/2013	Assessment (Part A & B) completed referral sent to Specialist Disability Team.  T/c to sister reported that the three people are long-term friends who had been living with them.	Frameworki Episode 6575725
30/10/2013	Social Worker Practitioner Manager completed a home visit on the 30/10/2013 with agreement form Ms and care package was put in place that started 02/11/2013. Head of service informed of case by email.	Frameworki case notes, 30/10/2013
31/10/2013	opening Safeguarding Referral (2013)	Framework episode 6578039
20/11/2013		Frameworki case note 20/11/2013

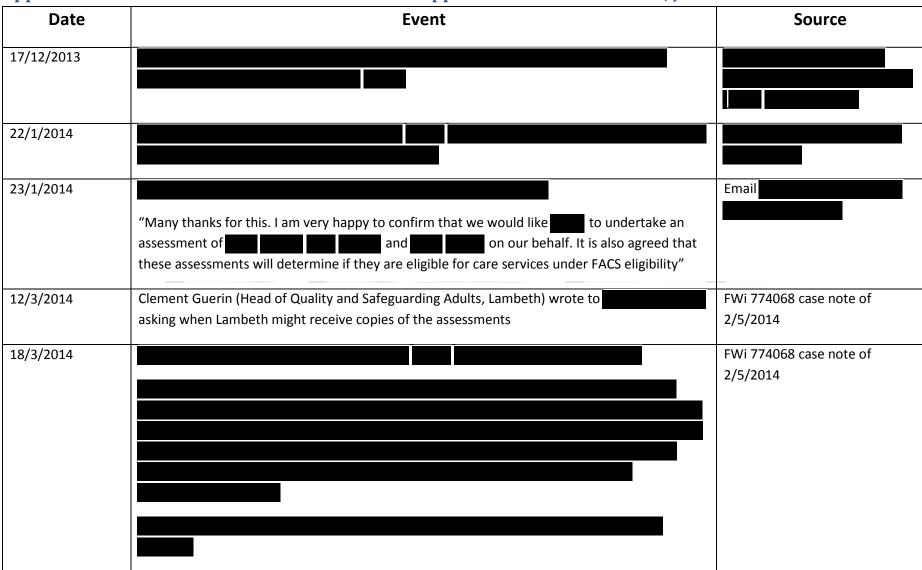
21/11/2013	regarding progress of	Frameworki case notes
	interviews; no timeframe given as when they would end, agreed that extra care hours provisionally arranged given emergency duty service contact details.	21/11/2013
21/11/2013	accommodation for Ms and her sister and brother in law.	Frameworki Episode 6588484
22/11/2013	to reduce the risk of press intrusion and in addition Ms had no access to any money.	Frameworki, case notes 22/11/2013
24/11/2013	to check on welfare; no concerns reported.	Frameworki case notes 24/11/2013
25/11/2013	Practitioner Manager and Social Worker undertook a welfare visit to	Frameworki, case notes 25/11/2013  LBL Assessment Frameworki episode id 6589379
26/11/2013	Lambeth Adult Social Services convened a Multi-agency strategy meeting. Actions: Information will be gathered from various agencies. Information cannot be shared with the Police without them following the correct protocols as this will prejudice any potential prosecution.	Frameworki, case note 26/11/2013  Minutes in documents section of framework





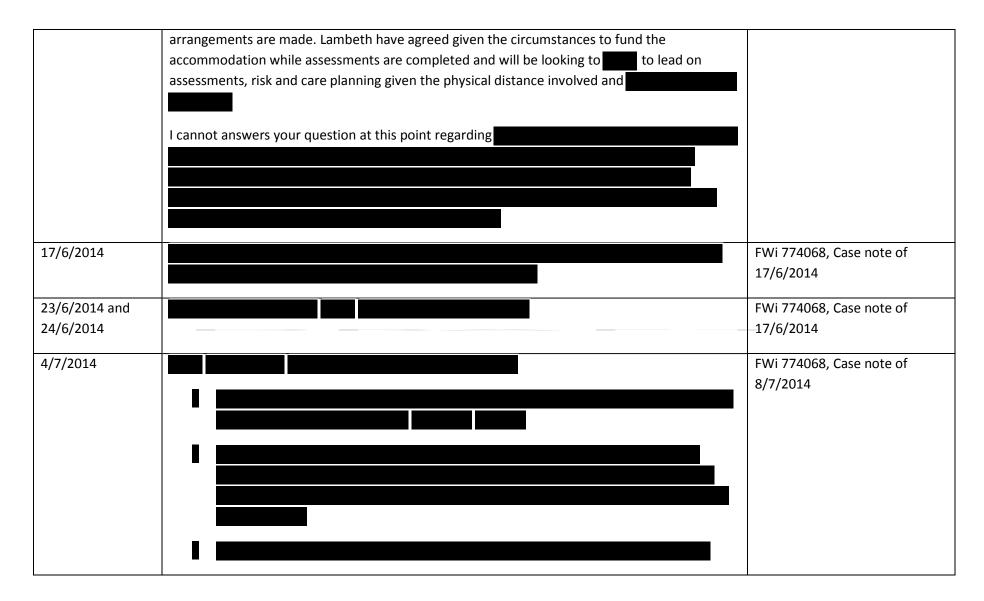
Adult Social Care Management Review					

## Appendix B Lambeth Adult Social Care care and support involvement with RD, JH and AW



26/3/2014	Clement Guerin wrote to to say	FWi 774068 case note of 2/5/2014
	"A summary of their current support needs would be very helpful - you can send this to my gcsx	
	email address. We had expected, though, that we would get the full assessments at some point	
	as is carrying these out on behalf of Lambeth. I'm sure there must be a way to resolve this."	
28/3/2014		FWi 774068 case note of
		2/5/2014
24/4/2014	Clement Guerin (Head of Quality and Safeguarding Adults, Lambeth) wrote to	FWi 774068 case note of
	asking when Lambeth might receive copies of the assessments	2/5/2014
1/5/2014	Clement Guerin (Head of Quality and Safeguarding Adults, Lambeth) wrote to	FWi 774068 case note of
	asking when Lambeth might receive copies of the assessments	2/5/2014
1/5/2014		FWi 774068 case note of
		2/5/2014

29/5/2014	would meet with colleagues to discuss assessment and support arrangements for the three people	FWi 774068 case note 29/5/2014
17/6/2014	"As discussed yesterday please can you provide copies of the assessments for the three women and any significant psychiatric or medical reports. Lambeth are currently funding the placements the women are residing in and want to have clarity as to their needs. If you are unable to provide copies of the assessments please clarify why?	FWi 774068 case note 29/5/2014
	I will be visiting the women the week of the 23/6/2014 to carry out community care assessments as I have not had any sight of assessments and I also I need to establish and clarify the wishes of the women involved, Lambeth would like to work with to ensure that there is a joint approach to supporting the three women in making longer term decisions as to where they will reside and whether they have eligible social care needs. As I will be in I would also like to meet with you and the social workers involved to share information and look at next steps. Particularly if the women are wanting to reside in	
	With regards to your questions about the duty of care; Lambeth is currently funding the accommodation costs for the three women and following assessments this would inform who and where the women wish to reside and what level of care may be required. Given that the women are in the duty of care would be with as the move to was not planned by Lambeth. Given the unique situation and background to this case Lambeth would want to work in partnership with to ensure the appropriate care and support	

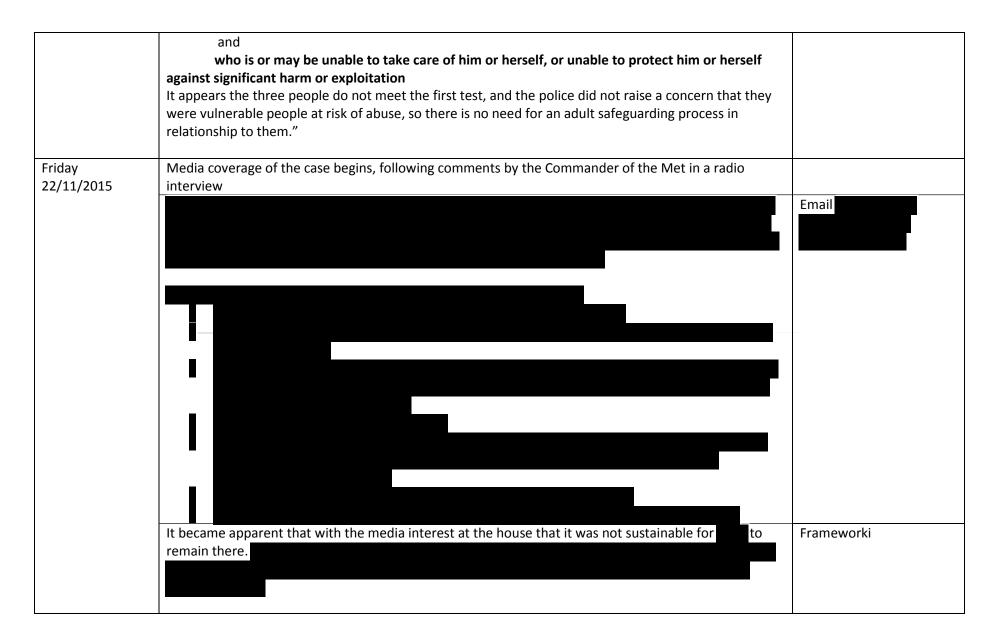


8/7/2014	wrote to to say	FWi 774068, Case note of
	"I am requesting copies of the following documents if you have them; Social Services	8/7/2014
	assessment(s); any relevant risk assessment. I have attached a signed consent form;	
15/7/2014	Lambeth wrote to to say appear to be ordinarily resident in	
22/7/2014	wrote to Lambeth	FWi 774068, Documents
4/9/2014	Lambeth wrote to . The letter includes	FWi 774068, Documents
	"My client correctly considers that the ordinary residence of the three women transferred to upon their arrival there in October 2013.	
	once my client became aware of this matter and its unique nature and the vulnerability of the three women, LB Lambeth agreed to fund the placement exceptionally and as a matter of good practice by way of s.2 LGA 2000. These placements could not have been funded under s.21 NAA 1948 as my client had no knowledge of the three women or any possible social care needs they might have and consequently asked to carry out the relevant assessments. It is my client's contention, as set out in my letter of 15 July 2014, that has a duty to assess the three women's community care needs and to put the appropriate support in place."	

9/9/2014	Lambeth wrote to	to give 28 days' notice of the	FWi 774068, Documents
	end of Lambeth paying for this arrangement.		

# Appendix C: Chronology of safeguarding adults work by Lambeth Adult Social Care October 2013 onwards

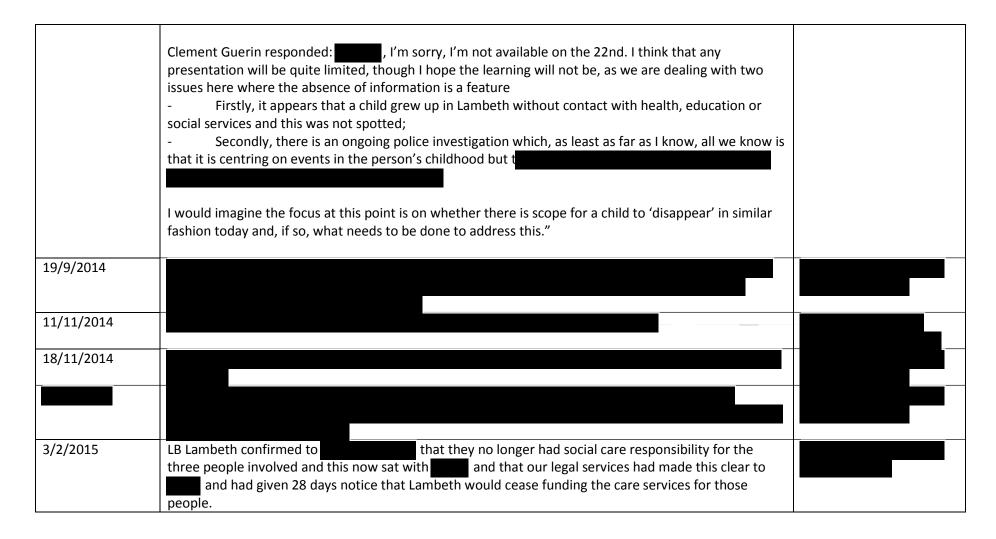
Date	Event	Source
28/10/2013	Police colleagues contacted adult social care following the 3 people leaving the home.	Frameworki
31/10/2013	Safeguarding adults referral episode created for Mrs Balakrishnan's sister.	Frameworki
5/11/2013	The Quality and Safeguarding Adults Service were providing daily advice sessions to the Specialist Disability Service at the time, as month-long arrangement in response to the findings from a QA Audit in September. The advice from Clement Guerin (Head of Quality and Safeguarding Adults) was that a safeguarding adults investigation was not required.  Notes from the discussions that day say  "The adult safeguarding referral came about from contact from the police.  Scope We had a discussion about the scope of the adult safeguarding work – would the three people be covered? It can be helpful to go back to the underlying mandate, the "No Secrets" statutory guidance. It says a vulnerable adult / adult at risk is a person who is or may be in need of community care services by reason of mental or other disability, age or illness;	Email from Clement Guerin to



Sunday 24/11/2015	Safeguarding adults referral episode for  • completed	Frameworki
Monday 25/11/2015	Adult Social Care and Childrens Social Care colleagues hold a planning meeting	
	Adult Social Care and Childrens Social Care colleagues hold a further planning meeting	
Tuesday 26/11/2015	7:18 AM Invitations sent to a strategy meeting at 3pm	Email invitation sent by Clement Guerin
	3:00 PM  A safeguarding adults strategy meeting was held  There were attendees from LB Lambeth, Childrens Social Care will lead on the safeguarding children elements Specialist Disability Team will lead on the elements relating to care and support needs The Quality and Safeguarding Adults Service will lead on the safeguarding adults elements	
3/12/2013		

9/12/2013	Another safeguarding adults strategy meeting was held.  The main outcomes from this meeting were	
	<ul> <li>For Adult Social Care to compile a chronology comprised of the information from all partner agencies, which would then be shared with the police</li> </ul>	
	A provisional date for a further meeting was agreed though it was noted that "It is foreseeable that this might not be needed if, for example, there was no imminent prospect of charges being made when the suspects attend police bail on 21st January."	
Tuesday 7/1/2014	Safeguarding adults strategy episode is created	Frameworki
Wednesday 8/1/2014	Safeguarding adults strategy episode is completed	Frameworki
Thursday	Safeguarding adults enquiry episode is started and completed.	Frameworki
9/1/2014		
	Safeguarding Adults Conclusion of Enquiry episode started	
10/3/2014		
8/4/2014	Safeguarding Adults Conclusion of Enquiry episode completed	Frameworki
Friday 11/4/2014	A meeting took place between  Clement Guerin (Head of Quality and Safeguarding Adults).	
	It was agreed that the LSCB's SCR Subcommittee would lead on looking in to the children's safeguarding issues and lessons to be learned.	

Saturday		
12/4/2014		
0/7/2011		
8/7/2014		Email
	to ask	
	"I am writing to see if the is an allocated manager or social worker working within CYPS, so I can contact them for progress / updates on the case. I am not aware of any upcoming strategy meetings since held the last one. ACS do not have any open safeguarding and we are still providing support to 4 of the 6 involved. I am the nominated manager for ACS."	
	replied : "There is none, there never was."	
	replied to say "Hi There was a decision I believe from the children's safeguarding board that Children's would lead on historic safeguarding issues / investigation from this case."	
	replied to say "There are none, . The child was never referred into Children's Services.	
	At the same time  to say "  It was to come within the remit of the LSCB SCR subcomittee (see attached), but I've not heard anything since then.  : are you able to give an update on progress with this?"	
16/7/2014		Email
10///2014		Linaii





# Management Review regarding the Balakrishnan case:

# **Benefits and Customer Services**



12 January 2016

## Introduction and background

We have been asked to look at the background of a number of cases due to an ongoing high-profile criminal case and how this part of the organisation was involved and to what extent with the parties concerned.

## Information provided to scrutinise

# **Subjects of interest**



#### **Addresses of interest**

Addresses





We have reviewed the information available to consider:

- Whether the work done was appropriate
  - o Did everything happen that should have?
  - o Did anything happen that should not have?
- Would anything be done differently if the same circumstances arose today?
- Are any changes lessons to be learned?

#### What we looked at

We have two systems where all the information is held in relation to any documents we receive relating to a benefit claim – Information@Work and the main processing system where this information is added to assess their benefit entitlement. This system is called and is provided by Both Benefits and Council Tax information is held in so we are able to see who was linked to particular properties based on the information provided to us to scrutinize. We can also see if any of the parties were connected to any claims for Housing and/or Council tax benefit.

# **Findings**

We interrogated both and Information@Work for all of the addresses and the parties concerned. The service was at that time contracted out to at the actual point of the claim being assessed.
What we found was as follows:
BALAKRISHNAN
Was liable for Council Tax  was also the claimant for HB purposes at this address  when the claimant became  the time and they appear to be sisters.
We have looked though back through the case notes on and there isn't anything to suggest that the claim has been dealt with in any way other than how it should have been.

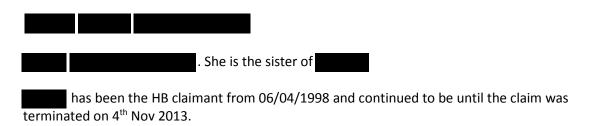
The claim appeared to have been set up in the name of the sister for an initial period and then it

was changed into name. From the paper file held in Information@Work we found that this should have been the case from the onset. That is not what we do now; that was what did though at that time. The process of changing the claimant on a claim is now to create a new case reference rather than change over the person that is the claimant.

The claim went to a review board regarding the status and deductions for non dependants and was then reviewed based on the outcome.

The claim was handled as it should have been and when it should have been; there is nothing untoward relating to the way the claimant or the claim itself were treated that would indicate otherwise.

The Benefits Service was brought back into Lambeth after the claim was assessed for many different reasons but I have no reason to think this would have been dealt with any differently.



REDACTED VERSION: CLASSIFICATION 'OFFICIAL'
The addresses at which the claim was paid are

#### **Conclusion**

From reviewing the information provided I can see nothing that would indicate that the claim had been dealt with incorrectly and the due process and procedures had been adhered to.

On that basis there is nothing here that would warrant changes to the processes and procedures that we have in place.

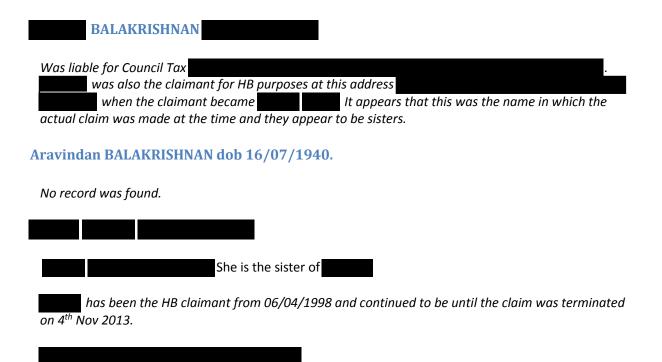
Our conclusion therefore including the consideration of changes needed – none.

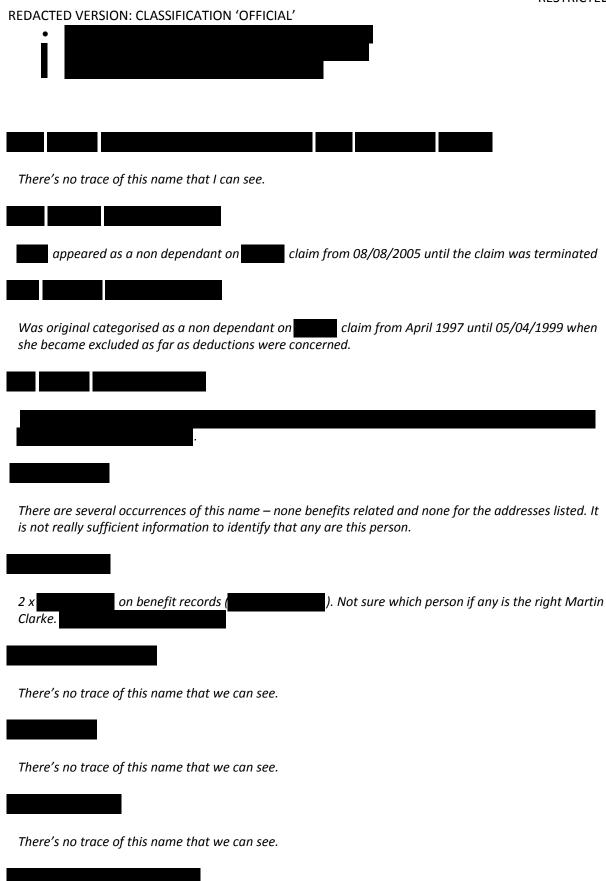
Lessons learned – none as all done correctly

Would we have done anything differently – no all done correctly

For information – please see additional notes below for the all of the parties and properties of interest; this is for information only.

#### **Subjects of interest**





There's no trace of this name that we can see.

03/05/2004 to 20/07/2009.	He was liable for CTAX for the period
There's no trace of this name that wel can see.	
Addresses of interest	
1C PECKFORD PLACE, BRIXTON, SW97BS	
The dates of residency were 08/08/2005 to 01/11/2013	
We can't link any residency to anyone at this address	
We can't link any residency to anyone at this address pre	dates archived data

We can't link any residency to anyone at this address pre dates archived data

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We can't link any residency to anyone at these addresses as this pre dates archived



# Housing management review: Mr & Mrs B



19/1/2016

Housing Management Review REDACTED VERSION: CLASSIFICATION 'OFFICIAL'

### **Background**

Mr & Mrs B were both arrested and taken into custody in November 2014 from the council property in which they had lived since 2005.

The Area Housing Office reports that there were no tenancy issues up to the point they moved out in 2014 and there are no records of any housing management visits to the property or of any tenancy issues arising. There have, however, been a number of home visits conducted by contractors in order to undertake repairs and to carry out annual gas safety checks at the property. No issues of concern have been noted in relation to those visits.

Following Mr & Mrs B's arrest and release from custody they were unable to return to the property. As the couple had no other accommodation available to them the council arranged temporary accommodation in line with the provisions of the homeless legislation.

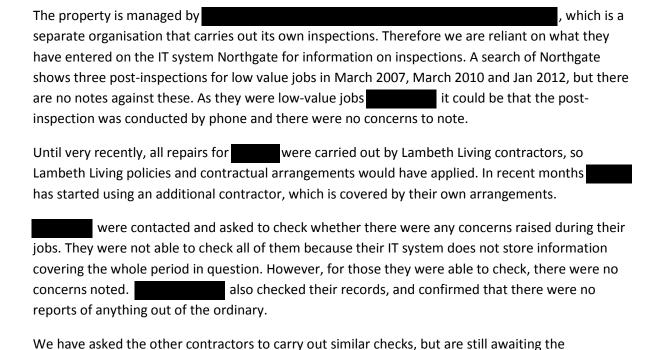
# **Chronology of contacts since 1993.**

1993	Mrs B's sister Ms applied to the council as homeless, with Mrs B included as a member of her household. They were placed in temporary accommodation at various addresses until taking up a secure council tenancy in 2005. During this period records indicate a number of contacts with Ms in relation to However, there is no record of any issues of concern during this period.	
2005	there is no record of any issues of concern during this period.  accepted the offer of a council tenancy and left temporary accommodation.  Housing management records indicate that since August 2006 there have been over 50 logged repairs and gas checks at the property. However, nothing has been flagged up on the system regarding any issues of concern arising from those visits.  The housing management organisation report no tenancy issues and there is no record of visits to the property for tenant management reasons.	
November 2013	Mr & Mrs B were arrested and held in custody	

# **Details of inspections**

We have traced all jobs raised to the property since 2006, the earliest we can go back to on the IT system.

Contractor		No. of visits
		26
	<u> </u>	1
		2
		10
		10
		3



#### Assessment of work done

information.

It is clear that there have been a number of contacts with this household since 1993. Since August 2006 there have been over 50 logged repairs and gas checks at the property. With regards to these contacts, it appears that the works were carried out in a way that would have been expected. However, apart from visits to conduct repairs and gas safety checks, households are not normally visited in their accommodation unless there are tenancy related issues which warrant a home visit. These might include issues arising from a breach of tenancy conditions or from complaints or concerns raised by neighbours or the household themselves. There are no records of such issues having arisen.

In these circumstances there is no indication of any failure to provide appropriate services to this household and the period during which they have had contact with housing services has been largely uneventful up to the time they were arrested. It does not appear from our records that there were any errors or omissions that may have had an impact on us failing to become aware of anything unusual occurring in this household. However, it is not possible to know whether the council's contractors who visited the property in order to carry out repairs and gas safety checks failed to recognise or report any concerns to the council.

Housing Management Review REDACTED VERSION: CLASSIFICATION 'OFFICIAL'

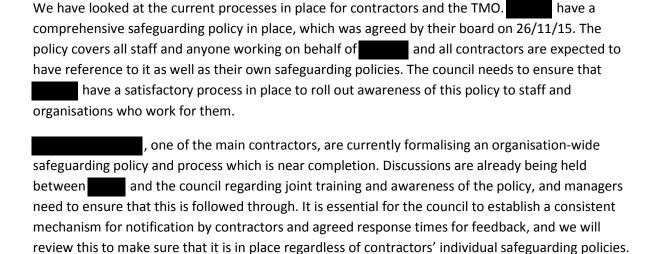
#### Lessons to be learned

One thing that has been highlighted through this investigation is the number of organisations that may be in contact with households throughout the course of their tenancy. This includes council contractors, their subcontractors, and Tenant Management Organisations. There is a need to ensure awareness of children's and adults safeguarding issues amongst our own staff and those of contractors. Because of this, it is important to ensure that safeguarding procedures are clear and built in to our commissioning arrangements with external organisations going forward.

The council needs to ensure that there are written policies and procedures that outline the process to be followed when safeguarding concerns arise as a result of visits to the property, and to record what action is taken. Our staff need to be made aware of this process through training and refresher sessions, with mechanisms for monitoring training put in to place, and this is being reviewed currently.

At present the council does not insist that our contractors have their own safeguarding policies, but we expect their operatives to comply with the requirement to report any incident causing concern. In the past contractors have been trained in awareness of safeguarding, and we must ensure that this is undertaken regularly with all contractors.

There are clear policies in place for dealing with child safeguarding issues and vulnerable adult tenants. The vulnerable adult tenant policy was updated in August 2015 and training rolled out for housing management staff. The intention is for this training to be a rolling programme and that take up is monitored to ensure all staff who may have contact with vulnerable children and adults have received it. Contractors are also being strongly encouraged to take part. Management need to ensure that the policies are regularly updated and circulated to all contractors so that they have reference to it along with their own safeguarding policies.



More generally, housing has been working with colleagues in the Quality and Safeguarding Adults Service and Workforce Development to ensure our staff are equipped with the necessary skills to comply with our obligations under the Care Act and ensuring that we have robust and sufficient procedures in place to support the safeguarding of vulnerable adults and for staff to know what to do if they have concerns about abuse. Housing is represented on The Lambeth Adult

Housing Management Review REDACTED VERSION: CLASSIFICATION 'OFFICIAL'

Safeguarding Partnership Board, which expects us to provide assurances around the effectiveness of our workforce. With that in mind we are about to roll out mandatory training for all housing staff. This training consists of the following:

- 1. The (M)e-learning Tool LEVEL 1 which will be mandatory for housing staff who have any type of client contact. We are expecting all officers to have completed the e learning modules by end of April 2016
- Classroom Module. This is an intensive one day classroom-based course to include adults
  and children's safeguarding, domestic violence and anti-radicalisation. This will build on the
  e-learning module and will be made available for staff (and contractors) who have greater
  contact with residents both in the office and in their homes. This will be delivered during
  March and April 2016.