Eleanor Safeguarding Adults Review

December 2024

Reviewer: Fiona Bateman
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Table of Contents

GLOSSARY **2**

1. **INTRODUCTION** **3**
2. **SCOPE OF THE REVIEW** **3**
3. **NATIONAL AND LOCAL POLICY CONTEXT** **4**
4. **CHRONOLOGY OF AGENCY CONTACTS WITH ELEANOR** **5**
5. **CASE ANALYSIS** **8**
6. **FINDINGS** **12**
7. **RECOMMENDATIONS** **13**

Glossary

ASC	adult social care
AMHP	approved mental health professional
CQC	Care quality commission
DHSC	Department for health and social care
ECHR	European convention on human rights
EDT	Emergency out of hours social care
FRT	First Response Team
HSAB	Haringey safeguarding adults board
KPI	Key Performance Indicators
LAS	London Ambulance Service
MASP	Multi- agency Solutions Panel
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983, as amended
SAR	Safeguarding Adult Review
SAT	Safeguarding Adults Team

1. Introduction

1.1. Eleanor[1] was a white, British woman of Scottish heritage and Christian faith. She was aged 74 when she died at home. Eleanor was described as a memorable lady, intelligent and articulate. Her family explained she knew her own mind and really valued her independence; she was concerned about becoming a burden to them. Eleanor had several health conditions, including an organic delusional disorder[2] as well as co-occurring physical health conditions[3] which had reduced her mobility. Eleanor had advised practitioners that she was reliant on her family for support and, by 2022, was housebound.

1.2. In 2020 she reported difficulties with her housing situation and personal care. Between 2020-22 she made regular calls to the council about the unsuitability of her housing and the impact this was having on her daily living activities. Her housing provider was also aware that she felt unable to make safe use of her home and had sought to arrange a management transfer to an alternative property. When they were unable to find accommodation that accorded to her wishes[4], they referred her to the Council for re-allocation. The Council completed their assessments and notified her of her allocation priority status in November 2022, but alternative accommodation in line with her wishes had not been identified by the time of her death. In November 2022, Eleanor (through her solicitors) wrote a letter of claim to the housing association setting out the house was unfit for human habitation due to mould and a large hole in the bathroom, rotten and cracked window in the lounge and a faulty extractor fan which had resulted in excessive cold within the house. This, she reported, exacerbated her arthritis in her knee and caused discomfort, inconvenience and distress.

1.3. In January 2021 she declined local authority assistance with personal care, reporting her family were assisting with this. In February 2023 she requested local authority assistance with personal care tasks. This request was passed for occupational therapy, but only passed in September 2023 to the ASC Assessment Team for a Care Act assessment. At this point, she reported that she was crawling around her property, sleeping downstairs on a sofa bed and could not get out of the house for hospital appointments. In late December 2023, an urgent package of care was agreed for her, though the care act assessment had still not been completed. Between mid-December to January 2023 her home was without heating. Eleanor passed away from acute left ventricular failure, hypertensive heart disease and obesity on 5th January 2024 before care was in place.

1.4. On the 20.06.24 the Haringey Safeguarding Adults Board [HSAB] SAR subgroup agreed to commission a discretionary Safeguarding Adults Review [SAR] under s44 to explore what, if any, learning could prevent future harm for adults living in unsanitary conditions. Safeguarding Circle were appointed on the 27.08.24. The terms of reference were agreed by the three statutory safeguarding partners on the 19.09.24. There are no outstanding criminal or civil proceedings directly relating to Eleanor and there was no inquest into her death.

2. Scope of the Review

2.1. The purpose of a SAR is not to re-investigate or to apportion blame; the focus is to understand what this case can teach us about potential changes and improvements that could strengthen the system for other people who find themselves in similar circumstances to Eleanor. SARs are future focused, so this report will reflect improvements in practice already implemented since Eleanor's death to bring together findings and recommendations for a whole systems approach for potential action which:

- Address any lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults;
- Review the effectiveness of procedures (both multi-agency and of individual organisations);
- Inform and improve local interagency practice and improve practice by acting on learning (developing best practice).

2.2. The review covers the period 01.01.23 – 05.01.24 though relevant information from Eleanor's background has been included to provide wider context of her needs. The key lines of enquiry will be:

[1] Eleanor's son requested the SAR is published using her real name.
[2] Her GP reported (24.11.22) she had suffered from persecutory ideas that she was a victim of voodoo for nearly 30 years. That she had, in the past, been seen by the community psychiatry team but had 'refused to engage' so had been discharged.
[3] She had high blood pressure, chronic kidney failure, underactive thyroid and knee osteoarthritis.
[4] She wanted to remain in the local area, move to a similar sized two- bedroom property with internal space to store her mobility vehicle.

i. Did agencies properly consider their relevant legal powers to address risks associated with her care needs and the unsuitability living conditions? Were concerns escalated (including via multi-agency routes) to support improved risk reduction?
ii. Were services responsive, given her presentations, to making reasonable adjustments so she could access appropriate support?
iii. What learning can be identified about working with family/informal carers to support safer transitions for older, frail residents?

2.3. Eleanor's family were contacted to inform them of this review. The reviewer was able to speak with one of her sons who throughout the period had acted as advocate for his mother. His experiences and concerns are reflected within this report. Following completion of the report, her son confirmed he agreed with the findings and hoped implementation of the recommendations would ensure that no-one else would have to experience the delays his mother suffered in getting urgent care.

3. National and local policy context

3.1. Statutory duties to assess social care needs under the Care Act 2014 are triggered on the deliberately low threshold of an appearance of need for care and support (s9 Care Act). There are also corresponding low thresholds and duties to assess if carers require support (s10). Whilst there are powers to meet urgent needs pending assessments (s19 Care Act), there is a prohibition on local authorities meeting needs under s18-20 Care Act if it is to provide services to meet health needs (s22 Care Act) or for accommodation (s23 Care Act). This legislative restriction is intended to give primacy within the statutory framework to obligations under the Housing Act 1996 (to meet housing need) and under the NHS Act 2006 (to meet health needs[5]). The impact of unsuitable housing and ill health has on social care needs and wellbeing is well understood. The Care and Support guidance[6] advocates that assessments should consider wider needs, that staff involved in the first contact must have the appropriate training and benefit from access to professional support from social workers, OT and other relevant experts (ch6.27) including to prevent needs escalating (ch6.60) and enable holistic assessments by making arrangements to carry out joint assessments, including with health and housing colleagues (ch6.75). Various statutory guidance and case law sets out how public bodies should apply each relevant statutory duty; all require practitioners to have regard to overriding duties to protect life and prevent against inhuman or degrading treatment. There are limited circumstances[7] when applicants could be accommodated under social care legislation, but this is usually prohibited if those needs can reasonably be met via Housing Act 1996 duties. Where, however, an adult with care and support needs is at risk or experiencing abuse or neglect and is unable to protect themselves, relevant partners are obliged to work together to safeguard the adult (s42 Care Act). This duty sits alongside, but does not replace, legal powers and duties to assess and meet health, housing and social care need under the principal legal provisions.

3.2. In 2022 the Council published their housing strategy[8]. This details comprehensively the challenges faced by residents in the borough and by the Council in meeting demand for homes. It noted that 10% of Haringey residents have a disability, 4,500 have a serious disability. As of 1 November 2024, the Council has confirmed there are over 2,000 households on the housing register are overcrowded and conversely 251 households are registered to move as having a home larger than their need. There were a further 2,675 residents that were homeless and living in temporary accommodation.

3.3. CQC's State of care report[9] highlights that in 2022-23 local authorities received over 2million requests for ASC support from new clients. By August 2023, during the period under review, almost 250,000 people were waiting for care act assessments in the UK. By April 2024 NHS England data shows the combined waits for care home and home-based care accounted for 45% of delayed discharges from acute hospitals. London was recorded as having the lowest proportion (17%) of delayed discharges from hospital for home-based care. The report also highlights that whilst demand for intermediate care (of the type Eleanor would have required) was higher than any previous period (245,000 in 2022-23), provision had not correspondingly increased, resulting in proportionately fewer care packages. The report goes on to highlight critical staff shortages (11.6% vacancy rates) and high staff

[5] Unless these are 'of a nature the local authority could be expected to provide and doing so would be merely incidental and ancillary' s22(1) Care Act, but see also National Framework for Continuing Healthcare
[6] Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
[7] See *R (on behalf of G, W, A) v Barnet LBC and others* [2003] UKHL 2003
[8] Available at: https://haringey.gov.uk/sites/default/files/2024-05/haringey_housing_strategy_2024_-_2029.pdf
[9] Available at: https://www.cqc.org.uk/publications/major-report/state-care/2023-2024/access/asc

turnover (20%) across the sector placed significant pressure on ASC staff to meet their statutory duties to assess and provide safe care in a timely way.

3.4. Locally, Haringey reported they were experiencing many of the same national pressures. Service delivery of the social care assessment function was split across the First Response Team [FRT] and specialist teams, such as learning disability, or older person's teams. The safeguarding adults team [SAT] and occupational therapy team [OT] were standalone teams. Any initial contact from a resident for social care support would be triaged by the First Response team or, between 5pm-9am the Emergency Out of Hours [EDT] worker. EDT support was typically provided by phone and limited to gathering sufficient information from the caller to enable triage either to providing information and advice or signposting to alternative support (e.g. community based early intervention services). In exceptional cases, the EDT worker could arrange urgent care for one night, though this also required an urgent onward referral (by email) to ASC for a more detailed assessment the following day. There was no way for EDT to track whether FRT had received and responded to those requests. The FRT were designed to complete initial triage and assessment; if necessary they were able to conduct face to face assessments. Thereafter they could arrange, if suitable,[10] a reablement care package. Alternatively, they could signpost those with longer-term or higher support needs (e.g. palliative care, respite requests or severe cognitive impairments) to ASC specialist teams or to the SAT if there were concerns the adult may be at risk of abuse or neglect. During the review period, the ASC reablement team had a high caseloads where significant case management responsibilities had resulted in significant delays. Once an assessment concluded a care package was necessary (including an interim assessment completed over the phone by FRT, or EDT deciding to put in urgent care under s19(3) Care Act) this request was passed to ASC's brokerage team to arrange.

3.5. Since the review period, ASC has reviewed its operational structure (moving to a localities model and increasing staff within those teams by 25%) and their practice; they now use an ASC strengths-based practice model[11]. They also report improved managerial oversight by introducing Key Performance Indicators [KPI's] dashboards and monthly meetings between the performance team, heads of service, service managers and team managers to discuss plans for improvement, with exceptions being taken to departmental management team. ASC reported that findings from case file audits are also discussed at these sessions to ensure there is a loop of learning and improving. During the learning events, practitioners commented they had started to see improvements in responses now the localities model has been implemented and that, where there were outstanding actions, it was easier to escalate that to relevant team or service managers. By the close of year 2024, waiting lists for assessments had reduced as the changes had resulted in a 70% increase in completed assessments compared to the previous 8 months, but there remained over 300 residents awaiting a needs assessment and over 50 carers awaiting assessment for support.[12]

4. Chronology of agency contacts with Eleanor

4.1. Eleanor's family explained throughout the time she lived at her address she had been unable to access the upstairs due to arthritis. She had a lifetime secure tenancy and was meeting the terms of that tenancy agreement. Her family reported, however, she had always understood that this accommodation would be temporary. The property had two bedrooms on the first floor, a living room (which she used to sleep), kitchen and bathroom on the ground floor. There was a 7" step and grab rail to access the property and another into the bathroom. The bathroom did not have a level access shower or adapted bath.

4.2. Eleanor had regular contact with the Council's Adult Social Care [ASC] services between 2009 until her death. Their records show her mobility difficulties were understood to impact on her ability to use her home safely. She had first been referred for an OT assessment and adaptation equipment in 2009 which had recommended a level access shower. Between 2015-19 further OT assessments confirmed this would be required, but as Eleanor had indicated she wished to move home, this was not progressed by the Council. Her landlord (a housing association) had agreed to her request for a management transfer to more suitable accommodation. Eleanor had given permission for her son to act with 'delegated authority' on her behalf with the housing association, but he was not recorded on

[10] This was determined by way of a set of descriptors, including that the person's care needs likely reduce over 6 weeks.
[11] This model was coproduced with practitioners (supported by Research in Practice as a critical friend) based on 11 strengths-based standards that practitioners are expected to demonstrate in all of their interventions with adults and carers. This has been adopted as a borough partnership model and is used by health, children and community colleagues.
[12] Taken from the CQC self-assessment report, p23.

the Council's housing or ASC's records as a someone she wished them to contact. He confirmed he had made numerous representations on her behalf to the housing association regarding disrepair at the property (including submitting photographs) and for a move to more suitable accommodation. He remembers being told by the housing association that adaptations and carers would be made available after her transfer.

4.3. In January 2020, during a further OT assessment, additional equipment was ordered to enable Eleanor to prepare food and to assist getting in and out of her bed. The OT also noted concerns about cluttering and disrepair at the property and reported these had been raised with the housing association. In October 2020 Eleanor advised ASC and her landlord she would not accept a transfer to a one-bedroomed flat as her son and granddaughter stayed over to support her. In 2021 Eleanor declined ASC offer to provide personal care, but accepted additional equipment to assist her mobility. In June the housing association identified an alternative ground-floor property, but recognised this would require some adaptations before Eleanor could move in. Eleanor worked with an allocated officer from the housing association's tenancy sustainment team to prepare for the move. She purchased items for her new home but the offer was withdrawn before the move as it wouldn't meet her requirements, nor was it structurally safe. The housing association concluded they did not have any suitable properties for the management transfer so referred Eleanor for re-allocation to the Council's housing department. Separately at this time, her tenancy sustainment officer raised concerns via the Council's safeguarding team that Eleanor may be at risk of abuse or neglect. When contacted by ASC staff, Eleanor confirmed she was not subject to abuse, but did request a carer. A case record notes she had been referred for a care act assessment, however, this wasn't actioned by any team.

4.4. In February 2022, the Council's housing allocation team registered her request for an allocation of an alternative property on medical grounds. Throughout 2022, Eleanor raised concerns to her GP and landlord that she had not been rehoused. Her GP provided letters[13] in support of the move, detailing her medical conditions. These were addressed 'to whom it may concern' or to the housing department. In November 2022 the Council requested and received a medical assessment from their provider (NowMedical). The Council's subsequent decision letter (dated 23.11.22) states this considered her representations, the health assessment form and OT form. It did not include consideration of her mental health. Eleanor was allocated a Band C rating (moderate medical priority-moderate medical or welfare needs[14]). She was also advised she had been allocated Band A for rehousing as her future housing needs were for a one-bedroom property so was under-occupying her accommodation. The letter provided details of how Eleanor could appeal the decision. Eleanor did not appeal this decision, though the housing association's tenancy sustainment officer did write out of time for the appeal (on 03.04.23) on her behalf requesting a review, but as there was no additional or new information provided so a further assessment wasn't undertaken. During the learning events, Council staff confirmed re-housing with a Band C priority is exceptionally unlikely. This information is not included within her decision letter so it is unclear if this was communicated directly to Eleanor. However, the Council publish information on average time for waiting by bed size on an annual basis.

4.5. In January 2023 her family requested support (an OT assessment) with rehousing. This was triaged and referred to Connected Communities. In February 2023 Eleanor contact ASC to request assistance with her personal care. She chased again in March, but was told she needed to wait. In May she was advised to contact another worker, though it isn't clear within case notes who that was and whether this was within ASC (e.g. an OT) or the housing team. By July she advised the Council's Emergency and out of hours team [EDT] of a serious fall and that she was unable to achieve three outcomes (cook, use her home or access the community). She called EDT again in August. Her GP reported attending the home in August 2023, she carried out a physical exam as Eleanor had reported physical symptoms[15]. Her GP, noting that the home conditions were reasonable, advised to purchase a blood pressure monitor and notify the practice is she had any concerns regarding her blood pressure. She was referred on the 04.09.23 she by the First Response Team [FRT] for OT support. Her safe and sound alarm stopped working on the 10.09.23 and in response EDT contacted

[13] Her GP records suggest that in 2020 (and again in 2022 and 2023) Haringey Council's housing dept. was contacted about the state of the property and its unsuitability due to her mobility issues

[14] Higher banding would only have been applied if there was evidence of 'serious medical or welfare need' (Band B) or 'the applicant's condition is life threatening (or likely to become life threatening) and their current housing is a major contributory factor' (Band A).

[15] Eleanor disclosed symptoms she believed were because of voodoo performed against her. The GP conducted an examination and provided reassurance she did not have injuries or illnesses she believed to have been inflicted on her.

her family (a son who lived nearby) who advised she was 'probably sleeping'. When she called back the next day, she was advised to call the assistive technology company or get her son to.

4.6. On the 12.09.23 her case was passed to ASC assessment team for a care act assessment. She called on the 18.09.23 to request a ramp for access out of the property and again on the 27.09.23 explaining she had to crawl on the floor and couldn't make meals. The case was allocated for an OT assessment a month later (on the 27.10.23); contact was made on the 02.11.23 by the OT who arranged to visit on the 07.11.23. Eleanor requested a ramp for the front door, but the OT did not believe a portable ramp would assist, noting Eleanor '*walks independently with walking stick and does not use any form of wheelchair…. The mobility scooter resides outside of the home and there would be no safe space to use the scooter within the home due to congested living space.' In addition, the OT observed it would be highly unlikely that a ramp could be positioned and still have room for her mobility scooter.*'[16] Again Eleanor was advised that, as she wished to move home, the OT would not suggest adaptations were done to the current property. Within ASC case notes the OT recorded '*housing discussed. Mobility reported to be 'good*''.[17] The OT noted Eleanor expressed delusional thoughts regarding her health issues arising from Voodoo inflicted by her ex-husband. The OT also spoke to Eleanor about the boxes and electronic heater in her living room and hallway which prohibited easy access and posed a fire risk. Eleanor explained the boxes were items she had purchased for her intended move. She did not believe she was hoarding or that this was clutter. The OT noted concerns had been discussed in 2019 so concluded it is '*not a new issue'*. The OT confirmed she had equipment in situ to assist with transfers in and out of the bath and a perching stool for washing. Over the following month the OT contacted the housing association to understand why the housing transfer had failed in 2021. The Council's housing team offered her a move to a one-bedroomed property in 2023, but this was turned down by Eleanor. The Council also confirmed that Eleanor would be low priority for a 2-bed property as her son did not live with her. It is understood that Eleanor's son had advised he worked full time and had caring responsibilities for children and so couldn't provide much support for her.

4.7. On 25.11.23 Eleanor contact EDT reporting an accident whilst cooking. They note she again expressed delusional thoughts. On 28.11.23 the OT reported Eleanor '*is still adamant about wanting a 2-bedroom property and unwilling to listen to OT reasoning. OT emailed Assessment team about this situation and also made reference to possible mental health issues but E not willing to address this*'.[18] On 08.12.24 Eleanor called again requesting help, as '*housebound isolated, frail with breathing problems and without family'*. The Senior OT requested assistance from the ASC assessment team. This was triaged by a duty social workers on the 11.12.23 for allocation of a care act assessment. Eleanor called again on the 11.12.23 and 22.12.23 asking for help with personal care and meals, explaining she kept falling. EDT returned her call on the 23.12.23 explaining they could not find domiciliary care agency to provide support. On the 24.12.23 the EDT worker contacted rapid response but were advised this was unavailable for Haringey residents. Eleanor advised her son could help temporarily but that she needed urgent support. On the 27.12.23 a further request was made by EDT to FRT for an urgent care package and to address heating issues. The following day the FRT worker confirmed the housing association was aware of the heating issues, had provided heaters but were also arranging repairs. On the 29.12.23 ASC panel agree 3 calls per day as an urgent care package.

4.8. Between the 01-03.01.24 Eleanor reported she couldn't get up and was advised by EDT to call 111 NHS if required assistance. A lack of a keysafe resulted in further delays in putting in place the urgent care. Her son confirmed she was not in receipt of the care package and was sleeping on the bathchair as she was unable to get up from her sofa-bed. They requested a profiling bed; FRT referred the request for equipment to OT. On the 03.01.24 Eleanor spoke with her GP and asked for assistance in getting a bed. Her GP explained that she couldn't get a new bed, but did email FRT to ask that they expedite her request for a bed. The case was reviewed by an ASC senior manager who gave permission to increase the care package, but there is no explanation on her records about what steps were taken to ascertain why a domiciliary care agency had not attended between 29.12.23-04.01.24. The records note that the allocated social worker was on annual leave. A visit was planned by the OT to assess on the 05.01.24 for the profiling bed and to check her family had decluttered a room so this could be installed. The domiciliary agency confirmed to commissioning they had

[16] Taken from the OT assessment completed on the 07.11.23 and uploaded on the 20.11.23
[17] Taken from the ASC chronology submitted for this review.
[18] ibid

completed their risk assessment and would start the service on the 05.01.24. Sadly Eleanor's health rapidly deteriorated over the 04.01.24. She was found by her son unresponsive after a fall, LAS attended but were unable to resuscitate her and she died in her home.

5. Case Analysis

5.1 Duties to maintain a property is usually shared between the landlord and the tenant, with the responsibilities and expectations to report and respond to disrepair set out in the tenancy agreement. In addition, the landlord is also statutorily required to ensure the property is fit for human habitation and keep in proper working order installations that supply gas and electricity, heating and hot water and water and sanitation[19]. A landlord is also responsible for keeping the structure and exterior of a property in good repair.

5.2 As noted above, Eleanor instructed solicitors in November 2022 who wrote to the housing association setting out an intention to issue civil proceedings because of the disrepair. The housing association conducted an inspection and responded accepting the windows were showing signs of disrepair, that they would wash down mould in bedrooms, stairs, hall and landing and treat the mould in the bathroom, repair the damage to the wall in the bathroom and redecorate and renew the extractor fan. They also offered to clear the garden and repair and renew damaged floor substructure and coverings. They subsequently wrote again to Eleanor's solicitors in April 2023 highlighting that Eleanor had failed to notify the housing association of the disrepair. A date for repair was suggested for May 2023, but the housing association reported their contractors were not given access to carry out the works. The housing association reported to this review further attempts were made to complete the works, but these proved unsuccessful. Eleanor's family dispute this, they explained they would have helped the repairs to have been completed had they been notified of the dates. They explained, Eleanor was desperate to get the house warmer and safe, but nervous of letting contractors in. The housing association accepted that their focus shifted to seeking to find (with the Council) an alternative property for Eleanor, in line with her wishes. They intended to thereafter complete the repairs to the property. In June 2023 Eleanor issued proceedings. The housing association filed their defence to those proceedings in October 2023. There has been no further correspondence from the Court in respect of these proceedings and it is believed these are ongoing. This review makes no findings in respect of the disrepair as this is the jurisdiction of the civil courts.

5.3 Practitioners first were aware of concerns regarding the unsuitable accommodation in January 2020, though her family report the house was never suitable as she had always been unable to access the first floor. Duties to make adaptations to properties are usually led by the Council through the Disability Facilities Grant [DFG] process. Where the property is rented, this will require permission from the landlord. The Council accepted that during this period there were significant delays in securing OT assessments for DFGs due to a paucity of OTs and rise in demand for that service following the pandemic. Currently there are over 300 people waiting for specialist adaptation and equipment, though the Council report they have agreed an action plan and steps to ensure managerial oversight of the prioritisation[20].

5.4 The housing association also confirmed they were aware of the needs for adaptations to the property, but that offers to improve the property had been frustrated as Eleanor remained clear that she wished to move so major renovations/adaptations could not be authorised. They explained they had tried to work with her, including providing additional support via their tenancy support staff, to facilitate a transfer but that this had not been possible as Eleanor was adamant that she would only move to a similar size property in the area. An OT assessment in November 2023 had considered if additional equipment would assist her to access the property and concluded she had all necessary equipment to meet her needs for cooking and bathing. The report noted she was '*observed to navigate her home environment independently with use of her walking stick despite the clutter observed in the walk way from the living room to the kitchen.*'[21] The OT noted concerns about cluttering in her hallway and ground floor rooms. Eleanor explained this was not clutter. There is evidence Eleanor accepted support to maximise her independence within the home, including assistive technology and equipment so she could access washing and cooking facilities. She was also advised that

[19] s9A and s.11 Landlord and Tenant Act 1985
[20] CQC self assessment report, p35
[21] Taken from the OT assessment report dated 24.11.23

adaptations would not be possible in the current accommodation, as she wished to move, so the resolution would be for her to be re-housed.

5.5 Notwithstanding this, her family remain of the view the property was ill-equipped for her needs due to the difficulties she had accessing the front door, first floor and using the bathroom. They also reported the disrepair in the property was significantly impacting her wellbeing and that for the last weeks of her life the heating was not operational. The housing association reported the boiler have been serviced in June 2023. Further, they confirmed this was tested again in November 2023 following complaints it had stopped working. On 16.12.23 this again stopped working, an engineer attended and found a generic fault cost on the boiler indicating this was overheating. The engineer reported Eleanor had refused temporary heaters. He also noted her disability and welfare concerns regarding cluttering in the property but did not raise a welfare concern or refer the boiler for onward action. Consequently this task was incorrectly sent to the warranty team, effectively placing it on hold. The following day, a further request was made by Eleanor's son for temporary heaters and this was actioned. On the 19.12.23, following a call from her son requesting help, a management review recognised parts were needed and these were ordered. A further attempt was made to fix the boiler, but this was unsuccessful. A further report on the 26.12.23, that the temporary heaters had stopped working, was responded to by an engineer who visiting the house and confirmed they were. On the 27.12.23 the housing association report the engineer was unable to get access to fix the boiler (following receipt of the parts). The engineer reported to the housing association abusive behaviour by Eleanor. Her family explained, she had asked to see his ID and he claimed this was in the van and when she asked if he had the part and he stated he didn't, she then swore as an expression of frustration. She asked him not to leave, but he refused. So this work was only completed on the 02.01.24. Eleanor's family felt this fell below what she should have received, they felt more consideration should have been given by contractors and the housing association to involving them to assist with resolving the disrepair/ heating issues and explaining why her move had been delayed. Recommendation 4 relates to this issue.

5.6 The second SAR national analysis[22] identified a key improvement priority was for SARs to build on previously completed reviews, including those undertaken locally [priority 3]. Within that context, the findings in Haringey SAB's 'Steve SAR'[23] where inappropriate housing conditions were noted by the social worker as preventing him from making use of his home safely (as with Eleanor). In the Steve SAR those risks were not addressed within the care plan as it was wrongly assumed this would be tackled separately. Partners had already agreed to implement the recommendations arising from the Steve SAR. As part of this, training was offered to staff detailing Steve's case and emphasising the importance of professional curiosity in November 2023 and in September 2024. It is noteworthy that this initial training was just as Eleanor was raising concerns that she was at high risk without the care she needed.

5.7 In contrast to the findings in the Steve SAR, it does appear practitioners took into consideration wider duties to maintain her wellbeing. There is evidence within the case files of attempts made to discuss directly with her the risks that the stored items posed, given her mobility, and the impact that was having on her ability to use her home safely. The housing association's tenancy support officer, GP and OT all felt confident that the home conditions, though not ideal, did not require onward referral to secondary mental health support to address or that this would constitute self-neglect of a level that should trigger a s42 enquiry. Eleanor was also deeply resistant to interventions from mental health support, believing that those who had labelled her beliefs as a mental health disorder were acting unlawfully.

5.8 Practitioners had voiced concerns about Eleanor's ability to make wise choices regarding her housing needs, but those who knew Eleanor believed she had capacity to make decisions, notwithstanding her assertions that many of her disabilities could be attributed to voodoo. This was confirmed by her family, who felt that despite her unusual beliefs she understood the choices available to her. There is no dispute that Eleanor's poor physical health had resulted in disability which made it more difficult for her to access the community. In January 2023 in response to a request for care and support, Eleanor

[22] Second National Analysis of Safeguarding adults Reviews (2024) Preston-Shoot et al, available at: https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2019-march-2023-executive-summary.
[23] Available at: https://www.haringey.gov.uk/sites/haringeygovuk/files/sar_report_steve_2023.pdf

was referred by the Council's FRT to 'Connected Communities'[24]. They were asked to allocate her a support worker to help her respond to letters. This service was set up to support adults newly in the UK to access Council services. It does not appear Eleanor received assistance from Connected Communities. Given the tenancy support officer's support she already had in place, if this referral was intended to mitigate risk of needs escalating whilst she was waiting allocation for a care act assessment, this was a duplication. What was needed was an opportunity to bring together those managing her needs during the waiting period (her GP, tenancy support officer, OT) so a shared plan could be put in place. Nonetheless, for most of the review period Eleanor was able to rely on her family to provide her shopping, and could use equipment provided through the OT service to meet her care needs.

5.9 Predominantly her requests for additional assistance with her health and social care needs were made out of hours either to 111 NHS services or to EDT. Neither of these services are intended to replicate health and social care services available during office hours. Within the Council's EDT there is usually one member of staff available to deal with any out of hours social care emergency. This includes responding if someone is in mental health crisis and requires an assessment by an approved mental health practitioner. Interventions are therefore typically very brief with limited opportunity to follow up. As noted above, during the review period there was limited capacity for strategic oversight to ensure internal onward referrals from EDT to ASC teams for follow up were actioned. Whilst structural and procedural changes have reportedly led to improvements, it will be important for KPIs to routinely report on protected characteristics data and outcomes. Similarly, 111 NHS act as a triage for patients, passing relevant information to GPs to assist with follow up care. There is also evidence that her GP made reasonable adjustments, conducting home visits, to assess and treat any health complaints.

5.10 Within her case records, staff working in both EDT and 111 NHS recognised Eleanor's behaviours may indicate reasonable cause for concern that her mental health may be deteriorating. This was largely in response to comments she made that challenges she was facing were because of voodoo. Within voodoo there is a belief that people can be cursed by a person who is unhappy with them. There is also a belief in predetermined fate, meaning that those who follow this religion tend to believe that their fate has been determined since birth which could dissuade them from seeking medical help for illnesses and injuries that they believe were "meant" to happen and are out of their control (DeSantis 1989). Research (relating to Haitian diaspora in the USA) demonstrates how increased cultural competency in respect of voodoo beliefs can improve health outcomes.[25] Eleanor is of Scottish heritage and was noted to be of Christian faith, her family and professionals were of the view that these beliefs indicated a delusional disorder, though it is important to note that a review of case records demonstrates this did not prevent them from respecting her stated view. There were examples within the case files of practitioners taking time to reassure her that she was not cursed, of careful examination and gently reaffirmation that she was not displaying symptoms and would benefit from support and of assessing her need for equipment objectively and, thereafter, providing this.

5.11 Prior to and throughout the review period Eleanor clearly articulated her wish to move, but also asserted she would only accept an equivalent offer. Her housing association, latterly through their tenancy support worker, took the lead in supporting her to be re-housed. There is evidence that the housing association initially identified a property within their own stock. After that offer was rescinded, they completed a re-housing request on behalf of Eleanor and, albeit out of time, on the 03.04.23 requested a review of her priority banding based on the information Eleanor had provided. Her family and practitioners, including the OT and her tenancy support worker, also discussed with her a move to more suitable accommodation. There is no record that practitioners identified any reasonable cause to suspect her beliefs were undermining her ability to understand or weigh up her housing options. Likewise, her family felt it was reasonable for her to decide to remain in her current property until an equivalent offer could be made.

5.12 Whilst the Care and Support guidance now advises *'a decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external*

[24] To provide advice and assistance, including mediation with private sector and housing association tenants. More information is available at: https://new.haringey.gov.uk/community-support-safety/connected-communities/how-connected-communities-can-support-you

[25] Taken from https://egrove.olemiss.edu/cgi/viewcontent.cgi?article=1081&context=southernanthro_proceedings

support.'[26] During the learning events practitioners demonstrated awareness of HSAB's multi-agency procedure[27] but were satisfied that Eleanor was able to request assistance and understood the advice she had been given to reduce risk. This changed towards the end of the review period, when (on 08.12.23), Eleanor's ability to meet her needs or stay safe deteriorated and, in recognition of this, the senior OT requested additional input from ASC in the form of a needs assessment. The subsequent delays and lack of effective escalation are explored below.

5.13 Research findings into self-neglect[28] warn practitioners that they should explore the person's ability to protect themselves. This is important in the context of safeguarding functions because it is the 'ability to protect themselves' rather than the capacity to make decisions that is the basis for safeguarding legal duties under s42 Care Act 2014. This duty sits alongside a general duty to carry out all social care functions in a way that promotes an adult's wellbeing. The 'wellbeing principle'[29] includes a focus on personal dignity, choice and control, but there '*is no hierarchy, and all should be considered of equal importance when considering 'wellbeing' in the round*'.[30] Equal weight should be attributed to duties to protect health, remove risks of abuse or neglect alongside respecting choice and control. Professional judgement is needed in such situations, practitioners must balance natural instincts to intervene with obligations (under s1 Care Act) to safeguard or promote independence with the need to respect autonomy and develop a relationship of trust. Similarly SAR reviewers must avoid the temptation of hindsight bias. In this case, the senior OT made the professional judgement to request for a care act assessment rather than raise a safeguarding concern. This was a reasonable decision in the circumstances, not least because then (and now) the Council's safeguarding adult team do not have delegated authority to put in place a care package even if they deem this necessary on an urgent basis whilst a full assessment is undertaken. Recommendations 2 and 3 relates to this issue.

5.14 The housing association's tenancy support worker confirmed that where they do have concerns that a tenant's home may be unsanitary or poses a risk to their health or wider public health/safety they would make a safeguarding referral. There was evidence also within Eleanor's case records that this officer was aware and had acted on concerns previously in line with safeguarding responsibilities. The worker also explained that where a tenant is at high risk and is not responding to advice, the housing association convenes a 'complex action group' to enable a 'team around the person' approach. This will usually also involve other agencies, such as ASC or the London Fire Brigade if a person-centred fire risk assessment indicates the person would benefit from a home safety fire visit and bespoke advice. This is in line with good practice responses to self-neglect.

5.15 Given the shared view that the property was not suitable, practitioners could have called a multi-agency strategy meeting or, if that was unsuccessful, used either the housing association's 'complex action group' or Council's multi-agency solutions panel [MASP][31] and thereafter consulted with Eleanor and her family so there was a collective understanding about what the allocation priority banding meant and how this would impact on timeframes for a suitable alternative property. This would also have provided an opportunity to explicitly record whether there was a shared view regarding her capacity to weigh up the information and execute a decision regarding suitable accommodation. It should also have facilitated practitioners, including her GP, tenancy support worker and OT to consider if further adjustments were needed (by them or the Council) to comply with Care Act, Mental Capacity Act or Equality Act duties or if an alternative accommodation pathway (e.g. supported or shelter accommodation) would be a more suitable option. A short strategy meeting of this nature would have likely resulted in an agreed plan, thereby reducing professional and family anxiety over the perceived delays to re-housing. Crucially, practitioners involved in this review were unaware of the MASP. Wider awareness raising of the MASP has been a feature of recommendations within HSAB SARs, but recommendation 1 is intended to complement the existing HSAB workplan to specifically address clearer practice guidance between primary health care, social care and housing practitioners.

[26] Ibid, pg.14.17
[27] This encourages practitioners to use the risk assessment tool and hold multi-agency meetings. It sets out the key agencies' roles and responsibilities. However, there is currently no mechanism (outside of s42 processes) to report on the outcomes of such meetings.
[28] For example, Bray, Orr and Preston-Shoot (2015) 'Serious case review findings on the challenges of self-neglect: Indicators of good practice' Journal of adult protection 17,2, 75-87
[29] S1 Care Act 2014
[30] Section 1.6 Care and Support Guidance, DHSC available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#general-responsibilities-and-universal-services
[31] Details regarding the purpose of the panel and referral forms are available at: https://www.haringey.gov.uk/sites/haringeygovuk/files/masp_faqs.pdf

5.16 It is likely that even if such a shared plan had been devised, this would have required a review as her needs changed. On the 08.12.23 the Council's senior OT appeared to recognise a change in such needs, and requested a care act assessment as, presumably, her needs could no longer be met or risks minimised by the provision of equipment. The subsequent delay in allocation of a social worker to complete this assessment or action taken to put in place an urgent care package pending the assessment was a missed opportunity. Eleanor and her family made repeated calls over the following weeks to request support and clearly articulated the urgency and adverse impact that the lack of care was having. This did not result in re-prioritisation or effective escalation. This was another missed opportunity. Conversely, the OT conducting the assessment on the 03.01.24 recognised a significant change in need and acted promptly to arrange delivery of a hospital bed. They were also able to make plans with her family to clear space so this could be installed. Sadly, this intervention was too late.

5.17 As noted above, the Council's ASC teams were experiencing significant demand and workforce pressures throughout the review period. It is also likely that an inadvertent negative consequence of DHSC's policy to improve hospital discharge was those pressures were felt most acutely by residents in the community. In discussions with the reviewer many felt the expectation that only social care staff within reablement or specialist teams could conduct care act assessments and, only after those had been completed, could a care plan be put in place, resulted in too many delays and unsafe practice. They questioned why practice had changed which prevented other trusted practitioners (such as from the OT or SAT teams) completing these. There was also, they felt, a lack of accountability for the reablement team's decisions to not take on cases that had been referred as urgent. Practitioners also spoke of a change in culture which made it harder than previously to escalate delays or unsafe circumstances to senior managers. This was particularly true, as in Eleanor's case, if urgent needs arose during busy holiday periods. As noted above, there have been improvements to those processes and reductions in the numbers of residents waiting for assessment. Senior managers and practitioners highlighted the introduction of a front door manager for each locality team has made it much easier to escalate. In addition, those managers (and senior leaders) can authorise an urgent care package where there is a risk of imminent, significant harm (as they did in Eleanor's case) pending the full assessment. They also now receive an alert if an assessment hasn't been completed within 28 days of the request. Senior managers also welcomed the transition to a locality model as this made it much easier to develop closer multi-agency networks across health and third sector staff providing early intervention support.

5.18 Senior managers and practitioners were unable to explain why it was not possible to commission a domiciliary care provider for Eleanor. They acknowledge that, even given the busy holiday period, it should have been possible to secure this or immediately obvious to senior managers that, though funding for the service had been approved, this care had not been arranged. Senior managers accepted it was not appropriate for EDT staff to be expected to chase brokerage/commissioners to ascertain which provider had been appointed. This must be a task undertaken during office hours. They also felt it was important to acknowledge that the organisational changes being introduced were in part to improve services, but also to meet very challenging expectations to manage budgetary pressures across the Council. They wished to highlight any recommendations would need to be cognisant of those pressures. There were, they felt, critical areas of learning within this review, not least the need to address the current gap for residents not accessing support via the discharge to assess hospital pathways, as there is no rapid response domiciliary provision in Haringey. This remains a significant gap and makes it more likely similar harm could occur in the future. Recommendation 2 relates to this issue.

6. Findings

KLOE 1: Understanding and applying duties to meet needs in unsuitable living conditions

6.1 Consideration was given by the Council's housing team, the housing association and the OT team to legal duties to address concerns regarding conditions in Eleanor's home. Practitioners' decisions to proceed with referrals to ASC for a needs assessment under s9 Care Act were reasonable in the circumstances and there is no indication that this should have been addressed as a safeguarding concern as Eleanor was, at least until early December 2023, able to keep herself safe.

6.2 There are, however, opportunities to improve multi-agency working, particularly by encouraging greater use of multi-agency strategy/ 'team around the person' approaches as advocated by the

MASP. This review has not found any evidence that the Council or HSAB partners acted in breach of their legal duties with respect to her wish to be re-housed into more suitable accommodation.

KLOE 2: Were services responsive, given her presentations, to making reasonable adjustments so she could access appropriate support?

6.3 There are examples throughout Eleanor's case records of health, housing, OT and social care practitioners explaining to her why adaptations would not be authorised in her current accommodation. There is also evidence of practitioners respecting her preferences and seeking to assist her to have the Council's allocations banding on medical need reassessed. Practitioners, including those responding out of hours or via duty contact, considered her stated beliefs that her disability was due to voodoo. They did not believe these beliefs prevented her from weighing up information or from seeking assistance. That professional judgement was reasonable and shared by her family. There is evidence that reasonable adjustments were made, e.g. conducting home visits. Her GP and tenancy support worker also actively supported her by making representations to the Council in respect of the housing allocation banding and in early January 2024, to seek to secure her urgent social care. There is currently insufficient guidance on the role that health and housing support can play in medical assessments.

KLOE 3: How should partners work with families or informal carers?

6.4 Eleanor's family felt they were not heard by the Council or housing association and that their role, as advocate for Eleanor, was not respected. They spoke about feeling 'stonewalled' and becoming frustrated as they couldn't understand what the barriers were to getting adaptations or moving her to more appropriate accommodation. There is no evidence that practitioners sought to explain directly to Eleanor or her family that she had the highest priority for re-allocation if she agreed to move to a one-bedroomed property. This may have been out of respect for her preference to retain a second bedroom so that, if needed, family could provide overnight care. It does not appear anyone considered working with her and her family to demonstrate how this could still be achieved within a one-bedroomed property.

6.5 Prior to her needs becoming urgent in December 2023, services worked directly with Eleanor, liaising where appropriate with her family. They do not appear to have placed unrealistic expectations on her or her family to meet her needs. But neither did they clearly set out to Eleanor or her family why they were limited in how they could support her to achieve her preferences. More could be done to work with families as allies, to support adults with care and support needs better understand how their frailty might impact on their wellbeing, but (as with Eleanor) wouldn't necessarily mean they qualify for higher banding or quicker re-housing. ASC understood her family was not able to provide daily care. Prior to December 2023 it did not appear this was assessed as an urgent need. However, when this was identified, ASC lack of resource and poor organisational arrangements resulted in unreasonable delay.

7. Recommendations

Prior to completing the report, the reviewer met with HSAB board manager and the SAR panel to better understand how partners were taking forward recommendations and actions to address learning from recent local reviews, particularly the Victoria SAR and Steve SAR. In light of their current workplan, the reviewer recommended HSAB partners focus on the following recommendations to complement previous recommendations and further improve responses where adults are at risk in unsuitable housing.

Recommendation 1: Wider awareness raising of the MASP is needed. It would also likely assist partner agencies better understand how medical needs are considered with regards to allocations bandings if NCL ICB working with the Council's housing allocations and registered social landlords were to provide a briefing detailing when and how NHS primary care staff, OTs or support officers should write letters of support. This would complement existing briefings on primary care's role in representations regarding disrepair, including damp and mould.

Recommendation 2: ASC should review current arrangements for authorising urgent care packages under s19 Care Act. ASC should provide assurance to HSAB that they have secured sufficient provision to meet likely demand for reablement support including for residents not accessing this through the hospital discharge pathway, as this should form part of hospital avoidance measures. ASC's brokerage/

commissioners should develop a reporting mechanism which will flag to senior managers within one working day if a s19(3) care package hasn't been delivered.

Recommendation 3: ASC should urgently review and provide assurance to HSAB and partners that revisions to structure and procedures, particularly in respect of arranging urgent care and support pending assessments has improved. Consideration should also be given to practice guidance for ASC brokerage to enable urgent re-prioritisation if notifications are received, by other professionals, of increased risk or escalating need. ASC may also wish to explore if SAT and OT staff could ease waiting list pressures by acting as trusted assessors for urgent s19(3) Care Act provision.

Recommendation 4: Housing providers working in Haringey should report[32] to the joint LSCP and HSAB task and finish group on safeguarding and disrepair the steps they have taken within their tenders and contracts to strengthen contractors' obligations to report welfare or safeguarding concerns and to make reasonable adjustments where the household experiencing disrepair include children or adults with care and support needs.

[32] In compliance with their duties under s44(5) and 45 Care Act