Domestic Homicide Review

Commissioned by the London Borough of Redbridge

-Overview Report-

Victims: Karen Read & John Down

Died: September 2015

Independent Chair

&Report Author: Stephen Roberts QPM, MA(Cantab)

Completed: February 2019

Contents

Review of the circumstances surrounding the deaths of John & Karen

1. Introduction

1.1 This is a report of a Domestic Homicide Review (DHR) conducted under the terms of section 9 of the Domestic Violence, Crime & Victims Act 2004. It examines the circumstances surrounding the killing of John Down and Karen Read by Karen's former fiancé, on 5th September 2015.

1.2 The review will consider what has been learned of John Down, Karen Read and their attacker (who is referred to in this review as "Peter"). It will focus on the period from 2008 to the date of the tragedy.

1.3 The key purpose for undertaking any DHR is to assess what, if any, lessons may be drawn from a particular case. Although neither the victims nor the perpetrator had come to notice in the context of domestic abuse (DA), all three lived in sheltered accommodation flats, managed by the London Borough of Redbridge (LBR). The flats housed vulnerable individuals who, if given extra support, could enjoy independent living. The adjacent flats in which Peter and John lived formed part of a block of such facilities. The premises are referred to in this report simply as Home House. Karen had a tenancy in different sheltered accommodation (henceforth referred to in this report as "Other House") but stayed with John regularly. Home House included staffing facilities for the Extra Care team. Staffing of the office and for the assistance/support of residents was on a 24 hour basis. It was felt by the Redbridge Community Safety Board that a review should be conducted to determine whether the tragedy could have been averted, and to learn from the event, considering any changes which could be made on the basis of the findings.

1.4 The review was formally commissioned on 28.01.2016. Prior to the trial of Peter, all agencies (see below) were asked to secure whatever material they might have to contribute to the review and, where appropriate, commence their own Individual Management Reviews (IMR).

1.5 Peter admitted killing John and Karen from the outset, but pleaded guilty to manslaughter by reason of diminished responsibility, rather than murder. On 21.04.2016 at the Central Criminal Court, His Honour Judge Marks, Recorder of

London, accepted psychiatric evidence, agreed between Defence and Prosecution, that at the time of the killings Peter was incapable of forming the necessary intent to be convicted of murder. The plea of manslaughter by reason of diminished responsibility was therefore accepted. In sentencing Peter to 19 years imprisonment, the judge expressed the view that:

> *"John and Karen were defenceless and highly vulnerable. They met their deaths in the worst possible circumstances. Yours has been a sad life devoid of proper relationships but what you did that evening can only be described as horrific and abhorrent"*

1.6 A Review Panel was formed consisting of the following members:

- Stephen Roberts, QPM, MA (Cantab) – Independent Chair
- Mark Benbow, LBR Director of Community Safety
- Val Scanlan, LBR Community Safety Officer
- Chris Kinkaid, Refuge (IDVA provider)
- Mary Byrne, LBR Head of Service C&L Cluster And Provision
- Mark Gilbey-Cross, Clinical Commissioning Group (CCG)
- Sue Tatch, North East London NHS Foundation Trust (NELFT)
- Peter McFarlane, Detective Chief Inspector, Redbridge MPS Borough Command Unit
- Angela Middleton, NHS England (NHSE)
- Julie Tweedy, Detective Sergeant, MPS Specialist Crime Review
- Justin Armstrong, Detective Inspector, MPS Specialist Crime Review
- Elaine Gosling, LBR Housing Services

Political and community accountability was provided by LBR Councillor Mark Santos.

1.7 Stephen Roberts, QPM, MA, was appointed as Independent Chair of the Review Panel and Report Author. He is a former Deputy Assistant Commissioner of the Metropolitan Police. He has extensive experience of partnership working at borough

and pan-London level. He is a former Director of Professional Standards and Director of Training & Development for the Metropolitan Police. He retired from the Metropolitan Police in 2009 and has since worked as a private consultant for a variety of London boroughs and other organisations, advising on community safety matters and community based counter-terrorism, as well as acting as Independent Chair/Report Author of DHRs on several occasions. He has completed training for the role (including update training in respect of the 2016 Statutory Guidance). He has successfully chaired and authored domestic homicide reviews for several other CSPs. He has no ongoing employment relationship with any borough and is entirely independent of the LBR CSP.

1.8 During the review it proved possible to engage extensively with relatives of both John and Karen. John had daughters by two separate marriages. Daughters from the first of these relationships (A, B, C, D) attended the trial of Peter and were subsequently consulted about the terms of reference for the review. They contributed specific questions for the review (see Appendix A) and were consulted concerning the draft Overview Report. They were supported during the review by a member of Advocacy After Fatal Domestic Abuse (AAFDA). Although contact details for these individuals were held by LBR, they were not nominated by John as next of kin. John's daughter by his second marriage (E) was his nominated next of kin. She also attended the trial of Peter and wished to be involved in the review. She was supported by the charities Victim Support and Hundred Families. She agreed that the draft terms of reference (which by then incorporated the specific questions from the other daughters) were satisfactory.

1.9 Karen had two sisters (F and G) both of whom attended the trial of Peter. Sister G suffers from learning difficulties and it was agreed by her sister, F, that she was the best person with whom to consult. F was content with the terms of reference for the review and was consulted concerning the draft Overview Report.

1.10 The Review Panel met on formally on 6th July 2016 and 27th March 2017. An additional meeting was convened by the Panel together with the daughters of John Down (and their advocates) on 12 May 2017.

1.11 The Independent Chair met with the relatives of John Down and their advocates on several occasions. The Chair also met Karen Read's sister once at her request.

1.12 The review was guided by the following terms of reference:

- To seek answers to the specific questions (see App. A) raised by the victims' relatives

- To establish what lessons may be learned from the case regarding ways in which local professionals and agencies worked individually and collectively to safeguard victims.
- To determine how those lessons may be acted upon.
- To examine and where possible make recommendations to improve risk management mechanisms within and between all relevant agencies.
- To identify what may be expected to change and within what timescales.
- To assess whether the relevant agencies have appropriate and sufficiently robust procedures and protocols in place and the extent to which they are understood and adhered to by their staff, including an examination of the metrics and management information mechanisms in relation to risk assessment and management.
- To improve service responses including, where necessary, changes to policies, procedures and protocols.
- To enhance the overall effectiveness of efforts to reduce domestic violence and its impact on victims through improved inter and intra agency working.
- To examine what information was shared between partners in this particular case.

Additional terms of reference were requested by NHS(E). to ensure that the mental health needs of Peter and Karen were covered:

- To review the mental health care, treatment and services provided to Karen and Peter by the NHS and other relevant agencies, identifying both areas of good practice and areas of concern during the relevant period, determining whether professionals (a) recognised domestic abuse indicators for either victims or perpetrator and (b) completed risk management plans and managed them.
- To determine whether the services provided were appropriate to the identified levels of risk
- To examine the effectiveness of the mental health care plan for each principal including the involvement of the service user and relatives.

- To determine whether single and multi-agency policies and procedures were adhered to and effective in the management of the case.
- If there were lapses in service provision to any of the principals were there issues in relation to capacity or resources that impacted on the ability to provide services to the principals and to work effectively with other agencies. Specifically, did the Trust adhere to the Did Not Attend (DNA) policy when Peter failed to contact the service or attend an appointment?
- To establish if an information governance breach has occurred when appointment letters to Peter were sent to the wrong address.
- Were equality and diversity issues including: ethnicity, culture, language, age, faith, disability considered?
- Were issues with respect to adult safeguarding adequately assessed and acted upon?
- To determine through reasoned argument the extent to which the deaths of John and Karen were either predictable or preventable, providing a detailed rationale for the judgment.
- Provide a written report to the Home Office and NHS England (London) that includes measurable and sustainable outcome focused recommendations.

1.13 The following agencies were asked to participate in the review process, conducting and reporting Individual Management Reviews (IMR) if appropriate:

- The Metropolitan Police (MPS)
- Refuge (IDVA provider)
- Redbridge Clinical Commissioning Group (CCG)
- LBR Adult Social Care Dept
- North East London NHS Foundation Trust (NELFT)
- NHS (England)
- The GP Practice which dealt with Peter, Karen and John

- LBR Housing Dept.
- Immaculate Health Care Services Ltd (John's personal care provider)

1.14 Each agency was asked to provide a chronological account of its contact with John, Karen and/or Peter. NELFT, the GP Practice and LBR conducted formal IMR processes. The remaining agencies submitted letters in lieu of IMR and thereafter responded to specific requests from the Independent Chair for clarification and additional information where necessary.

1.15 Prior to the establishment of this review, Peter was charged with murder. The MPS granted access to the evidence gathered by its homicide investigation team at various stages of the review. This enabled a more detailed picture to emerge of the background to the tragedy than might otherwise have been possible.

1.16 The following documentary evidence was provided by various agencies to the review:

- Correspondence between LBR and the Care Quality Commission re. the incident.
- Copy of the Home House office diary/log.
- Psychiatric reports prepared on behalf of both Defence and Prosecution setting out the findings of Consultant Clinical Psychiatrists'[1] assessments of Peter's mental state at the time of the incident and the extent to which he was capable of forming a criminal intent.
- Crown Prosecution Service legal advice on acceptance of Peter's guilty plea on the basis that where Defence and Prosecution experts agree that if the defence of diminished responsibility is available to accused, a plea of guilty to manslaughter rather than murder should be accepted.
- Home House Staff Guidance on emergencies
- LBR Statement of Purpose re. Extra Care provision

[1] Dr. J Blandford DClinPsychol, CPsychol, CSi, AFBPsS , Dr. I Cumming MB, BS, FRCPsych.

Dr. M.K. Laker MRCGP, FRCPsych. Dr. S. Young, BSc, PhD, DClinPsy, CPsychol

- GP records for John, Karen and Peter
- Correspondence re. referral criteria for GPs to NELFT
- Pathologist's report re. John
- LBR Tenancy Agreement
- London Ambulance Service records re. call out and arrival times on 05.09.2015
- LBR statement re. the formal status of Home House
- Care Plan records for John
- Immaculate Health Care Ltd statement

1.17 As mentioned above (see para.1.12), the terms of reference of this review were extended at the request of NHS(E). Some two years after the commissioning of this review, the Independent Chair became aware that in fact, NELFT had also initiated an internal review, in addition to the IMR and produced a Mental Health Panel Enquiry Report (MHPER) which was finally signed off on 17.03.2017. The content of the MHPER, though similar to that of the NELFT IMR, identified additional failings within the administrative and decision-making procedures of NELFT. It transpired that relatives of Karen and John had not been notified of this additional review and were unaware of the contents, despite the statutory guidance that the findings should have been disclosed to relatives[2]. The Independent Chair notified the relatives of the existence of the MHPER and its findings have been incorporated into this DHR process. NELFT has indicated that the problem arose due to unfamiliarity of some staff with the DHR process. It is a matter of some concern that this situation could have arisen. NELFT remains concerned that disclosure of its internal report raises issues relating to the protection of the sensitive, confidential patient information. Unfortunately, what appears to the relatives as a lack of transparency inevitably raises in them a degree of suspicion. The issue is addressed at Recommendations 8 to 11.

1.18 In a further effort to identify the underlying causes of the tragedy, the Independent Chair attended the trial/sentencing of Peter at the Central Criminal Court in

[2] NHS Care Serious Incident Framework & NHS Guidance on Contact with Families for Providers of Mental Health Services Following a Homicide

order to hear the evidence in the case, obtain a copy of the Pre-Sentence Report and to note the judge's remarks.

1.19 In September 2015 the Independent Chair contacted Peter via the Governor of HMP Belmarsh to seek his agreement to an interview. In late June 2016 Peter agreed to be interviewed. His perspective on the tragedy is incorporated into this report.

1.20 Completion of the review was necessarily delayed by the need to await the outcome of Peter's trial May 2016. Additional delays arose in arranging to interview Peter in prison as well as the time taken for the draft of this report to be disclosed to the various relatives of the victims and their comments and perspectives taken into consideration. The late discovery of the Mental Health Panel Report further extended the duration of this review.

1.21 Karen's relatives expressed themselves content with the draft report at an early stage. John's daughters had a number of concerns about the first draft of the report and sought further information from the Independent Chair, LBR and NELFT. They also sought access to the various IMRs and the expert psychiatric reports presented to the court at Peter's trial. After advice from Home Office and a decision by the Review Panel, these requests were declined. In an effort to satisfy the daughters' concerns a meeting was held in May 2017, chaired by the Independent Chair and attended by senior representatives of LBR, NELFT, the CCG, John's daughters (A,B,C,D), their advocates and the advocate of John's other daughter (E).

1.22 At the above meeting, John's daughters insisted that the final version of the report must fully identify John by name, rather than by use of initials. Karen's relatives subsequently agreed that it would also be appropriate for her to be properly identified

1.23 Overview and Executive Summary reports were ultimately agreed by the Review Panel on 07.02.2019 and the Community Safety Partnership Board on 8th April 2019.

2. Case History

2.1 The principal subjects of this report are the victims, Karen and John, whose identifying particulars were:

Karen Read – born 1962

Resident of the London Borough of Redbridge (Other House)

Ethnicity: White, British

Stated religion: Church of England, Anglican

Suffered from, inter alia, a congenital muscle-wasting disease resulting in poor mobility and the need to make frequent use of a wheelchair.

John Down –born 1928

Resident of the London Borough of Redbridge (Home House)

Ethnicity: White, British

Stated religion: Church of England, Anglican

Suffered from poor vision effecting both eyes

John's daughters, A, B, C and D, asked that the following pen picture of their father be included in this report to give readers a better appreciation of his history and personality:

"John William Hugh Down, the only surviving child of Harry Down and Dorothy (nee Burt). Born 01.10.1928. Head Boy at Summerbee Secondary School. Served 2 years National Service in the Royal Air Force. Married twice with a total of 5 daughters and 2 sons, 20 grandchildren and even more great-grandchildren. An intelligent man who never reached his full potential, settling for jobs that paid enough to keep a roof over his families' heads. He was an artist who loved to sing and entertain. He was a good

father. A gentle giant of a man. He was much loved and is desperately missed. He wanted to live to be 100 – he was cheated of 14 years."

Similarly, John's daughter, E, asked that the following pen picture of her father be included:

"My Dad was friendly, humorous, generous and knowledgeable man. If there was someone who needed help or just someone to talk to, he was the person. I grew up with him seeing all the help he gave to others. He cared for my Nan, my Mum's mother, who was suffering from Parkinson's disease. He used to carry her cradled to the bathroom, fed her when she was unable and I remember watching him holding her hand as she was dying. He then looked after my Grandad, my mum's Dad when he was in late stages of cancer and dementia. The care and respect he had for them had no bounds.

My Dad never raised a hand to me, even in times where I was quite difficult. He often just sat and explained why he was angry and used it as a discussion rather than a telling off. He was hardworking, and I was fortunate to go on holiday every year when I was young. This hard work continued after he retired where he became a Parent Governor at my children's school and played Father Christmas every year both in Romford and Ilford shopping centres.

He had a love of football, reading (until his eyesight failed him) and was very proud to wear the RAF badge. He was always telling me and my children how proud he was of us all. My children were both very close to him as he childminded them when they were both toddlers whilst I worked. If I needed a babysitter, he was the first to be there.

When my Mum passed away, I always thought that he was so strong. Looking back now when I have come to lose both my parents, I now know that he was shielding a lot of pain from me, forever being my protector. I, my children and husband share very dear memories of my life and our time together. He always had a smile, loved the sun and relished company and friends. Dad was an amazing father and we are incredibly proud to be his daughter, son-in-law, grandsons and granddaughter (whom he never sadly got to meet). The pain and heartache that this has caused us all has been unimaginable, but I am truly blessed to have been raised by such an incredible man and hope that some of his characteristics, morals and virtues have been handed down to me and my family."

2.2 John and Karen were killed by Peter, whose identifying particulars are:

Born 1964

Resident of the London Borough of Redbridge (Home House)

Ethnicity: White, British

Stated religion: Church of England

Suffers from: Incontinence, Depression, Osteoarthritis, Deep Vein Thrombosis, Ulcerative Colitis, Esophagitis with nausea, vomiting, inflamed joints, anxiety and panic attacks.

2.3 The focus period of this review starts in March 2008 when Peter was first referred by his GP to the Redbridge Community Mental Health Team, West (CMHTW). The team is part of NELFT – its role is to provide secondary mental health care and community support to people between the ages of 18 and 65. In June 2008 Peter was examined by a doctor of the CMHTW as a result of which he was discharged from Mental Health Services, referred to the Community Support Team (CST), the Befriending Service and to the care of his GP. The CST is a Local Authority team intended to support people with less severe mental health problems who are assessed as needing support to live independently in the community. The staff consists mainly of support workers who have acquired appropriate National Vocational Qualifications. In order to support Peter, he was offered an appointment to assess his suitability for Art Therapy, an arts-based psychological therapy service for people under secondary mental health services. Peter failed to attend the appointment or respond to a letter asking if he still wished to be referred. Later in 2008 Peter fell victim to a burglary at his home. By this time, Peter had been allocated a care/support worker and in 2009 the care worker informed the Police that Peter was being harassed for money by a neighbour. Police issued a harassment warning to the neighbour.

2.4 In October 2009, Peter's care/support worker referred him back to the Community Recovery Team, West (CRTW), the renamed Community Mental Health Team. The CRTW duly reviewed the referral and passed the case to the Redbridge Assessment, Access & Brief Intervention Team (RAABIT). RAABIT is the first point of entry into secondary mental health services. It is part of NELFT and maintains local computerised records on a system known as RIO. Its role is to screen and assess referrals, signposting to the appropriate agency or offering short term support to people with less complex mental health needs. This referral led to joint visit by Peter's CST

care worker and a member of RAABIT resulting in an appointment being made for him to have a medical review. Unfortunately, Peter failed to attend the first appointment but in November 2009, Peter was seen by an appropriate RAABIT doctor and given advice concerning local anxiety management groups. Peter failed to attend a series of further appointments with his RAABIT doctor culminating in his discharge back to his own GP, who was informed of the discharge by letter.

2.5 Only a few weeks later, Peter's CST care/support worker felt it necessary to refer him back to RAABIT and following liaison between the worker and RAABIT staff, Peter was given (and attended) an urgent appointment the following day, at which his medication was increased and follow up appointments made. He was subsequently considered for psychological interventions but was assessed as unsuitable.

2.6 In July 2010 Peter's CST worker became aware that he was being intimidated by his neighbours and possibly victimised. RIO records state that:

> *"[Peter] apparently ran out of his house with a knife in anger but didn't do anything. The support worker feels that he could use some counseling in controlling his anger. Maybe a care coordinator could be assigned? Another accommodation has been offered but won't be available for four weeks"*

There is no direct evidence in the RIO record that the administrator shared the details of this incident with clinicians in the team, other than by recording it on RIO. With the agreement of CST and RAABIT it was decided by LBH that the best course of action would be for Peter to leave his accommodation and move to a flat where he would be safe from such problems but also benefit from the enhanced level of support available at Home House. No evidence has been forthcoming to indicate that any risk assessment was completed by LBH as part of this decision. A month later, Peter signed the lease for a flat in the Home House facility and moved in. When interviewed in HMP Belmarsh by the Independent Chair, Peter confirmed that he had been very grateful for the move from a flat in which he had been bullied and intimidated by predatory neighbours to Home House. He said that for the first time in years, he felt safe and secure. In January 2011, RAABIT staff met Peter to discuss his progress and explained that his difficulties were regarded as primarily social rather than psychiatric and that accordingly there was very little the team could do to assist him. He was referred back to the care of his GP.

2.7 John became a permanent tenant at Home House in February 2013. He was elderly and suffering from a progressive complaint affecting his vision and causing him

to suffer a number of falls. In view of his age (85) and condition, he was considered suitable for the Home House facility. Despite his disabilities, John remained active, engaging with other residents as well as attending social functions beyond Home House.

2.8 In July 2013, Karen was given temporary accommodation (initially 4 weeks) at Home House to assist and support her decision regarding housing needs. She had separated from her husband but was considered vulnerable because she suffered from a muscle wasting condition and needed to use a wheelchair much of the time. Shortly after her move, Karen agreed that the care package she had previously enjoyed via the direct payments process, should be reduced from 17.45 hours per week to 6 hours per week. After 4 weeks she was offered a tenancy at Other House.

2.9 Although the precise date is unknown, it is clear that by early August 2013, Karen and John had formed a relationship and that Karen was staying in John's flat rather than her own. Some residents of Home House started to make complaints about Karen's behavior, complaining that some of her and John's comments were sexually explicit and inappropriate for the shared residents' lounge. The Operational Manager at Home House discussed these matters with John and Karen, advising them to take their relationship slowly and avoid sharing sexually explicit information with other residents.

2.10 On 9th August 2013, John spoke to the Home House warden, explaining that he and Karen had ended their relationship. On the same day, the warden also became aware that Karen and Peter had started a romantic relationship. Despite this new relationship, Karen signed a tenancy agreement for a flat in Other House. By 20th October she had told the Other House Operational Manager that she was seeking a divorce from her husband and wanted to spend the rest of her life with Peter at Home House. The fact that Karen held the Other House tenancy but was effectively living with Peter in Home House constituted a breach of her tenancy agreement and various LBR officials pressed upon her the importance of occupying Other House. These efforts continued for several weeks with officials explaining that if she continued to breach her tenancy, her accommodation at Other House might be withdrawn and she could become homeless. It appears that despite these warnings, Karen continued to spend the majority of her time at Home House.

2.11 In January 2014, Peter called Police to report that a drunken male had touched his arm. He did not want to make any criminal allegations, simply to bring to notice the drink and drugs problems in the area. As a result of this encounter with the Police, the officers believed that Peter was a vulnerable individual and duly completed an entry on

the MERLIN system. This system is intended for recording non-crime matters where vulnerable people have come to police notice. Each entry is considered by an oversight group to determine whether any CSP agency should take action to reduce the risks to persons identified. In Peter's case, because no specific risk could be identified, information about the incident was not disseminated to other agencies.

2.12 It appears that around this time, John, Peter and Karen became friends. John and Peter's flats were adjacent. In September 2014 Peter complained that John had three of Karen's "alcoholic friends" in the flat. In the weeks that followed, there were repeated problems with groups of non-residents entering Home House and being identified as unwanted. The staff effectively barred these non-residents from entry. Also during this period, Peter alleged that one of the care staff at Home House had shouted at him, been "rude and nasty" to him, causing him to feel anxious, have panic attacks and become unable to sleep or concentrate. Peter's complaints initiated a properly recorded Adult Safeguarding Alert and in subsequent weeks he was assisted by a professional advocate from the Independent Mental Capacity Advocacy (IMCA) Service. Peter confirmed to the advocate that whilst he was feeling unwell, he was being adequately supported by his GP.

2.13 In October 2014 Peter again became concerned about friends of Karen visiting, whom he regarded as undesirable. Home House staff advised him that it was something he should discuss with Karen herself.

2.14 In February 2015 Karen and Peter separately informed staff at Home House that they had ended their relationship and Karen stated that she had resumed her relationship with John. Despite this change of circumstances, it appears that John, Karen and Peter remained friends or at the very least, in daily contact due to the proximity of Peter's flat to John's (where Karen was frequently staying). It was Peter that informed Home House staff that John had an infected foot which made it impossible for John to push Karen's wheelchair from Home House to Other House. In addition to the medical treatment, staff notified John's care providers (Immaculate Healthcare Ltd) that his flat was being allowed to be in poor condition. The relationship between John and Peter is further evidenced by the fact that Peter told the staff that John had told him that Home House did not organise the sort of activities that he enjoyed. John, was, in fact, quite content to seek entertainment outside Home House.

2.15 Whilst it is certainly the case that John, Karen and Peter remained in close and frequent contact, tensions arose. By late April, Peter had more than once complained about the injustice of the fact that he had bought a bed for Karen's use but that she no

longer wanted it because she was staying with John. The warden offered to make a GP appointment for Peter because he seemed depressed but Peter declined the offer. By the end of that month, relationships had clearly deteriorated to the point where Karen had told Peter to "Get lost". On one occasion in April 2015, Peter was making his lunch when, having seen John leaving Karen alone in his flat, he seized the opportunity to speak to Karen on her own. He entered John's flat but when Karen told him that she wasn't interested in him, he stabbed a hole in the wall with the butter knife he had been using to make lunch. John did not inform staff of the incident until 29th April 2015. The same day all three were spoken to in the Home House office. Peter was firmly told that it was unacceptable to hold a knife while arguing with anyone. It was suggested that Peter and John should not go into each other's flats unless and until matters calmed down. It appears that by the following day, either that matters had cooled down or that the good advice was being ignored – because when staff went to John's flat they found Peter was also there, apparently at John's invitation.

2.16 On 20th May 2015 John and Karen informed Home House staff that they intended to marry. John told Home House staff that Peter was unhappy about it and Karen told the staff that every time John left her alone in his flat, Peter would enter and argue with her. Staff advised John to make a habit of locking his door to prevent Peter entering at will.

2.17 On 23rd May 2015 Peter alleged that he had been invited into John's flat and assaulted by a friend of John. A police crime report was recorded but Peter refused to substantiate the allegation. The suspect was removed from Home House by police and subsequently arrested for being drunk and disorderly. Three days later a meeting was arranged between LBR staff, the Home House Manager, Karen, John and John's nominated next of kin, E. The manager informed John that the events of 23rd May were unacceptable and that John and Karen were giving "mixed messages". The following day, Peter was asked if he wished to have these events reported to the Adult Safeguarding Team but he refused, stating that he would go to the Housing Department himself. It cannot be confirmed whether or not it was his intention to seek alternative accommodation. He did not want the matter taken further by the Police.

2.18 Because of their concern for his welfare, Home House arranged for Peter to be visited by his GP (on 27.05.15). The doctor found no injuries but that Peter was suffering from low mood and anxiousness. When asked, Peter denied having any thoughts of suicide. In interview in prison after conviction, Peter admitted that in fact he had been thinking about suicide and had used the internet to look for poisons (a fact confirmed by the homicide investigations). Peter agreed to being referred to the

Community Mental Health Team and that same day, the GP faxed a referral to RAABIT giving the reasons as depression, anxiety and suicidal ideation. It is now clear that this referral correctly identified Peter's address at Home House.

2.19 Despite the attentions of his GP, Peter remained quite anxious and reported feeling unsafe because of the earlier events. Home House staff advised him to spend more time in the residents' lounge with other people. Peter made derogatory remarks to his GP about John in relation to his (John's) relationship with Karen but there is no indication that the GP regarded the remarks as significant.

2.20 On 9th June 2015, in response to Peter's GP referral (of 27.05.15), a RAABIT Community Mental Health Nurse telephoned the Home House office number in an attempt to complete a telephone assessment of Peter. A secretary in the office explained that the number was simply the office and that the caller should telephone Peter direct on his mobile number. Three calls were made to Peter's mobile phone and two messages left, asking him to call RAABIT. Because there was no response from Peter to these phone messages, the following day, RAABIT staff sent a letter to Peter asking him to make contact and arrange an assessment appointment. Such letters are known as "opt in letters". A second similar letter was sent some days later when there had been no response to the first. Records on NHS patients are held both nationally (on what is known as the NHS Spine) and locally on the RIO system. The NHS Spine and RIO are not automatically synchronised, consequently, problems can occur when the two sets of information differ. NELFT management had been aware of this possible source of errors and had ensured that the RIO system generated an automatic prompt to operators reminding them to ensure local and national records were the same and if not to synchronise them. It was only discovered in the process of this review that although the GP records and the referral form gave Peter's correct up to date address, the local RIO Electronic Patient Record for Peter had not been updated since he moved to live at Home House. As a result, the "opt in letters" had been sent to the out of date address. RAABIT administrative staff should have checked the RIO system against the information held nationally, on the NHS Spine. They should then have synchronised the two systems and thereby been enabled to send the "opt in letters" to the correct address. Peter's case record (which included his address and the contact details of his GP) was not synchronised and therefore his previous (out of date) details were used. The consequence of the failure to respond to the automatic reminder to update/synchronise RIO and NHS Spine records is described by NELFT in its MHPER as a clear breach of information governance. Immediate remedial actions have been taken.

2.21 In its review of the treatment of Peter, the clinical expert members of the Mental Health Panel of NELFT concluded that the evidence provided by Peter's GP was sufficient for him to be considered as an adult at risk. No such identification was made by the GP on the referral form. Similarly, the Mental Health Panel concluded that RAABIT had failed to recognise from the GP referral and the mental health records held by NELFT (specifically, the knife incident in 2010), that Peter *may have been* an adult at risk. The three telephone messages left on Peter's 'phone failed to elicit a response and both letters (set to Peter's former address) were necessarily ineffective. The overall result was that the failure to establish communication with Peter prevented an appropriate assessment of his mental state.

2.22 On 11th June 2015, as a consequence of the events of 23rd May, a Housing Officer visited Peter to discuss his accommodation options. Peter told the officer that he did not want any specific action but that he was upset by the fact that Karen wanted John and not him. Peter was again advised to stay away from Karen and John and to report any further incidents to the Housing Officer. The officer then visited Karen and John in John's flat. John was very apologetic about the incident and explained that he had actually invited Peter into his flat on 23rd May for a drink because the three of them had been friends. Karen and John told the Housing Officer that they planned to marry on 23rd October 2015 and that John would give up his tenancy at Home House so the couple could both live in Karen's flat in Other House. The Housing Officer advised John against this course of action because he might be made homeless if the relationship broke down. So concerned was the Housing Officer about John's plans that she obtained contact details for John's next of kin and the following day, 'phoned John's daughter, E, to express concern that an 86 year old should risk giving up his tenancy. E, though grateful for the advice, explained that it was hard to speak to her father without Karen being present. The Housing Officer told daughter E that she was reluctant to accept John's termination of tenancy before E had at least tried to convince him that he was being unwise. Finally, the Housing Officer told E that LBR would take no immediate action on John's tenancy. Although John's daughter E was asked to help advise John, his other daughters, A, B, C, and D were not told about the issue because they were not listed as next of kin. In such circumstances where there are complex, extended family structures, it would be helpful for support workers and other staff to be enabled to engage a wider range of relatives. Such a course would, however, only be possible with the consent of residents. (see Recommendation 5)

2.23 On 6th July 2015, RAABIT reviewed Peter's case (i.e. the GP referral for assessment). Peter was discharged from RAABIT back to the care of his GP on the

basis that he had failed to respond to three 'phone messages and two letters sent to what was (wrongly) believed to be his home address. **Letters setting out this decision were sent to Peter's (incorrect) address and (in error) to his former GP.**

2.24 NELFT has an established policy and procedure for dealing with managing missed appointments and/or the non-attendance of adults. The Policy and Procedure for Managing Missed Appointments/Non-Attendance for Adults and Children's Appointments, section 6.1 states:

> *Where high risk issues are identified then contact must be made by telephone with the GP and/or referrer (where appropriate) other agencies involved with the patient/carer and the clinical team involved to establish a plan to minimise risk. If the patient cannot be contacted by telephone, it may be necessary to carry out a home visit to assess the situation. Actions must be taken in relation to the current risk assessment or risk identified and the care plan or contingency plan where this is available. Consideration must be given by the clinical team, giving due regard to issues of confidentiality and only where previously agreed to contacting relatives or others in the patient/carers informal support network. Engagement with other agencies who may be involved with the patient/carer is useful in establishing whereabouts, alternative contact details. All of the above must continue until contact has been made with the patient/carer. It may be necessary to contact the Police to request a welfare check.*

The Mental Health Panel concluded that there had been a lack of adherence to this policy by RAABIT. Peter had not been recognised as presenting a potentially high risk in relation to safeguarding and the subsequent failure to make contact meant that a proper assessment of these issues did not take place. It is noteworthy that neither Peter's GP nor RAABIT staff recognised the fact that within Peter's mental health history (held by RABBIT) was the incident in 2010 (see para. 2.6) when he ran out of his property with a knife due to extreme anxiety and anger, having allegedly been intimidated and threatened by his neighbours.

2.25 On 5th August 2015 John went to the Home House office to report that Peter had entered John's flat to speak to Karen. John said Peter had become so angry that he had asked him to leave. Peter was then called down to the office and asked why, after all the problems he had yet again gone into John's flat. Peter became angry, shouting and spitting at John. Peter was then told to leave the office. Home House staff then became concerned that Karen would be alone in John's flat and, on checking found Peter standing over her demanding to know what she had said to John about him.

Peter was asked to leave and did so, after which staff advised John to keep his front door locked.

2.26 A month later at about 15.00 hours on 5th September 2015, a Home House resident heard Peter saying that he "felt like stabbing" John and Karen. The resident told him that he shouldn't do so but when interviewed subsequently by police, insisted that he had regarded Peter's words as flippant rather than as a statement of intent.

2.27 At about 21.45 hours that same day one of the Home House staff heard Peter complaining to fellow residents about the unfair way Karen and John had dealt with him. About 10 to 15 minutes later, she heard Peter shouting through John's letter box (implying that the door was locked) "Karen, you've done wrong, I'll fuck you up." The care worker told Peter to stop and go back to his own flat, which he did. A short time later (it is impossible to be more precise about the time, despite access to the homicide investigation papers, including the formal statement of the care worker) she heard a disturbance from the vicinity of John and Peter's flats and went to see what was happening. Once she was closer to John's flat she heard Karen screaming and could see John's door partly open but with blood on it. On looking into the flat she saw Peter stabbing Karen.

2.28 The care worker then ran downstairs to look for her colleague and to call her supervisor. The following timings have been derived from the records of London Ambulance, the Metropolitan Police ("the 999 system") and from call times retained on the mobile phones of the staff at Home House and their off-site supervisor. The supervisor told the care worker to call 999 immediately. The call to the supervisor was made at 22.16. At 22.18 the carer called 999. Standard procedure for such calls is that the incident would be referred to the police and subsequently the London Ambulance Service (LAS). LAS records show that it was informed of the incident at 22.21 hours and dispatched a vehicle which arrived at 22.36 hours by which time Police were already on scene and had arrested Peter. London's Air Ambulance was diverted to the incident and arrived at 22.42 hours. Karen's life was pronounced extinct at 22.50 hours. Despite Air Ambulance staff attempting to save John, his life was pronounced extinct at 23.05 hours.

2.29 From the outset, Peter admitted killing both John and Karen. He was charged with the murder/manslaughter (as alternate counts) of both John and Karen. As a result of psychological examinations on behalf of both Defence and Prosecution, the Crown Prosecution Service (CPS) determined that the appropriate indictments should be for

the manslaughter of both John and Karen, to which Peter pleaded guilty. He was sentenced to imprisonment for 19 years.

3. Analysis

3.1 The significant factors in the tragic course of events may best be considered under a number of headings:

- The admission criteria for Home House and standard tenancy agreement.
- Care Quality Commission (Registration) Regulations 2009.
- Duty of care owed to Home House tenants and their rights to privacy.
- Role of Home House support staff.
- Failed efforts to assess Peter's possible need for psychiatric intervention.

Admission Criteria & Tenancy Terms

3.2 The 52 units which constitute Home House are intended to provide sheltered accommodation for residents. At the time of the incident there were 25 tenants who were in receipt of Extra Care. Extra Care is a domiciliary care service provided to those who for reasons of health or disability need additional support to live independently. Potential residents are offered tenancies only after a comprehensive care assessment either in hospital to support discharge or a community assessment by the LBR Assessment Team. Extra Care provision is different to nursing and residential care because Extra Care service users have their own tenancies. At the time of the tragedy 27 of the tenants occupied flats at Home House but received no Extra Care support. Peter and John were two of the 27 residents not receiving Extra Care.

3.3 Under the terms of their tenancy agreements, both John and Peter were in a similar position to "ordinary" council tenants with the right to have the maximum personal independence consistent with their health. The tenancy agreements signed by John and Peter differed slightly. Both agreements have been examined by the Independent Chair. There is no significant difference in the specified duties and responsibilities of tenants and as such only the agreement signed by John is reproduced at Appendix C. Section 4.3 of the agreement prohibits tenants from causing distress or alarm to others. Whilst at various times there were undoubtedly tensions between the victims and perpetrator (which staff attempted to defuse), in most instances, Peter was seen as a victim and John declined to have the problems addressed formally. Even had John made a formal complaint, it is very doubtful that any of Peter's actions would have been regarded as a firm basis for the termination of his tenancy. Both men were free to have visitors staying with them as and when they pleased – a right both Peter and John exercised at various times in respect of Karen. As residents they were entitled and indeed encouraged to use the communal facilities at

Home House (a residents' lounge and laundry facilities) and to take part in social activities organised for the benefit of all residents in order to combat isolation and encourage social integration. Additionally, they had the benefit of on-site support and assistance from the care staff and should emergencies arise, the staff were available to assist. The important distinction between Peter, John (and Karen) and other residents of Home House is that whilst other residents were in receipt of the Extra Care service, the victims and perpetrator were simply tenants in a facility equipped and staffed to offer limited support to them.

Care Quality Commission (Registration) Regulations 2009

Health & Social Care Act 2006

3.4 Extra Care is domiciliary CQC registered service provided in Home House by the LBR. Regulation 18 requires that the CQC is informed of a range of untoward incidents which might impact on the welfare of residents of such premises (see App. C). The service maintains a 24/7 presence at the unit, providing domiciliary care for those who need it. Not all Home House residents, however, were in receipt of domiciliary care. Both John and Peter lived independently in self-contained flats within Home House and although Karen frequently stayed in John's flat, she had a tenancy elsewhere.

3.5 John was in receipt of personal (i.e. not domiciliary) care but this was provided under a personal care budget by an independent company, Immaculate Healthcare Services Ltd. After the homicides, relatives of John recovered from his flat a folder containing, inter alia, the log sheets showing details of the day to day services provided to John. Examination of these notes shows that John was visited regularly over an extended period by the same individuals. The Independent Chair contacted the company in an attempt to arrange an interview with the carers who supported John to discover if he had mentioned to them any concerns about his safety. The company declined, stating that its managers had spoken to the staff who had no recollection of John mentioning any such concerns.

3.6 After the homicides, LBR informed the CQC about the incident but thereafter the Commission had no direct involvement because the victims (and the perpetrator) were not domiciliary service users. Similar considerations applied to the reporting of the previous instances of conflict between Peter and John/Karen – i.e. they were living independently within Home House, rather than being formal care users. An allied issue is the relevance of the LBR Adult Safeguarding processes and whether they might have

been engaged to ameliorate the problems. There is clear evidence that Home House staff were alert to the relevance of Adult Safeguarding. In September 2014 the safeguarding mechanisms were triggered when Peter complained that he was the victim of rudeness and abuse from one of the staff. His allegations were investigated and he was provided with the services of a professional advocate. Peter finally said that he was receiving adequate support from his GP and did not wish the matter to be taken further. Similarly, in May 2015 Peter reported to Home House staff that he had been assaulted by one of John's friends and the Police had been called – leading to the removal and arrest of the suspect. Because all concerned were living independently and the incident was so contained that it had no impact on other residents, there was no requirement to report it under Regulation 18 of the CQC Regulations. LBR by contrast evidently took the matter seriously, arranging for John's registered next of kin, E, to be present at a meeting with a Home House manager, Peter and Karen, intended to ease the conflict. Peter declined to make a formal allegation to Police and refused to report the matter as an Adult Safeguarding issue. Over the next few weeks various LBR staff, including a Housing Officer, met with Peter to explore options for alternative accommodation but he declined the offers, wanting to stay at Home House. The officer also visited John and Karen in a continuing effort to resolve matters. John was very apologetic but explained that in fact, he and Karen planned to marry that October and leave Home House to live in Karen's flat in Other House, thus resolving the conflict. The Housing Officer clearly regarded this course as unwise since it would risk John becoming homeless. So great was her concern that she contacted John's daughter, E, asking her to dissuade her father from giving up his tenancy, insisting that LBR would take no immediate action.

3.7 Whilst Peter was keen to report incidents in which he was the victim, but thereafter decline any specific actions, John appears to have taken a more phlegmatic attitude to the situation. On 29th April 2015 he told Home House staff that after an argument some days earlier; Peter had taken a butter knife into John's flat and stabbed the walls. Peter, Karen and John were all called to the Home House office where staff tried to calm the situation and advised Peter and John to avoid each other. Despite this advice, the next day the two were found together in John's flat apparently on friendly terms. Similarly, in August of 2015 after another argument between the two men, an incident occurred in the Home House office in which Peter spat at John. Again, John preferred to minimise the issue and asked that it not be reported either to Police or as a safeguarding matter.

Duty of Care versus Rights to Privacy

3.8 Given the terms of John's and Peter's tenancies at Home House, as well as Karen's at Other House, all three had a right to a private life without interference from support staff. Thus, the extent to which staff or officers of LBR could intervene in the tensions and conflicts between John/Karen and Peter was distinctly limited. It is at least arguable that the entirely well-intentioned mediation attempts and advice given by staff and officers, were an impingement on the rights to a private life of Peter, John and Karen. This should not be taken in any way as a criticism of the staff and officers. This case demonstrates that the working practices of care staff sometimes go beyond that which is required, albeit motivated by their sense of duty and human kindness. The risks in this situation are that it may generate a higher than intended degree of dependency amongst residents and, significantly, an unrealistic expectation among their relatives of a greater level of care and more frequent welfare interventions. These risks could be mitigated by clear explanations to tenants, staff and relatives of the nature and extent of the support services offered (see Recommendations 1 to 4).

3.9 The conflict between maintaining tenant's rights to privacy and ensuring that relatives are aware of problems raises an additional issue. LBR collects details of various relatives of residents at Home House. In difficult situations it is sometimes the case that relatives are willing and able to intervene where staff cannot. Residents are required to nominate a next of kin to whom information may be disclosed but the provision of information outside this consent would be a breach of residents' right to privacy and a breach of data protection rules.

3.10 In addition to the problem of dealing with relatives who have not been nominated as next of kin, there is a similar issue in respect of disclosing what tenants might regards as private information to social workers and even into the Adult Safeguarding mechanisms. If an individual wishes to make light of a problem, as John did when he was spat at, then unless a case could be made out that the incident was evidence of a significant risk, it would be improper for staff to disclose it. Staff should, however, be aware that even where an individual does not regard an incident as a safeguarding matter (or even specifically declines to agree to a referral), if the staff member regards the incident as sufficiently serious/worrying then it may still be referred in spite of the wishes of the "victim". The process of identifying safeguarding risks and deciding to make referrals in serious cases without reference to victims might be assisted by a change in the record keeping arrangements. At Home House, the warden's log of incidents (as supplied to the review) is simply a chronological record of events in the building and might mention any one of the many residents. It is within the knowledge of

the Independent Chair that in similar establishments, separate records are maintained for each resident. Staff and supervisors are thus better able to identify potential matters of concern about specific residents that might be otherwise be overlooked (see Recommendation 3).

3.11 The problems of potential disclosure of information about residents could be overcome by prospective tenants being asked for explicit consent to disclosure as a prelude to taking up a tenancy. It would be open to the prospective tenant to decline consent and it would a matter for the individuals to nominate (or fail to nominate) particular relatives, social work staff etc. (see Recommendation 5).

Home House Support Staff

3.12 As previously mentioned, there is clear evidence that the support staff and managers at Home House routinely attempted to support Peter, John and Karen. Support staff repeatedly intervened well beyond their remit in attempts to defuse the inevitable tensions and give sensible advice. These well-meaning interventions even extended to the night of the homicides. Earlier that day, one of the residents heard Peter say that he felt like stabbing John and Karen. It was not the first time Peter had shared his sense of grievance with staff and/or residents. On this occasion, as on so many before, the resident regarded the remarks as flippant and simply told Peter "Not to." Later that day, a member of staff, P, again heard Peter complaining to other residents about the way he had been treated by John and Karen. P was then occupied by her routine duties for about 20 minutes after which she had a chance encounter with Peter on the stairs. She asked Peter if he was going to bed but received no answer. Some moments later when she heard Peter shouting abuse she intervened, arguably beyond her duties but was sufficiently concerned for the welfare of residents that when she heard a disturbance a few moments later she went back upstairs to see what was happening. These were not the actions of a person unconcerned for the welfare of residents. Having discovered what had happened inside John's flat, it is understandable that P panicked and *did not immediately comply with the emergency guidance instruction for Home House (see Appendix D), which require that a staff member discovering an emergency should dial 999 immediately*. In fact, P 'phoned her off-site duty supervisor but was immediately told to dial 999 and did so. It is thus the case that P's short-lived panic introduced only a very brief delay of approximately 2 minutes in the emergency services being called. Police officers were first to arrive at the scene followed 2 minutes later by London Ambulance Service (LAS) staff. LAS

Control Room records show that the ambulance arrived at 22.36, a matter of two minutes after the police officers had declared the scene safe enough for ambulance staff to enter. HEMS arrived 6 minutes later but despite working on both victims, neither was saved. Post mortem examination of John revealed that his jugular vein, heart and lung had been penetrated by stabbing and the consequent blood loss caused his death. There is no indication in the pathology report that earlier medical intervention would have saved John.

Psychiatric Interventions – Peter

3.13 As is clear from the case history, Peter has a long history of medical and mental health treatments and frequently failed to engage with mental health services. This review had access to the psychiatric and psychological assessments of Peter that were prepared for the information of the court. These include his life history as well as the results of various personality and mental health audits. Separate assessments were made on behalf of the Defence and the Crown. The shared conclusion of the assessments was that Peter could make out the partial defence of diminished responsibility for both homicides. This conclusion left the court with no option but to accept Peter's plea of guilty to manslaughter. A key issue for the victims' relatives is understanding how before the tragedy, Peter could be *well enough* not to receive treatment from mental health professionals and yet after he had killed two people, he was assessed to be *sufficiently unwell* to claim the defence of diminished responsibility.

3.14 Peter was under the care of RAABIT from October 2009 to January 2011 at which point he was discharged back to the care of his GP. Perhaps the matter of greatest concern is the fact that Peter was referred back to RAABIT by his GP on 27th May 2015 after the altercation on 23rd May in John's flat between a friend of John's and Peter. The incident included Peter alleging he had been assaulted, albeit he declined to support a prosecution of the suspect. In the days that followed the incident, LBR staff and officers called a meeting between John/Karen and Peter but including John's registered next of kin. It is important to emphasise that during this period, Peter was treated (correctly) as a *victim* potentially at risk. When seen by his GP, Peter said that he was keen to be referred to the Community Mental Health Team. Because of his history and the fact that Peter reported he was suffering from low mood and anxiety, the GP made a fax referral to RAABIT. The referral form has been traced. The form contained Peter's correct address at Home House.

3.15 As part of this review, the Independent Chair sought access to the formal criteria on which such referrals are made by GPs. No such criteria existed at the time of Peter's referral.

3.16 It is well known by NELFT senior management that the local and national IT database systems are not automatically synchronised and that as such the two systems may hold different data on the same person. The problem has been addressed by ensuring that operators are sent an automatic prompt to remind them of the of the need to ensure that the most up to date data is synchronised between the two systems. Despite this automatic prompt, the staff dealing with Peter's referral failed to do as required and accordingly, despite the GP having supplied the correct name and address for Peter and the correct GP details, an out of date address was used to contact Peter and when eventually a decision was made to discharge him back to the care of his GP, the discharge was made to the wrong GP. The initial attempt to arrange an assessment appointment was made by telephone to the office at Home House, presumably because the referral form included that number. The Home House office staff referred RAABIT staff to Peter's personal mobile phone number but three calls to the number went unanswered as did the voicemail messages left for him. Peter was eventually discharged back to the incorrect GP after his case was reviewed in July 2015. The overall effect of the administrative errors was that despite the GP's concerns, Peter was never assessed by a mental health professional and the incorrect discharge meant that even his GP was unaware of the failure and thus could not take remedial action. The homicides occurred two months later.

3.17 Despite the failure to ensure that Peter was properly assessed, RAABIT staff had sufficient information available to them to conclude that he was *potentially* high risk – specifically the information on RIO concerning the knife incident in July 2010 (see para. 2.6). Enhanced efforts should have been made to contact him for proper assessment. The established policy and procedure for such cases is set out at para. 2.22. The NELFT Mental Health Panel concluded that it had not been followed in this case. As this DHR proceeded, despite repeated requests from the Independent Chair, no details were forthcoming explaining NELFT policy/procedure for dealing with such cases. It was only on discovery of the existence of the Mental Health Panel Enquiry Report that a clear statement of policy was obtained. Whatever the cause, it is a matter of some concern that NELFT officials were apparently unable to access their own policies.

3.18 Despite the failure of NELFT processes, there was an opportunity for the office staff of Home House to take a message and pass it on to Peter rather than simply referring the caller to Peter's mobile phone. However, as with the issues identified at

3.1 to 3.10 (above) there is an inherent conflict between allowing and encouraging the independence and privacy of residents and providing support where needed. This conflict is especially sensitive when confidential matters relating to mental and physical health are involved. Ultimately the nature and extent of support and assistance becomes a matter of personal decision by staff members. It is unsurprising that these decisions can be inconsistent. Group training based on the recommendations regarding duty of care and expectations of service should enable the development of shared standards and thus more consistent responses. (See Recommendation 4)

3.19 It is at least *possible* that had Peter been seen in July/August 2015, he might have received effective treatment. Peter had not been seen by mental health clinicians since 2010. The psychiatric and psychological assessments from that time reveal no indication that, had Peter actually been successfully referred to RAABIT, the tragic outcome would have been avoided. The fact remains, however, that an assessment opportunity was missed due to administrative errors. These errors resulted in Peter's discharge back to the wrong GP because NELFT failed to comply with its own operating procedure to ensure a rigorous decision-making process. (see Recommendations 6 to 8)

3.20 As mentioned at para. 1.17, a difficulty arose during this review because in addition to the DHR process, NELFT completed a more detailed internal enquiry into its actions and produced a Mental Health Panel Enquiry Report which was disclosed to neither the DHR Independent Chair nor the relatives of John and Karen. It is suggested by NELFT that the problem arose because some members of staff were unfamiliar with the DHR process. An additional difficulty identified by NELFT is that because its report contains confidential medical information relating to three people, full disclosure of an unredacted version of the report to any of the relatives would entail disclosure of medical information about the other two subjects. NELFT are equally concerned that disclosure of suitably redacted reports would raise a perception among relatives of a lack of transparency.

3.21 The very detailed Mental Health Panel Enquiry Report (MHPER) was prepared in parallel with the DHR process but without any indication of its existence to the Independent Chair. The IMR prepared by NELFT did not contain significant information about the various administrative process errors which resulted in Peter failing to be given an effective assessment appointment. Well established NHS(E) guidance clearly requires an open and transparent enquiry process and disclosure of the eventual report to relatives. The late discovery of the existence of the MHPER and its content has almost inevitably led to the perception by the relatives of an attempted "cover-up". This

impression has been severely reinforced by the failure of NELFT to disclose the MHPER to relatives, despite repeated requests from their advocates.

3.22 The response of NELFT to the DHR process has delayed completion of the review and unnecessarily exacerbated the grieving process of the relatives. Given the fact that the contents of the MHPER are now included in the Overview Report, it should be a simple matter for NELFT to now disclose its report and offer an appropriate apology to relatives for its earlier omission. Additionally, there is a clear and obvious need for additional guidance on this problem to NELFT staff (see Recommendations 8 to 10).

4. Conclusions & Recommendations

4.1 There can be little doubt that throughout his life, Peter was regarded by the various agencies as a very vulnerable person. After the death of his parents, he had difficulties living alone and suffered from poor mental health as well as a variety of serious medical conditions and physical disabilities. It was the recognition of these vulnerabilities that eventually led the agencies, and in particular LBR, to offer him accommodation in the caring and supportive environment of Home House. Even after his conviction for manslaughter, when interviewed in prison, he was unable to explain why it was that on 5th September 2015 he suddenly changed from victim to aggressor, a fact he deeply regrets. Until he met Karen he had never had an adult relationship with a woman. The disintegration of the relationship was thus especially painful for him and even more so since it was his friend, John, to whom Karen transferred her affection. Peter had been the subject of a number of Adult Safeguarding alerts and as a result, only three months before the tragedy he was invited to consider alternative accommodation in order to remove him from daily contact with John and Karen – regrettably, he declined the offer.

4.2 The failure of RAABIT staff to ensure that their attempts to arrange for Peter's mental health to be assessed in May/June 2015 is a troubling aspect of this case and resulted in a clear breach of appropriate information governance standards. The administrative errors which led to the problem undoubtedly require the corrective action that has already taken. The combined effect of the various errors within NELFT resulted in a failure to assess Peter either in terms of his own vulnerability or for any consideration of whether or not he may have been a danger to others. The expert opinion of the NELFT Mental Health Review Panel is that the incident in 2010 (where Peter ran out into the street in a fit of anger carrying a knife) would not, of itself, be sufficient to justify him as being regarded as a high risk to others. What is clear however is that no mental health or medical professional considered this incident as part of even a preliminary risk assessment to determine the appropriate actions when he failed to respond to the attempts to make an assessment appointment. In reviewing Peter's history, it is apparent that referrals to mental health services often resulted in him not attending appointments and/or being referred back to his GP because, as was concluded in 2011 (see Para 2.6), his difficulties were assessed as primarily social. Thus, even if contact had been established there can be no confidence that Peter would have attended an appointment or that if he had done so, his mental state would have been improved. All that can be said with any certainty is that in the absence of an effective consultation, there was no possibility of such a positive outcome. The

seriousness of the overall impact of the errors was compounded by a failure to notify PM's GP of the problem, which would at least have made it possible for corrective action to be taken. This history, together with the detailed psychiatric and psychological assessments made after the homicides, precludes the conclusion that the breakdown in communications was a causal factor in the tragedy.

4.3 John and to a lesser extent Karen had far more robust personalities than Peter. Despite his age and slight infirmities, John remained physically active and took the various altercations less seriously than Peter: so much so that he declined to make formal allegations even after the more serious incidents. He even seems to have tried to maintain some sort of amicable relationship with Peter. There is no indication that either John or Karen perceived any danger from Peter.

4.4 The fact that neither John nor Karen perceived any danger from Peter should not be taken in any sense as blaming them for their fate. The police investigation identified several Home House residents, as well as support staff that had heard Peter complaining bitterly about how he had been treated by John and Karen. One resident even heard Peter saying that he wanted to stab John and Karen but regarded the statement as flippant. It is a common thread running through witness statements of LBR care workers and staff, as well as medical/psychiatric practitioners, that Peter was perceived as vulnerable victim not as a danger to others. Whilst John and Karen were, to an extent, ready to move away from Home House to live at Other House where Karen had a tenancy, they also seem to have encouraged or at least accepted Peter's company. They do not seem to have taken Peter's outbursts any more seriously than the residents and staff of Home House, even when those outbursts included spitting and stabbing the wall of John's flat.

4.5 The psychological phenomenon known as "outcome (or hindsight) bias" is a common feature of the way in which those analysing a sequence of events allow their knowledge of the outcome to influence their beliefs about the correctness of decisions prior to a crisis. The phenomenon applies with particular force in a case such as this, where deaths have occurred. In reviewing the history of the case, this review has focused only on what was known at time to those making decisions. Whilst it is certainly the case that mistakes were made by NELFT and LBR staff it is not possible to conclude that these were the cause of the final tragedy.

4.6 Notwithstanding the above, this review has identified various weaknesses within agencies which are the subject of recommendations for improvement:

Recommendation 1

LBR specifies for the benefit of residents and their relatives the extent of services offered to supported tenants with a view to promoting realistic expectations of the support available.

Recommendation 2

Amendments of the current LBR Carers Handbook to include

- information and guidance on domestic abuse including abuse by coercive control.
- The circumstances under which it is permissible to initiate safeguarding procedures even where the victim of an incident does not consider themselves at risk or does not wish such procedures to be started.
- The need to refer all potential safeguarding incidents to managers

Recommendation 3

LBR to review the incident recording process within supported living units and consider separate records for each resident thereby making it easier to identify the emergence of problematic patterns of behavior.

Recommendation 4

That LBR institute collective training and familiarisation for all relevant staff/carers, based on the products of recommendations 1 to 3 (above).

Recommendation 5

Supported tenants are invited to give explicit consent for information about their mental and physical health as well as more general welfare matters, to be shared with relevant LBR staff, external partner agencies and specified relatives.

Recommendation 6

NELFT must review its staffing, training and administrative processes – especially those relating to the synchronisation of national and local records - to ensure that its information governance complies with national standards.

Recommendation 7

The systemic problem of the non-synchronisation of local and national records is of national relevance and should thus be addressed via Home Office to Department of Health & Social Security.

Recommendation 8

NELFT to ensure all relevant staff are familiar with:

- DHR processes and their relationship to other NHS review processes
- Adult Safeguarding policy
- Policy & Procedures for Managing non-attendance etc.
- The necessity to base risk assessment processes on all available information

Recommendation 9

NELFT to issue appropriate apologies to the relatives of the deceased together with disclosure of the MHPER in accordance with established national guidance.

Recommendation 10

NELFT to reconsider its MHEPR process to ensure compliance with existing national guidance, specifically the extent of process transparency and disclosure of reports.

Recommendation 11

The family of John Downs have remained engaged with this review throughout the process and made significant contributions to its outcome. His daughters are anxious that the circumstances surrounding the death of their father are not repeated. It is recommended that LBR nominate an individual to ensure that they are updated on the progress of the Action Plan.

Action Plan

Recommendation	Action	Ownership	Target Date/outcome
Recommendation 1 LBR specifies for the benefit of residents and their relatives the extent of services offered to supported tenants with a view to promoting realistic expectations of the support available.	1.Review Statement of Purpose for Extra Care service to include a section on the Warden role in relation to sheltered housing 2. Review the current handbook for residents and highlight the difference between Extra Care and ordinary sheltered housing. ASS to work with Housing Dept. To explain the sheltered element	LBR	Completed Completed
Recommendation 2 Amendments of the current LBR Carers' Handbook to include • information and guidance on domestic abuse including abuse by coercive control. • The circumstances under which it is permissible to initiate safeguarding procedures even where the		LBR ASS/Housing Dept.	Completed Fully aware and actioned

victim of an incident does not consider themselves at risk or does not wish such procedures to be started. • The need to refer all potential safeguarding incidents to managers			Fully aware and actioned
Recommendation 3 LBR to review the incident recording process within supported living units and consider separate records for each resident thereby making it easier to identify the emergence of problematic patterns of behavior.			Completed
Recommendation 4 LBR to institute collective training for all relevant staff/carers based on the products of recs. 1-3	1. Review of staffing. Training with specific reference to synchronisation of local & national patient records		Completed

Recommendation 5 Supported tenants are invited to give explicit consent for information about their mental and physical health and welfare, to be shared with relevant LBR staff, external partner agencies and specified relatives.	A requirement to share confidential information is subject to data protection legislation and will be considered within the context of DOLS		Completed. A new form was created for supported tenants to sign and information to be shared on a need to know basis
Recommendation 6 NELFT to review its staffing, training and administrative processes to ensure that its information governance complies with national standards		NELFT	
Recommendation 7 The systemic problem of the non-synchronization of local and national records is of national relevance and should thus be addressed via Home Office to Department of Health & Social Security.		Department of Health	
Recommendation 8 NELFT to ensure all staff are familiar with: • DHR processes and their relationship to other NHS review		NELFT	

processes • Adult Safeguarding policy • Policy & Procedures for Managing non attendance etc. • The necessity to base risk assessment processes on all available information			
Recommendation 9 NELFT to issue appropriate apologies to the relatives of the deceased together with disclosure of the MHEPR in accordance with established national guidance.		NELFT	
Recommendation 10 NELFT to review its MHEPR process to ensure compliance with existing national guidance, specifically the extent of process transparency and disclosure of reports.		NELFT	
Recommendation 11 LBR nominate an individual to ensure that they are updated on the progress of the Action Plan.			Completed: Nominated person Abdelilah Bouziane, HASS/Service Manager

Consolidated Chronology

Date	Org./IMR Ref.	Event	Comment
01.10.1928	MPS	John born	
19.02.1962	MPS	Karen born	
19.10.1964	MPS	Peter born	
22.06.2000	MPS Chron.	Peter victim of a theft whilst in hospital. Case closed because he did not communicate with police	
30.12.2003	MPS Chron.	Karen's then husband called police after receiving threats re an unpaid debt. Karen had received similar calls. Case closed when Karen's husband declined to assist the investigation	
15.06.2004	MPS Chron.	Peter victim of an assault when unidentified driver alighted from his vehicle punched Peter and decamped. Case closed due to inability to identify the suspect	
01.11.2006	MPS Chron.	Peter's bike stolen whilst left outside a shop. No suspects - case closed	
25/03/2008	NELFT	Peter referred to Redbridge Community Recovery Team West (CRTW) received from GP Referral logged on RIO (electronic patient records system) & placed on CRTW waiting list for assessment.	
24.03.2007	MPS Chron.	Peter victim of a theft from his accommodation. An identified male stole money and medication whilst in Peter's flat but after reporting the matter, Peter declined to communicate with police and the case was closed	
16.04.2007	MPS Chron.	John victim of a theft. His wallet was snatched in a shop. No suspect identified – case closed	
25.03.2008	NELFT	Peter referred to Redbridge Community Recovery Team by GP	

20.06.2008	NELFT	Peter assessed by Dr W and DG from Redbridge CRTW Referred to Community Support Team (CST) & Befriending Service. Discharged from Mental Health Services to GP (03/07/2008)	Entry in Rio progress notes
14.07.2008	NELFT	Peter offered Art Therapy assessment appointment with CR on 28/07/2008	
28.07.2008	NELFT	Peter did not attend (DNA) art therapy assessment. Further letter sent to confirm whether he wishes to have appointment	
30.07.2008	MPS Chron.	Peter victim of burglary. Phone and medication stolen. No suspects identified and case subsequently closed	
01.05.2009	MPS Chron.	Peter's care worker informs police that Peter was being harassed for money by a neighbour. Police issued a harassment warning to the neighbour	
08.10.2009	NELFT	Peter referred from Community Support Team (CST) support worker CD to CRTW received. Referral reviewed by CRTW on 14/10/2009 & passed to Redbridge Access, Assessment & Brief Intervention Team (RAABIT). RAABIT referral logged 12/10/2009	By this point Peter's "old address" would have been included in the RIO system
22.10.2009	NELFT	JT (RAABIT) telephone call to support worker CD (CST) to discuss referral. Joint home visit for assessment arranged with CD (CST) & RAABIT for 23/010/2009	

23.10.2009	NELFT	CS (RAABIT) & CD (CST) assess Peter at home. Medical review with Dr N booked for 30/10/2009	
30.10.2009	NELFT	Peter DNA medical review with Dr N. Medical review rebooked for 16/11/2009	
16.11.2009	NELFT	Peter seen by Dr N. Follow up medical appointment booked with Dr N for 11/01/2010. Peter given details of anxiety management groups RIO progress notes. Dr N letter to GP	
11.01.2010	NELFT	Peter DNA appointment with Dr N. RIO progress notes. Dr N letter to GP Appointment rebooked for 08/02/2010	
08.02.2010	NELFT	Peter DNA appointment with Dr N. Telephone call from CD (CST) to request further appointment. RIO progress notes. Dr N letter to GP Appointment rebooked for 03/03/2010	
03.03.2010	NELFT	Peter DNA appointment with Dr N. Next appointment with Dr N 26/04/2010	

		Dr N letter to GP	
07.04.2010	NELFT	Telephone call from CD (CST) to CMHTW. CMHTW pass referral onto RAABIT. CS (RAABIT) telephone call to CD to discuss her concerns about Peter. CS (RAABIT) telephone call to Peter to discuss his difficulties. Urgent appointment for 08/04/2010 arranged for Peter	
08.04.2010	NELFT	Peter seen by Dr S & CS (RAABIT). Medication increased. Follow up appointment with Dr N 26/04/2010 GP letter. RIO progress notes	
26.04.2010	NELFT	Seen by Dr N. Follow up appointment with Dr N booked for 21/06/2010. Peter referred to CRTW (referral logged 29/04/2010) GP letter RIO progress notes	
07.05.2010 – 17.05.2010	NELFT	CRTW refer to psychology (R M-L) for possible allocation. Not suitable due to art psychotherapy referral. Passed back to CRTW duty – discharged from CRTW (17/05/2010) Letter	

		RIO progress notes	
09.07.2010	NELFT	Clinic cancelled due to staff sickness. "Knife incident" - Peter has become angry with neighbours and run into the street with a knife. JT (RAABIT) spoke to CD (CST) who explained that Peter is being intimidated by neighbours and should be moving to new accommodation. Appointment rearranged for 20/07/2010	
20.07.2010	NELFT	Peter attended appointment 45 minutes late so unable to be seen. Dr S spoke to CS regarding future options for Peter to get support as not suitable for MH services	
03.08.2010	LBR Prison interview notes	Peter signed his tenancy agreement for Home House and moved in 09.08.2010 Peter states that he had to move to somewhere like Home House because he was not looking after himself and was being bullied in his former home	
19.08.2010	LBR	Peter cancelled his Community Meals service	
01.09.2010	LBR	Home House staff contacted CST to express concern that rubbish was piling up in Peter's flat	
06.10.2010	LBR	Peter told his CST worker that "some drunks" had pushed him as he entered Home House the previous day.	

30.01.2011	LBR	CST worker recorded that Peter had started to take responsibility for his own health	
31.01.2011	NELFT	CS met with Peter and explained RAABIT role and limited support team can offer regarding social difficulties. Peter in agreement that he would be discharged back to GP's care. Closed to RAABIT (31/01/2011) GP letter (18/02/2011) RIO progress notes	
21.02.2011	LBR	CST worker called a commercial premises on behalf of Peter because their fire door kept slamming, disturbing the Home House residents	
29.06.2012	LBR	Peter informed LBR staff that he no longer needed care workers to assist him with his personal care or meal preparation	
15.11.2012	LBR	John discharged from hospital for a transitional bedsit at Home House	
27.11.2012	LBR	Care Review held re Peter at which it was decided that he could cope with his own daily tasks.	
07.12.2012	LBR	John accepts the offer of a tenancy at Home House	
20.12.2012	LBR	John joined in at the Home House Christmas Party and started to help staff setting the tables at lunchtimes, calling bingo and socialising with other residents in the lounge	

11.02.2013	LBR	John becomes a permanent resident at Home House	
02.08.2013	LBR	John started a relationship with Karen. Home House warden advised them to take matters slowly and expressed her concern that other residents had complained that some of Karen's comments were sexually explicit and inappropriate to be shared with other residents.	
09.08.2013	LBR	John told the Warden that he was no longer in a relationship with Karen. Warden became aware that Karen had started a romantic relationship with Peter.	At this time Karen's proper accommodation was at Other House.
21.08.2013	LBR	Karen signs a tenancy agreement for a flat at Other House (Extra Care housing), moving in on 04.09.2013 and receiving furniture delivery from British Heart Foundation.	
20.09.2013	LBR	Karen informs her care manager that she is seeking a divorce from her husband and wants to spend the rest of her life with Peter at Home House	
09.10.2013	LBR	Meeting between Karen, a housing officer, and the Home House warden. It was explained to Karen that because she was staying with Peter at Home House, the Other House warden had to make phone calls to ensure she was safe. The tenancy agreement was read to Karen to ensure she understood that she should be occupying her own flat at least 4	

		nights per week.	
10.10.2013	LBR	Warden spoke to John about his welfare because he was pushing Karen in her wheelchair to and from Ilford and to and from her proper accommodation	
18.10.2013	LBR	LBR officer met Karen to ensure she understood the repercussions of not staying at her own bedsit i.e. that she could be made homeless. It was further explained to Karen that failing to pay her rent and service charges could also affect her tenancy. Karen was offered the help of staff to manage her finances better.	
08.11.2013	LBR	Joint meeting with Home House staff, Other House staff and LBR staff plus Karen and Peter. Discussion that Karen would spend more nights at her home (rather than Home House). Karen disclosed that she and Peter had become engaged but didn't want people to know because Karen was still married	
06.12.13	LBR	Karen did not attend her specialist day centre for adults with physical difficulties	
19.12.2013	LBR	Karen failed to attend her day centre again	
10.01.2014	LBR	Karen did not attend the day centre	
15.01.2014	MPS Chron.	Peter called police to report that a drunk male had touched his arm as he returned to his home. He did not want to make any allegations but wanted police to be aware of the drink and drugs problems in the area. Recorded that Peter suffers from various medical conditions which make it difficult for him to look after himself. Adult MERLIN record completed. Assessed as level one	

		blue as there was no specific risk identified. No further dissemination to other agencies.	
20.01.2014	LBR	Karen informed her day centre that she no longer wished to attend	
07.02.2014	LBR	Home House manager expressed concern to John that he is losing weight and about him getting involved in activities again	
19.08.2014	LBR	Peter spoke to staff saying he had concerns about Karen's friends who were alcoholics and drug users. He was advised to discuss his concerns with Karen	
20.08.2014	LBR	John went to the office expressing concern about Karen's friends. He did not want to associate with them but also didn't want to leave Karen on her own with them	
22.08.2014	LBR	Arrangements made for a Care Review for John involving His specified next of kin (SY), LBR and Immaculate Care	
09.09.2014	LBR	Peter complained to staff that John had three of Karen's "alcoholic friends" in his flat. John informed staff that he was trying to get rid of them. They left when staff asked them to.	
09.09.2014	NELFT	Peter telephone call to Home Treatment Team (HTT) to complain about one of his carers at his care home. Peter was advised to speak to management team at the care home. Case closed.	
10.09.2014	LBR	Manager spoke to John about the previous evening. John stated that he had not invited them but that they had followed him in to the building. Peter had a disagreement with staff at	

		Home House in which he was very abusive and started throwing things	
12.09.2014	LBR	Peter received a call from a Social Worker in the Home House office. After this he expressed his concerns about Karen's friends. He was very tired and said he had not slept because Karen was staying with him. It was suggested Peter should ask Karen to sleep at her own bedsit so he could get some rest.	
14.09.2014	LBR	Karen admitted to hospital for shortness of breath	
15.09.2014	LBR	Warden noticed friends of Karen coming to the front door of Home House. They asked for John. Warden explained that they could not be let in and told them she would inform John. John stated he did not and would not invite them into Home House.	
16.09.2014	LBR	Karen discharged from hospital	
17.09.2014	LBR	Care Review re John Safeguarding adult alert – Peter made allegations against a Home Care Worker at Home House. He alleged that she mostly shouts at him and has been rude and nasty leading him to feel anxious with panic attacks, inability to sleep or concentrate. Also alleged that the worker suggested his wheelchair-bound partner (Karen) is lazy and will say things to her like "Get up and walk". He claims this is affecting his mental health. Peter also alleges that a group of six criminals, "drug addicts and murderers" who are friends of Karen visit Home House regularly. Peter also alleges the worker has been abusive to John	
24.09.2014	LBR	Social Worker contacts John to see if he any concerns regarding what Peter had alleged.	

06.10.2014	LBR	Professional Advocate from IMCA met with Peter re his allegations. Peter reported he was not feeling in great health but confirmed he was getting support from his GP. Peter did not want any further meetings with the advocate or support	
27.10.2014	LBR	Peter entered the Home House office to express concerns about Karen's friends. He was advised that the staff would support him by keeping a check on who visited Home House	
28.10.2014	LBR	Peter again entered the Home House office to express concerns about Karen's friends. He was advised that the staff would support him by keeping a check on who visited Home House	
06.01.2015	LBR	Karen asked that her care package be suspended	
18.02.2015	LBR	Karen and Peter separately reported to a member of staff that her relationship with Peter had ended and that she had resumed her relationship with John	
02.03.2015	NELFT/NHS	IAPT message left for Karen to call back to arrange for an assessment meeting	
03.03.2015	NELFT/NHS	Karen confirmed her appointment for 30.03.2015	
26.03.2015	LBR	Peter informed the office that John could not walk and that Karen would be unable to get to her home. Staff found John in an armchair with a very swollen sore foot and Karen asleep in John's single bed	
27.03.2015	LBR	GP attended and checked John's foot. He was told he must rest until an infection had cleared. LBR staff informed Immaculate Care about the (poor) condition of John's flat	
31.03.2015	NELFT/NHS	IAPT review assessment and treatment plan for Karen and send it to her GP	

02.04.2015	LBR	Peter informed the Home House office that he had ordered a single bed for Karen. Peter claimed another resident at Home House had been rude to him	
08.04.2015	NELFT/NHS	IAPT discuss with Karen the plan for her Step Two work	
14.04.2015	LBR	Peter informed the Home House staff that John was very upset that Home House does not do activities that John likes. When asked, John stated that he had not asked Peter to do this and that he goes out every week to a local choir and is capable of doing things by himself	
20.04.2015	LBR	Peter went to the office to say that he was quite upset because he has been arguing with John and Karen because Karen had told Peter that she wants to marry John. Peter was upset because he had bought Karen a new bed but that she doesn't want it because she is now staying at John's flat. The warden offered to make an appointment for John to see his GP because he seemed depressed but Peter declined the offer saying if he needed to see his GP he would make the appointment himself.	
28.04.2015	LBR	Peter entered the Home House office and told staff that Karen had told him to "Get lost". He then told staff of all the things he had bought for Karen and asked why she would do this to him. At that point, Karen and John passed the office and Peter wanted to confront them. He was advised to calm down and leave them alone.	
29.04.2015	LBR	John told staff that Karen had argued with Peter because she did not want to be with Peter anymore. He also reported that Peter had taken a butter knife into John's flat and stabbed the	

		wall, making a hole. John was not in the flat at the time but Karen was. All three were spoken to in the office. Karen confirmed she did not wish to be with Peter anymore. Peter accepted this but said he felt he had been used. Staff explained to Karen that it was unfair to play with Peter's emotions. It was suggested that Peter and John do not go into each other's flats for a while. Staff also told Peter that it was unacceptable to be holding a butter knife while arguing with someone, as he had been with Karen	
01.05.2015	LBR	Staff went to John's flat. Both Peter and John were present. Peter said he had been invited because he still wants to be friends	
20.05.2015	LBR	John and Karen inform staff that they intend to marry the following October. John said that Peter was not happy about it and Karen said that every time John goes downstairs, Peter comes to his flat. Staff advise John to lock his door so Peter cannot simply walk in	
23.05.2015	MPS & LBR	Peter alleges he was assaulted in John's flat by an identified person who was a friend of John. A police CRIS report was created but Peter refused to substantiate the allegation. The suspect was removed by police and subsequently arrested for being drunk & disorderly.	
26.05.2015	LBR	Manager and staff went to see John and Karen in John's flat. John's daughter (E) was also present. John asked Peter to join them. Manager informed John that the events of 23.05.2015 were unacceptable and that John and Karen were giving Peter "mixed messages"	This arranged meeting, though a sensible and well-intentioned attempt to improve behaviour was beyond the remit of staff

27.05.2015	LBR CCG Records	Peter was asked if he wanted to report the events of 23.05.2015 to the Safeguarding Team. Peter refused this stating he would go to Housing himself and presumably ask for a move. Peter was reassured to keep his emergency pendant with him at all times and advised not to go into John's flat even if invited. Peter did not want the matter taken further with the police. Dr R from the Ilford Medical Centre visited Peter and will refer him to the Community Mental Health Team – Peter agreed to this course of action. Dr R examined Peter and found no injuries but that Peter was anxious and suffering from a low mood. Peter denied any thoughts of suicide. Peter also told Dr R that he was keen to be seen by the Mental Health Team. Dr R recorded that Peter denied any thoughts of suicide.	
27.05.2015	NELFT	GP faxed referral for Peter to RAABIT. Reason for referral: depression, anxiety, suicidal ideation. Triaged for screening assessment	GP records contained the correct address (i.e. Home House) and this correct address was used for the referral form.
29.05.2015L	LBR	LBR Housing Officer wrote to John and Peter advising them that she would visit on 11.06.2015	
31.05.2015	LBR	Peter entered the Home House office and was quite anxious about what had happened with Karen, John and her family on 23.05.2015. He said he still	

		feels unsafe. He was advised to spend more time in the lounge with other people. When asked about what he would like to happen. Peter insisted that "something needs to be done" about John	
09.06.2015	NELFT	Telephone call from OM (RAABIT) to Peter – answered by secretary who stated this is office phone and to call Peter on mobile. 2 x telephone calls (13.36hrs, 15.49hrs) to Peter's mobile (07847225476) by OM (RAABIT). 2 x messages left on Peter's voicemail asking him to call RAABIT	
10.06.2015	NELFT	RAABIT opt-in letter sent (to Peter's pre 2010 address) as no response to telephone calls Second opt-in letter sent.	
11.06.2015	LBR Housing	Housing Officer visited Peter as planned. Peter told her he did not want any specific action but that he was upset by the fact that Karen wanted John rather than Peter to care for her. Peter was advised to stay away from Karen and John and to report any further incidents to the officer. Housing Office then visited John as planned and Karen was present in John's flat. John was very apologetic about the incident and explained he had invited Peter into his flat for a drink because they had been friends. Karen and John informed the Housing Office that they planned to marry on 23.10.2015 and John said he was able	

		to care for Karen and they didn't want any help (from Peter). John stated that he would give up his tenancy at Home House and move with Karen to her flat. He was advised against this because if anything went wrong with the relationship, he would then be homeless. NoK details for John provided to Housing Officer	
11.06.2015	LBR Housing	Housing Officer 'phoned SY (NoK of John) to express her concern that, given his age (86) John proposed to give up his secure tenancy and move to Karen's flat. Daughter E was grateful for the Housing Officer's advice but explained it was hard to speak to her father without Karen being present. Housing Officer said she was reluctant to accept John's termination of tenancy without E trying to speak to John. E was advised that LBR would not be taking immediate action about the tenancy	
06.07.2015	NELFT	Peter's case reviewed & discharged as no response to opt-in letters or telephone calls. Discharged from RAABIT Letter sent to GP & client	
05.08.2015	LBR	John went to the office to report that Peter had gone into John's flat to talk to Karen. John said Peter had got angry and John asked Peter to leave. Peter was called to the office and	

		asked why, after all the problems, he had gone to John's flat. Peter got angry and started shouting at John then spat at him. Peter told to leave the office. Home House staff then went to John's flat, concerned that Karen would be in there alone. Peter was found standing over Karen asking what she had said to John about him. Peter was asked to leave and did so. He appeared very angry. Warden advised John to keep his front door locked.	
05.09.2015 15.00 (approx) 21.45 (approx) 22.15 22.16 22.18 22.19 22.21 22.30	MPS	 Witness hears Peter say "I feel like stabbing John and Karen." Witness tells Peter that he shouldn't but regards remarks as flippant Care worker hears Peter complaining about his treatment by John and Karen Staff member discovers the incident Staff member calls out of hours supervisor Call to 999 system from Home House stating that a woman had been stabbed and suspect still on the scene Out of hours supervisor arrives at Home House LAS informed and responded plus HEMS Police arrive at the scene and declare it safe for ambulance staff to enter	 Approximate time Approximate time Precise time from mobile 'phone MPS gives this precise time LAS gives this precise time MPS gives this precise time

22.36 22.42 22.50 23.05		LAS ambulance arrives at the scene LAS Air Ambulance arrives Karen life pronounced extinct HEMS work on John but life finally pronounced extinct	LAS gives this precise time LAS gives this precise time

Appendix A

Specific Questions from Victims' Relatives

Question	Response
1. Were the police called to any of the previous incidents; particularly the incident involving a knife?	**Yes, the police were called on 23rd May 2015 following the incident involving Peter and John's visitors.** **In relation to the incident with the (butter) knife, John only reported the incident to the warden a few days after the event. John was not involved in the incident and he made it clear he did not want to pursue the matter.**
2. Was John's Social Worker or the Social Worker of Peter informed of these incidents?	**Home House staff did not contact social workers because there was none allocated to Peter at that time. However a Housing Officer was informed and spoke to John, Karen and Peter.**
3. As a result of the incidents, did Fernways request a revue meeting with the Social Worker(s)?	**As above. The Housing Officer was informed and spoke to Peter, John and Karen. It should be noted that all three had always rejected interventions.**
4. Fernways had a duty of care to protect John and all the other people living/working there. Did Fernways raise any safeguards as a result of any of the incidents?	**LBR takes reasonable steps to identify the possibility of abuse and prevent abuse from happening** **Staff had been trained in safeguarding vulnerable adults and knew what to do in the event of suspected abuse.**

	The incident referred to were never referred to the Safeguarding Team because the people involved objected to that course of action
5. Did Fernways raise the issues as an urgent safeguarding matter with the Safeguarding Team at Redbridge Social Services?	**As above (4)**
6. Was there any consideration given to moving either John or Peter? If not why not and if so, why didn't it happen?	**No consideration was given to moving either Peter or John as no formal request was made by either of them. The Housing Officer did ask Peter if he would like to move after the incident on 23rd May but he declined. She also spoke to John regarding his giving up his tenancy to move in with Karen at Other House and even tried to get his NoK to dissuade him from this course of action.**
7. Under regulation 18 of the CQC "Adult Protection from Incidents of Abuse Regulations", the Home Manager should have notified the CQC of any incidents where the police were called or where safeguarding issues arose. Were any incidents reported to the Care Quality Commission (CQC) using the relevant notification procedure?	**Home House is registered under Section 60 of the Health & Social Care Act 2008 and complies with the regulations associated with the Act. It is registered as a domiciliary care agency and is part of the community services provided by LBR. It is also one of the borough's sheltered housing units and provides an extra care service to a number of its tenants. The service offers individuals personal care, support and extra care they require to continue to live independently. At the time of the tragedy, there were 26 people receiving the extra care service but John and Peter were not among them. Residents, including John had a choice of care provider. John chose Immaculate Healthcare Services Ltd. John had full mental capacity and as such**

	there was no duty of care to relay incidents to his care agency without his permission. **The role of the Warden (whose in an LBR employee, is as an intermediary between tenant and their care agency, GP, Pharmacies etc. The Warden is the "go to person" for the tenant, e.g. when a care agency person had failed to attend or there are problems with the delivery of medicines. The Warden is not an advocate for the tenant or a social worker with the authority to monitor tenant's relationships or intervene with a tenant's life choices.** **Even had John wished it, Home House would not have notified the CQC of incidents. Immaculate care might have done so but in fact were unaware of the incidents which, in any case, John did not want reported.**
8. Were the incidents recorded?	**All incidents were recorded in the Warden's log book and one incident (on 23rd May) was reported to the Health & safety Executive.**
9. Did Fernways use proper Incident Forms?	**Home House used standard LBR Accident & Incident Report forms.**
10. Were the records audited by the Manager/Deputy Manager (this should have been treated as a "red flag warning")?	**The management and office staff are all based in the same office and information is shared widely and constantly. In the absence of the Operational Manager, the office staff will report any significant events, incidents or accidents to the manager on their return or they will call them or one of the other**

	operational managers or the service manager if the matter is urgent.
11. What action did the management of Fernways actually take following the various incidents?	**All parties were spoken to after every incident with a view to solving the issues. Both parties were offered the options available to them, i.e. reporting to the police and/or Safeguarding Team etc.**
12. At some point before 5th September Peter was seen to spit in John's face in front of the manager of Fernways. What action was taken?	**The incident took place after staff had acted to ask Peter what he had been doing in John's flat. Once Peter had left the office, John was asked whether he wanted to report the matter but he declined.**
13. The lock on John's front door was defective, allowing Peter to get into the flat at will. In light of the previous incidents, why was the security of the flat not corrected?	**Following the above incident the office staff suggested to John that he keep his door closed. He replied that he liked keeping the door on the latch and went on to say that he had lost his keys. A new lock was fitted as a consequence. John was an independent tenant and unless faults in his flat were reported the office would not know of them.**
14. In the afternoon of 5th September, a member of the staff heard M shouting threats/abuse though John's door. What action was taken?	**This incident happened in the evening and a member of staff asked Peter to return to his flat and stop shouting. He complied.**
15. In the afternoon of 5th September, other residents heard M saying he had a plan to kill John and Karen. Was this reported to staff and if so, what action did they take?	**This fact was not known to staff and was only discovered as part of the subsequent police investigation.**
16. Had the staff been trained appropriately for such serious incidents and what was	**The staff are trained to deal with incidents and emergencies that are likely to occur but**

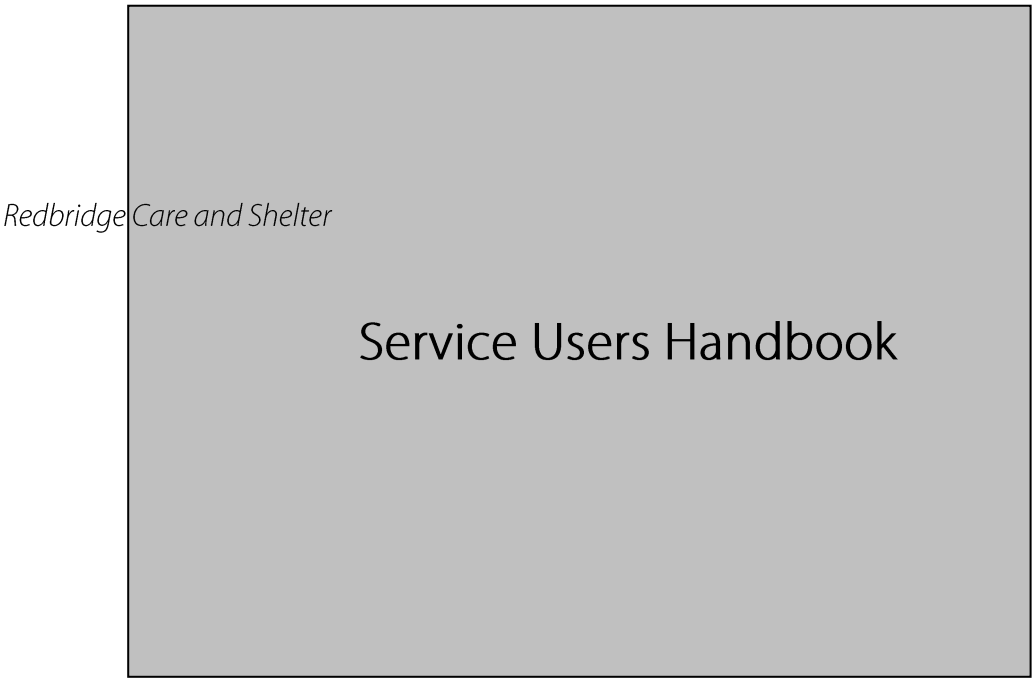
the nature of that training?	**not incidents of this type. There is an annual staff training programme based on the needs of the individuals, the service and the organisation. The training needs are identified following staff appraisals and discussions.**
17. Why didn't the staff member dial 999 immediately?	**The member of staff who discovered the incident and partially witnessed the attack on Karen contacted the out of hours supervisor who told her to dial 999. The member of staff was clearly shocked and traumatised by what she had seen but the delay in dialling 999 was 2 – 3 minutes.**
18. A member of staff saw through the door of John's flat that a very serious assault was taking place. Why did she not call 999 straight away but instead only call the manager?	**As above**
19. How many staff were on duty on the night of the homicides and were they employees or agency staff?	**There were two members of staff on site: one permanent and one agency (she had been working at Home House for 2 years). The out of hours support worker was on a visit to the closest unit and joined them when called**
20. Who did call the Emergency Services?	**See 17, above.**
21. Were the staff able to speak English sufficiently well to deal with the incident?	**Staff employed in our service have to be able to communicate effectively both in writing and verbally. Those present that evening were able to communicate efficiently.**
22. We believe there was a 15 minute delay	**This is a misunderstanding of the evidence**

between the incident becoming known and the first call to the Emergency Services. This must have delayed potentially life-saving action. Why?	**given in court. There was a 12 minute delay between the first call to the emergency services and their attendance. The sequence was:** **22.15 Incident discovered** **22.16 Staff member called Out of hours supervisor** **22.18Staff member called 999 and spoke to the police controller** **22.30 Police arrived on scene and declared it safe for ambulance staff to enter.**
23. Why did the manager lock the member of staff in the office until the arrival of the Emergency Services arrived?	**The out of hours supervisor put Peter in the office and a member of staff with him to await the emergency services. Some of the actions taken that evening were instinctive and not in compliance with guidance.**
24. Did night staff at Fernways have mobile 'phones with which to call for help in an emergency situation?	**Yes, and every flat is equipped with an emergency pull cord to alert staff.**
25. Why were John's daughters by his first marriage not informed immediately by the police?	**This was a police decision based on the fact that they notified the nominated next of kin.**
26. Fernways had been given the contact numbers of John's daughters by his first marriage but the only time they were contacted (in February 2015) was to seek payment of the debt incurred by John for unpaid fees. Why didn't Fernways inform	**John had full mental capacity and was able to choose for himself what he disclosed to which family members. It would have been improper for staff to take it upon themselves to make such decisions.**

these same daughters about the various incidents including the final fatal incident?	
27. Why was Peter not properly assessed and treated for his mental condition?	**Peter was seen by his GP and referred to the Community mental Health Team. Please see the full report for the explanation of why the referral failed**
28. What exactly was/is the status of Fernways in respect of its obligations to the CQC	**Home House is registered with the CQC as a domiciliary care agency.**
29. What is the admissions policy of Fernways?	**Those admitted should:** • **Have an assessed need** • **Be 18 years or older** • **Support pain control with the aid of medication** • **Able to weight-bear through upper and lower limbs to mobilise and transfer** • **Able to transfer from sitting to standing with minimal to moderate assistance of one person** • **Be motivated to improve functional/social independence** • **Suffer from no more than mild depression/anxiety** • **Suffer from no more than mild to**

	moderate memory difficulties

Appendix B



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EMERGENCY TELEPHONE NUMBERS
IN THE FIRST INSTANCE PRESS THE EMERGANCY PENDENT.

POLICE,	999
AMBULANCE,	999
FIRE SERVICE	999

ILFORD POLICE STATION	0300 123 1212
GP	IN YOUR HOME FILE
GAS LEAKS	0800 111 999 (FREEPHONE)
ELECTRICAL EMERGENCIES	0800 096 9000 (FREEPHONE)
WATER LEAKS	0845 920 0800
NHS DIRECT	0845 4647

REDBRIDGE CARE AND SHELTER OFFICE
HOURS AND LOCATIONS

Redbridge Care and Shelter provides a support service between the hours of 7.00 am - 11.00 pm 7 days a week, 365 days per year.

The Extra Care Team Office at:

"Other House" can be contacted on: [number deleted]

- - 7.00am – 5.00 pm

"Home House" can be contacted on: [number deleted]

- 020 8708 9401 - 7.00am – 5.00 pm

[Location deleted] can be contacted on: [number deleted]

- 020 8554 2714 - 7.00am – 5.00 pm

In the first instance please press your pendant and connection to the Lifeline centre will be made and they will respond to your request.

INTRODUCTION

The main aim of Community Care is to help people to live with dignity in their own homes and communities as independently as possible. The Home Care Service, within Community Services, plays a major role in this and has appointed its 'in-house' service, Redbridge Care, to deliver your service.

We undertake, where possible, to provide our own regular Home Carers, however this is not always possible. On occasions where, for instance, Home Carers have annual leave or periods of sickness we provide home care services by using External Providers. In such cases a letter will be sent to you with a breakdown of the care and the responsibilities and contact details of each Home Care Provider involved with your care package.

This handbook is intended as a quick reference guide that will give you information concerning the services you can expect from Redbridge Care. It also gives other information that may be of interest to you.

Redbridge Care is keen to attain and maintain the highest standards in the provision of home care services and we welcome any comments you may have concerning our Home Carers, the services you receive and the future delivery of home care services and split home care services.

Please keep this handbook with your home care day file for easy reference.

Finally, I hope you find the handbook useful. Please let us have your comments regarding ways in which it can be improved in later editions.

Mary Byrne

Principal Officer

Care and Support

AIMS AND OBJECTIVES
COMMUNITY CARE MISSION STATEMENT

Redbridge Care's objectives are:

- To enable you to live independently in your own home
- To enable you to maintain and improve your mobility
- To enable you to maintain your personal hygiene and appearance
- To enable you to access and use bathroom facilities
- To enable you to achieve physical comfort
- To provide activities to support your daily living

PLANNING YOUR SERVICE

OUR FIRST VISIT

- We visit each new Service User to establish how the services will be provided
- An Operational Manager will carry out a risk assessment to ensure that your home is a safe environment for our Home Carers and yourself.
- A risk assessment is undertaken for all Service Users and their property for Health & Safety reasons.
- During the period your service is in force your Home Carer will monitor and report any potential dangers that arise. Any concerns will be reported to the Home Care office.
- Your Home Carer will inform the Home Care office if further hazards are identified during the period of service.

INFORMATION IN YOUR HOME

- We will provide a file for you to keep copies of documents in your home.
- Your Home Carer will need to write in this file each visit.
- You will receive a copy of your Risk Assessment, Care Plan and Service Specification. These will detail the services you will receive and the days and times your Home Carer will call.

FIRST AID

- Home Carers are not allowed to put Service Users or themselves at risk by giving first aid. They will, however, call for an ambulance if required and contact the Operational Manager/Support Worker and seek advice.

HEALTH & SAFETY

Following the initial risk assessment Redbridge Care will:

- Ensure that working systems are safe and without risk to health.
- Handle and transport articles and substances in a safe manner, without risks to health.
- Ensure that persons not in its employment, who may be affected by its activities, are not exposed to risks to their health and safety.
- Provide competent technical advice on health and safety issues wherever necessary to avoid risks to health.
- Your initial assessment will have defined whether assisted movement is a necessary part of your care plan. Two Home Carers may be required to undertake this task.

- Electrical appliances must not be used if they appear to be in a dangerous condition.
- Home Carers will not attempt to fix a hazard e.g. electrical, or plumbing appliances, themselves.

Under NO circumstances will an appliance be used if it is considered to be dangerous.

Any appliances that appear to be dangerous will not be used and will be reported to the Redbridge Care Office.

DELIVERING YOUR SERVICE

WHAT YOU MUST PROVIDE

- A safe working environment for our Home Carer.

YOUR RIGHTS

As a Service User of Redbridge Care you have certain rights in respect of the service you receive.

You have the right:

- To have your personal dignity respected, irrespective of physical or mental condition.
- To retain personal independence, personal choice and personal responsibility for actions, including acceptance of risk.
- To expect personal privacy for yourself, your belongings and your affairs.
- To have your cultural, religious, sexual and emotional needs accepted and respected.
- To have care appropriate to your needs from suitably trained and experienced staff.
- To have and to participate in, regular reviews of your individual circumstances and to have relatives, Home Carers or friends present if you so wish.
- To participate as fully as possible in the formulating of your own individual care plan and services.

YOUR FINANCES

- Your Care Plan will detail what financial matters your Home Carer can help with.
- Our Home Carers are not permitted to become involved with any financial affairs unless they are specified on the care plan.

- Our Home Carers are not permitted to act as witness to, or executor of, a Will or Last Testament. Your Home Carer will follow strict procedures and guidelines when dealing with your finances, for instance when paying bills for you.

  These procedures include:

  Recording all money taken from you

  Returning your shopping in good condition

  Giving a retailers receipt to you for all money spent

  Counting out your change with you on return

- Your Home Carer is not permitted to write cheques for you or take or use your credit card, unless agreed by the Operational Manager if you have one and its pin number.
- Your Home Carer is not permitted to offer any financial advice.

YOUR HOME CARER

- Your Home Carer is employed by the London Borough of Redbridge and is managed by Redbridge Care through a nominated Operational Manager.
- All our Home Carers are suitably trained to NVQ Levels 2 and 3 and supervised.

You can expect your Home Carer to:

- Wear her identity badge at all times.
- Wear uniforms and gloves as a matter of course when providing personal care.
- Maintain a Service User Day File in your home in which he/she will record all duties carried out for you in accordance with the agreed care plan.
- Communicate with your family or friends when you want them to be involved in planning your care. Your Home Carer will be pleased to pass on any comments that you, or your family and friends may have. Although your family's opinions are important final decisions regarding care can only be made by Community Care.
- Remain professional and courteous at all times and to respect other people and organisations working to provide your care.
- Be concerned about your general health and well being and record any concerns in the Day File in your home and make a report to the Home Care office.
- Keep information concerning you and your service confidential and not impart any information to another person or organisation unless necessary for your well being.

YOUR HOME CARER'S VISIT

DUTIES AND TASKS OF YOUR HOME CARER

- The care that will be provided will be detailed on your care plan, a copy of which is to be found in the home care file located in your home.
- Redbridge Care may provide domiciliary help in addition to personal care but only where this forms part of the care plan.

Your Home Carer is NOT permitted to:

- Move heavy furniture.
- Climb on anything other than proper step-ladders.
- Undertake any invasive procedure i.e. enema, suppository, giving injections, catheterization
- Change sterile dressings
- Cut toenails
- Give advice concerning medication
- Give financial advice
- Witness any legal document for you such as a will.
- Place bets or buy gaming tickets (including the Lottery) on your behalf

CHANGES IN YOUR NEEDS

- The service you receive will be automatically reviewed every 6 months.
- You have the right to request a review of your service at any time if you feel your needs have changed by contacting the Operational Manager responsible for your care.
- Redbridge Care undertakes to supply services in accordance with the care plan in force at any given time.

WITHDRAWAL OF THE SERVICE

- Redbridge Care expects its Home Carers to conduct themselves in a professional, polite and efficient manner at all times. It expects its Service Users to treat Home Carers with respect and not to:
  A. continually refuse access
  B. provide an unsafe working environment
  C. subject Home Carers to harassment or prejudice in any form
- In certain cases, where problems such as, but not exclusive to, the above persist Redbridge Care may withdraw services.

EQUAL OPPORTUNITIES

- Our aim is to provide quality services which are relevant to the needs and responsive to the views of all sections of the local community, irrespective of their race, gender, disability, culture, religion, age, sexual orientation or marital status etc,
- We will develop services that reflect current needs as well as entitlement.
- The quality of life of all who live, work, do business, invest in or visit the Borough is important to us. We will seek to ensure quality of access for all sections of the community to Council and other services.

HARASSMENT

- Redbridge Care will not tolerate harassment or discrimination against you or its Home Carers on the grounds of race, religion, gender, age, sexual orientation and disability.
- If you feel you have been discriminated against, for any reason, you should contact the safeguarding Adults Team on 020 870 87333.
- You may, if you prefer, choose to speak in confidence to a Service Manager or Operational Manager in the Home Care Office on the relevant unit number in the front of this handbook. All reports of harassment are treated with the utmost discretion.
- The London Borough of Redbridge serves a multi-cultural area of outer London employing staff from a wide variety of backgrounds.
- The London Borough of Redbridge is committed to observing the rights of its Service Users and Employees. This means that all persons are to be treated fairly and allowed to carry out their daily activities in an environment where they feel safe and respected. Discrimination is not acceptable on grounds of:

  Race

  Colour

  Sex

  Sexual orientation

  Age

  Disability

  Religion, or any other reason.

- Discrimination may also take the form of:
  Threats of or actual physical violence

  Sexual harassment that may include:

  Actual physical contact

  Indecent suggestions or behaviour

  Inappropriate comments about appearance or lifestyle

  Sexual acts

  Pornography that offends

- Verbal harassment because of:
  Race or colour

  Gender

  Sexual orientation

  Age

  Disabilities

  Religion

  Any other reason

  Allegations motivated by prejudice

  Refusal of, or request for specific workers motivated by prejudice

- The London Borough of Redbridge treats any accusation of discrimination seriously and will investigate all reported cases.
  Workers who discriminate against Service Users will be subject to disciplinary action.

  Service Users who discriminate against Council Employees may ultimately have their service withdrawn

ABUSE

- You must never give or accept abuse in any form.
- If you are concerned for any reason, please contact the Home Care Office.
- Any calls are confidential and all are taken very seriously.
- We have a duty to investigate and resolve issues of abuse and will do all we can to stop it immediately.
- If you are concerned about making a report, do not mention your intention to contact us to anyone.

MEDICATION

- Medication can only be prescribed by your Doctor or Hospital.
- Our Home Carers can monitor the taking of medication as long as this is part of your agreed Care Plan.
- Your Home Carer is not allowed to give advice regarding medication.

LAUNDRY

- This service will be provided only if your care plan demonstrates sufficient need.
- Home Carers will wear disposable gloves and aprons.
- Laundry must be returned to Service Users home in a clean, neatly folded and in good order.
- Any items missing or damaged must be reported to the Operational manager as soon as possible.

DOMESTIC PETS

- Is your pet friendly? If not, please put your pet in a separate room with the door closed while the Home Carer is with you.
- Our Home Carers cannot work with unfriendly animals in the room and will report any incidents to the Home Care Office.

SMOKING, ALCOHOL AND UNAUTHORISED PERSONS

- Your Home Carer will not bring any unauthorised person into your home, nor will he or she smoke or consume alcohol whilst in your home.
- Please do not embarrass your Home Carer by offering cigarettes and/or alcoholic drinks.

IDENTIFICATION BADGES

- All Redbridge Care Home Carers carry identification badges with their photograph clearly shown.
- As a general rule, do not let anyone into your home unless they have made an appointment, carry an identification badge or you know the person. If in doubt contact the Home Care Office.

KEYHOLDING AND HOME SECURITY

- Redbridge Care does not retain keys unless authorised by yourself or by your next of kin. If you are unable to get to your door you will be assessed for entrance equipment.
- When leaving your property, the Home Carer will ensure you are left in a safe environment by closing you door behind them.

GIFTS AND GRATUITIES

- Redbridge Home Carers are not permitted to accept gifts or money from Service Users in their care.
- A simple note of thanks would be welcome if you feel the need to express your appreciation.

INSURANCE

- Our Home Carers are insured under the London Borough of Redbridge's Public Liability Insurance.
- Breakages are covered under this policy. The following action must be taken when making a claim:
  a) You must write to Redbridge Care with an estimate of the cost of replacement and make your claim.
  b) Your Home Carer must write to Redbridge Care with an explanation in support of your claim

QUALITY ASSURANCE

- The London Borough of Redbridge believes in Quality Assurance. This is reflected in the work done by its Quality Monitoring Team. The Team's remit is to ensure that all providers offer the same quality of service throughout the borough. It offers protection for users and their families and keeps other agencies such as the NHS Trusts, Primary Care Groups informed.
- Procedures that affect Service Users are called Care Management Procedures and have been put in place to ensure that all service providers supply services to uniform standards. The procedures also provide operational guidelines to staff regarding Service User Assessments and Care Management. Procedures are reviewed on a regular basis.
- Local performance indicators are collected and monitored regularly to ensure service quality remains high. The results of such monitoring are submitted to The Audit Commission, the Department of Health and Best Value Reviews who incorporate the results into national performance indicators.
- The Government publishes information on comparative Performance Indicators annually so you can be kept informed as to the performance of your Borough and the services it provides.
- Redbridge Care aims to provide the best possible service. To achieve this we train all Home Carers to a high standard.
- Redbridge Care undertakes performance monitoring of its Home Carers at regular intervals by supervision and home visits where a Team Leader assesses the Home Carers' performance.
- Your service will be reviewed at regular intervals. Your Home Carers Team Leader also undertakes spot checks each month to ensure Home Carers are performing their duties to an acceptable standard.
- You may be asked to complete simple questionnaires from time to time and will be given the opportunity to attend meetings.

LIMITS OF THE SERVICE

- Home Carers play a vital role in helping our Service Users remain in their own homes within the community. However, Home Carers offer a professional service and must not become involved with individuals outside times detailed on Care Plans.
- Home Carers will not give out their private telephone numbers.
- If Home Carers feel they are being asked to undertake work over and above that detailed on the care plan, they will discuss this with their line manager who may decide a review of the service is required.
- Home Carers are not allowed to enter your home without your permission or when you are away – in hospital, for example.
- Although your care plan may allow a Home Carer to pay bills, collect pensions and buy shopping for you, they should never carry exceptional sums of money or take your money home, even for a short time.
- If you wish to go outside your home, for example to the shops, hairdressers, chiropodist or hospital, the Home Carer can accompany you provided that prior agreement has been sought and given by their relevant line manager. This will be dependant upon you having been assessed for the service and that the journey can be completed within the time specified on your care plan. And the availability of staff.

COMMENTS, COMPLIMENTS and COMPLAINTS

- A leaflet entitled 'Comments, Compliments and Complaints' is to be found in the home care file in your home. Please use this to help you make comments, compliments and complaints concerning our services or the conduct of our Home Carers.
- You may also be invited to take part in meetings with Redbridge Care, Redbridge Homes.
- An Operational Manager who may make unannounced visits from time to time will monitor the service you receive.

If you require any further information, please contact the Redbridge Care Office on the relevant number at the front of this handbook.

If anyone feels that Redbridge Care has not dealt with a complaint to their satisfaction, they have the right to complain to the Care Quality Commission who regulates our Service.

Care Quality Commission
Citygate
Gallowgate

Newcastle Upon Tyne
NE1 4PA

E-mail: enquiries@cqc.org.uk

Tel: 03000616161

As a matter of course Redbridge Care would notify the Care Quality Commission of any complaints received and how the matter was resolved.

-

CONFIRMATION OF RECEIPT

WE NEED TO ENSURE THAT ALL SERVICE USERS RECEIVE A COPY OF THIS HANDBOOK

PLEASE SIGN BELOW AND RETURN THIS SHEET
TO THE HOME CARE
OFFICE

MANY THANKS, REDBRIDGE CARE

SERVICE USERS NAME: _____

DATE OF RECEIPT: _____

Appendix C

LBR Tenancy Agreement – as signed by John

Tenancy Agreement For Introductory and Secure Tenants

Contents Page Number

1 About your Tenancy Agreement

Introduction

These are the conditions of your tenancy. They have been set out so that both you (the tenant) and us (your landlord, the London Borough of Redbridge) are clear about our respective rights and responsibilities to each other.

The London Borough of Redbridge (The Council) is your landlord. It is important that you fully understand these conditions because they explain what you can and cannot do in your property. It is important that you keep to these conditions as you may lose your home if you break them. This agreement provides you with a summary of the grounds for possession. These grounds are set out in detail in schedule 2 of the Housing Act 1985, as amended by the Housing Act 1996. A copy of the detailed grounds for possession is available on request.

Advice and guidance

Some parts of this agreement are for advice and guidance and are printed in blue

Secure tenancies

1.1 This agreement only makes you a secure tenant if:

• you are an existing secure tenant of London Borough of Redbridge; or

• you are a secure tenant of another local authority; or

• you are an assured tenant with a housing association.

1.2 It means you keep your home as long as you want it unless there is a legal reason to evict you (called a "ground for possession" in the Housing Act 1985 as amended by the Housing Act 1996) and a Court agrees with the Council's request to evict you or to move you to another home. The Council would take possession of the property for one of two main reasons:

a) because of your own action or the action of someone living with you or visiting you; or

You must have broken a rule in this agreement, for example non-payment of rent, or given false information in your housing application. In these cases we will not offer you another home.

b) because special circumstances mean the Council must move you out.

This could be either temporary or permanent. These circumstances are described in sections 3.9 and 6.11 of this agreement. You will be offered a suitable alternative home and you will normally get compensation or help with moving costs (or both) depending on your circumstances.

1.3 As a secure tenant the Council cannot terminate your tenancy without first serving Notice on you and/or obtaining an order from the Court. Any Notice served on you must give at least four weeks' notice before proceedings can be taken against you.
The Council **does** have to prove a ground of possession when evicting a secure tenant.
Eviction action is likely to be taken against you for breach of your tenancy, (such as nuisance or rent arrears) but there may be other circumstances in which the Council may wish to gain possession of the property. A '*Notice of Seeking Possession'* must contain information as to why eviction action is being taken against you.

Introductory tenancies

If this is your first tenancy with the London Borough of Redbridge you will automatically be an introductory tenant for the first year. Introductory tenancies differ from secure tenancies, for example in the way that we can repossess the property and you will not have the *'Right to Buy'* (see section 8.1). Only secure tenants have the Right to Buy.
1.4 As an introductory tenant you are not yet a secure tenant of the Council. In particular you will not be entitled to take in lodgers, sub-let the property, make improvements, or exchange the property.
Under certain circumstances the Council may allow you to take in a lodger, make improvements or exchange the property. Contact us for more information.
1.5 The Council cannot terminate your tenancy without first serving a '***Notice of Proceedings for Possession'*** on you and obtaining an order from the Court. Any Notice served on you must give at least four weeks' notice before proceedings can be taken against you.
The Council **does not** have to prove a ground for possession when evicting an introductory tenant. Eviction action is likely to be taken against you for breach of your tenancy conditions, (such as nuisance or arrears of rent) but there may be other circumstances in which the Council may wish to gain possession of the property.

2 Rent

2.1 You must pay your rent on time.
Your rent may include a service charge and an amenity charge and payment is due on the Monday of each week. If you prefer to pay fortnightly or monthly, then you must pay in advance. You are responsible for paying for any gas, electricity or water used in the property and Council Tax.
If you are entitled to Housing Benefit, it is your responsibility to ensure payments are made to your rent account.
2.2 If you do not pay your rent when it is due, the Council can go to court to get legal permission to evict you from the property.
If you have any difficulty paying your rent you should contact us immediately. Help and advice is also available through our partnership organisations such as Citizens Advice Bureau and welfare benefit agencies.
2.3 If you are joint tenants you are each responsible for all the rent and for any rent arrears.
The Council can recover all rent arrears owed for the property from any individual joint tenant. Should one joint tenant leave, the remaining tenant, or tenants, are responsible for any rent that may still be owed.
2.4 The rent may be increased or decreased from time to time. You will be told in writing at least four weeks before any rent change.
We will usually consult you about increases or decreases in rent and the amount of rent you pay depends on the amenities in the property, its size, type and location.
2.5 If you vacate, abandon, or are evicted from your property, you will still be liable, and therefore pursued, for any rent arrears.
As a former tenant of the Council, you, or any joint tenant, are liable for rent arrears accrued as a result of non-payment of rent. If you fail to clear the arrears, or make an arrangement with us to do so, your debt will be passed to a debt collection agency or court bailiff.

3 Repairs and maintenance

Your rights

3.1 You have the right to have repairs done within a reasonable time. In some cases you have a legal *'Right to Repair'*
Sometimes some repairs you ask for will be added to a future major work programme, consequently specific timescales to do this work may vary.
You may be able to get compensation if certain repairs are not done within a reasonable time. Contact us for more information.

Your responsibilities

3.2 You must:

• report any faults or damage to the property to us immediately;
• keep the property clean, in good condition and use the fixtures responsibly;
• pay for repair, replacement and/or reinstatement if damage is caused deliberately or by your own neglect (for example wall and floor tiling, smashed windows or broken doors). The costs will be charged in addition to your rent. This also includes the cost of special cleaning that is needed because you have allowed the property to become unreasonably dirty or infested;
• do small repairs which includes things such as, unblocking sinks or replacing tap washers or internal door handles, wall and floor tiling; and
• allow staff, contractors or agents into the property to inspect and carry out repairs, improvements and annual gas safety checks. You must move furniture, fittings, carpets and anything else you own if it will make it easier to do the repair.

3.3 You must not:

• Remove walls or take out any other part of the property, make other alterations, put up structures such as sheds, satellite dishes, TV aerials, extensions, loft conversions, garages or pigeon lofts anywhere without getting written permission from us.
If in doubt please ask us.
3.4 You are responsible for decorating inside the property.
If the property is damaged by a third party the Council will not be responsible for putting this right. We strongly advise all residents to take out their own contents insurance. You can talk to us about this.
3.5 You are responsible for repairing and maintaining your own equipment such as cookers or washing machines.
See 6.4 for more information.
3.6 You are responsible for keeping in good repair any fences, gates, walls or other boundaries to the property.

Our responsibilities

3.7 We will repair:
• the structure and exterior of the building - this includes roofs, walls, floors, ceilings, window frames, external doors, drains, gutters and outside pipes;
• kitchen and bathroom fixtures - these include basins, sinks, toilets and baths;
• electrical wiring, gas and water pipes;
• heating equipment and water heating equipment; and

• communal areas around your home - this includes stairs, lifts, landings, lighting, entrance halls, pathways, shared gardens, parking areas, service roads, fencing, gates and rubbish chutes.
3.8 We will:
• paint the outside of your home at regular intervals;
• do repairs in a reasonable time;
When you request a repair we will tell you when the work will be done by (this depends on how urgent it is).
• clear up after a repair; and
We will leave the decoration as close as possible to how it was before the work was done.
• give you or send you written confirmation of your request for a repair. Please keep this confirmation in case you want to make an enquiry later.

3.9 There are special circumstances when the Council has the legal right to take possession of the property because work needs to be done on it. They are:
• If the property needs to be empty for major building repair, for complete redevelopment or because it has to be demolished you will be offered a suitable alternative property. You will receive compensation and help with moving costs depending on your circumstances. Your move could be permanent or temporary; and
• If you agree to a temporary move we have the right to take possession of your temporary property when the work on your original property is finished.
3.10 We will give you reasonable notice if we intend to visit to inspect or repair the property and we reserve the right to force entry under the following circumstances:
• to comply with our statutory duties and obligations, for example, to check the safety of gas appliances and installations and any other services; and
• to inspect or rectify a situation where there is an emergency or a health and safety issue. Where the need for forced entry has arisen we reserve the right to recharge you for the cost of gaining entry to the property, including any legal costs.
Never let anyone in without seeing some official identification. If you are in doubt contact us. If you do not let us in you could be putting yourselves and your neighbours at risk.

4 Responsibilities to your community

Your responsibilities

4.1 You are responsible for the behaviour of every person and animal living in or visiting the property. You are responsible for them in the property, on surrounding land, in communal areas including stairs, lifts, landings, entrance halls, paved areas, shared gardens, parking areas and in the neighbourhood around the property.

4.2 You and they must not cause a nuisance, annoyance or disturbance to any other person. This includes:

- playing loud music;
- noise from televisions and radios;
- loud arguments and door slamming;
- dogs barking and fouling;
- feeding and attracting birds or animals;
- offensive drunkenness;
- rubbish dumping in communal areas, landings and balconies, or leaving rubbish outside your home;
- throwing things off balconies or out of windows;
- failing to control children who are causing a nuisance or damage to property including graffiti;
- spitting or urinating anywhere in the communal areas of a building or estate; or
- doing anything that interferes with the peace or comfort of other people.

4.3 You and they must not cause alarm, harassment or distress to any other person. This includes:

- racist language or behaviour;
- any type of abusive behaviour, verbal or otherwise;
- using or threatening to use violence;
- damaging or threatening to damage another person's property or possessions; and

• writing threatening, abusive or insulting graffiti.

You will have to pay for any damage caused or for the removal of graffiti. The costs will be charged in addition to your rent.

If you, or a member of your household, or visitor to your home break any of your conditions of tenancy, or cause a nuisance or annoyance to other people, then legal action can be taken against you. For example:

• we can ask a court for an anti-social behaviour injunction. Injunctions are orders to stop behaviour that causes nuisance or annoyance and if you break them you can be fined or imprisoned; and

• we can also ask a court to give us possession of the property and evict you and everyone who lives with you.

4.4 You must not perpetrate or inflict domestic violence on your partner or member of your household.

Domestic violence can be physical, psychological, sexual, emotional, verbal or financial and can be inflicted directly or indirectly.

4.5 You and any person visiting your property must not:

• use the property or communal area for any illegal or immoral activitiy such as selling drugs or allow the property to be used for storing banned substances or stolen goods;

• damage or deface Council property;

• interfere with any security and safety equipment; or

You should not jam doors open and you should not let strangers in without identification.

• break any of the Council's byelaws.

You can ask to see the byelaws at a public library.

4.6 If you live in a flat on an estate you have the right of entry to the block in which your flat is situated and to any communal areas for lawful purposes. You must not enter any other block unless you have a lawful reason to do so.

4.7 You must not keep a dog or cat at the property without getting written permission from us. This does not apply if you need a guide dog, hearing dog or disability assistance dog. Contact us for advice on this.

4.8 If you have written permission from us to keep a dog you must:
• keep it under proper control;
• keep it on a lead when on the estate or the surrounding area to the property;
• not allow the dog to frighten or annoy other people; and
• clear up any mess (such as fouling) caused by your dog on the estate or the surrounding area to the property.
4.9 You must not keep any animal that we consider to be dangerous or could cause a health hazard.
Contact us before getting any pets.
4.10 You must keep all communal areas clean, tidy and clear of obstruction.
For example do not leave bikes, pushchairs, plant pots, rubbish bags or other obstacles in communal areas. Do not put carpet in communal areas.
4.11 You must not:
• hang washing, mats or rugs from windows, balconies or communal landings or stairwells;
• store personal items in loft spaces other than those where access is gained from within the property;
• advertise or run a business from the property unless you have written permission from us;
• park a vehicle anywhere on the estate or on the property except on a driveway or area intended for parking;
• park a vehicle on greens or grass verges. If there are allocated parking spaces in force you must not park a vehicle other than in the space allocated to the property;
• park any caravan or motor home or lorry on the estate or the area around the property or on any communal parking area without getting written permission from us;
• park, or allow your visitors to park, anywhere that would obstruct emergency services;
• carry out major car repairs on the land or road around the property; and

• park an untaxed or unroadworthy vehicle, or one which may not be legally driven on the highway, the land or the road around the property.
This applies to all vehicles even those with Statutory Off Road Notification (SORN).
4.12 You must keep your garden and balcony tidy, for example by cutting the lawn and trimming the hedges. If the garden is overgrown and you are unable to clear it yourself, we can clear it and charge you for the work.
We might be able to help you if you are elderly or disabled – contact us for more information.
4.13 You must take reasonable action to prevent fire, flooding, frost, or other damage to the property. You must not use or store paraffin, petrol or other inflammable gases, liquids or dangerous substances in the property. You may only keep bottled gas and use it according to the manufacturer's instructions.

Our responsibilities

4.14 If you report nuisance or harassment to us we must give you help and advice. We will investigate your complaint and decide what action to take.

5 Consultation and information

Your rights

5.1 You have the right:

• to see information we have about you, your partner or your family; and

You can get copies of the information but you may have to pay. Contact us for information about how to do this. In certain circumstances you will not be able to see everything – for example details about other people.

• to start or join a local residents' group.

Contact us for information about groups in your area or about how to start one.

Our responsibilities

5.2 We will:

• ask your views about any housing plans if they substantially affect you;

For example we will consult you about modernisation or improvement work that is planned for your home or estate. We will inform you or your residents' group about local housing issues.

• ask your views about any planned changes to the Tenancy Agreement. You will be told in writing if these changes are to go ahead;

• send you regular information, which describes our work and performance; and

• deal with your complaints efficiently and effectively. Contact us if you need to make a complaint.

6 Living in your home

Your rights

6.1 You have the right to take in lodgers but you must get written permission from us.
This must not result in you overcrowding the property. A lodger is someone who lives in the property but doesn't have exclusive rights to any one part of it and who gets some sort of service from you such as cooking or cleaning. This might affect any benefits you are entitled to.
6.2 You have the right to sub-let **part** of the property, but you must get written permission from us.
Sub-letting means that someone pays you rent to have exclusive rights to part of the property. They will usually do their own cooking and cleaning. You must not sub-let the whole of the property and you may lose the property if you do so. You may also be breaking the law and we will take all possible action against people who sub-let.
6.3 You have the right, provided you have got written permission from us, to put in your own improvements such as central heating, a shower or a gas fire. Contact us if you want to get permission. We will not refuse permission unless there is a good reason. However it is your responsibility to get any necessary planning permission, building regulation approval and other necessary consents. You should contact the appropriate department within the Council with any enquiries about such matters.
You can sometimes get compensation when you leave the property for some improvements you have carried out yourself. Contact us for more information.
6.4 If you make an improvement you will be responsible for repairing and maintaining it. You can ask us to repair and maintain it for you and if we agree we may charge you for the cost of doing this.
Contact us for more information.

Your responsibilities

6.5 You must tell us, in writing, of any changes to the number of people living with you in the property.
6.6 If you make an improvement or alteration to the property without first getting our written agreement we may tell you to return the property to how it was before. If you don't, we may do the work and make you pay for it even after you have left the property.
6.7 Any improvement, alteration, repair or decoration that you do must be carried out to a standard which is acceptable to us.

We will be able to advise you as to standards considered acceptable.
6.8 Laminate or other wooden flooring may only be installed in ground floor properties or individual houses. If you install laminate flooring and it causes a disturbance to your neighbours, you will be asked to remove it.
If you have a specific medical condition that requires you to have laminate flooring then you need to contact us to discuss this.

6.9 You must:

• use the property as your only or principal home;
• tell us if you will be away from the property for more than a month; and
• tell us, in writing with reasons, if you intend to be away from the property for more than three months. You run the risk of losing the property if you do not live in it and have not given us a satisfactory reason why you do not live there.

6.10 You must not:

• overcrowd the property; or
We can advise you of the maximum number allowed. If you are expecting a baby or the number of people living in the property changes, and exceeds this number, then you may be entitled to larger accommodation. Contact us if your circumstances change.
• keep mopeds or motorbikes inside the property or inside any council owned building (excluding garages) or communal area.

Our responsibilities

6.11 There are circumstances when the Council has the legal right to take possession of the property. One of these is that we can move you if the property has special adaptations for a disabled or elderly person who no longer lives there. But we only do this in **very exceptional cases** and only if the property is needed by another elderly or disabled person who has nowhere suitable to live. Even if this does happen you will be offered another suitable property before you have to move out.

7 Moving home

Your rights

7.1 You have the right to apply to move to another Council property.
You will have to go on a waiting list. An offer of a new property depends on the urgency of your housing need, how long you have been waiting and what accommodation is available. Certain conditions must be met before you can move and these are set out in Section 7.4.
7.2 You have the right to see our Allocations Policy (the Council's rules for deciding who gets offered housing).
We can give you a summary of these rules. Contact the Council's Housing Advice Centre for more information about this.
7.3 You have the right to swap the property (called a 'mutual exchange') with another tenant of the Council, a registered provider or another council provided they have their landlord's agreement. You must get the Council's agreement in writing before such exchanges can take place.
We can only refuse permission on certain grounds, for example:
• one of the properties would be overcrowded – we can tell you the maximum number of people allowed;
• the Council is taking legal action to get possession of the home of any of the tenants involved;
• the exchange would mean that a property adapted for elderly or disabled people would have no-one living there who needed the adaptation; and
• one of the homes would be too large for the new tenants. Contact us for further details.

Your responsibilities

7.4 There are certain conditions that you must meet before the exchange and or transfer can go ahead. These include:
• you must not owe any rent (unless you have been keeping to a rent arrears repayment agreement for a set time);
• the property and/or garden must be in good condition; and

• if you have made improvements or alterations without our written permission you may have to return the property to how it was before.

7.5 If you do exchange without our written agreement we may take legal action to evict you and/or the people you have exchanged with. You may not be allowed to return to the original property and it may affect your right to be offered alternative housing.

It is illegal to pay someone to exchange homes with you.

8 Ending your tenancy

Your rights

8.1 You have the right, under certain circumstances, to buy the property provided you have been a tenant of the London Borough of Redbridge or any other public sector landlord (e.g. other council or registered provider) or lived in armed forces accommodation. Among other requirements you must have lived in this sort of housing for a total of five years or more and it does not have to have been a continuous five-year period.
Introductory tenants do not have the 'Right to Buy' but any time spent as an introductory tenant will count towards the qualifying period. Contact us for more information.

Your responsibilities

8.2 You must:

• tell us in writing at least four weeks before you want to leave the property;
You will need to complete a termination of tenancy form, which you can get from your housing office, and return it to the address shown on the form. If you leave without giving four weeks' notice we can still charge you rent until we legally take the property back.
• allow us to inspect the property and carry out minor repairs during this notice period. This four week notice period must end on a Monday and you must return your keys to the housing office no later than the day you leave. Failure to return keys by 12 noon on the date of vacation will mean you are liable for a further week's rent;
• leave the property, the fixtures and any furnishings we have provided in good condition when you go; and
Do not leave any of your belongings behind - we may dispose of them, and recharge you.
• pay for repair, replacement and/or reinstatement if damage has been caused deliberately or by your own neglect. You will not have to pay for normal wear and tear.

8.3 You must not:

• leave anybody else living in the property when you move out.
You cannot pass on your tenancy to anyone else except in very limited circumstances. Contact us for further details.
You may not be entitled to another Council property in the future if:

• you have been evicted;
• you still owe rent; and
• you left the property in poor condition and have not paid for repair or replacement.

8.4 If you are joint tenants either of you can end the tenancy by giving us four weeks' notice. We will decide if the remaining joint tenant(s) can stay in the property.

Your tenancy when you die

8.5 In certain circumstances the tenancy of the property can pass automatically to a family member/relative when you die. This is called **'succession'**. The legal description of how this can happen is set out in the Housing Act 1985. However, an important rule laid down in the Act is that tenants are **only entitled to one automatic succession**.

Therefore if you are already a tenant by succession, then on your death, there cannot be another succession. However, in these circumstances, we will consider the housing needs of family members/relatives who resided with you for at least 12 months prior to your death and if appropriate provide housing assistance (in accordance with the Council's Policy). If a new tenancy is awarded it will not be a succession but will be a new discretionary tenancy to a suitably sized property (see succession notes below).

Succession notes

Here is a summary of the rules governing succession. Further details can be obtained from your housing office.

• if you are a joint tenant, the tenancy will pass to the other joint tenant(s) on your death.
• if you are married and your husband, wife, or civil partner is not a joint tenant, then the property will pass automatically to them. Your partner may also succeed the tenancy so long as they have lived with you for at least 12 months prior to your death.
• if you are not married or your partner, husband, wife or civil partner does not want to live in the property, then succession can take place to a member of your family who has lived with you continuously for the previous 12 months. A "member of your family" includes a parent, child, sibling or grandchild etc. If there is more than one "member of your family" who wants to, and is entitled to, succeed then they can agree between themselves who should succeed. If they cannot agree then the Council will decide; and
• the husband, wife, civil partner or member of your family who succeeds will be a secure tenant (unless the previous tenant was an Introductory Tenant). They can keep the property as long as they want it. They will be bound by the same Tenancy Agreement that you had.

8.6 If a family member succeeds the tenancy and the property is bigger than they need, we have the legal right to move them out. However, we will offer them a suitable alternative accommodation. We will not ask your husband, wife or civil partner to move out if the property is bigger than they need.

Passing your tenancy to someone else

8.7 If you are a secure tenant you have the right to pass your tenancy to someone else, this is called an 'Assignment' and there are three ways this can be done.

Assignment by mutual exchange

You can exchange your property with someone else provided you get written permission from both landlords. The person you wish to exchange with must also be a secure tenant or an assured tenant of a registered provider.

Assignment by court order

Is where a judge will order the transfer of a tenancy from one party to another.

Assignment to a potential successor

Your tenancy can be assigned to someone who is a potential successor (see 8.5).

There are rules governing assignments and we cannot refuse permission unless there is a valid reason. Contact us for more information.

9 Notices

9.1 The following information is intended to comply with the Landlord and Tenant Act 1987, Section 48. If you need to serve a legal notice on us as set out in Section 48 of the Landlord and Tenant Act 1987 you should send it to **London Borough of Redbridge, 17 – 23 Clements Road, Ilford, Essex, IG1 1AD.**

9.2 The following information is in accordance with Section 196 of the Law of Property Act 1925 which shall apply in respect of this agreement.

A notice given in connection with this agreement by the Council is properly served in any of the following ways:

- by handing it to you personally;
- by leaving it for you at the property;
- by affixing it to the property;
- leaving it for you at your last known place of abode; and
- by sending it by recorded delivery to the property or your last known place of abode.

9.3 With the exception of changes to your rent and other charges this agreement can only be changed if we:

- serve a Notice of Variation on you and the provisions of Section 103 of the Housing Act 1985 apply (this variation will not be regarded as creating a new tenancy); or
- the law has changed and it allows us to change this agreement.

10 Addresses for Letters

10.1 For routine matters and those referred to in this agreement please contact the housing office. The address is:

Orchard Housing Office 152 Broadmead Road, Woodford Green, Essex IG8 0AG.

Telephone 020 8518 2400 21

TENANCY AGREEMENT **This is a legal contract.**

It describes the rights and responsibilities of the London Borough of Redbridge and of you the tenant. Wherever the conditions of tenancy states "you must" or "we must" this is intended to impose a legally binding obligation under the agreement on the relevant party. Wherever the conditions of tenancy refer to "tenant's responsibilities" or "Your responsibilities", this includes the fact that the tenant is responsible not only for his or her acts and omissions, but also for the acts and omissions of other occupiers and visitors to the property.

All new tenancies (but not transfers by existing tenants or tenants in other limited circumstances) are introductory tenancies for a period of 12 months, unless before the 12 month period comes to an end, the Council has started legal proceedings against you for possession of your home or your tenancy ceases to be an introductory tenancy under the Housing Act 1996.

The obligations of each party to this agreement are governed by legislation, in particular the Housing Act 1985, as amended by the Housing Act 1996, as well as this agreement. Legislation can change and you should always obtain up to date advice if you are in doubt as to your rights and responsibilities.

If there is anything you do not understand please ask us. You can also get independent legal advice from a Citizens

Advice Bureau, law centre or solicitor. Introductory tenants should make a special note of sections 1.4 and 1.5. Joint tenants should make a Special note of sections 2.3 and 8.4.

This is a **secure/introductory Tenancy Agreement** (delete as necessary) between: The London Borough of Redbridge, 17 – 23 Clements Road, Ilford, Essex IG1 1AG and

Name of tenant(s) (full name(s) in capitals)

Address of property

Tenancy start date **Rent start date**

Rent and charges **Weekly rent** **£** **Service charge** **£**
due weekly from the start of the tenancy Eligible for housing benefit

Amenity charge **£** **Water** **£**
Not eligible for housing benefit

Details of property **Flat** **Floor** **House** **Maisonette** **Garage**
(Tick box or insert no.)

Shed **Garden** **Bedrooms** **Maximum occupancy level**

We must protect the public funds we handle and we may use any information you have provided to prevent and detect fraud. This may include matching any information we hold about you from other sources including data held on computer records. We may also share this information, for the same purposes, with other organisations.

All tenants should sign below after reading the Tenancy Agreement.

The information I (or we) gave in the housing application form was and still is true. I/we have read and understand the terms of the Tenancy Agreement and understand the provisions of Section 48 of the Landlord and Tenant Act 1987, set out in Section 9 of this agreement. I/we confirm that the property rented to me/us is in a good state of repair.

Signed by the tenant(s)

Signed on behalf of London Borough of Redbridge

Name of officer **Date**

Appendix D

Regulation 18: Notification of other incidents

Care Quality Commission (Registration) Regulations 2009: Regulation 18

The intention of this regulation is to specify a range of events or occurrences that must be notified to CQC so that, where needed, CQC can take follow-up action.

Providers must notify CQC of all incidents that affect the health, safety and welfare of people who use services. The full list of incidents is in the text of the regulation.

All providers must send their notifications directly to CQC unless the provider is a health service body, local authority or provider of primary medical services and it has previously notified the NHS Commissioning Board Authority (now known as NHS England).

CQC can prosecute for a breach of this regulation or a breach of part of the regulation. This means that CQC can move directly to prosecution without first serving a warning notice. Additionally, CQC may also take any other regulatory action. See the offences section for more detail.

CQC must refuse registration if providers cannot satisfy us that they can and will continue to comply with this regulation.

The regulation in full

18—

1. Subject to paragraphs (3) and (4), the registered person must notify the Commission without delay of the incidents specified in paragraph (2) which occur whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity.
2. The incidents referred to in paragraph (1) are—
    a. any injury to a service user which, in the reasonable opinion of a health care professional, has resulted in—
        i. an impairment of the sensory, motor or intellectual functions of the service user which is not likely to be temporary,
        ii. changes to the structure of a service user's body,

iii. the service user experiencing prolonged pain or prolonged psychological harm, or
iv. the shortening of the life expectancy of the service user;

b. any injury to a service user which, in the reasonable opinion of a health care professional, requires treatment by that, or another, health care professional in order to prevent—
i. the death of the service user, or
ii. an injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a);

c. [omitted]
d. [omitted]
e. any abuse or allegation of abuse in relation to a service user;
f. any incident which is reported to, or investigated by, the police;
g. any event which prevents, or appears to the service provider to be likely to threaten to prevent, the service provider's ability to continue to carry on the regulated activity safely, or in accordance with the registration requirements, including—
i. an insufficient number of suitably qualified, skilled and experienced persons being employed for the purposes of carrying on the regulated activity,
ii. an interruption in the supply to premises owned or used by the service provider for the purposes of carrying on the regulated activity of electricity, gas, water or sewerage where that interruption has lasted for longer than a continuous period of 24 hours,
iii. physical damage to premises owned or used by the service provider for the purposes of carrying on the regulated activity which has, or is likely to have, a detrimental effect on the treatment or care provided to service users, and
iv. the failure, or malfunctioning, of fire alarms or other safety devices in premises owned or used by the service provider for the purposes of carrying on the regulated activity where that failure or malfunctioning has lasted for longer than a continuous period of 24 hours;

h. any placement of a service-user under the age of eighteen in a psychiatric unit whose services are intended for persons over that age where that placement has lasted for longer than a continuous period of 48 hours.

3. Paragraph (2)(f) does not apply where the service provider is an English NHS body.
4. Where the service provider is a health service body, paragraph (1) does not apply if, and to the extent that, the registered person has reported the incident to [the National Health Service Commissioning Board].
[(4ZA) For the purposes of paragraph (4), where a person has reported an incident to the NHS Commissioning Board Authority, established under Article 2 of the NHS Commissioning Board Authority (Establishment and Constitution) Order 2011, before the establishment of the National Health Service Commissioning Board ("the Board"), that

report is to be treated as having been made to the Board.]
[(4A) The registered person must notify the Commission of the following events, which occur whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity—

a. any request to a supervisory body made pursuant to Part 4 of Schedule A1 to the 2005 Act by the registered person for a standard authorisation:
b. any application made to a court in relation to depriving a service user of their liberty pursuant to section 16(2)(a) of the 2005 Act.
4b. Any notification required to be given in respect of an event in paragraph (4A) shall be given once the outcome of the request or application is known or, if the request or application is withdrawn, at the point of withdrawal and shall include a statement as to—
c. the date and nature of the request or application;
d. whether the request or application was preceded by the use of an urgent authorisation, within the meaning of paragraph 9 of Schedule A1 to the 2005 Act;
e. the outcome of the request or application or reason for its withdrawal; and
f. the date of the outcome or withdrawal.

5. In this regulation—
   a. "the 2005 Act" means the Mental Capacity Act 2005;
   b. "abuse", in relation to a service user, means—
      i. sexual abuse,
      ii. physical or psychological ill-treatment,
      iii. theft, misuse or misappropriation of money or property, or
      iv. neglect and acts of omission which cause harm or place at risk of harm;
   c. "health care professional" means a person who is registered as a member of any profession to which section 60(2) of the Health Act 1999 applies;
   d. "registration requirements" means any requirements or conditions imposed on the registered person by or under Chapter 2 of Part 1 of the Act;
   e. "standard authorisation" has the meaning given under Part 4 of Schedule A1 to the 2005 Act;
   f. "supervisory body" has the meaning given in paragraph 180 (in relation to a hospital in England) or paragraph 182 (in relation to a care home) of Schedule A1 to the 2005 Act;
   g. for the purposes of paragraph (2)(a)—
      i. "prolonged pain" and "prolonged psychological harm" means pain or harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days, and
      ii. a sensory, motor or intellectual impairment is not temporary if such an impairment has lasted, or is likely to last, for a continuous period of at least 28 days

Appendix E

Guidelines for Dealing with Emergency Situations at Fernways

These guidelines are to assist in the making of decisions when a service user/tenant finds themselves in emergency situations.

If a Service User has a Fall or Accident

- If the service user/tenant has had a fall, basic first aid should be carried out. This means checking the individual over for injuries, asking if they have any pain anywhere and if they do to describe the pain.
- If at any time you are unsure as to whether the person requires medical attention call 999.

When a Service User/Tenant Needs an Ambulance/Police

After contacting the Emergency Services please take the following steps:

- Retrieve a print out of the persons details, this can be found in the Warden's Office in the folder "Hospital Print Outs".
- Ensure that medication details are available for the emergency crew.
- Record down what time you dialled 999 and what time the crew arrived.

When to Contact Family/Next of Kin

If a service user has had an accident and does not need to go to hospital, the family or next of kin must be contacted so that they can be informed of the following;

- Reassure the family/next of kin that their relative is ok.
- Inform the family/next of kin what happened and of any injuries, bruises or marks that may have been sustained.

- Reassure the family/next of kin that their relative will be monitored and if anything changes they will be called again to be informed of this and medical advice will be sought.
- If this has occurred out of hours, please ensure that you have checked the contact card for the family/next of kin's agreement/preference to be called.
- If there is a preference not to be contacted, ensure that all of the details are handed over so that the day staff can contact the family/next of kin.
- If the situation deteriorates and the service user requires hospital attention please refer to the instructions below.

When a Service User/Tenant is Taken to Hospital

When it has been confirmed that the Service User/Tenant is going to be taken to hospital the following should be noted and done:

- Find out which hospital the person is being taken too.
- Ensure that all medication and print out has been given to the Ambulance Crew.
- Once the person is in the Ambulance contact the next of kin, details of which can be found on the index cards in the black box on the Wardens desk.
- If there are 2 contact numbers e.g. Home and Mobile, contact the home number first.
- If there is no reply and there is an answerphone, leave a message with the details as follows…

  ”Hello, I am (name) from Fernways. (Name of Person) has been taken to (name of hospital and brief reason why they were taken). I will try your other contact number but if you get this message please call me back on (give both the Warden Mobile Number and the Office Number).
- If the emergency is during 11Peter – 7am ensure that all details have been recorded in the Wardens Handover Book and that a message is passed to morning office staff so that we can be sure the next of kin has received the message.

When a Service User/Tenant Refuses to be Taken to Hospital

If a service user has sustained a fall but does not want an ambulance called or does not want to go to hospital then the following steps should be taken:

- Contact the Out of Hours Support Worker or Operational Manager with regards to the nature of the fall and explain the circumstances of why the person is refusing medical treatment.
- Contact the family or next of kin to inform them of the situation and what has happened. Explain clearly the reasons why the service user/tenant is refusing to go to hospital. Also explain that you will be contacting a GP to request a visit to check the person over.
- If you have concerns and feel that the person should be checked over ask the Warden to contact the GP (if during the day) or ensure that this has been left in

the handover for the morning staff (if out of hours) so that a GP visit can be arranged.

- If at any time you are unsure of what should happen next, contact your Operational Manager or the Out of Hours Support Worker.

When a Service User/Tenant is Missing

Remember that Fernways is an independent Sheltered Housing Unit. This means that people live here independently and are able to come and go as they please. However, there are times when a Service User/Tenant is missing and the following should be adhered too.

- Check the person's property and ensure that they are not in there.
- Contact the next of kin and ensure that the service user/tenant is not with them.
- Call 999 and ask for Police and give a description of the person including date of birth (which can be found on their contact card in the Warden's office).
- Give any details of why the person is vulnerable, e.g. the Service user is elderly and suffers with dementia or that they have medical issues.
- Inform family or next of kin of the situation. They may be able to tell you frequented places that the service user used to visit.
- Record all action taken in the handover book for the next shift.

CONFIRMATION OF RECEIPT

I am signing to confirm that on (date)_____ I received a copy of the Guidelines for Dealing with Emergencies at Fernways Policy.

CARERS NAME: _____

I am also confirming that on (date)_____ I have read and fully understood this document. If I have had any questions about it I have spoken to my Operational Manager

Signature:

Glossary

AAFDA – Advocacy After Fatal Domestic Abuse

ACAT – Acute Crisis Assessment Team –24 hour/365 day secondary mental health service for people experiencing an acute mental health crisis who require same day assessment. Provides treatment in service users own homes as an alternative to inpatient admission or to facilitate early discharge from mental health in-patient wards as part of the Home Treatment Team (HTT)

Art Therapy – arts-based psychological therapy service for people under secondary mental health services

CBT – Cognitive Behavioural Therapy – a psychological talking therapy often used for depression and anxiety usually consisting of a short course of up to 12 sessions

CCG – Clinical Commissioning Group

CPN – Community Psychiatric Nurse. Also known as CMHN – community mental health nurse

CMHTW – Community Mental Health Team West – secondary mental health care and community support for people with severe and enduring mental health difficulties living in the west sector of Redbridge, aged 18-65

CPS – Crown Prosecution Service

CQC – Care Quality Commission

CRTW – Redbridge Community Recovery Team West – new name for CMHTW following service re-organisation in 2009

CST – Community Support Team. Local Authority Team to support people with mental health needs living in the community. Staff mainly consist of support workers, without formal health or social care professional qualification.

CSP – Community Safety Partnership

DA – Domestic Abuse

DNA – Did not attend

GP- General (medical) Practitioner

HTT – Home Treatment Team - see ACAT

IAPT – Improving Access to Psychological Therapies – psychological therapy service for adults not under secondary mental health services suffering mild mental health difficulties considered low risk

IDVA – Independent Domestic Violence Advisory (Service)

IMR – Individual Management Review

LBR – London Borough of Redbridge

MA – Master of Arts (degree)

MPS – Metropolitan Police Service

NELFT – North East London (NHS) Foundation Trust

NHSE – National Health Service England

NoK – Next of Kin

PC-MIS – Primary care electronic patient records management system (used by GP's and IAPT)

QPM – Queen's Police medal

RAABIT - Redbridge Access, Assessment & Brief Intervention Team - first point of entry into secondary mental health services. To screen and assess referrals, sign-posting to the appropriate agency or offering short-term work to people with less complex mental health needs who are not open to other mental health teams.

RiO – NELFT electronic patient records management system

Notes