SAFEGUARDING BOARD
ISLE OF MAN

The Isle of Man Safeguarding Board

The Learning from a Serious Case Management Review in respect of Mr H

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1.0 Introduction

1.1. The Safeguarding Board (Qualifications and Procedures) Regulations 2019 state:

"The Serious Case Management Review Panel must conduct a review in any case where— (a) a vulnerable adult has died and where abuse or neglect is known or suspected; (b) a vulnerable adult has suffered serious harm; and the condition in paragraph (6) is satisfied. (6) The condition in this paragraph is satisfied if there is cause for concern about the way the following, namely—

> *(a) the Board;*
>
> *(b) any of the bodies listed in paragraphs (a) to (d) of section 4; and*
>
> *(c) any other relevant body; have worked together to safeguard the vulnerable adult."*

1.2 The purpose of a Serious Case Management Review (SCMR) is to identify learning to improve multi-agency safeguarding practice. SCMRs are not about apportioning blame or about disciplinary, criminal, or coronial matters. They should, wherever possible, identify good practice as well as identifying areas for improvement.

1.3 SCMRs enable all the information known to agencies to be seen in one place. This is beneficial to learning but the SCMR also recognises that this benefit of hindsight was not available to individual practitioners at the time.

1.4 The Isle of Man Safeguarding Board commissioned an independent author/lead reviewer Domini Gunn-Peim MA(Hons). The author is an experienced inspector, housing professional and author of multi-agency reviews. She has a professional background in housing, health, social care and the role of housing providers in safeguarding and partnership working. The author is independent of IOMSB and its partner agencies. Details of her experience are attached at Appendix1.

1.6 A Review Panel, made up of managers, who were not involved in the case, provided oversight, information and support to the Review, and challenged and commented on the Report.

1.7 The reflective and thoughtful contributions of everyone involved in the review, is appreciated by the Safeguarding Board.

1.8 Considerable efforts were made to involve Mr H's family, but they declined.

1.9 The identification of the subject of the SCMR is referred to as 'Mr H' to protect his identity and preserve his dignity.

2.0 Executive Summary

2.1. Mr H died from natural causes in 2019, he was in his early fifties and had a long history of poor health, exacerbated by his lifestyle. At the time of his death, he was living in

privately rented accommodation, following eviction from his local authority flat eight months earlier.

2.2 Mr H's eviction from his former home had an impact on the quality of his life and his wellbeing. The poor state of his flat at the time of his eviction evidenced his inability to care for himself.

2.3 Medical staff, and staff from other agencies, had expressed concern about his vulnerability, due to poor physical and mental health over a number of years. He had regular contact with services between 1991 and 2017 which included his GP, Hospital Emergency Department, the Police and a local authority housing provider. Between 2010 to 2018 there were referrals to Social Care and Mental Health Services. From late 2018 to early 2019 there was intensive involvement from Community Health Services and voluntary sector housing support and advice organisations.

2.4 The SCMR found that, except for the prison, there was a lack of co-ordination across the agencies with whom Mr H had contact.

3.0 Summary of the learning from the review

3.1. Local Authority Housing policy & practice. Safeguarding for housing providers: awareness, training, referrals, and protocols.

3.1.1 There is a lack of rigour and consistency around these issues across local authority housing providers. This has an impact on the approaches taken to identifying needs and managing risks, most notably for vulnerable tenants.

3.2 GDPR data protection:

3.2.1 There was a marked difference in the approaches to information sharing taken by the local authority concerned and other service providers in Social Security, Health and Social Care that supported Mr H. The local authority believed it was not possible to share information about Mr H due to data protection rules. They did not seek Mr H's written permission to share information about his eviction at any time during the eviction process.

3.2.2 Other agencies did proactively exchange information about Mr H with the prison who had secured his written consent to do so. The Department of Health and Social Care shared information to enable them to act in Mr H's best interests to secure Manx Lottery funding to cover his rent, unsuccessfully due to administrative errors, and services that could offer him support, treatment and advice.

3.2.3 It is imperative that this lack of consistency in the approaches to information sharing is formally resolved in order to avoid any future risk of vital information being withheld, that could help to protect a person at risk of eviction in the future.

3.2.4 Progress has been made in including information sharing protocols in more recent local authority tenancies (post 2014) but this does not address the issue for long standing tenancies. **It would be beneficial to include information sharing as part of regular tenancy reviews. Protocols for information sharing should also be included as part of the eviction**

process. Further advice from the Information Commissioner following this review would be helpful in ensuring a consistent approach.

3.3. Tenant profiling:

3.3.1 Although there is a needs assessment for supported housing there is no formal approach to tenant profiling on the Isle of Man, for general needs housing. In other jurisdictions, customer profiling is widely used by commercial companies, and some social housing providers, to enable them to tailor services to meet the needs of their customers. This proves effective in making the best use of resources and in securing the best outcomes for tenants. New ICT systems are being introduced that may help to address these issues and **it would be helpful to review the implementation in light of the findings of this review.**

3.4 Managing risk:

3.4.1 There is no risk assessment process in place that enables all local authority landlords to identify the impact of their housing processes. Staff are not trained in identifying and managing procedural risks and in assessing the impact of actions. **It would be beneficial to develop and introduce a formal approach to risk and impact assessments.** This would assist in providing a robust audit trail and in providing improved clarity to the effectiveness of decision making.

3.4.2 **Identifying needs**: there is no needs assessment carried out as part of the tenancy agreement. No questions are asked about tenancy support needs or circumstances that might impact on managing and sustaining a tenancy. In 2017 there was no system for a regular review (a minimum of every 5 years) of tenancies to determine if a tenant's needs have changed and, dependent on the outcomes, to signpost tenants to additional support services.

3.4.3 **Housing related support:** the local authority that provided accommodation to Mr H do include leaflets with their correspondence with tenants in rent arrears that signpost them to housing related advice, information and support agencies. However, **there needs to be a more pro-active approach to signposting tenants at risk of eviction to sources of advice and support. This support signposting needs to be informed by the needs of each tenant and the risks to them of eviction action**.

Tailored signposting to timely advice and support does require the local authority landlord to understand the tenant's needs and to review these on a regular basis. This need not be unduly onerous as risk assessments can be used to flag up priorities for more regular review. For example, those dependent on social security benefits and older people can be given priority for a review. There should be proactive attempts to secure written consent from tenants to share information so that referrals to other agencies can be made.

More recent local authority housing tenancies, post 2014, do include information on sharing information consent requests but this is not the case with long standing tenancies and needs to be addressed.

3.4.4 **External agencies**: report a lack of consistency when working with local authority housing providers across the Island. Housing issues are recognised by some agencies but access to, or sustainment of, a home is not consistently identified as part of risk assessments and local authority housing providers are not consistently invited to contribute to discussions where risks are identified.

3.4.5 There is widespread acknowledgement that good, secure and affordable housing is critical in enabling people to live healthy and secure lives and to recover and/or rehabilitate after a crisis. **It is important that this acknowledgement is translated into formal protocols, shared training, information sharing agreements and joint working policies and practices. There is a need to identify shared clients who are clearly vulnerable, have complex needs and are at risk.** Eviction from one's home is a very high risk for anyone, but particularly for a vulnerable person.

4.0 Information sharing: Health & Social Care key learning points

4.1 GDPR – data protection: It would be helpful to **create more opportunities for joint working and improved understanding of roles and processes. Further discussion needs to take place to identify shared risks and ensure that information sharing protocols and practices are consistent and robust.**

4.2 Awareness, training, referrals and protocols: there have been changes in policies and practices since Mr H's case came to light. There is recognition of the need **to identify weaknesses in current policies and practices; to improve the consistent application of housing policies and procedures; and increased recognition and dissemination of good practice.**

4.3 Capturing and sharing key information across all agencies about individuals who are frequent attenders at the hospital's emergency department; repeatedly referred to social care and mental health services; are known to be at risk of homelessness or homeless; and those who regularly come to the police's attention **should be identified through a shared referral process**. Many (most) of these individuals are likely to be vulnerable and there will be safeguarding concerns in some cases.

5.0 Cross agency working key learning points

5.1 Scope and agree the agencies and organisation to be included in current and new approaches to cross agency working. This should include representatives from the Housing & Property Division at the Department of Infrastructure. These representatives can then identify any other housing providers that need to be involved where a risk including a safeguarding concern are identified.

5.2 **There is a lack of knowledge and understanding of the responsibilities of all statutory agencies across the island in engaging fully with safeguarding policies and practices.** This includes understanding and delivering what safeguarding means for different agencies, assessing risk and making effective referrals. All agencies must understand their duties under the safeguarding legislation including the requirement to share information to

safeguard and assist in reviews. It is not the duty of the different agencies to determine the outcome of a safeguarding case, but it is their duty to identify risk and refer appropriately.

5.3 **Identifying shared vulnerable customers/ regular attendees**: an important outcome from improved joint working should be **an agreed and documented risk assessment and flagging process where each agency can flag a potential safeguarding concern and call a multiagency case conference.** This would enable individuals presenting with a range of needs and vulnerabilities to be flagged and a shared approach to be adopted.

6.0 Isle of Man Prison key learning points. The record keeping and admission processes in the prison are examples of good practice. The key agencies providing services to new prisoners prior to sentencing are identified and contact is made at a very early stage. Vulnerability and risk are assessed. Health needs are identified, and appropriate treatment and medication is secured. Detailed notes are recorded and there are regular reviews of health and wellbeing. For prisoners on short sentences, less than six weeks, there is no monitoring following release as a probation officer is not assigned. This gap could be addressed through multi agency risk assessments and the adoption of care and support plans where required.

7.0 Social Security key learning points

7.1 Maintaining prisoners' housing: people on remand continue to receive social security benefit allowances towards housing costs, if there is an intention to return to the premises after the period in prison, but these cease as soon as someone is given a custodial sentence, regardless of the length of the sentence. This means that any benefit payments to cover rent made directly to a local authority or private landlord also stop. This results in offenders who are tenants immediately going into rent arrears and they are then at risk of eviction. The outcome will be that on release they will be homeless or at high risk of becoming homeless.

Given the high social and economic costs of eviction and homelessness this is not the most effective course of action particularly where sentences are relatively short. Other breaches of tenancy are likely for offenders on longer sentences, including a charge of abandonment when a property is not occupied for a significant amount of time. **The Isle of Man should consider addressing this issue.** In the UK rent continues to be paid for prisoners on short sentences. The following link to Nacro's website explains the rules in England: https://www.nacro.org.uk/resettlement-advice-service/support-forindividuals/housing/advice-while-serving-your-prison-sentence/

8.0 Private rented housing sector key learning points

8.1 There is a shortage of affordable housing across all housing tenures. In the private rented sector, the shortage is compounded by the absence of regulation and is resulting in poor quality accommodation being offered for rent. In addition, given the reluctance of some private landlords to let to tenants who are dependent on benefits, significant levels of public subsidy through the social security benefits system are being paid to private landlords for poor housing. **There is no rent deposit scheme to support people to access privately**

rented accommodation and there is no lettable standard. Legislation is being drafted that will, if approved, address many of these issues.

8.2 It is difficult for people seeking affordable rented housing on the island to access local authority housing. There is a ten-year residency requirement prior to application and once that has been achieved a significant waiting list. This means that many people who cannot afford to buy a home rely on the private rented sector. It is noted that in 2019 Tynwald approved new allocation criteria that, with the revised priority pointing based on housing need, had reduced the waiting times for more vulnerable people.

8.3 For people on low incomes the private sector rent levels are high particularly when compared to local authority housing. In addition to the rent there are usually requirements to find a significant deposit. In the case of Mr H social security were paying 100% more for his rent in poor privately rented accommodation following his eviction from his local authority flat.

8.4 According to representatives of housing advice and support agencies, most private landlords are reluctant to accept people in receipt of benefits and this reluctance often results in the less desirable, cheaper and poorer quality accommodation being the only choice available to people who cannot access a local authority home. **A minimum Isle of Man lettable standard would help to raise standards across all rented housing.** This should be addressed if the new proposals to regulate the private rented sector are approved and implemented.

9.0 Acting on Learning

9.1 It is good practice for improvements to policies and practice to be made as learning arises during an SCMR or following the incidents that led to it being commissioned.

9.2 Since April 2018, the Department of Infrastructure has worked with local authority social housing providers to implement changes when eviction is being considered that are relevant to the circumstances of this review, some as a direct consequence of the learning from this case.

9.3 The changes include, but are not limited to, the following:

9.4 The Department of Infrastructure implemented a new rent recovery process in June 2019 which the local authority immediately adopted. The main changes are:

- As part of the process a “Housing Matters” leaflet is now hand delivered to all tenants prior to the Notice to Quit (NTQ) being issued.
- Stage One: Action starts after two successive missed payments (Formerly one). If a tenant has a history of rent arrears, contact is made with the Social Security Division (SSD) of The Treasury to see if direct payment can be arranged.
- Stage Two: Contact is made with Social Services to enquire if there are any concerns of a welfare nature and to discuss the implications of rent arrears. If appropriate, contact with SSD about direct payments is made.

- Stage Three: An additional arrears letter is now sent prior to the Notice to Quit (NTQ) letter.
- Stage Four: Issue NTQ which now allows three weeks to make contact/arrangements prior to referral to advocates, these letters are now delivered by the Coroner.

9.5 Additional key changes:

- Data sharing agreement with the Treasury Social Security administrators
- Confirmation has been received from the Information Commissioner that contact can be made with Social Services due to potential safeguarding issues in eviction cases.
- "Housing Matters" & "Graih" leaflets now hand delivered prior to NTQ stage
- Safeguarding courses are now being identified for all Housing Officers for 20/21
- Mental Health Awareness Training being identified for 20/21
- Additional recording of communications/issues being recorded on rent management records.

10.0 Recommendations

10.1 In addition to the developments noted in section nine, some of the agencies made recommendations for their own service.

10.2 The author has taken these into account and made some additional recommendations for the relevant agencies individually and/or as part of a new approach to multi-agency working.

10.3 The Safeguarding Board should undertake the following specific actions that are relevant to its role and monitor and assure itself that all actions recommended in this report, for other agencies, are implemented.

10.4 The Safeguarding Board should discuss with the Department of Infrastructure's Housing Division the introduction of new approaches to improving the relationships between local authority housing providers and their tenants. These should include:

- Safeguarding policies and practices, that recognise and understand the approach to safeguarding, the implications for housing providers and the legal requirements for information sharing, including when a Serious Case Management Review is undertaken.
- Tenant profiling: needs and risk assessments should be carried out where vulnerability is identified. This may be due to a range of triggers. For example: domestic violence, poor mental health and substance misuse
- Multi-agency case conference to be held, once a notice to quit is prepared
- Identify training needs, scope a programme of training and ensure that this is delivered to existing staff and forms an integral part of induction training for new staff. This should start no later than 1 September 2020 and needs to be refreshed on a regular basis.

10.5 The Safeguarding Board should consider identifying and agreeing senior responsible named officers for safeguarding within each partner agency and ensure that they are given the training, knowledge and support required to carry out their duties effectively. Carry out quarterly audits of the number of safeguarding flags from each agency and a review of progress. These should be reported to the Safeguarding Board.

10.6 The Safeguarding Board should also support the following:

- Information sharing protocols need to be developed with the prison for offenders in receipt of short sentences (less than six months) on admission to the prison to secure a planned release that ensures that all offenders have a home to return to. Local authority housing providers should take a constructive approach to working with their offending tenants to minimise their risk of becoming homeless. This will contribute to reducing some of the risk factors known to contribute to reoffending. The development and implementation of the protocols should be agreed with the Information Commissioner.
- Continuing benefit payments towards housing costs for prisoners on short sentences should be considered. In considering this policy change Treasury should undertake an assessment of the average costs of eviction and homelessness if a prisoner's accommodation is lost due to arrears resulting from short periods in prison.
- Frequent hospital attenders: Nobles Hospital Emergency Department current work to develop procedures and practices for identifying people who regularly present following emergencies/ crises should be shared with all relevant agencies. This should include senior representatives from DHSC; the Police; mental health services; prison and probation services; Department of Infrastructure Housing and a voluntary sector representative. A multi-disciplinary approach to identifying needs and assessing risks should be developed and agreed. This must include advice from the Information Commissioner. This will ensure that new approaches are in line with the island's legal framework for data protection.
- Voluntary sector agencies with skills and expertise in providing housing related support should be more closely involved when eviction action is being considered. This must go beyond simply including a leaflet and should include direct referrals. Other agencies, including the hospital and the prison, need to be made fully aware of the support that these voluntary agencies can provide and greater clarity on referral processes. This will place increased demands on the voluntary sector, and this should be reflected in any future grant settlements to support their work. Cross agency funding should be considered as successful interventions will result in a reduction in pressure on budgets.

10.7 The Isle of Man Government

10.8 Homelessness The Isle of Man Government should consider drafting a Homelessness Bill for debate and consideration. The lack of a legislative framework for housing advice, temporary housing and sources of support are resulting in residents relying on the voluntary sector as the only source of emergency accommodation, advice and support. The main housing charities are experiencing increasing demand for their services and are struggling to

meet demand in the current housing market. The lack of affordable housing is resulting in increasing numbers of people at risk of homelessness or homeless.

10.9 Private rented housing The Isle of Man Government should consider expediting the introduction of regulation of the private rented sector. Poor standards in some privately rented housing, combined with far higher rents, are resulting in vulnerable people living in homes that are in poor repair and prejudicial to the health and wellbeing of the occupants. Many of the low-income tenants in this sector are claiming high levels of public subsidy through social security rent payments to private property owners. The introduction of a lettable standard for the private rented sector would have many benefits including ensuring that publicly funded housing subsidies through social security payments are not used to support poor quality accommodation.

Appendix 1

About the reviewer

The review was conducted by Domini Gunn MA(Hons). Domini works across the statutory and voluntary sectors on a wide range of housing, social care and health issues. Until 2107 she was responsible for the development of policy and practice across housing, health and social care at the Chartered Institute of Housing (CIH) and direct delivery of support and advisory services through CIH consultancy. Prior to her role at CIH she worked at the Audit Commission, in the health service and in local government.

Domini was a member of the Care Act (England) 2014 advisory panel and chaired the Department of Health (England) Hospital2Home advisory group. She is working with regulators across the UK, voluntary sector organisations and with housing providers on strategies, change management and service delivery. Domini works with NHS Partnership Trusts and lectures at the University of Leicester. She is a trustee of Care & Repair (England) and has worked on a wide range of European and international projects.