Publication of Safeguarding Adults Review: 'Robert'

Independent Chair's Statement on behalf of Haringey Safeguarding Adults Board (HSAB)

In January 2016, the man referred to as Robert died aged 32. In June 2017, the Coroner for the case reached an open verdict about Robert's death, highlighting his grief over the death of his father and worry about his housing situation, as he was about to be evicted from his family home. There had been recent contact with Haringey agencies prior to his death.

The Haringey Safeguarding Adults Board (HSAB) is the partnership within Haringey of agencies who seek to keep vulnerable adults safe. Our collective role is to promote effective joint working, and to hold each agency to account. Following Robert's death, the Board commissioned an independent author to lead the process of reviewing the work of all agencies and seeking to identify learning. Agencies have engaged fully in the review, and have worked hard to agree on areas of learning. The review has identified some occasions where agencies could have initiated assessments of mental capacity and vulnerability, examining risks more closely and identifying support needs. It does not identify a causal link between these occasions and his death in January 2016, which it concludes could not have been anticipated, but some significant learning has been identified and acted upon.

In particular, the review focused on three principal issues where practice could have been improved. The first issue is about the lack of face to face communication with Robert about his housing needs, which led to poor quality information, lack of understanding of the nature and extent of his vulnerability, and affected decision making about Robert's housing and the communication of those decisions. The second issue is about the lack of a clear and well understood multi-agency referral pathway and protocol at the time for assessing and responding to the needs of vulnerable adults threatened with, or at risk of, homelessness. Lastly, the review has identified the need for better understanding of mental capacity across the partnership. As stated above, it has been concluded that there is not a causal link between these occasions and his death in January 2016. However, had relevant enquiries of mental capacity been made at the outset, this would probably have resulted in Robert having an assessment of his needs and vulnerability; the one crucial piece of information that was missing in this case.

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