Peabody

June 2022

Confidential

Peabody Trust

The Sheila Seleoane Report 2022

Lessons Learned

Altair

Contents

1. Executive Summary

1.1. Introduction and approach

1.1.1. On Friday 18th February 2022 the police entered a flat owned by the Peabody Trust (Peabody) and discovered the body of a 61-year old woman, Ms Sheila Seleoane, (referred to throughout this report as Ms S) following concerns raised by neighbours. The actual date of death is not known but, it has been widely reported by the press that the body may have lain undetected for over two years.

1.1.2. This independent report provided by Altair Consultancy and Advisory Services Ltd (Altair) commissioned by Peabody examines the policies and controls that were in place between 2019-2022 in order to determine whether there were any control failures and to identify the lessons to be learned by Peabody and the sector and recommendations on where changes could be made and controls strengthened. Within our work we also examined whether the actions taken by Peabody could have identified any earlier that Ms S had passed away.

1.1.3. The scope of the review was wide-ranging and included a detailed review of documents (policies and procedures, information and reports relevant to the review etc.), interviews with staff involved in the different processes and interviews with residents within the block of flats. We also examined the involvement of any statutory bodies, such as the police.

1.1.4. In addition, the impact of COVID-19 was examined, and the effect that any changes to policies and processes may have had on the case.

1.1.5. Cross-sector experience was also a feature and fourteen sector leaders took part in two round -table discussions. Other organisations provided policies and procedures for the benchmarking review.

1.2. Context for the review

1.2.1. To give context to the incident, people dying at home is probably more common than expected. According to the Nuffield Trust[1] the proportion of people dying 'in their normal place of residence' has increased over time. In 2021 49% of people dying did so in their normal place of residence, a decrease from 52% in 2020 (which was reported to be linked to COVID-19); between June and September 2020 the number of deaths at home was above average. There is no formal data related to people dying alone in their homes.

1.2.2. The date of Ms S's death is unknown, but the last recorded interaction and contact with Ms S was in August 2019, some seven months prior to the pandemic.

1.3. Tenants' rights

[1] Nuffield Trust. End of Life Care, Quality Watch (Updated 24 February 2022)

1.3.1. Advice provided by Devonshires Solicitors, acting for Peabody, gives context to the rights of tenants in living in their home.

1.3.2. Tenants have an implied right, which is usually expressed formally in tenancy agreements, to quiet enjoyment of the property they are let. [...] The tenant should have possession without interference or interruption from the landlord, their staff or agents.

1.4. Missed opportunities

1.4.1. Our work has confirmed that there were no failures of controls and the policies and procedures implemented were appropriate and followed and Peabody has acted at all times within the Regulator of Social Housing's (RSH) regulatory framework.

1.4.2. As part of the review we assessed the attempted contacts between Ms S and Peabody. The last interaction with Peabody was a rent payment made in August 2019. Since this time and the discovery of her body in February 2022 when police carried out a forced entry there were 89 attempted contacts with Ms S.

1.4.3. We conclude that there were missed opportunities where there may have been opportunities to discover the body at an earlier point, when contact was attempted and not followed through.

1.4.4. These opportunities ranged from the change in behaviour when rent payments suddenly ceased, concerns raised by neighbours, multiple attempts to contact Ms S (specifically regarding rent payment and gas servicing), several reports into the customer hub of smells and one of maggots and flies (although this was reported as possibly coming from the rubbish area).

1.4.5. These incidents were all dealt with in isolation, following due process, but in our opinion, did not 'put the customer at the heart of the actions'. Our observation is that the customer got lost; culturally it appears that the focus was on fulfilling the task rather than putting the customer first.

1.4.6. Importantly there were two visits made by the police to Lord's Court. The first, in the summer of 2020, followed a neighbour's call requesting a welfare check. The police did attend but did not force entry as there were not enough indicators to warrant this action. The second welfare visit was at the request of the Neighbourhood Manager (NM) in October 2020. On this occasion the police informed the NM that they had spoken to the resident who 'was safe and well'. This assurance resulted in the welfare case being closed.

1.5. The impact of COVID-19

1.5.1. We conclude that COVID-19 exacerbated the length of time that the body remained undiscovered, but was not the cause of the delay.

1.6. Emerging themes

1.6.1. Our work identified a number of key themes that illustrate areas that Peabody may wish to consider further:

- Culture and behaviours – in this instance it appears that the culture that Peabody strives to achieve through its stated values and behaviours, were not translated into practice

- Customer touchpoints – there are a significant number of touchpoints that a customer will have with Peabody, all routed through the customer hub, however there is little interaction between the different departments of Peabody
- Silo working – there is a siloed approach to dealing with customers at Peabody and our view is that the role of the NM is very transactional. In this particular case, the NM was new to the patch and lockdown occurred six-months into the role which will have had an impact on knowledge of the patch, tenants etc.
- Insight and intelligence – the systems enable those identified individuals to drill down into activity related to a tenant, their property, block and estate. This is not used to provide insight which is planned for the Autumn 2022
- A transactional approach – in our opinion the NM role is very transactional. In this particular case the NM did respond to the issues raised by the customer hub and followed due process, but there is not the ability or time, through easy access via the systems, to 'join the dots' on all activity concerning a tenant
- Stakeholder and partner engagement – the communication and engagement with stakeholders and partners could be improved.

1.7. Sector practices and benchmarking

1.7.1. Round table sessions were held with sector leaders to discuss what lessons could be learned and to hear about where organisations have implemented policies and procedures that could strengthen the relationship with tenants.

1.7.2. The topics explored covered investing in tenancy sustainment, culture, the role of the housing officer/neighbourhood manager, data insight and business intelligence, welfare dashboards, partners and gas safety.

1.7.3. These discussions were supported by benchmarking across the sector that examined policies and processes to determine good practice and common themes.

1.8. Lessons learned

1.8.1. The lessons learned, which are detailed in the report focus on:

- Communication with tenants, meaningful and two-way
- Greater joined-up working and sharing of business intelligence within organisations (within data protection) putting the customer at the centre
- An organisational culture that encourages curiosity, to ask questions and follow through. 'See something, say something, do something'
- Ensure the role of the NM/housing officer moves away from being transactional to provide a more holistic approach to the tenant
- Test patch-sizes to ensure they are appropriate for the type of property/estate/location
- Use data to provide insight and triggers (where things may be going wrong)
- Improve and strengthen relationships with partners and stakeholders
- Update training for suppliers and contractors to include safeguarding and reporting anything unusual (specifically those who have regular contact/visits to the property)
- Continue to provide regular training on gas safety procedures, ensuring communication across functions when no-access is a feature

- Landlords to focus on the 'social' part of social housing, to be outcomes-based and take on a duty to follow through.

1.9. Conclusions and recommendations

1.9.1. This was a very distressing case for all involved but we conclude that Peabody's policies and procedures were followed and there was no failure of controls. Data shows that the percentage of people who die in their normal place of residence is higher than expected. What is different is the amount of time that Ms S's body remained undiscovered, we also examined this aspect of the case and concluded there were missed opportunities.

1.9.2. It is classified as an extreme case. Most bodies are discovered within days or even weeks. We were asked to examine the impact of COVID-19 and whether it had a part to play. We conclude that COVID-19 exacerbated the length of time the body remained undiscovered, but was not the cause of the delay.

1.9.3. There were missed opportunities, detailed above which may have discovered the body of Ms S at an earlier point in time.

1.9.4. We conclude that it was not a failure in governance. The board does not monitor individual cases, but seeks assurance that tenants are provided with a good service and have safe and affordable homes.

1.9.5. The way Peabody is structured does not provide the 'one view of the customer': this must change. The use of data to highlight where there may be problems has to be implemented. The culture of the organisation needs to change, with front- line staff, in particular, being 'professionally curious' and proactively using the systems available to them. These will all strengthen the way the service is delivered and provide the board with assurance that an incident such as this should be identified at a much earlier stage.

1.9.6. Our recommendations for Peabody and the sector cover the following:

- Culture
- Change programmes
- Neighbourhood management services
- Insight
- Policies and processes
- Stakeholders

2. Our thanks

2.1.1. This was a very upsetting and difficult case for all involved. We are grateful to the tenants who spoke to us for their time and insight, specifically their view on what it is like to be a tenant of Peabody.

2.1.2. We thank everyone, including those leading and involved in the day-to-day operations for their co-operation, openness and honesty, and for unrestricted access to data.

2.1.3. Finally, we thank those leaders from the sector who joined the round table and gave us their insights as well as providing their policies and procedures to assist us in developing the lessons learned, good practice for the sector, and recommended approaches to improve practices in the future.

3. Introduction

3.1.1. On Friday 18th February 2022 the police entered a flat owned by the Peabody Trust (Peabody) and discovered the body of a 61-year old woman (referred to throughout this report as Ms S) following concerns raised by neighbours. It has been widely reported by the press, through interviews with neighbours, that the body may have lain undetected for over two years. The actual date of death is not known as the coroner's report is not yet available.

3.1.2. Altair Consultancy and Advisory Services Ltd (Altair) was commissioned by Peabody to undertake an independent review into the incident, specifically how Peabody's policies and processes were implemented, whether there were any control failures and to identify the lessons to be learned by Peabody and the sector and recommendations on where changes could be made and controls strengthened. Within our work we also examined whether the actions taken by Peabody could have identified any earlier that Ms S had passed away.

3.1.3. This report also identifies changes that can be adopted by organisations within the sector to strengthen their own policies and processes.

3.2. Scope and approach

3.2.1. The review was independent and wide-ranging. The agreed scope included:

- An analysis of the processes to identify routine/annual customer touchpoints
- Examination of the relevant policies that were in-place over the alleged period
- Interviews with staff involved in the different processes to understand where information is sourced and handed on etc.
- Reviews of any relevant documentation
- The involvement of the police and any other statutory bodies over the period
- Interviews with residents within the block of flats, documenting their stated interactions with Peabody, following these into and through Peabody
- Documenting attempted contact with the resident and any subsequent actions identified and taken.

3.2.2. In addition, the impact of COVID-19 was examined, and the effect that any changes to policies and processes may have had on the case.

3.2.3. Cross-sector experience was also a feature and fourteen sector leaders took part in two round -table discussions. Other organisations provided policies and procedures for the benchmarking review.

3.2.4. Altair has had unrestricted access to data, records, policies and processes, and held interviews with individuals involved in some way with the processes of housing management, repair, investment and collections: all specific customer touchpoints within Peabody that have had some interaction with the deceased resident or with the block of flats where the resident lived.

3.2.5. Discussions were held with a number of tenants from Lords Court who have helped give insight and context from their important perspective.

3.2.6. A second case that was highlighted in the press shortly after the discovery of Ms S was reviewed. This case was significantly different. It has been investigated by Peabody and, following a review, it was concluded that there were no indicators that Peabody missed, and no reports that caused concern.

4. Context for the review, an external perspective

4.1.1. To give context to the incident, people dying at home is probably more common than expected. According to the Nuffield Trust[2] the proportion of people dying 'in their normal place of residence' has increased over time. In 2021 49% of people dying did so in their normal place of residence, a decrease from 52% in 2020 (which was reported to be linked to COVID-19); between June and September 2020 the number of deaths at home was above average. There is no formal data related to people dying alone in their homes.

4.1.2. In London, the percentage of people dying at home was 40.3% in 2019, 44.6% in 2020 and 42.1% between October 2020 and September 2021.

4.1.3. However, dying at home and not being discovered for some length of time is less common. A study[3] published in the Journal of Clinical Pathology on the impact of the pandemic found that, of the bodies referred for autopsy during 2019-2020, 16.4% had marked decomposition; this rose to 27.9% during the pandemic. This was attributed to more people dying at home and remaining undiscovered as in this particular case. It should be noted that the length of time the body remained undiscovered is exceptionally rare.

[2] Nuffield Trust. End of Life Care, Quality Watch (Updated 24 February 2022)
[3] Journal of Clinical Pathology. T Estrin-Serlui. Putrefaction in the pandemic: a comparative study of the frequency of advanced decomposition change in coronial autopsies since the start of the COVID-19 pandemic. 17 September 2021

4.1.4. Although the date of Ms S's death is unknown, the last interactions and contact with Ms S was in August 2019, some seven months prior to the pandemic.

5. Background to Ms S

5.1.1. Ms S started her assured tenancy in February 2014. She was a regular payer who routinely made payments to her account every one to two weeks and was not in arrears before the payments ceased.

5.1.2. Ms S's flat is on the top floor of the block of flats, Lords Court, at the front end of the building and has a balcony. There is another flat diagonally opposite and the two other flats on that floor are on the other side of the central lift. The layout of each corridor is such that there would be no direct casual passers-by near her front door.

6. Tenants' rights

6.1.1. This section is extracted from advice provided by Devonshires Solicitors, acting for Peabody, to give context to the rights of tenants in living in their home and is pertinent to the review.

6.1.2. "Tenants have an implied right, which is usually expressed formally in tenancy agreements, to quiet enjoyment of the property they are let. This reflects that the tenant has been granted exclusive possession of the property and means that the tenant should have possession without interference or interruption from the landlord, their staff or agents.

6.1.3. Should a tenant's quiet enjoyment be interfered with, by forcing entry without justification for example, then this would be a breach of the implied/express rights of the tenant and potentially derogation of grant. This in turn could lead to a claim for damages and damage to reputation.

6.1.4. Such interference with a tenant's right to quiet enjoyment could also cause Peabody to breach the requirements of the Tenancy Standard, which requires it to "***meet all applicable statutory and legal requirements in relation to the form and use of tenancy agreements or terms of occupation***".

6.1.5. Article 8 of the European Convention of Human Rights as implemented into domestic law by the Human Rights Act 1998. Article 8 provides for a right to respect for private and family life and states a follows:

- *Everyone has the right to respect for his private and family life, his home and his correspondence.*
- *There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others"*

7. Attempted contacts

7.1.1. An important feature of the review was to examine the attempted contacts between August 2019, the last payment and interaction with Peabody by Ms S, and February 2022 when the police carried out a forced entry and discovered her body.

7.1.2. Our review shows that there were 89 attempted contacts with Ms S by Peabody between September 2019 and February 2022, the majority being from income collections (rent arrears) and the gas servicing contractor (access for servicing). The majority of the contacts were through letter, email, SMS or voicemail.

7.1.3. There was one proactive visit by the NM following a period of no contact between August and October 2020. The following day there was a report of a strong smell 'like a dead body' and this led to a police welfare check being requested. This is detailed in para 8.1.3 below.

8. Missed opportunities

8.1.1. Our work has confirmed that there were no failures of controls and the policies and procedures implemented were appropriate and followed and Peabody has acted at all times within the Regulator of Social Housing's (RSH) regulatory framework. This section examines where there may have been opportunities to discover the body at an earlier point.

8.1.2. We have concluded that there were missed opportunities where contact was attempted and not followed through. For example, the changes in rent payment behaviour and numerous attempts to get in touch across the different functions at Peabody (specifically gas servicing) should have shown that something was amiss. However, each interaction was dealt with in isolation, following due process, but, in our opinion, did not 'put the customer at the heart of the actions'. Our observation is that the customer got lost; culturally it appears that the focus was on fulfilling the task rather than putting the customer first.

8.1.3. Crucially, there were two requests for welfare checks to the police. The first by a neighbour in the summer of 2020; the police attended Lord's Court but did not force entry as there were not enough indicators to warrant this action. The second occasion was on 20th October 2020 where, following the request from the NM for a welfare visit the police verbally reported back to the NM that they had spoken to the resident who 'was safe and well'. This assurance resulted in the welfare case being closed and no further concern was raised (although collections continued to message via SMS and phone) until April 2021. We have requested information from the police, but at the time of writing have not heard from them.

8.1.4. A summary of what we believe were missed opportunities is below:

- The change in behaviour with the payment of rent, with the last payment being on 20 August 2019

- A report of maggots and flies (which occurred within weeks of rent payments stopping). It was reported that this may be coming from the rubbish area but was not investigated further and the case was closed on 23 September 2019
- Possession proceedings due to arrears were sought in January 2020 and again in February 2022. It does not appear that any abandonment checks had been done
- The forced entry process for gas compliance was started just before lockdown and then paused during the first lockdown. It was restarted in June 2020 but forced entry was not carried through (on 19 June 2020) as the gas meter could be capped from the outside. This process was also undertaken in May 2021, but as the gas meter was already capped, no action was taken
- The persistent welfare calls from the neighbours including a visit from the police in the summer of 2020 following a request from a neighbour. There was no forced entry as the police deemed there were not enough indicators to warrant this action
- There were several reports into the Customer Hub of a smell/stench within the building, specifically on the top floor. One particular report in October 2020 mentioned that the smell was akin to a 'dead body', the response was that smells are not investigated
- Two reports from neighbours (in April and August 2021) of Ms S's mail being scattered on the floor and in the lift. This was triaged as low risk and no action taken.

8.1.5. There were two process occurrences, that should be seen as missed opportunities from the point of view of providing learning for Peabody and the sector. The common feature is that these processes did not require Peabody to have any *meaningful* contact with the tenant to make sure the tenant still lived at the property and was well, and these were undertaken regardless of whether the tenant had been spoken to. Contact was required, but this was through email, SMS, letter or by phone (leaving a message) and this was done. We recognise that in some cases 'meaningful' contact will be very difficult, but there are organisations within the sector that do attempt this before significant action is taken. The particular incidents were:

- The application for direct payment of Universal Credit by the collection team, which was applied for in March 2020, six months after the final rent payment
- The capping of the external gas meter in June 2020, which could be done without talking to the tenant because it was an external meter.

9. The impact of COVID-19

9.1.1. There was a six-month window when contact could have been made with Ms S or action taken, between 20th August 2019 (when the last rent payment was made and payment behaviour changed) and 26th March 2020 when the UK went into lockdown.

9.1.2. There was a series of events prior to lockdown where contact was attempted by various colleagues from Peabody and there was activity within Lords Court by contractors, primarily lift engineers, pest control and the weekly cleaning service. Nothing untoward was reported by any contractors. There were no estate inspections in the period July 2019 to lockdown, even though these were scheduled to be quarterly.

9.1.3. Lockdown occurred mid-process in attempting to gain access to Ms S's flat for the annual gas safety check. All forced entries were halted on 31st March 2020, the date

that a forced entry notice was posted on Ms S's door indicating they would force entry on the 7th April. Lockdown did therefore, in this one instance, prevent an opportunity to enter the flat and possibly delayed the discovery of Ms S, although we note that a contractor did visit the building on the 7th April, and noted that no access was given.

9.1.4. With the exception of this particular planned intervention, it is our opinion that COVID-19 exacerbated the length of time the body remained undiscovered, but was not the cause of the delay.

10. Emerging Themes

10.1.1. The timeline, discussions and review of documentation identified a number of key themes that are set out below:

Theme 1 - Culture and behaviours

10.1.2. In this particular case it appears that the culture of Peabody, its stated values and behaviours, was not translated into practice.

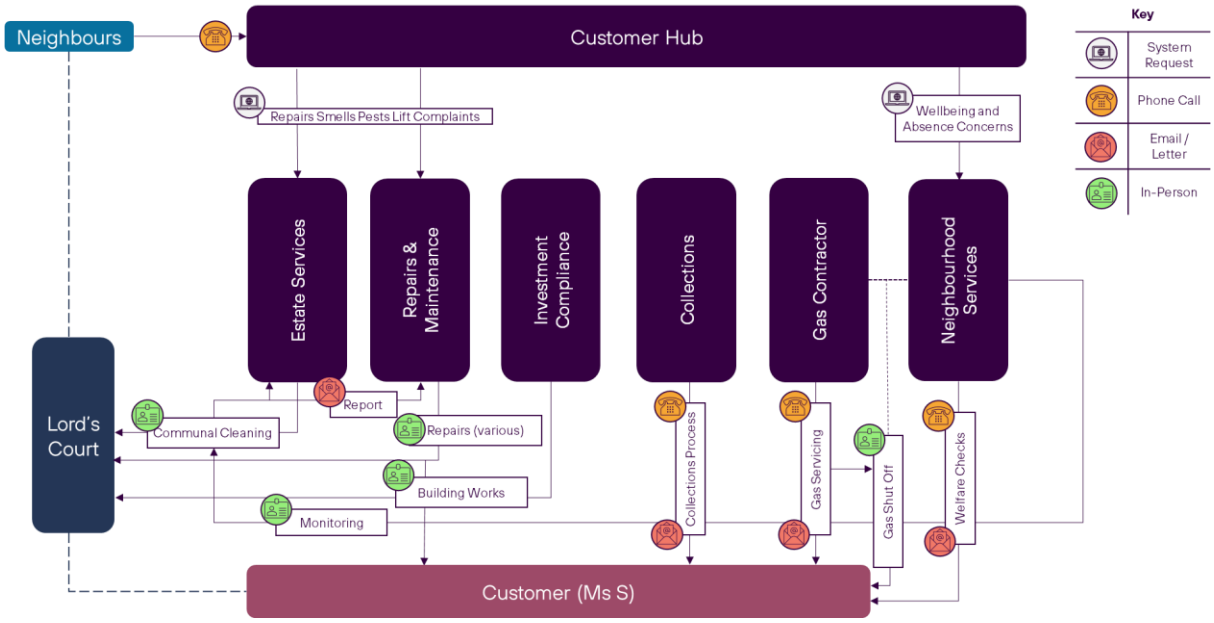
10.1.3. In 2019 the values were: ambitious, caring, collaborative, empowering and trusted. Peabody also embraced a 'People First' programme to create change through putting people first, focused on three principles: effortless experience, working together, and human and kind.

10.1.4. We cannot comment on the culture and behaviours across Peabody at this time, but the findings of the review are at odds with the values and principles of the People First programme. The 'human' element in recognising there was an issue, the lack of 'professional curiosity', and being target driven all combined to miss the fact that Ms S's behaviour had changed. The many attempts to contact her by methods that were digital which did not include any human interaction illustrate the mismatch between the words and the actions.

Theme 2 – Customer touchpoints

10.1.5. The review has brought into sharp focus the number of different touchpoints that a tenant will have with Peabody and that their access to Peabody is through one channel, the Customer Hub. The diagram below demonstrates the different interactions between the neighbours of Ms S and the Hub, the Hub and the various functions within Peabody, and those functions' individual interactions with the customer.

Diagram 1: Customer touchpoints



10.1.6. The essential feature is that, although there are many touchpoints with the customer, there is little or no interaction between the different departments of Peabody. The Customer Relationship Management (CRM) system gives those identified colleagues involved with a customer the ability to drill down into activity. It is striking that this did not happen in this case and, during our initial interviews, no-one mentioned that this capability was available. This leads to a view that it may not be common practice, but it is another indicator of the task-oriented nature of the culture at the time.

Theme 3 – Silo working

10.1.7. The diagram above shows the 'siloed' approach to dealing with customers. Our observation is that the way the housing management functions (neighbourhoods, collections and repairs/compliance) are set up, and the specific role (profile) of the NM, dictates a transactional relationship. The exception is if the tenant choses to engage with the financial inclusion team or the family support team where a more holistic approach is provided.

10.1.8. The NM role and patch size means that 'thinking time' and time to be able to look at the rent statement (provided for all NMs) is not available. The newness of the NM into the role (not knowing the patch intimately) followed by lockdown six-months into the role must have had a bearing on what would normally be seen as 'joining the dots' through experience of knowing the block and the tenants, seeing colleagues etc.

10.1.9. We have noted that the NM is not informed of issues such as increasing rent arrears, the commencement of possession proceedings, the failure to secure an appointment to service the gas boiler and check the meter leading to forced entry processes being started and eventually the gas being capped, and the investment works that were undertaken on Lords Court in September-November 2021.

Theme 4 – Insight and intelligence

10.1.10. It is clear that data has not been used to provide insight.

10.1.11. The CRM system, which interfaces with the main housing management programmes, gives identified users the opportunity to enquire about and have visibility of activity relating to a tenant, their property and, if they live in a flat, their block and estate. It is a multi-layered system and, at present, the information needs to be 'pulled out' by the user rather than 'pushed' from the system.

10.1.12. Further work is being done on providing insight and it is planned that this will be available, including a welfare dashboard, in the autumn of 2022.

Theme 5 – A transactional approach

10.1.13. Changes in the neighbourhood model in 2019 which increased patch sizes (typically 800+ units) but also increased the number of caretakers within estate services and environmental services to provide a revised approach of reactive engagement was intended to deliver a more efficient service and better planning coupled with updates to the systems.

10.1.14. Lord's Court continued with a cleaning contractor throughout this time which indicates that the queries directed to NM that would have been routed through a caretaker in the new operating model, continued. Lockdown did prevent visits (estate inspections) by the NM, which is the only proactive visible interaction they have with Lords Court. All other interaction is via the Customer Hub, as designed; the process dictates that communication with residents is via letter, phone, SMS and email.

10.1.15. The review identified that the NM did respond to each of the issues raised by the Customer Hub and followed due process. In our opinion the role of the NM is very transactional and there is not the ability or time, through easy access via the systems, to 'join the dots' on all activity concerning a tenant.

Theme 6 – Stakeholder and partner engagement

10.1.16. The engagement and communication with strategic partners is very important. Communication over this incident with Southwark Council could have been better, This is being rectified and Peabody is now working closely with Southwark to strengthen the relationship for mutual benefit.

10.1.17. The relationship with the police at an operational level appears to be good with NMs saying that they know and speak with the Police Community Support Officers (PCSOs). But there appears to be few relationships at a more senior level, and the police are not 'round the table' in discussions that would help strengthen the relationship and help both sides in dealing with community issues.

10.1.18. This case did not highlight particular issues with other stakeholders. Underlying problems are likely to be more within the community; these should be identified and a strategy for engagement developed.

11. Sector practices

11.1.1. Two round-table discussions were held with sector leaders. These were to assist in developing the lessons learned for the sector by highlighting key points, including Peabody's learnings from the incident at Lords Court, and to hear about where

organisations have implemented policies and procedures that could strengthen the relationship with tenants.

11.1.2. The topics explored included:

- Working and organisational practices
- Data insight and business intelligence, including triggers that may alert the organisation to a change in behaviour.
- Culture and the wider dilemmas and challenges facing landlords to balance their discretionary activities that focus on the wellbeing of general needs tenants and proactive interventions of support, while respecting their privacy and the right to have 'quiet enjoyment' of their homes.
- Integrated agency approach and working with partners.

Investing in tenancy sustainment

11.1.3. All those at the round table commented that their investment in tenancy sustainment had increased during COVID-19, had remained at these levels, and is even more important now with the increasing cost of living pressures for tenants. A number of organisations provided a £500 budget to their NMs with discretion to spend/allocate where necessary.

11.1.4. It was noted, however, that these sustainment efforts could only work if tenants were willing to accept them. The difficulty of engaging with hard-to-reach tenants still exists. One organisation asks all customers to undertake their own 'person-centred Fire Risk Assessment', resulting in contact, interaction and engagement in the majority of cases.

11.1.5. One model that has gained traction is based on three themes: improved wellbeing, employment opportunities and empowerment. These have formed the basis for community and individual discussions and have helped to increase engagement.

11.1.6. A discussion of the stigma associated with social housing progressed into understanding of the stigma of poverty and how this should be explored to be able to help tenants in this situation. Unlocking this with tenants is difficult. Having an 'immediate relief of need fund' as part of the social investment strategy was important as was working with partners proactively.

Culture

11.1.7. How far the duty of care for general needs tenants extends is another open question. All tenants are entitled to live in their own home and not be bothered by their landlord and, if they do not want contact, that should be respected. Relationship management by front-line staff is key to supporting tenants appropriately.

11.1.8. Looking at wellbeing in a more data-driven way (and within data protection) should be underpinned by a clear culture of empowerment which some described as 'a professional curiosity and making every visit count.' It needs officers to recognise triggers, respond appropriately and be accountable.

11.1.9. By necessity, the pandemic resulted in different means of communication and the experience of being a housing officer changed. Using technology to send an email or letter does not mean there has been a 'meaningful' interaction, termed by one as 'contact but no contact'.

11.1.10. Landlords are questioning what is the modern housing officer role? They identify a requirement for teams to have the desire to deliver and see things through; to provide a range of different products to support different wants and needs of their tenants. Some have already changed their housing teams, with emphasis on having the right values and behaviours and following through on outcomes.

Housing officer/neighbourhood manager

11.1.11. Many landlords are reflecting on the type of relationship they have with their general needs tenants without being intrusive. Tenants without a known vulnerability will have differing needs and expectations, it was stated that quieter tenants can still be in need of support.

11.1.12. The challenging operating environment post-pandemic, including rising costs of living and energy prices is 'desperate and getting worse.' Many are considering that more conversations are needed to understand in what ways people may need help, with the relationships being 'built on trust' and 'not just the immediate need but their aspiration for better lives.'

11.1.13. The housing management model used by some housing providers has moved away from local patches over recent years, but many expressed their intent to move back to, or have introduced, a locality or neighbourhood model - a more intensive approach with smaller patch sizes

11.1.14. The NM becoming 'part of the community network' was stressed, as well as a model where 'walking and talking remains one of our most important ways of understanding what is going on'. Some landlords are increasingly making use of home visits, at least annually, to engage directly with their customers and provide an opportunity to check on their welfare.

11.1.15. The number of cases overseen by a housing officer varies between landlords and ranges between 200 to over 800 properties. Some are adopting a dynamic approach to patch sizes, depending on density, location and property type etc.

11.1.16. Some landlords are joining up their housing management and repairs services, to create a more holistic view of customers' welfare and service delivery requirements, using data from all interactions. Two different approaches were put forward: A 'Wellbeing 10' model is being used, with operatives spending an extra ten minutes in the property to check on the welfare of tenants, and 'See something, say something, do something' making this everyone's responsibility.

Data insight and business intelligence

11.1.17. There is increasing reliance on the use of data and information to understand customers' needs. To a varying degree, the sector is some way off having fully integrated and intelligent business systems to enable this to happen most effectively.

11.1.18. Many described the implementation of integration programmes (including from legacy systems following mergers) as 'work in progress' as landlords develop their use of technology and data to 'join the dots'.

11.1.19. Noting the requirements of data protection some gave examples of using internal teams to stand back and review report data, looking for the triggers that demonstrate

changes in behaviour and potential needs or safeguarding issues. For example, changes in rental payments and tenants starting to fall into arrears will have an underlying cause.

11.1.20. Some are questioning whether there should be a 'broader definition of safeguarding, to widen the lens to identify where wellbeing support may be needed'. Another trigger was those tenants who had not been in touch to request a repair in the last twelve months and those with low levels of contacts (identified through tenancy audits) where a welfare call may be made.

Welfare dashboard

11.1.21. Again, within the requirements of data protection some landlords are creating 'welfare dashboards' to help housing teams understand how they oversee specific welfare needs and generate a responsive approach and be more outcomes focussed.

11.1.22. 'What gets measured gets valued.' The extent to which officers can give time to what customers are telling or not telling them is a big challenge. For example, performance measures of 'time on and time off the phone, resolving an issue at first contact' breeds a behaviour of getting away from the query each time rather than acting on the underlying cause.

Partners

11.1.23. The operating environment is getting harder. Local partnerships, including with councils, will help maximise the availability of benefits, including grant funding. Borough plans were identified as a good starting point to find out what is available.

Gas safety

11.1.24. The practice of capping gas, to cut off supply and make safe appliances when tenants fail to respond, or the property becomes empty, will only happen following a rigorous risk assessment and due process. Some sector leaders remarked that their organisations would only do this following direct contact with the customer, which did not apply in this case. Identifying the unintended consequences of capping is important, not just the act of making safe.

11.1.25. Not all properties have gas. With the increase of combined heat and power and the demise of gas, some landlords have started to audit properties with no gas even where there are no identified support needs for the customer.

12. Sector benchmarking

NM workload/Patch sizes

12.1.1. Patch sizes, over the last few years, have reduced in response to the changing nature of housing management and the different roles that NM may have.

12.1.2. Our benchmarking showed that on average the patch sizes were 250-500 units; traditional LSVTs tended to have larger patch sizes of circa 650 units. Peabody's current patch size in 800-1000 units, but this is being reduced as the new localities model is developed.

Policies and processes

12.1.3. As part of this review, we have undertaken a benchmarking exercise to understand the wider sector approach to policies and procedures in applicable areas. Major points are drawn out below.

- Across the sector, the approach to housing management is generally reactive to incidents occurring, rather than proactively responding to data and intelligence gathered through customer touchpoints. Reactive housing management processes for income collection, abandonment and gas servicing are driven by meeting legal expectations. Within these policies and processes there should be reference to listening to tenants.
- Most policies and processes give guidance for handling an incident after it has occurred, rather than giving advice on how to identify if a tenant is in need in the first instance, or warning signs that something may be wrong. Better practice procedures provide front-line housing staff with examples of the type of issues of which they should be aware. Organisations usually have some form of campaign within safeguarding guidance to raise staffing awareness.
- Most organisations struggle to determine what level of professional judgment to expect of their front-line housing staff. There is often a lack of clarity between giving housing management staff higher autonomy or offering highly prescriptive processes and guidance; the approach differs both across the sector and departmentally within organisations.
- One organisation reviewed has a planned approach to identify and follow up with 'silent tenants'. Its structured approach includes identifying tenants who have not engaged with the organisation over a significant period by analysis of contacts made by the tenant through touchpoints.
- Very few abandonment policies highlight either the potential for a tenant passing away or for staff to consider other issues that may affect the tenancy. The abandonment policies reviewed, although very effective at swiftly seeking a resolution for potential abandonment cases, focus on understanding only if a tenant has in fact abandoned a property and ensuring that possession of the property is sought legally.
- There is an inconsistent approach across policies reviewed regarding external gas capping. Of the policies that do mention capping of gas externally, there is usually a thorough escalation and legal process if the tenant has failed to reply to gas safety check requests. The external capping of gas is usually a last resort after all methods to contact the tenant have been exhausted and, ultimately, is undertaken in the interests of safety.
- Cross-team working is generally not mentioned other than in safeguarding policies and processes. They are generally clear and prescriptive on when and how other teams and agencies need to be engaged following a suspected safeguarding concern.
- Most income collection procedures show a detailed escalation process to contact the tenant, usually first through non-personal means such as a standard automated letter. A few organisations make it a priority to engage with the tenant at an earlier stage of the income collection process to ensure future arrears do not accumulate. This may include providing close ongoing support to the tenant and having face-to-face meetings where possible. None of the policies reviewed have triggers or warnings to examine possible other issues as part of the income collection process.
- Based on our benchmarking, the chart below shows to what degree each policy area is proactive in its escalation steps and considers tenant wellbeing. Please note, some

policies and processes reviewed vary from that below; the purpose of the chart is to show a collective, average view.

Diagram2 : Illustration of the average sector approach to pro/reactive policies against the regard to tenant welfare

12.1.4. The above demonstrates inconsistency across the sector, with processes being primarily driven by the landlord requirements, rather than an approach that recognises the needs of the tenant as well as the requirements for the landlord to remain viable and sustainable.

12.1.5. We have developed some over-arching principles to help start this debate. These are detailed below.

13. Overarching Policy and Process Principles

13.1.1. Policies and procedures should strongly link to the organisation's strategy, culture, and values. They should be grounded in an understanding of the relationship with customers, and the services and support offered to them. Policy and process should not run counter to the established customer relationship and customer offer; there must be good reason for any exceptions.

13.1.2. This 'golden thread' linking strategy, culture, values, policies and procedures with the established customer relationship should be evident in how all departments deliver services

13.1.3. Leaders should establish how front-line operational staff balance using their professional judgement with prescriptive processes. This balance should be clear in policies, supplemented by an appropriate level of training and development.

13.1.4. Housing providers require a sound awareness of operational risks, including external risks to customers. Specifically, policies should take account of current socio-economic risks, and an understanding of the needs and challenges faced by social housing tenants. Providers should be alert to the changing needs and vulnerabilities of their customers.

13.1.5. Risk assessment should establish and mitigate the unintended consequences of a policy or process, such as the impact on a customer's mental wellbeing of an arrears escalation process.

13.1.6. Policies should be monitored and evaluated as a whole, and individually. An overarching assessment of policies should consider any differing policy positions across the organisation and identify potential conflicts with the established customer relationship, strategic position, or culture of the organisation.

13.1.7. For policies requiring tenancy enforcement (such as income collection, abandonment, gas servicing) the customer's perspective should be recognised. Our findings in this review have established that often enforcement policies are primarily driven by the landlord's need taking precedence over the customers' need.

13.1.8. Enforcement policies often start with the position of the customer being in the wrong and in breach of tenancy terms. In implementing enforcement policies, organisations should consider how to nurture a strong collaborative relationship with customers to identify solutions for tenancy breaches while meeting expected requirements for legal enforcement.

13.1.9. Policies and processes should align operational delivery and compliance. They should empower colleagues to put customers at the heart of what they do, giving staff the capacity to care for customers, and a commitment to seeing things through.

Policies and processes should encourage professional curiosity and enable front-line staff to consider other factors outside the usual process.

13.2. Specific policy principles

13.2.1. We have shown that it is common for abandonment policies to lack consideration of customer need. We found that abandonment policies and processes focus on a landlord's need to obtain possession of the property; the welfare and whereabouts of the vacating occupants are rarely considered. The circumstances of customers should be included in abandonment policies.

13.2.2. Very few organisations have established processes for identifying customers who have not engaged with them over a period of time. Having these in place is vital both for effective housing management, and customer welfare.

14. Lessons learned

14.1.1. There were undoubtedly factors associated with the pandemic that influenced this case, with a number of missed opportunities. Our view is that COVID-19 exacerbated the length of time the body remained undiscovered, but was not the cause of the delay.

14.1.2. Peabody has already taken some action in response to the tragedy, taking account of what has now been established.

14.1.3. The lessons learned below should be balanced with the tenants' right to 'quiet enjoyment of their property'.

Changes already implemented or in-train

14.1.4. There have already been changes to policies and practices within Peabody and work carried out to identify those residents that Peabody has not had contact with for the past twelve months.

14.1.5. The immediate changes to improve two-way communication and oversight include:

- Ceasing gas capping – and not making any changes to the gas supply without first making contact with the tenant unless there is an emergency situation
- Updating the Gas Safety policy, specifically regarding the process of forced entry
- Alternative Payment Arrangement (APA) and Managed Alternative Payment Arrangement (MAPA) – ensure contact with the customer is established prior to changes being applied to redirect Universal Credit payments to cover rent payments.
- A Welfare Dashboard (within the requirements of data protection) is being developed to define what indicators should be measured and monitored to provide clearer oversight of tenant welfare.

The lessons learned from this tragic event lead to recommendations for Peabody (and the sector) to consider

14.1.6. These are to:

14.1.7. Where possible, ensure direct contact and two-way communication is made with the tenant:

- prior to making a major change to a tenancy, for example, gas capping or redirecting their Universal Credit
- at least annually, even if this is to confirm or re-confirm that they do not wish to have further regular contact with their landlord.

14.1.8. Identify across the organisation customer touchpoints and re-consider the current siloed approach in housing and tenancy services, to explore where there may be greater joined-up working and sharing of business intelligence.

14.1.9. Develop an operational culture that encourages colleagues to be curious, to ask questions and follow through on customer queries and their welfare: 'see something, say something, do something'.

14.1.10. Review the role of the NM (or equivalent front-line roles) to move away from the purely transactional nature of the current role and provide more capacity for 'thinking time', and 'human interaction' to provide a more holistic approach to the tenant.

14.1.11. Test the patch size proposals within the design of any new localities model. Round table participants had patch sizes from 200 – 800, some designed on a more dynamic model using data to formulate the requirements of the NM. Also, examine the

frequency of estate inspections and whether being visible twice or four times per year is consistent with a more holistic role.

14.1.12. Use data to provide insight, triggers and a welfare dashboard that covers all customer touchpoints. Suggested triggers are:

- Changes in behaviour (rent payments, response to access requests, lack of repairs calls)
- Lack of contact/access – the silent tenant
- Neighbour concerns
- Tale-tell signs such as 'smell/stench' reported multiple times (these need to be logged), maggots and flies.

14.1.13. Improve relationships with partners: local authorities, police, other statutory bodies, and third-sector agencies.

14.1.14. Update training for suppliers and contractors to include safeguarding, wellbeing checks and reporting anything unusual, specifically involving cleaners or caretakers and those that have regular contact/visits to the property.

14.1.15. Continue providing regular training on gas capping procedures to NMs and contractors, ensuring communication across functions when no access is a feature.

14.1.16. An overall theme that came through both round-table discussions was for landlords to focus on the 'social' part of social housing, to be outcomes-based and take on a duty to follow through.

14.2. Conclusions

14.2.1. This was a very distressing case for all involved but we conclude that Peabody's policies and procedures were followed and there was no failure of controls. Data shows that the percentage of people who die in their normal place of residence is higher than expected. What is different is the amount of time that Ms S's body remained undiscovered, we also examined this aspect of the case and concluded there were missed opportunities.

14.2.2. It is classified as an extreme case. Most bodies are discovered within days or even weeks. We were asked to examine the impact of COVID-19 and whether it had a part to play. Based on the last known interaction with Ms S, some seven months before the pandemic was declared and the UK entered lockdown, we conclude that COVID-19 exacerbated the length of time the body remained undiscovered, but was not the cause of the delay.

14.2.3. To provide further context, this case occurred mid-change programme (in 2019 post-merger with Family Mosaic) where the housing management function was restructured, new NMs and patches implemented, and policies and processes revised. For Lords Court this change took place in October 2019, five months prior to lockdown.

14.2.4. There were missed opportunities and other factors which have been detailed above and are summarised below:

- The structure of housing management activities, including rent collection and the maintenance and compliance functions, which operated in isolation.

- What may have been designed as a service centred on the customer failed to work. Instead, the focus became the processes themselves and Peabody appears not to have seen the triggers, listened to Ms S's neighbours, or to have joined the dots. This also illustrates the point that a target-driven culture can sometimes produce behaviours that are at odds with the values of the organisation
- The role of the police and the outcome of the welfare check in October 2020 which meant the case was closed by the NM. We have not heard from the police, and the response to Peabody was to wait for the coroner's ruling as the case will go to inquest, and so we cannot conclude on this point
- The data to alert colleagues to issues was available, but in isolation, although, if the system were to be interrogated, the information would have been accessible to those that required it.
- Patch sizes within Peabody are large, an outlier from the benchmarking undertaken, although they are being reduced as the new localities model is adopted. The work/case load of the NM is significant and does not afford the time for them to stand back and holistically look at all data related to the resident and/or the patch. This would have undoubtedly highlighted the need for different action at an earlier date, possibly before lockdown. Prior to lockdown the incidents were:
  - Rent payments suddenly stopping – a significant change in behaviour
  - The report of smell/stench (Lords Court)
  - The report of maggots and flies (Lords Court)
  - Failure to contact Ms S by the collections team, despite many attempts
  - The approval of an application for possession in January 2020
  - Repeated attempts at contact and the commencement of the gas safety policy in February 2020.
- At no point during this period did the collections or gas teams contact the NM to inform them of the difficulty they were having in trying to contact Ms S. This illustrates the silo-working that occurred and the transactional nature of dealing with tenants, a culture that is evident in this case. It should be noted that all the above bullet point information was available through the CRM system and could have been accessed by those that required it
- There should have been better communication with Southwark Council
- There is no doubt that Peabody's reputation has been damaged, with stakeholders, the sector and, importantly, with its tenants. There is work to do to restore their reputation

14.2.5. Finally, regarding governance and whether this is a failure in governance. There were missed opportunities but this was an isolated extreme case. The way Peabody is structured does not provide the 'one view of the customer': this must change. The use of data to highlight where there may be problems has to be implemented. The culture of the organisation needs to change, with front- line staff, in particular, being 'professionally curious' and proactively using the systems available to them. These will all strengthen the way the service is delivered and provide the board with assurance that an incident such as this should be identified at a much earlier stage.

14.2.6. We conclude that it was not a failure in governance. The board does not monitor individual cases, but seeks assurance that tenants are provided with a good service

and have safe and affordable homes. Adopting the recommendations that follow will provide further assurance that an incident like this should not occur again.

15. Recommendations

15.1.1. The recommendations are set out below:

Ref.	Theme	Recommendation
	Culture	
15.1.2.	Be alert and curious, a proactive approach to welfare	• *'See something, say something, do something'*, a powerful slogan used by one organisation. Discuss developing/adopting an equivalent
15.1.3.		• Define how to be proactive in ensuring the following: '*We have a duty to follow through on the social part of social housing*' while recognising the tenant's right to have quiet enjoyment of their own home.
15.1.4.	Organisational culture	• Where there are 'hard' targets, ensure these do not create a culture or drive behaviours that are at odds with the values
	Change programmes (post-merger)	
15.1.5.	Large scale restructures	• Ensure that there is sufficient handover, training and familiarisation prior to full implementation
15.1.6.		• Test new policies and processes and review 1/3/6 months post-implementation
	Neighbourhood management services - the localities model	
15.1.7.	Patch sizes, case/workload	• Review patch sizes to ensure that the NM (or equivalent front-line position) is able to spend time knowing and understanding the patch and able to engage with their tenants
15.1.8.		• Examine different models dependent on stock type and location

15.1.9.	Joined-up approach	• Ensure services that are 'tenant centric' are managed together, for example collections, financial inclusion and neighbourhood management. This should enable a move from a 'silo approach' to a more integrated approach
15.1.10.		• Ensure the NM is informed of impending investment works and any contact issues arising from these
15.1.11.		• Join-up neighbourhood management and welfare with repairs. Operatives trained and asked to comment on any welfare issues if identified
15.1.12.		• Have a mechanism for and update training of contractors visiting sites to report anything unusual and for those in receipt of that information to follow-through
15.1.13.	Neighbourhood manager role	• Define the values and behaviours required in the role
15.1.14.		• Review and redefine the role profile to have clear accountability to follow through on concerns raised, to join the dots and be 'professionally curious'
15.1.15.		• Within the role provide 'thinking time' to be able to look at the data and evidence
15.1.16.		• Enable and empower officers to get to know their neighbourhood and encourage them to follow up anything unusual or worrying
15.1.17.		• Review frequency of estate inspections, using them as an additional opportunity to liaise with/involve tenants as well as assess the environment
15.1.18.		• Follow-up any requests for repairs/issues following an estate inspection
15.1.19.		• When court action (Ground 8) is being planned, makes sure the NM is informed

		and that there is meaningful contact with the tenant if possible
	Insight	
15.1.20.	Data insight and intelligence	• Use the systems that provide 'one view of the customer' and 'neighbourhood' to better understand if there are underlying welfare problems

15.1.21.		• Provide insight and intelligence for those delivering and managing the service
		• Specific requirements may include:
		  • Identify changes in behaviour – the 'silent tenant'
		  • Monitor rental payments for sudden changes in pattern from regular payments
		  • Cumulative attempted contacts with no response

15.1.22.	Welfare dashboard	• Develop a welfare dashboard, working with others in the sector to provide good practice examples
15.1.23.	Implementation of insight and dashboard	• Assurance should be sought through other methods prior to the insight and welfare dashboard being available
	Policies and processes	
15.1.24.	Policy review	• Review all tenant-facing policies to ensure they do not operate in silos and include meaningful interaction with tenants where appropriate. Identify interdependences/links with other functions to alert/discuss the issue
15.1.25.		• Where no-contact is evident and attempted contacts fail do not assume that letters/voicemail, SMS and emails are being received. Other ways to contact (visits out-of-work hours, involvement of other agencies) need to be deployed
15.1.26.		• Change the response to complaints of maggots and flies. Officers should be

		trained to understand that these could be an indication of a more serious event that should be investigated
15.1.27.	Customer voice	• Recognise issues/join-the dots and listen to customers when they call with complaints and observations e.g. mail box overflowing, persistent smells • Empower call-handlers to follow through
15.1.28.	Rent collections	• Applications for direct payment for Universal Credit should only be made if there has been direct contact and engagement with the tenant if possible
15.1.29.	Gas servicing	• Inform the NM if problems with contact and arranging appointments
15.1.30.		• If forced entry processes are agreed as the only course of action, prior to legal action commencing, ensure the NM is informed and the tenant has engaged (if possible)
15.1.31.	Abandonment policy	• All colleagues involved in neighbourhood services to be trained and be open to recognising signs of abandonment e.g. no contact, no water or electric usage (if accessible), mail box full, changes in routines etc.
	Stakeholders	
15.1.32.	Local authorities	• Strengthen relationships with the local authority across all areas, re-establish the role of strategic partner
15.1.33.	Police and other public bodies	• Strengthen the relationship at all levels with the police and other public bodies.
15.1.34.		• At a senior level, ensure the right people are 'round-the-table' to provide a joined-up approach to the community
15.1.35.	Other agencies/stakeholders	• Map those stakeholders with relationships and those without that may be important. Develop a plan to engage for the benefit of the community and individual tenants

15.1.36.	**Sector learning**	
15.1.37.	Learning from others	• Provide opportunities for sector leaders to come together to share experiences
15.1.38.		• Continue to learn and adopt good practices from others within the sector