

IN THE GRENFELL TOWER INQUIRY

ML/4

2 Bed 3 person Mobility 2 uses Zimmer frame.

SUITABILITY RE-ASSESSMENT

Date	19/6/2017	HML Ref No.	[REDACTED] KAC Call C
Main Applicant	Monica Lokko, Flat 3, Grenfell Tower, London, W11 4DU TEL: [REDACTED]		
Other household members/relationship to applicant	1 - SARAH ASANTE [REDACTED] (Daughter) Tel: [REDACTED] Would stay with mother 3-4 times a week. Daughter now suggests she wants to live with mother for emotional support, because she suffers from mental health. → Applicant now wants to apply with her daughter for a 2 Bed property because of her care needs.		
Current T Ref (if applicable)		Current TA Address (if applicable)	368 3rd Floor Captiven TARA Hotel
Name of person requesting this re-assessment		Clearly state <u>why</u> this re-assessment has been requested.	Re-Housing due to a fire at Grenfell tower. → She had a two-bed before and now needs it back. → Wants to remain in KCA and

referred to Soc Services 12/16 - Dr Lw Eludwan N/A

EDUCATION	
Child's Name and DOB	School attended (Please make note if studying for exams: GCSE/A-Levels)
N/A	N/A

How do the children currently travel to school?	
Does any child in this household have special educational needs?	<p>Details</p> <ul style="list-style-type: none"> • Who • Where • How often
Please provide details of extra care required or SUPPORT plans in place.	

CHILDCARE ARRANGEMENTS

Any current childcare arrangements in place?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<p>Details</p> <ul style="list-style-type: none"> • Who Provides • Where • How often/Hours • Cost
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MEDICAL INFORMATION

Does anyone in the household have medical problems?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Please provide summary details below	
WHO/CONDITION	HOW LONG	TREATMENT / MEDICATION/ MEDICAL EQUIPMENT REQUIRED?	IS TREATMENT ONLY AVAILABLE IN RBKC?
High Blood Pressure	2-3 years	Medication	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Depression / Chronic	many years	Medication	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Migraine	many years	Medication	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Arthritis of Hip & Knees	Recently	Medication	Yes <input type="checkbox"/> No <input type="checkbox"/>

NB: Client states that worse & other issues as a result of her previous rendezvous. Uses a shoulder now *Bariatric support*

New knee replacement. Due but wait list required.	To be agreed	To be agreed	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>															
			Yes <input type="checkbox"/> No <input type="checkbox"/>															
			Yes <input type="checkbox"/> No <input type="checkbox"/>															
Can any care package/healthcare options be transferred?	Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	If yes, would transfer of care package/healthcare options severely impact on ability to engage with treatment/care plan? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>																
Can all household members use a lift?	Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> TRAUMA OF FIRE, DOES NOT WANT LIFTED PROPERTY.	If no, please provide details. (Evidence must be provided) <ul style="list-style-type: none"> Who - Applicant How long has this been a problem - since fire Has treatment been sought/given - Not yet. 																
Can all household members manage stairs?	Three flights or more (36 steps or more) <input type="checkbox"/> Two flights (approx 24 steps) <input type="checkbox"/> One flight (approx 12 steps) <input type="checkbox"/> No flights <input type="checkbox"/> Six steps <input checked="" type="checkbox"/> Needs re-assessment for a 2 bed property. Difficulty climbing two steps <input type="checkbox"/> (Need for internal step free? <input type="checkbox"/>)																	
Does any household member have difficulty walking?	Indoors? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Outdoors? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	If yes, please provide details. <ul style="list-style-type: none"> Who Applicant Do they use mobility aids? - yes - Stander <table border="1"> <thead> <tr> <th>AID</th> <th>INDOORS</th> <th>OUTDOORS</th> </tr> </thead> <tbody> <tr> <td>STICK(S)</td> <td><input checked="" type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>CRUTCHES</td> <td></td> <td></td> </tr> <tr> <td>FRAME</td> <td><input checked="" type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>WHEELCHAIR*</td> <td></td> <td></td> </tr> </tbody> </table>		AID	INDOORS	OUTDOORS	STICK(S)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	CRUTCHES			FRAME	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	WHEELCHAIR*		
AID	INDOORS	OUTDOORS																
STICK(S)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>																
CRUTCHES																		
FRAME	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>																
WHEELCHAIR*																		
*If the household includes a wheelchair user please complete the below																		
Type of wheelchair used: <input type="checkbox"/> Electric Scooter <input type="checkbox"/> Electric Wheelchair <input type="checkbox"/> A wheelchair that someone has to push <input type="checkbox"/> A wheelchair the user propels themself																		
How long have they used the wheelchair?																		
How did they get the wheelchair?																		

<input type="checkbox"/> NHS <input type="checkbox"/> Private Purchase <input type="checkbox"/> Gift <input type="checkbox"/> Other (please specify).....		
Can all household members use a standard bath?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>But would require additional Help.</i>	If no, please provide details. <ul style="list-style-type: none"> Who - Applicant Do they use bathing aids/equipment? <i>Yes of old Cromwell Trust.</i> How do they currently manage to wash?
MEDICAL PROFESSIONALS CONTACT INFORMATION		
GP's Name	DR. PATEL	Hospital Specialist/Consultant
Address		Treatment
Telephone		Address
When Registered with Surgery		Telephone
Date Last Seen		Date Last Seen
Occupational Therapist		Physiotherapist
Treatment		Treatment
Address		Address
Telephone		Telephone
Date Last Seen		Date Last Seen
Other Professional		Other Professional
Treatment		Treatment
Address		Address
Telephone		Telephone
Date Last Seen		Date Last Seen
SOCIAL CARE INVOLVEMENT		
Does anyone in the household have a social worker?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <ul style="list-style-type: none"> Who 	Details <ul style="list-style-type: none"> Name of SW: Address: Telephone Email Nature of Support How Often Date Last Seen

OTHER SOCIAL SUPPORT?						
Where?		N/A				
Name, address and telephone number & role		N/A				
What support is provided/how often?		N/A				
COMMUNITY LINKS?						
Where?		N/A				
Details of involvement?						
Do the clients attend a place of worship?						
SUPPORT RISKS/CONCERNS						
Is anyone in the household:						
Subject to Mental Health CPA?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>		
Subject to Child Protection Plan?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>		
Subject to a drug intervention programme?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>		
Subject to an Anti Social Behaviour Order?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>		
An ex-offender or currently on probation?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>		
Subject to MAPPA?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>		
Referred to MARAC?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>		
Please give date of referral						
Victim or perpetrator?						
Risk flagged:						
If yes to any of the above, please summarise details:						
<p>Client suffers from Anxiety, Flashbacks & Depression due to the fire. Client will require a full medical assessment for vulnerability. Stated she felt suicidal etc. Social worker stated she needs an assessment will require walking shower etc</p>						
EMPLOYMENT						
Are any household members employed?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>	Specify who:	
Type	Permanent	<input type="checkbox"/>	Temporary	<input type="checkbox"/>	Self Employed	<input type="checkbox"/>
	Maternity Leave	<input type="checkbox"/>	Date to Return to work			
Occupation/s?						

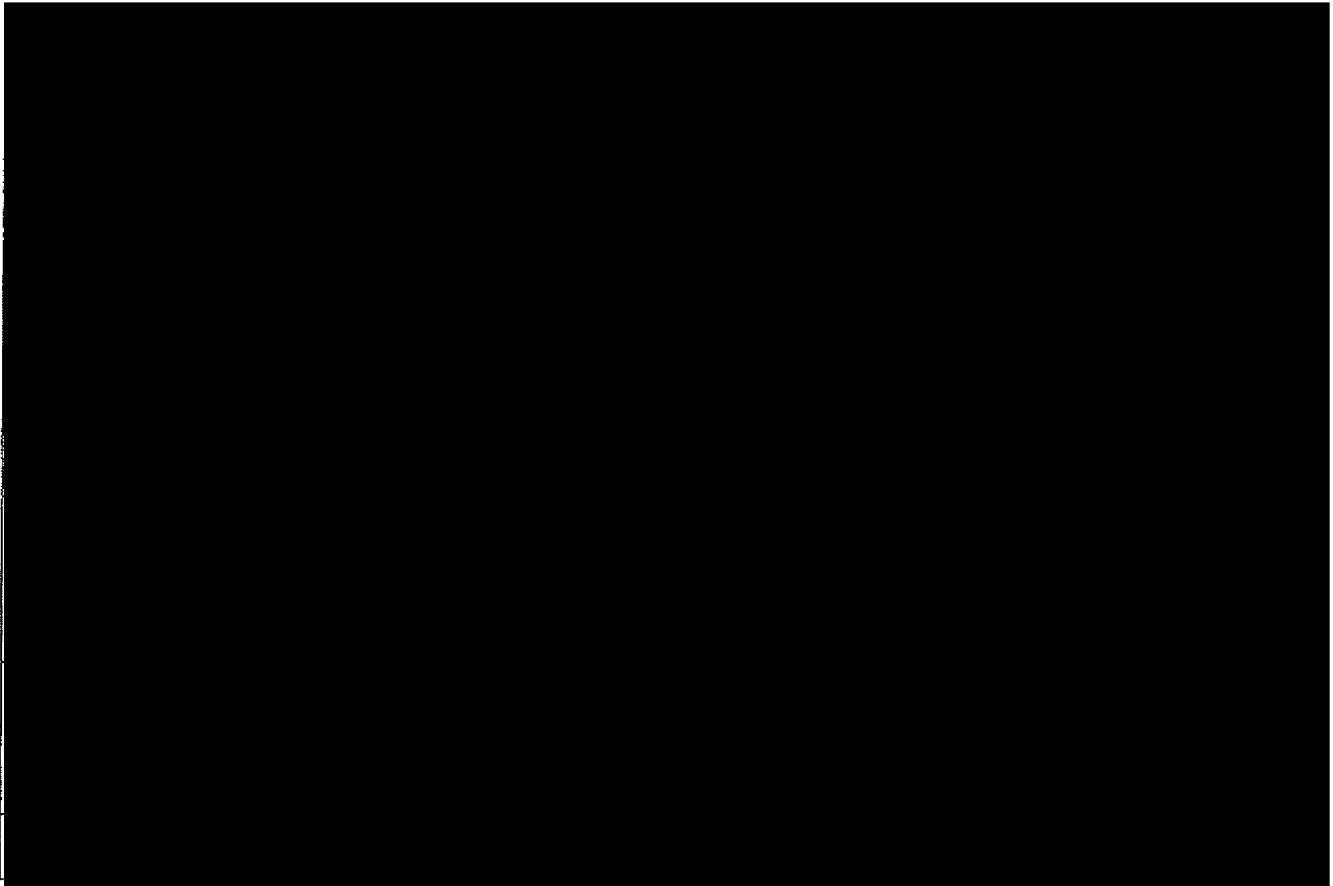
Hours of work/Shift pattern (start and end times)			
Employer Details (name/address)			
Date employment started/...../.....		
Gross Income	£.....per week/ or month		
Current travelling time and costs to workplace?			
Are any household members currently attending a training course?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Details <ul style="list-style-type: none"> • Who • Where • How Often • Course Duration • Course End Date 	
Current travelling time and costs to training?			
CARING COMMITMENTS			
Is anyone in the household caring for someone else (other than dep children)?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
Who is being cared for?	Address of person being cared for?	Is anyone in the household in receipt of Carer's Allowance?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Applicant + Daughter - Both under - 18	368 COP TOWN TARA HOTEL	Verified by HB system/evidenced?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Caring Arrangement	Details <ul style="list-style-type: none"> • Nature of Care • How Often 		
	N/A		

	<ul style="list-style-type: none"> • Times • Has a Carer's Assessment been completed? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> • Are the In receipt of Carer's Allowance Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
CARING NEEDS	
Does anyone in the household receive personal care? (eg. washing, dressing, feeding)	Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> • Who <div style="float: right; width: 400px;"> Details • Please list care they receive <i>Needs Care from her daughter, especially at night time. She needs to be moved for a 2 bed for this reason.</i> </div>
Who provides the care?	<input checked="" type="checkbox"/> Resident Family Member <input type="checkbox"/> Non-resident Family Member <input type="checkbox"/> Friend <input type="checkbox"/> Social Services Home Carer (direct payments, agency carer or personal Budget) <input type="checkbox"/> Private Home Carer
Does anyone in the household receive help with domestic tasks? (eg. cooking, cleaning)	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> • Who <div style="float: right; width: 200px;"> Details • Please list care they receive <i>cooking, washing - cleaning</i> </div>
Who provides this help?	<input checked="" type="checkbox"/> Resident Family Member <input type="checkbox"/> Non-resident Family Member <input type="checkbox"/> Friend <input type="checkbox"/> Social Services Home Carer (direct payments, agency carer or personal Budget) <input type="checkbox"/> Private Home Carer
TRANSPORT	
Does anyone in the household have any of the following? (Please specify who)	<input type="checkbox"/> Blue Badge <input checked="" type="checkbox"/> Taxi Card <input checked="" type="checkbox"/> Freedom Pass <i>— lost in fire — needs a new one.</i>
Which of the following transport methods do your household use regularly?	<input type="checkbox"/> Driver in own car* <input checked="" type="checkbox"/> Passenger in a car <i>— sister —</i> <input type="checkbox"/> Underground/Overground <input type="checkbox"/> Bus

	<input checked="" type="checkbox"/> Other (please specify) <u>Deal - a - ride taxi service.</u>
*If car owner, details of when vehicle is used and by whom.	<input type="checkbox"/> School Run <input type="checkbox"/> Applicant <input type="checkbox"/> Partner <input type="checkbox"/> Other When.....
	<input type="checkbox"/> Work <input type="checkbox"/> Applicant <input type="checkbox"/> Partner <input type="checkbox"/> Other When.....
	<input type="checkbox"/> Training <input type="checkbox"/> Applicant <input type="checkbox"/> Partner <input type="checkbox"/> Other When.....
	<input type="checkbox"/> Caring <input type="checkbox"/> Applicant <input type="checkbox"/> Partner <input type="checkbox"/> Other When.....
	<input type="checkbox"/> Other (please specify).....

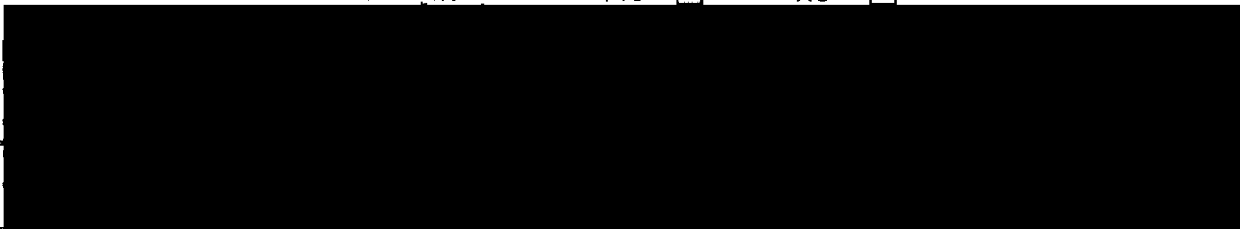
WELFARE BENEFIT INFORMATION

Does the applicant receive any of the welfare benefits below:



Any Additional factors to be considered? Yes ☒ No ☐

Detail



Medical Screening triggered? Yes ☐ No ☐

BASED ON THE INFORMATION PROVIDED ABOVE DOES THIS APPLICANT/HOUSEHOLD WARRANT:

LOCAL TEMPORARY ACCOMMODATION.....

☒

GREATER LONDON TEMPORARY ACCOMMODATION.....

☐

OUT OF LONDON TEMPORARY ACCOMMODATION.....

☐

APPOINTMENT ARRANGED WITH CLIENT DETAILS

DATE:.....

TIME:.....

Signed..... (Accommodation Officer)

Date:.....

Authorised by Tenancy Team Leader / Accommodation Team Leader / A&I Manager
(please delete as appropriate)

Signed.....

Date:.....

AREA CODE ENTERED BY PO:

Yes ☐ No ☐

BEDROOM SIZE CHECKED ON HOMELESS BY PO:

Yes ☐ No ☐

SECTION THREE: PROPERTY SUITABILITY ASSESSMENT – to be completed by Property Officer	
APPLICANT:	REFERENCE:
PROPERTY REFERENCE NUMBER:	
ADDRESS:	
Is the area suitable for the client? - In accordance with Location Suitability Assessment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the client fleeing violence from this area?	Yes <input type="checkbox"/> No <input type="checkbox"/>
How many bedrooms required? <input type="text"/>	How many bedrooms are available? <input type="text"/>
How many bedspaces are required? <input type="text"/>	How many bedspaces are available? <input type="text"/>
Lifted Property? Yes <input type="checkbox"/> No <input type="checkbox"/>	Floor Level? <input type="text"/>
How many external <input type="text"/> steps?	How many internal steps? <input type="text"/>
Has household's AHR Cat been assessed? Yes* <input type="checkbox"/> No <input type="checkbox"/>	Property AHR = <input type="text"/>
If Yes - Household AHR Category = <input type="text"/>	Is property suitable when compared against the household AHR Category
Any other Medical recommendations.....	Yes* <input type="checkbox"/> No <input type="checkbox"/>
Nearest transport links?	Nearest amenities?
Provider Name:	Client charge: £
Property Type: B&B/PLA/PSA/PMA/TMO/NHHG	Furnished: Yes/No

EDUCATION	
Schools available in receiving borough?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Postcode of School?	
Actual travel time from proposed address to school?	
Travel costs to school?	
Is proposed travel route to school suitable?	Yes <input type="checkbox"/> No <input type="checkbox"/> Details:
EMPLOYMENT	
Postcode of Work Place	
Have you considered applicant's shift pattern/working hours as listed in Section 2?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Actual travel time from proposed address to work place?	
Travel costs to work place?	
Is proposed travel route to employment suitable?	Yes <input type="checkbox"/> No <input type="checkbox"/> Details:
CHILDCARE	
Postcode of Child Care	
Have you considered applicant's childcare arrangements as listed in Section 2?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Actual travel time from proposed address to childcare?	
Travel costs to childcare?	
Is proposed travel route to childcare suitable?	Yes <input type="checkbox"/> No <input type="checkbox"/> Details:
CARING COMMITMENTS	
Postcode of address where Caring commitments take place.	
Have you considered applicant's caring commitments as listed in Section 2?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Actual travel time from proposed address to caring commitments?	
Travel costs to caring commitments?	
Is proposed travel route to caring commitments suitable?	Yes <input type="checkbox"/> No <input type="checkbox"/> Details:
If Care is being provided to any household member, have you considered Carer's journey to new property?	
MEDICAL	
Can medical treatment be transferred to local medical services?	Yes <input type="checkbox"/> No <input type="checkbox"/>

If yes, have local medical services been checked?	GP <input type="checkbox"/> Hospital <input type="checkbox"/>
If no, how frequently is treatment being received? Treatment completion date:	
Does suitability of property need to be reviewed when treatment has been completed.	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date of review.....
WELFARE REFORM	
If the client exempt from the Benefits Cap?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If no, what is the maximum HB this client would receive?	£.....
<u>Will income team need to complete a DHP form with applicant?</u>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<u>Is this property within the Universal Credit Area</u>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is this property affordable for the client?	Yes <input type="checkbox"/> No <input type="checkbox"/> Details:

Any additional factors to be considered? Yes ☐ No ☐

Details.....
.....
.....
.....
.....

Based on this assessment, is this property considered suitable for this household?

Yes ☐ No ☐

Signed..... (Property Officer) Date

APPOINTMENT ARRANGED WITH CLIENT DETAILS

DATE:.....

TIME:.....

AREA CODE ENTERED ON HOMELESS ENQUIRY BY PO:

Yes ☐

No ☐