Croydon Safeguarding Adults Board

Safeguarding Adult Review: DUNCAN

September 2021

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Contents

Glossary

ASC – Adult Social Care
CHAIN – Combined Homelessness and Information Network
CHS – Croydon Health Services NHS Trust
CPA – Care Programme Approach
CSAB – Croydon Safeguarding Adults Board
DWP – Department for Work and Pensions
ED – Emergency Department
HAWK – Housing Advice Worker
IMR – Independent Management Review
MPS – Metropolitan Police Service
SABs – Safeguarding Adults Boards
SAR – Safeguarding Adult Review
SHS – Single Homeless Service
SLAM – South London and Maudsley NHS Foundation Trust
SNAP – Support Needs and Assessment Placement Service

1. Introduction

1.1. Duncan was born on 29th April 1983 and died at the age of 35 on 5th October 2018. He was White British. Duncan had fallen from a building and cause of death was regarded as a possible suicide.

1.2. The Safeguarding Adult Review (SAR) referral was received from Crisis Skylight. Duncan's lived experience was described as including mental illness (schizophrenia), substance misuse, periods of hospitalisation, times when homeless or living in temporary accommodation, and episodes of non-engagement and anti-social behaviour.

1.3. Records indicate that Duncan had been adopted at the age of 7 but later his relationship with his adoptive parents is said to have broken down. He was apparently unwilling to speak about his life[1]. Police records[2] list crimes of theft, assault and drug possession. He received an adult caution for assault and tram fare evasion in April 2014. He was fined in May 2014 for assault, including of police officers. In November 2014 he was charged with possession of cannabis for which he was fined in April 2015.

1.4. Police records noted mental health issues in September 2013 following an investigation of a neighbour dispute. The local authority's anti-social behaviour team was informed. Of significance, given the circumstances of his subsequent death, is that Duncan disclosed suicidal ideation to the police in March 2014 and again in June 2014 when he thought of jumping from a high-rise flat. On the first occasion he was initially signposted to agencies that could support him. Later the same day, his sister contacted the police concerned for her safety and that of her family because of Duncan's mental health issues. He was taken to hospital by the London Ambulance Service but left before being assessed. On the second occasion the police used their powers in Section 136 Mental Health Act 1983. Since detailed police records have been "weeded" it is not possible to confirm whether or not Adult Social Care was informed of either episode by the police.

1.5. In December 2014 Duncan was unwilling to support the police as a witness to a disturbance at the residential block where he was living. The police found evidence of cannabis cultivation at these premises. The chronology in the police IMR then falls silent until February 2017. These subsequent details are discussed in the combined chronology later in this report.

1.6. Medical records released by the GP practice 1, where he was a registered patient from 13th August 2013, begin with a letter from the SLAM Croydon Promoting Recovery Team dated 7th December 2012. He was being discharged from mental health services due to non-engagement and unwillingness to be seen. This letter followed a home visit when Duncan was described as "looking rough" but declining mental health service support. It is recorded that his last overdose was in 2008. He was assessed as low risk, with no history of violence to others. His diagnosis was given as drug-induced psychosis. Cannabis use was recorded, with paranoia more likely with excessive use.

[1] Information obtained from the South London and Maudsley (SLAM) NHS Foundation Trust Mental Health Investigation Report (2018).
[2] Extracted from the Metropolitan Police Service Independent Management Report (IMR).

1.7. GP practice 1 records of a patient consultation on 25th March 2014 note the absence of professional input for six months and Duncan being upset about the psychiatric care received. He denied suicidal ideation. The GP recorded Duncan as needing social and housing help but liaised with mental health services. GP records contain a copy of a letter to Duncan from SLAM Croydon Promoting Recovery Team, dated 11th April 2014, that referred to an A&E attendance followed by hospital admission for anxiety and suicidal thoughts. Assessment had identified paranoid thinking. Duncan had not attended an appointment or responded to messages left for him on his mobile phone. The letter advised that he would be discharged in 14 days if he did not respond.

1.8. On 12th May 2014 Croydon Health Services NHS Trust has recorded that Duncan attended an Emergency Department in police custody following an altercation in public. No further details of the altercation were recorded. He was assessed, treated and discharged back to police custody. ECG and chest X-ray found nothing abnormal. The following was recorded on Duncan's records: "No consent to send discharge summary to GP. No concerns."

1.9. On 21st May 2014 a GP in practice 1 saw Duncan and decided to re-refer him to mental health services. Duncan is recorded as having reduced his alcohol intake, feeling low, with no suicidal ideation but some paranoid thinking. A letter to the GP from the SLAM Croydon Promoting Recovery Team gives a diagnosis of complicated grief reaction and associated stress. He had been reviewed as an out-patient that day, had a care coordinator, and was noted as non-compliant with medication because he felt it made little difference. He was offered bereavement counselling as a result of reporting "multiple losses" – his dog, a friend and his grandmothers.

1.10. Between 23rd June and 24th July 2014 Duncan was an inpatient. He was discharged to the Home Treatment Team with an allocated care coordinator. His detention under Section 3 Mental Health Act 1983 was rescinded on 5th August 2014. He had been admitted with paranoid thinking, including auditory hallucinations telling him to kill himself. Records indicate ongoing irritability and thought disorder. He did not entirely accept his diagnosis or think that medication was helping him. There was concern about ongoing drug misuse when given Section 17 Mental Health Act 1983 leave. Diagnosis is described as a "complex picture of co-existing psychosis, possibly drug-induced, continuous substance misuse and unspecified personality disorder."

1.11. Croydon Promoting Recovery Team wrote to Duncan on 9th December 2014 since he had missed two medical review appointments with a consultant psychiatrist and his care coordinator. He had not collected his prescription. The care coordinator had been unable to contact him. A further appointment was offered. The letter was copied to his next of kin, namely his father.

1.12. On 21st September 2015 Croydon Promoting Recovery team wrote to his GP following an out-patient review by a consultant psychiatrist and his care coordinator. At this time he was living in a hostel and was assessed as low risk. His diagnosis is given as paranoid schizophrenia. He had not shown significant psychotic symptoms but was using Spice. He was signposted to services and advised to increase activity to address his social isolation. Changes were made to his medication because of reported side-effects.

1.13. A summary provided for this review by his then GP gives a diagnosis of paranoid schizophrenia with suicidal ideation. It notes psychiatric management dating back to April 2014, including stress and anxiety, missed appointments and poor compliance with medication. His symptoms included auditory hallucinations. It noted that he regularly used cannabis, had a history of substance misuse and financial difficulties, and disliked the neighbourhood in which he was living.

1.14. Information provided by Turning Point records two self-referrals in April and August 2015. On the first occasion a recovery plan was commenced; on the second a needs assessment was completed and he was allocated a key worker and offered appointments. On each occasion he failed appointments and his case was closed following use of a faltering engagement policy and outreach. He presented again at Turning Point in September 2016. An assessment of need was again completed and he was allocated a key worker. The faltering engagement policy was used again but his case was closed due to non-engagement. In both 2015 and 2016 there is a record of Duncan having used the breakfast club intermittently. Turning Point's chronology stops with case closure in December 2016.

1.15. Adult Social Care records contain no information about his relationships and no medical reports confirming his mental health diagnosis. The records contain reference to three completed mental health assessments, in April and May 2008 and March 2009. However, no details have been recorded within the local authority's record system. Similarly, a substance misuse assessment was undertaken in May 2008 by Croydon Substance Misuse Team and mental capacity was apparently considered in December 2011, possibly as part of a mental health assessment, but no details have been recorded.

1.16. Adult Social Care has records of two police MERLINs for April and June 2014. On both occasions Duncan had been expressing suicidal thoughts. On each occasion he was transported to hospital, under Mental Health Act 1983 section in June 2014.

1.17. Throughout Duncan's life there was no active Adult Social Care involvement. Local authority records note that Duncan was known to SLAM from 2008, Croydon Single Homeless Service from 2007 and Crisis Skylight Croydon from March 2017. Records held by the Department for Work and Pensions (DWP) note that Duncan claimed welfare benefits, including Incapacity Benefit and Income Support (2012), Employment and Support Allowance (ESA) (September 2014) and Personal Independence Payment (PIP) with enhanced daily living allowance (February 2016). A new application for Universal Credit was made in September 2017.

1.18. His most recent hospital discharge occurred in November 2017, having spent some four months in hospital where he was described as largely cooperative with treatment. The focus had been on working with problems associated with accommodation, finances and drug misuse. Upon discharge Duncan had been living in a hostel, awaiting a move into supported housing.

1.19. The SAR referral highlights that Duncan was still living in the hostel almost twelve months following his final hospital discharge. It observes that the closure by mental health services of their involvement with Duncan had restricted his move-on options and that

practitioners working with him had been unable to find him appropriate alternative accommodation.

2. Safeguarding Adult Reviews

2.1. Croydon Safeguarding Adults Board (CSAB) has a statutory duty[3] to arrange a Safeguarding Adults Review (SAR) where:

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and
- There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

2.2. CSAB has discretion[4] to commission reviews in circumstances where there is learning to be derived from how agencies worked together but where it is inconclusive as to whether an individual's death was the result of abuse or neglect. Abuse and neglect includes self-neglect.

2.3. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future[5]. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

2.4. Care and support needs arise from or are related to physical or mental impairment or illness. This can include conditions as a result of physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury[6]. **Commentary:** Duncan clearly had care and support needs according to this definition.

2.5. The SAR referral was dated 9th November 2018. It raised concerns about how services worked together, being of the view that agencies should have collaborated more effectively to protect him. It recorded that Duncan had been closed to mental health services and had lost the support of his Care Co-Ordinator in September 2018 and therefore was no longer able to access mental health supported housing. **Commentary:** the referral provided sufficient information to establish cause for concern about how services worked together to safeguard Duncan. The referral form in use at the time asked the referrer to state whether or not a statutory review was required. This is an inaccurate reading of Section 44 Care Act 2014. As identified above, all reviews are statutory, the distinction being whether a SAR is mandatory or discretionary[7]. The referral form in use at the time did not ask the referrer to identify the type(s) of abuse or neglect involved. This too is a shortcoming.

2.6. CSAB's SAR tracker records that the referral was discussed on seven occasions between January 2019 and January 2020. Initial decision-making about the referral was deferred until receipt of the SLAM mental health investigation (serious incident report). Owing to

[3] Sections 44(1)-(3), Care Act 2014
[4] Section 44(4).
[5] Section 44(5), Care Act 2014
[6] Care and Support (Eligibility Criteria) Regulations 2014.
[7] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.

amendments being made to that report and then internal consideration of it, it was not until September 2019 that it was available to inform consideration of the SAR referral. It appears that further information was requested at meetings in September and November 2019, with a recommendation being sent to CSAB's independent chair for a workshop or similar learning event. **Commentary:** Whilst the referral itself was timely, subsequent decision-making was not, meaning that opportunities to appraise, improve or enhance services as a result of learning from the case were lost. CSAB's tracker has recorded that the Board's independent chair had recommended that a SAR being undertaken but the tracker does not record what consideration was given to that recommendation. Although CSAB's independent chair agreed with the recommendation for a workshop-style learning event, this was not held until October 2020. Moreover, it is not recorded on the tracker how decision-making had been informed by the criteria outlined in Section 44 Care Act 2014.

2.7. Conversations about the SAR referral continued after the workshop. Some CSAB SAR sub-group members felt that the workshop addressed key areas; others disagreed, concerned that issues relating to hospital discharge, risk assessment, family involvement and use of the care programme approach could have been explored further. The independent chair resolved the position by commissioning this SAR as a discretionary review. **Commentary:** much of the focus of the sub-group's discussion throughout was the SLAM serious incident investigation and report; after the workshop the focus turned to what changes had been implemented by SLAM following Duncan's death. It is important to remember that this investigation and report focused mainly on one agency and the service it provided. The focus of a SAR is multi-agency; SLAM was not the only service involved with Duncan. The independent reviewer does agree with an observation made by a member of the sub-group that a clear audit trail is required of decision-making for cases referred under Section 44 Care Act 2014.

2.8. The record of the workshop held in October 2020 in response to Duncan's case records an action, namely a thematic review of SAR referrals.

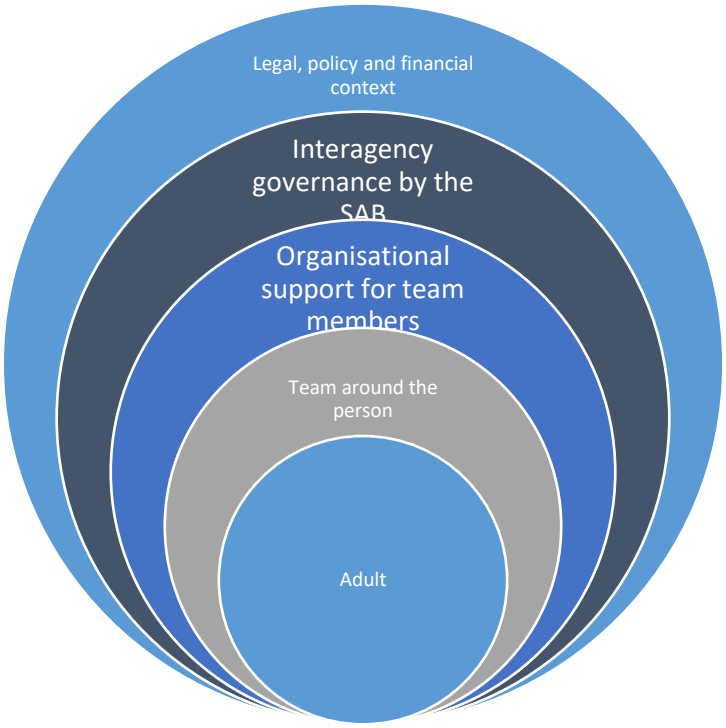
2.9. **Recommendation One: CSAB is advised to review its understanding of the mandatory and discretionary criteria for SARs as outlined in Section 44 Care Act 2014 and to assure itself that its decision-making is informed by a referral form that captures essential information and is fully compliant with statutory guidance[8].**

[8] DHSC (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office.

3. Review process

3.1. The case has been analysed through the lens of evidence-based learning from research and the findings of other published SARs[9], especially those concerned with adults who experience homelessness[10], alcohol-dependence[11] and self-neglect[12]. Learning from good practice has also been included. By using that evidence-base, the focus for this review has been on identifying the facilitators and barriers with respect to implementing what has been codified as good practice.

3.2. The review has adopted a whole system focus. What enables and what obstructs best practice may reside in one or more of several domains, as captured in the diagram. Moreover, the different domains may be aligned or misaligned, meaning that part of the focus must fall on whether what might enable best practice in one domain is undermined by the components of another domain.



3.3. The overarching purpose of the review has been to learn lessons about the way in which professionals worked in partnership to support and safeguard Duncan. Specific lines of enquiry, or terms of reference, were identified as follows:

3.3.1. The provision of mental health services and support;
3.3.2. How services responded to Duncan's substance misuse;

[9] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.
[10] Preston-Shoot, M. (2020) *Adult Safeguarding and Homelessness. A Briefing on Positive Practice*. London: LGA and ADASS.
[11] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK.
[12] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

3.3.3. How services responded to Duncan's homelessness and experience of temporary accommodation;
3.3.4. How services and practitioners worked together to support Duncan, to prevent any deterioration in his mental wellbeing, and to assist with his recovery;
3.3.5. Multi-agency case management;
3.3.6. Partnership working between mental health, housing and homelessness services.

3.4. It was agreed that the timeframe for the review would cover the period from 1st January 2017 to the date of his death over the weekend of 5th October 2018. However, information from outside this timeframe has been included when significant for understanding learning from this case.

3.5. Agencies provided independent management reports (IMRs) of their involvement with Duncan within the agreed timeframe. They were advised to also include anything that they judged significant that fell outside the agreed timeframe for the review. The following agencies submitted IMRs:

3.5.1. Crisis Skylight Croydon
3.5.2. Metropolitan Police
3.5.3. GP Practice 1
3.5.4. GP Practice 2
3.5.5. Croydon Health Services NHS Trust
3.5.6. South London and Maudsley NHS Foundation Trust (SLAM)
3.5.7. Adult Social Care (ASC)
3.5.8. Single Homeless Service Croydon Council (SHS)
3.5.9. Department for Work and Pensions (DWP)
3.5.10. Croydon Reach/Thames Reach
3.5.11. Turning Point (chronology only)

3.6. A learning event with practitioners and managers involved in Duncan's case and/or with knowledge of services locally was held virtually. Given the time that has elapsed since Duncan's death, the focus of the learning event included how service provision had changed recently. The outcomes of this learning event have been included in the subsequent analysis of the case. The outcomes of the previously held workshop have also informed the analysis in this report.

3.7. Thus, a hybrid methodology has been used, designed to provide for a proportionate, fully inclusive and focused review.

3.8. As required by statutory guidance, Duncan's family was informed of the review and invited to participate. This included signed receipt for a recorded delivery letter. No response was received.

4. The Evidence-Base

4.1. Reference has been made to research and findings from SARs[13] that enable a model of good practice to be constructed in relation to adults who self-neglect. The model comprises four domains. In line with Making Safeguarding Personal, the first domain focuses on practice with the individual. The second domain then focuses on how practitioners worked together. The third domain considers best practice in terms of how practitioners were supported by their employing organisations. The final domain summarises the contribution that Safeguarding Adults Boards can make to the development of effective practice with adults who self-neglect. The domains are summarised here.

4.2. It is recommended that direct practice with the adult is characterised by the following:

4.2.1. A person-centred approach that comprises proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes; work to build motivation with a focus on a person's fluctuating and conflicting hopes, fears and beliefs, and the barriers to change[14];

4.2.2. A combination of concerned and authoritative curiosity appears helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills; early and sustained intervention includes supporting people to engage with services, assertive outreach and maximising the opportunities that encounter brings[15];

4.2.3. When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage; failing to explore "choices" prevents deeper analysis;[16]

4.2.4. It is helpful to build up a picture of the person's history, and to address this "backstory"[17], which may include recognition of and work to address issues of loss and trauma in a person's life experience that can underlie refusals to engage or manifest themselves in repetitive patterns;

4.2.5. Contact should be maintained rather than the case closed so that trust can be built up;

4.2.6. Comprehensive risk assessments are advised, especially in situations of service refusal and/or non-engagement, using recognised indicators to focus work on prevention and mitigation[18];

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[13] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

[14] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[15] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK. Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[16] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK.

[17] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[18] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

4.2.7. Where possible involvement of family and friends in assessments and care planning[19] but also, where appropriate, exploration of family dynamics, including the cared-for and care-giver relationship;
4.2.8. Thorough mental health and mental capacity assessments, which include consideration of executive capacity; assumptions should not be made about people's capacity to be in control of their own care and support[20];
4.2.9. Careful preparation at the point of transition, for example hospital discharge, prison discharge, end of probation orders and placement commissioning;
4.2.10. Use of advocacy where this might assist a person to engage with assessments, service provision and treatment;
4.2.11. Thorough assessments, care plans and regular reviews, comprehensive enquiries into a person's rehabilitation, resettlement and support needs[21]; taking into account the negative effect of social isolation and housing status on wellbeing[22].

4.3. It is recommended that the work of the team around the adult should comprise:

4.3.1. Inter-agency communication and collaboration, working together[23], coordinated by a lead agency and key worker in the community[24] to act as the continuity and coordinator of contact, with named people to whom referrals can be made[25]; the emphasis is on integrated, whole system working, linking services to meet people's complex needs[26];
4.3.2. A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture;
4.3.3. Detailed referrals where one agency is requesting the assistance of another in order to meet a person's needs;
4.3.4. Multi-agency meetings that pool information and assessments of risk, mental health and mental capacity, agree a risk management plan, consider legal options and subsequently implement planning and review outcomes[27];
4.3.5. Use of policies and procedures for working with adults who self-neglect and/or demonstrate complex needs associated with multiple exclusion homelessness, with

[19] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.
[20] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.
[21] Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.
[22] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.
[23] Parry, I. (2014) 'Adult serious case reviews: lessons for housing providers.' *Journal of Social Welfare and Family Law*, 36 (2), 168-189. Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.
[24] Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.
[25] Parry, I (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.
[26] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.
[27] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

specific pathways for coordinating services to address such risks and needs as suitable accommodation on discharge from prison or hospital[28];

4.3.6. Use of the duty to enquire (section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy;

4.3.7. Evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy;

4.3.8. Clear, up-to-date[29] and thorough recording of assessments, reviews and decision-making; recording should include details of unmet needs[30].

4.4. It is recommended that the organisations around the team provide:

4.4.1. Supervision and support that promote reflection and critical analysis of the approach being taken to the case, especially when working with people who are hard to engage, resistant and sometimes hostile;

4.4.2. Access to specialist legal, mental capacity, mental health and safeguarding advice;

4.4.3. Case oversight, including comprehensive commissioning and contract monitoring of service providers;

4.4.4. Agree indicators of risk that are formulated into a risk assessment template that will guide assessments and planning;

4.4.5. Attention to workforce development[31] and workplace issues, such as staffing levels, organisational cultures and thresholds.

4.5. SABs:

4.5.1. Ensure that multi-agency agreements are concluded and then implemented with respect to working with high risk individuals; this will include the operation of MAPPA, MARAC, MASH[32] and other complex case or multi-agency panel arrangements, responding to anti-social behaviour, domestic abuse, offending (community safety) and vulnerability[33]; strategic agreements and leadership are necessary for the cultural and service changes required[34];

4.5.2. Develop, disseminate and audit the impact of policies and procedures regarding self-neglect;

4.5.3. Review the interface between housing/homelessness and adult social care, mental health, and adult safeguarding, and include housing in multi-agency policies and procedures[35];

4.5.4. Establish a system to review the deaths of homeless people and/or as a result of alcohol/drug misuse;

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[28] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE.

[29] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

[30] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[31] Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.

[32] Multi-Agency Public Protection Arrangements (MAPPA), Multi- Agency Risk Assessment Conferences (MARAC), Multi-Agency Safeguarding Hub (MASH)

[33] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

[34] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[35] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

4.5.5. Work with Community Safety Partnerships, Health and Wellbeing Boards and partnership arrangements for safeguarding children and young people, to coordinate governance, namely oversight of the development and review of policies, procedures and practice;

4.5.6. Provide or arrange for the provision of workshops on practice and the management of practice with adults who self-neglect.

4.6. Reference has been made to multiple exclusion homelessness. This comprises extreme marginalisation that may include childhood trauma, physical and mental ill-health, substance misuse and experiences of institutional care[36]. For many individuals, street sleeping is a long-term experience and associated with tri-morbidity (impairments arising from a combination of mental ill-health, physical ill-health and drug and/or alcohol misuse) and premature mortality[37].

4.7. This model enables exploration of what facilitates good practice and what act as barriers to good practice. The analysis that follows draws on information contained within the IMRs, including agency chronologies, and discussions during the learning event and at panel meetings. Where relevant, it also draws on available research. It follows the whole system framework for analysis presented above, beginning with the components of direct work with individuals and moving outwards to the legal, policy and financial context within which adult safeguarding is situated.

[36] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14.

[37] Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness. A Briefing on Positive Practice. London: LGA and ADASS.

5. Combined chronology

5.1. From January 2017 until his hospital admission in July Duncan was under the care of the Primary Care Mental Health Team who provide low intensity support to patients who are in the process of being discharged to their GP. They also provide low level maintenance for those patients whose mental health is stable but who have complex health issues that may not be managed by a GP practice. Thus, on 23rd January a community psychiatric nurse liaised with the hostel where Duncan was living to check on his compliance with medication.

5.2. On 6th February Duncan had a consultation with a GP at practice 2 regarding a lump on his right elbow. The lump was thought to be a lipoma[38]. Duncan was referred for ultrasound in order to confirm diagnosis. Duncan had already failed to attend an ultrasound appointment so the GP confirmed that his contact details on the system were correct and Duncan confirmed that they were. There is a letter to say that Duncan did not attend for his second ultrasound appointment.

5.3. On 16th February 2017 police conducted a stop and search for possible drug misuse. No further action was taken. On 27th February a duty worker again liaised with the hostel regarding Duncan's medication compliance. **Commentary:** liaison with the hostel was good practice but there is no record of Duncan having been seen.

5.4. Croydon Reach first recorded Duncan as sleeping rough in Croydon on 9th March 2017. On the same day a community psychiatric nurse offered Duncan support following his eviction from the hostel for using and supplying drugs on the premises. Advocacy with the hostel was unsuccessful as were contacts with shelters. Duncan was assisted to complete a homeless application but the lack of a mobile phone made liaison with him difficult. He was advised to return the following day for further support. **Commentary:** it is not clear whether advocacy was offered in terms of whether Duncan came within the provisions for homeless people under the Housing Act 1996, namely someone in priority need and with a local connection.

5.5. On 20th March a community psychiatric nurse provided Duncan with a food voucher and help with claims to DWP for welfare benefits. A plan was agreed that Duncan would attend Croydon Outreach the following day to address his homelessness. On 23rd March Duncan was provided with another food voucher. On both contacts Duncan was recorded as well-kempt. On the second occasion it was recorded that he had obtained some money from his father; no evidence of mental disorder was seen. **Commentary:** offers of support to address his financial and accommodation issues were good practice. Advice was also given about his physical health. However, support with completion of a referral to the local authority's Support Needs Assessment and Placement Service (SNAP) team was delayed because Duncan had been under the influence of drugs. The expectation appears to have been that Duncan would be able to keep to planned arrangements, which without outreach support might have been unrealistic.

5.6. A stop and search on 5th April proved negative and no further action was taken. Duncan was recorded as being of no fixed abode.

[38] Benign tumour made of fat tissue.

5.7. On 17th April Croydon Health Services NHS Trust (CHS) has recorded that Duncan attended an Emergency Department requesting a psychiatric review. Duncan was assessed by the Mental Health Liaison Team and his record showed "No mental health instability found." Duncan was advised to contact the Community Mental Health Team the following day. Duncan was discharged. It was stated in his records that he was homeless. It was noted that no discharge summary was sent to his GP and Duncan's records noted: "No consent to send discharge summary to GP. No concerns." Duncan had no physical examination and was referred directly to Mental Health Liaison Team. There is no evidence that Duncan was referred to the CHS homeless team for support and or follow-up. **Commentary:** the CHS IMR reflects that information-sharing with a GP following admission to an Emergency Department is part of CHS guidance on safe discharge; however, there is no information to suggest that Duncan lacked capacity and it was possible that staff were simply following his wishes. In this instance, the clinical documentation was unclear as to whether consent was sought and not given or whether consent was sought and Duncan refused. It is critical to note that a similar recording appeared in his records 3 years earlier.

5.8. Duncan attended a duty appointment with Crisis Skylight Croydon Mental Health Coordinator on 18th April and signed up as a Crisis member. Duncan was reluctant to disclose information and unable to explain what support he would like from Crisis. He expressed that he would like to find private rented accommodation and had approached a housing provider about a property. He disclosed that he had been diagnosed with paranoid schizophrenia but declined to discuss his mental health needs in more detail. Following from the duty appointment, it was decided that Duncan would not be allocated a lead worker immediately, but he was encouraged to let reception staff know if he wanted any support and it would then be decided how he could best be supported.

5.9. On 20th April Duncan failed to attend court for an offence of cannabis possession. He was recorded as being of no fixed abode. The chronology from Adult Social Care (ASC) notes that he was provided with information and advice by the Contact Centre on the same day but no other detail had been recorded. He was arrested on 11th May for failing to appear at court, when he appeared to be under the influence of drugs. He received a fine for the offences of possession of drugs and court non-appearance[39]. He remained of no fixed abode.

5.10. Croydon Reach recorded that Duncan was again seen sleeping rough in Croydon on 21st April. An entry on the SLAM IMR for 21st April records that Duncan had been arrested for possession. No evidence of mental disorder was found when he was assessed in police custody. The custody nurse recorded that he was dressed in new jeans and trainers, described as "incongruous presentation for a rough sleeper." On 27th April Duncan was seen by a psychiatrist for a medical review. There was no evidence of psychosis and he was provided with a food voucher. The same day a community psychiatric nurse assisted Duncan to complete a Housing SNAP application despite Duncan not having an appointment. **Commentary:** Duncan referred to a previous attendance at an Emergency Department during his psychiatric review, for which SLAM had no evidence. This may have been the attendance on 17th April and highlights the importance of information-sharing between secondary healthcare and secondary mental health providers. The support provided by the

[39] Information from the Metropolitan Police Service IMR.

community psychiatric nurse is evidence of making every contact count, especially since it had been difficult to contact Duncan previously to complete this task.

5.11. On 29th April Duncan again presented at an Emergency Department[40], this time with palpitations and anxiety about his living situation. He received a full set of baseline observations at triage and later a physical examination because he presented with mild tachycardia. It was noted Duncan was of no fixed abode and that he was non-compliant with prescribed medication (Risperidone[41]). Investigations were done for palpitations and Pabrinex was prescribed[42]. Duncan was referred to the Mental Health Liaison Team (there is no record of the outcome of this assessment). He was then discharged to the care of the Community Mental Health Team (CMHT). Following on from this it was recorded "No consent to send discharge summary to GP. No concerns". **Commentary:** critical analysis provided by CHS in its chronology observes that Duncan was clearly at risk. His consent to inform his GP and CMHT of the visit should have been sought. This information should have been shared with these agencies without consent on safeguarding grounds. Emergency Department staff should have sought advice from the safeguarding team, the lead nurse for mental health services and CHS homeless team. A referral should have been made to the local authority by the Emergency Department to address the risk from homelessness and non-concordance with medication. Referral to the CHS Housing Worker and Alcohol Services could also have been completed.

5.12. The SLAM IMR for 29th April records that Duncan was assessed by a psychiatric liaison nurse when at the Emergency Department. No evidence of psychosis was observed. Duncan wanted accommodation and was advised to contact his community team who were endeavouring to assist him. **Commentary:** this entry alongside the CHS entry for the same date would appear to highlight again the importance of information-sharing and recording between secondary healthcare and mental health providers.

5.13. On 8th May there is an administration note by one of the GPs in practice 2 to say that Duncan was assessed by the psychiatric liaison team during a hospital admission; 'no urgent action needed, patient still admitted under the medical team'.

5.14. On 11th May a community psychiatric nurse considered reporting Duncan as a missing person, having been unable to contact him. The community psychiatric nurse contacted the SNAP Team for assurance that the referral had been received. On 16th May Duncan was reported to the police as missing. Croydon Reach informed the community psychiatric nurse that Duncan was on the waiting list for a hostel place. On 19th May Duncan was seen. He said that he had been staying with a friend. No deterioration in his mental health was observed. **Commentary:** the delay in reporting him as missing may have been due to Duncan having difficulty in keeping appointment times and the team's flexibility in supporting him.

[40] Information derived from the CHS IMR.
[41] Risperidone is an anti-psychotic medication prescribed to treat Schizophrenia.
[42] Pabrinex is a Vitamin B compound given by Intramuscular injection to patients with alcohol dependence. This is prescribed to prevent Wernicke's encephalopathy.

5.15. On 9th June SLAM staff were unable to contact Duncan to inform him that a hostel place was available. Lack of a mobile phone made contacting Duncan difficult.

5.16. On 22nd June Crisis Skylight Croydon contacted Croydon Council's SNAP team (now Single Homeless Service (SHS)) and Croydon Reach (Thames Reach) explaining that Duncan had intermittently been coming the Skylight to use showers and washing machines and recently had expressed he would like help to apply for a Freedom Pass but had not been engaging with Crisis services otherwise. Croydon Council confirmed that he was not under the Care Programme Approach (CPA) with SLAM but that he had been referred to two supported hostels by Evolve: Alexandra House and Palmer House. Crisis Skylight emailed SLAM to enquire whether Duncan was receiving support from them. No reply has been recorded on the database.

5.17. On 24th June Duncan was taken to hospital having been run over. He was discharged after treatment. Crisis was given as his home address. No MERLIN has been recorded. On the same day SHS has recorded that Duncan was placed in emergency accommodation on behalf of Croydon Reach, advocated for by Crisis.

5.18. On 28th June Duncan expressed frustration about his housing situation to a Crisis staff member. He raised his voice stating no-one cared. Crisis staff discussed the situation with him and agreed to buy him some food, and to contact Croydon Council for an update about his housing. The following day Duncan was offered a 6 weeks' stay in emergency accommodation. Staff accompanied Duncan to Croydon Council to sign his licence agreement. Duncan stated that Crisis had not been helpful and therefore refused an offer to help him to transfer from Employment Support Allowance to Universal Credit.

5.19. A SLAM IMR entry for 6th July records the support being offered by Crisis Skylight and the hostel placement. A community psychiatric nurse provided support to help Duncan access welfare benefits and liaised with the hostel. The following day another community psychiatric nurse was informed by DWP that Duncan did not qualify for Universal Credit as he was not actively seeking employment. Attempts to contact the local authority for advice were unsuccessful. There was a plan to liaise with the hostel. **Commentary:** the SLAM chronology is silent on whether liaison with the hostel occurred and whether there were further attempts to secure access to welfare benefits.

5.20. On 8th July, when of no fixed abode, he visited a police station to report that he had been stabbed with a needle whilst sleeping rough. There was no visible injury but he was advised to attend hospital. The police sent letters to his father's address in an attempt to follow-up this incident but received no response. Police understood that Duncan collected his correspondence from his father's home. The CHS chronology confirms that Duncan attended an Emergency Department with what appeared to be a needle stick injury. There are no details of where or how the needle stick injury was sustained. Duncan was seen and discharged by psychiatrists. The reason for referral to Psychiatry is not recorded. At the point of discharge a summary was sent to the GP. **Commentary:** the SLAM IMR also records this episode.

5.21. On 10th July the SLAM IMR records that Duncan was being evicted from the hostel as the placement was only ever meant to have been temporary. **Commentary:** the SLAM chronology does not record any follow-up in response to this information.

5.22. On 19th July Crisis Skylight learned from SLAM that Duncan had been evicted from his previous accommodation for drug dealing. The mental health coordinator at Crisis Skylight informed SLAM that Duncan's mental health appeared unstable.

5.23. On 23rd July Duncan was arrested for criminal damage to a vehicle. He was recorded as being of no fixed abode. As a result of his "difficult and aggressive behaviour, a mental health assessment was completed and he was admitted to hospital under Section 2 Mental Health Act 1983. No criminal charge was pursued. The SLAM IMR entry for this episode records that Duncan was experiencing paranoid ideas with tactile hallucination. He was transported to hospital from a police cell the following day.

5.24. On 25th July a ward round recorded risk of self-neglect on Duncan's admission. There was evidence of perceptual disturbance. As per the treatment plan, the hostel was approached and confirmed that Duncan could return there on discharge. Over the first few days of his admission, Duncan was observed as maintaining his personal hygiene. The working diagnosis was recorded as schizophrenia. Efforts were made to contact Duncan's father.

5.25. On 26th and 27th July the police were notified of apparent threats and assaults involving another patient. The incidents were dealt with by the hospital. The SHS chronology for 27th July records that emails were sent to Crisis and to Croydon Reach raising concerns about Duncan's non-engagement with services, lack of contact and rent arrears. The SLAM chronology for 31st July records that Duncan encountered a degree of hostility from fellow patients during his admission and that safeguarding adult concerns were raised. It is documented that on occasions he would provoke others; at other times there was no clear trigger for the aggression. Attempts were made to transfer him to another ward and increased observation was put in place to mitigate the risk. The police were informed and assessment at Accident and Emergency facilitated. **Commentary:** no outcome for the safeguarding adult concerns is recorded. The SHS chronology observes that the SNAP team appeared unaware that Duncan had been admitted to hospital. If so, this would represent shortcomings in terms of information-sharing and multi-agency collaboration.

5.26. On 31st July the CHS chronology observes that Duncan was brought to hospital from Bethlem Royal Hospital (BRH) following a fight with a fellow patient. He had sustained a minor head injury and a fractured toe. It was noted he was under Section 2 Mental Health Act 1983 and was escorted. It has been recorded that Duncan had a past medical history of paranoid schizophrenia. Investigation diagnosed Duncan with a minor head injury; an X-ray diagnosed that Duncan's toe was fractured. Advice given to Duncan was to rest, elevate and ice the affected limb. Duncan was referred to fracture clinic for follow-up. A victim of assault form was completed by the police. A safeguarding referral was completed by the Mental Health Liaison Team and Duncan was discharged. A discharge letter was written but there is no evidence that this was sent to the GP.

5.27. The SLAM chronology records that discharge planning began at the end of July with liaison with the community team. Transfer to another ward following the incidents with other patients was not achieved because of Duncan's ongoing use of cannabis, which required additional observation to minimise his access and use. He was referred to the housing support worker. **Commentary:** the focus on discharge planning was good practice.

5.28. On 3rd August Duncan was reviewed in the Virtual Fracture Clinic. This means that his clinical records were reviewed without Duncan being present. It was noted that an appointment in the Fracture Clinic would be made for Duncan. The following day an outpatient department clerk attempted to phone Duncan to arrange follow-up appointment with the Fracture Clinic. It was recorded that they were "unable to leave message" No further action was taken. **Commentary:** critical analysis by CHS in its IMR observes that it is not documented whether staff at the fracture clinic took further steps to contact Duncan or whether concerns about his fracture were shared with his GP or whether they were aware of his vulnerabilities and social circumstances. Given this and the fact he was homeless, the fracture clinic staff could have liaised with the Community Mental Health Team or his GP for support with the appointment and taken guidance from the CHS Safeguarding Policy and Discharge Policy. This issue highlights the need for greater professional oversight over how appointments for "vulnerable" patients are managed before discharge. A review of CHS Discharge Policy suggests that there is a need for greater clarity and guidance regarding circumstances such as this.

5.29. Also on 3rd August SLAM's housing support worker confirmed with the hostel the availability of accommodation for Duncan on discharge. A nursing review the following day recorded his continuing use of cannabis and self-reported paranoia on escorted leave. Escorted leave was suspended on 7th August because of his ongoing access to, and use of cannabis, and increased evidence of mental disorder in the form of delusional thought processes. A SLAM welfare benefit advisor provided assistance to reinstate Duncan's claim and the housing support worker continued to liaise with the SNAP Team and housing providers. Information was obtained from Duncan's father who reported that Duncan had been unable to stay with him because he had not contributed towards rent or food, and had been aggressive. **Commentary:** the focus on his accommodation and financial situation was good practice, as was liaison with his father.

5.30. A ward round with a consultant psychiatrist on 9th August recorded paranoid and delusional thinking. Duncan is recorded as accepting the diagnosis regarding paranoia but not the attribution of schizophrenia. The welfare benefits advisor and the housing support worker continued with their efforts regarding access to benefits and mental health supported accommodation. A referral was also made to the Recovery Team to flag that Duncan would require intensive follow-up after discharge. However, on 16th August a decision was made to recommend detaining Duncan under Section 3 Mental Health Act 1983 as there was evidence of a treatable mental disorder that required a further period of treatment. The same day the hostel placement was lost, with the housing support worker exploring other mental health specific supported housing. The hostel placement was no longer available because of his admission and the accumulation of rent arrears as Duncan was not in receipt of Universal Credit.

5.31. On 20th August the SLAM chronology records a conversation with Duncan in which he admitted using cannabis and spice, and was reluctant to be discharged to a particular hostel because of other residents using drugs there. He also admitted that the criminal damage which had precipitated his latest admission was because he wished to go to prison or hospital. The following day his leave was suspended because of drug use and he was formally detained under Section 3 Mental Health Act 1983.

5.32. On 22nd August Duncan requested an update from the police concerning an assault that he had reported previously. The following day his welfare benefits were reinstated. On 29th August the SLAM chronology records that Duncan was not engaging with the housing support worker, terminating meetings. The housing support worker's view is recorded as being that the rent arrears and Duncan's substance misuse would need to be resolved before he could return to a hostel where he had lived previously. **Commentary:** the persistence shown by the housing support worker was good practice. No chronology has focused hitherto on what efforts were made to help Duncan address his substance misuse.

5.33. In early September the SLAM chronology records ongoing efforts to engage Duncan concerning accommodation and compliance with medication, and to enlist advice and support from the Crest Team to set up repayments to clear the rent arrears. A Community Treatment Order was considered but it was thought doubtful that Duncan would meet the criteria. Duncan was challenged about an altercation with another patient and about his cannabis use on the ward. This altercation with another patient has been recorded on the ASC chronology for 11th September. Duncan sustained a head laceration that was cleaned and dressed. **Commentary:** ASC's chronology contains the observation that the stage 1 safeguarding concern document was not fully completed. Accurate and comprehensive recording is a key component of best practice.

5.34. On 14th September the hospital reported Duncan missing[43]; he had failed to return from authorised leave. He returned the following day, giving cannabis use as an explanation for his lateness, and was debriefed by hospital staff rather than the police. A MERLIN was not shared with Adult Social Care. **Commentary:** the police IMR notes that Duncan was known for cannabis, crack and alcohol misuse and could be verbally aggressive when intoxicated. The record further states that he did not comply with treatment and was not known to be suicidal. This latter observation is surprising given that Duncan had previously talked of suicidal thoughts with police officers. The IMR questions whether police officers should have been involved in the debriefing.

5.35. On 16th September Duncan alleged assault by hospital staff. No further action was taken after police officers spoke with ward staff; no restraint had been used despite Duncan experiencing a mental health episode.

5.36. Throughout the remainder of September the housing support worker continued with efforts to create a safe discharge plan with respect to accommodation for Duncan. This involved liaison with the local authority's SNAP Team for a repayment plan for rent arrears and for a supported placement. Duncan remained reluctant to engage with these efforts. On 27th September DWP recorded a new application for Universal Credit. ASC's chronology

[43] This information comes from the Metropolitan Police Service IMR. It is not referred to in the SLAM IMR.

records a safeguarding diary note for 28th September as a result of the fight between Duncan and another patient. The ASC record indicates that a social worker and team leader should establish the risk, protection plan and desired outcomes. **Commentary:** the ASC record contains no information to suggest that this was done. It may have been agreed procedure at the time to transfer referrals of people involved with mental health services to the mental health provider without initial investigation. However, the section 42 Care Act 2014 duty to enquire rests with the local authority and, if the local authority causes an enquiry to be made by another service, ASC nonetheless remains responsible for the performance of that duty.

5.37. On 4th October DWP recorded that Duncan had provided mental health documentation and had been advised that additional information would be required if he wished to apply for back-dated payments. On 5th October Duncan returned to hospital from unescorted leave under the influence of cannabis. On 6th October Duncan attended a duty appointment at Crisis Skylight. He had been in hospital and wanted to know whether he could return to his temporary accommodation. On 10th October there was email correspondence between Crisis Skylight, SLAM and Croydon Council regarding his temporary accommodation. **Commentary:** the SHS chronology records multiple emails between a SLAM housing discharge worker planning for discharge back to Wellington House and negotiating arrangements for supported housing referrals and regarding rent arrears. It also records that in October a referral was made to a high support hostel, Palmer House, noting this as the first attempt to move Duncan from emergency accommodation into a 24-hour supported hostel. Duncan is recorded as having declined this option.

5.38. On 10th October Duncan outlined his stated intentions to a SLAM occupational therapist. He declined referral to Turning Point to address substance misuse and stated his intention to continue to use cannabis and spice. The same day the housing support worker recorded that the first instalment to pay off his rent arrears had been made and that a B&B placement was to be sought until a hostel vacancy became available. Also on the same day, DWP recorded that Duncan had attended an appointment, apparently with hospital staff. He was advised to provide a fit note. **Commentary:** ongoing communication between the housing support worker and other services was good practice. Staff supporting Duncan to attend an appointment with DWP was good practice.

5.39. On 16th October, accompanied by his support worker, Duncan provided DWP with additional medical information and a work capability assessment referral was initiated. On 17th October Duncan was allowed on extended leave to stay at a B&B pending a hostel vacancy, with a plan for depot injections to maintain his mental wellbeing. The Section 3 order was rescinded on 2nd November and he was discharged to the community team. His GP was notified.

5.40. On 2nd November Duncan contacted DWP as his welfare benefit payment had not arrived. He was advised to check with the housing department at the hospital regarding his bank details into which payment would be made.

5.41. Initially in early November his care coordinator was unable to contact Duncan to administer his depot injection and review his mental wellbeing. On 9th November Duncan refused the medication and told the care coordinator that he was not in receipt of welfare

benefits. He was given a food voucher. The care coordinator provided a fitness for work sick note on 15th November to help with Duncan's welfare benefits claim and a consultant psychiatrist completed a medical review. Duncan continued to refuse medication but at this point no overt signs of mental deterioration were seen. On 22nd November DWP requested verification from Croydon Council of Duncan's housing costs. His medical information had been received to cover the period from 7th November 2017 to 7th February 2018. An Alternative Payment Arrangement was completed. **Commentary:** the 7-day follow-up and completed review were good practice. Duncan's refusal of anti-psychotic medication was an indicator of risk. Indeed, SLAM's chronology within its investigation report contains an entry for 21st November that Duncan was non-complaint with medication and showing poor insight.

5.42. During November GP practice 2 sent a letter to Duncan to invite him for his annual weight, blood pressure, blood tests and ECG. Duncan did not attend or have his blood test or ECG. **Commentary:** this does not appear to have been followed up.

5.43. On 28th November DWP recorded that Duncan had received a budgeting allowance for clothing and was advised of repayment options. DWP records contain an entry for 29th November that the department had been advised of his hospital discharge. On 5th December Duncan contacted DWP to ask when his landlord would receive payment. He was told that payment had already been sent. The following day DWP recorded that Duncan was still unwell and experiencing difficulty as the repayment rate was high for his advance payment. Duncan had gone to the food bank. **Commentary:** Duncan's recovery appears to have been affected by poverty and the challenge of providing him with coordinated support to meet his accommodation and income needs.

5.44. On 14th December a housing advice and support worker attempted to contact Duncan. Duncan's housing preference had been documented as independent living. As no contact could be made and as Duncan had refused the supported living pathway, the housing support officer arranged to transfer the case to Hestia.

5.45. On 21st December the care coordinator attempted to show Duncan how cannabis might impact on his life. However, Duncan would not accept this and declined referral to Turning Point to address his substance misuse issues.

5.46. On 28th December the SHS chronology records an email from Hestia declining the referral unless it could be guaranteed that all fortnightly meetings would be attended by Duncan's community psychiatric nurse/care coordinator. This was emphasised because the SNAP team had declared its intention to close down its involvement with Duncan but also because Duncan was reported to not acknowledge his mental health issues or use of drugs and alcohol, was not taking medication, and had a history of high level violence. Hestia requested that the SNAP team confirm this proposed arrangement with SLAM.

5.47. On 2nd January 2018 Duncan visited DWP to complain about the amount of benefit he was receiving. He queried the amount he was having to repay for the advance payment and asked DWP to liaise with Croydon Council. DWP staff explained that Duncan was currently paying back 3 advances. Duncan explained that he only had £80 left to live on this month. As he was currently in financial need DWP agreed to defer repayment of the most

recent budgeting advance. **Commentary:** this decision, presumably to support his recovery, represented good practice.

5.48. In early January 2018 the housing support worker continued their efforts to keep other agencies informed about the attempts to secure settled permanent accommodation for Duncan. He sent an email to the care coordinator, Hestia and SNAP, outlining that Hestia had agreed to provide housing support in terms of locating accommodation but this needed to be done in collaboration with care coordinator; otherwise the alternative would be a hostel placement. This was followed six days later with a further email to inform the care coordinator and Hestia that Duncan had cancelled his Credit Union account, set up to pay off arrears. This raised an issue that this might amount to Duncan making himself intentionally homeless[44]. **Commentary:** this was good practice by the housing support worker. The SLAM chronology does not indicate what responses were received or what action was taken as a result of the housing support worker's communications.

5.49. On 28th January Duncan was notified by DWP that he no longer needed to submit medical statements or statement of fitness for work from his medical practitioner or GP at this time. Duncan also wanted to know why the work capability assessment decision had taken so long before transferring from ESA to Universal Credit. **Commentary:** this does not appear to have been an unreasonable question to ask. Duncan's experience of poverty was not assisting with his recovery.

5.50. On 30th January the care coordinator presented Duncan's case to the complex case forum within the multi-disciplinary team. **Commentary:** this was good practice. However, what follows in the SLAM chronology does not suggest that any change of approach for managing risks of relapse was instituted. Indeed, SLAM's investigation report comments that the risk assessment was not updated. This despite the care coordinator having observed Duncan's self-neglect on 24th January and having recorded that Duncan would not engage regarding his drug use and medication.

5.51. On 31st January Duncan attended a meeting with his care coordinator and a Hestia housing support worker. He appeared under the influence of drugs and refused assistance to access Turning Point. The Hestia support worker stated that there needed to be evidence of Duncan's willingness to address drug misuse. This collaboration between the care coordinator and Hestia housing support worker continued with a meeting with Duncan on 14th February when he was asked to self-refer to Crisis Skylight for a course on how to sustain a tenancy. He was also advised to consider self-referral to Turning Point if he wished to improve his chances of obtaining move on accommodation from his current hostel. A further joint meeting on 21st March noted that oral medication was overdue. Duncan had not collected his prescription. Duncan was irritable when drug support was raised in the meeting. It was decided that the care coordinator would assist him in making a referral to Turning Point at the next appointment. **Commentary:** whilst joint working was good practice, reliance on Duncan self-referring seems questionable. It does not seem that he was ready to address his substance misuse, at least without more assertive outreach. Non-concordance with medication was also a risk indicator.

[44] The SHS chronology records an email from SLAM to the SNAP team and Hestia confirming that Duncan would lose his place at Wellington Hostel if he cancelled his credit union account.

5.52. On 15th March Duncan contacted DWP to ask for an update on when arrears would be paid. Arrears of £1725 were paid the following day. This was Duncan's last recorded contact with DWP.

5.53. On 26th March the care coordinator sent an email to Hestia housing. Duncan had not attended a meeting the day before to complete his referral to Turning Point nor did he register for Crisis Skylight maintaining a tenancy course. It is documented that he was assumed to have mental capacity to make decisions regarding these choices and was aware of the impact of his choices on obtaining more secure housing. **Commentary:** mental capacity should have been assessed and not assumed.

5.54. On 4th April the SLAM chronology records an entry from a clinical psychologist relating to a complex care forum discussion. Duncan was declining to accept support offered in relation to tenancy, drug use and psychiatric medication, only engaging with the team when he required something from the service, for example food vouchers. He was not taking medication consistently and was not able to make use of standard psychological input due to drug use. There were no signs of relapse in mental state. A decision was reached to hold a CPA review and to discharge Duncan in his absence to his GP if he did not attend. Information was to be gathered from the police to inform the discharge risk assessment. The consultant psychiatrist was requested to revise the diagnosis to drug-induced psychosis. The care coordinator was to update the risk assessment to include unmanaged risks. **Commentary:** the SLAM chronology comments that the risk assessment was not updated. In addition, Duncan was being expected to self-refer and to attend appointments at fixed times and in designated places. An alternative approach, namely assertive outreach, could have been attempted prior to any decision about discharge.

5.55. On 14th April Duncan did not attend a joint meeting with the care coordinator and Hestia housing support worker[45]. On 16th April a CPA discharge meeting was held. As a result of his non-engagement, he was discharged to his GP with a request that his physical health be monitored. It is stated that Duncan had decisional capacity regarding decisions to engage and to decline interventions. **Commentary:** there has been no assessment of mental capacity. Moreover, as a result of his Section 3 admission, there was an absolute duty on health and social care agencies to provide an after-care plan[46] for as long as Duncan had needs arising from mental illness. Case closure by SLAM also jeopardised ongoing involvement by Hestia.

5.56. On 29th April 2018 Duncan was searched for drugs by police officers. He was described as "shaking and unusually thin." Nothing was found and no further action was taken. **Commentary:** his appearance might have suggested self-neglect and indicated referral as an adult safeguarding concern and/or follow-up of his need for health and/or mental health care.

[45] The SHS chronology records that Duncan's care coordinator was leaving and another would need to be allocated before a joint meeting with Duncan could be arranged. Hestia only agreed to take this case on if joint meetings with a community psychiatric nurse could be agreed due to safety issues. Duncan has not been following through on any support goals or attending meetings with Hestia and SLAM, so his case might be closed by SLAM at which point Hestia would also close.

[46] Section 117 Mental Health Act 1983.

5.57. A CPA meeting was held on 16th May. No family member was invited to attend. The risk assessment and plan was not updated. Duncan was discharged. Around the same time the SNAP team sought an update from Hestia. On 22nd May Duncan saw a SLAM duty worker requesting to see his care coordinator. He was informed that he had been discharged. Duncan reported that he had been experiencing seizures, which was why he had not been engaging. **Commentary:** the SLAM chronology observes that no checks were made with primary or secondary healthcare services. A protocol exists that Accident and Emergency Departments will inform SLAM of patient contacts. No such notifications had been received.

5.58. On 14th June there was a second attempt by the SNAP service with Croydon Reach to move Duncan from emergency accommodation into 24-hour supported accommodation. Apparently Duncan declined again, not wanting to be admitted to a hostel, and was not engaging with efforts to secure him more appropriate accommodation. There was a danger that Duncan could become homeless. He also reported being bullied at Wellington House and that he had not taken any medication for several months. **Commentary:** it would appear from the SHS chronology that the SNAP service may not have known that SLAM had discharged Duncan, with an email being sent on 18th June asking for clarification. That represents a breakdown in inter-agency collaboration. There was also concern expressed by the SNAP service to Croydon Reach and SLAM regarding his reliance periodically on food vouchers and whether he was being financially exploited by other residents in the emergency accommodation. A SNAP worker questioned whether a safeguarding concern had been raised, which was good practice, but this was not followed through with a safeguarding referral. An update was also requested on his substance misuse and whether he had engaged with Turning Point.

5.59. On 26th June the chronology in the SLAM investigation report records that Duncan informed a care coordinator that he was hearing voices. He was advised to comply with his medication. **Commentary:** given that Duncan had not been taking medication for months, this recorded response is questionable.

5.60. On 3rd July the SNAP service requested information from a care coordinator about what work was being undertaken with Duncan. No response was received[47]. **Commentary:** requests for information should be answered.

5.61. On 22nd July Duncan presented at SLAM duty desk for his prescription and for a food voucher. On 27th July Duncan saw a care coordinator for his prescription. He complained about the voices and about having no money. The same occurred on 10th August when Duncan also complained about being on too much medication. **Commentary:** the SLAM investigation report observes that the risk assessment was not updated, there was no mental state examination and no reassessment of his medication.

5.62. On 15th August Duncan was informed of his discharge by a team manager. On 18th August a SLAM team manager sent an email to Duncan's GP stating that he had been discharged to the care of the GP and had consented to this. On 15th August there is an administration note in GP practice 2 records to say that Duncan had moved out of area and so the practice could no longer take over his care for medication monitoring. **Commentary:** it

[47] This was repeated on 28th August with the same outcome.

would appear that the email from SLAM to Duncan's GP was not picked up by practice 2 because he had been de-registered. It appears that he remained without a GP from this point until his death and no agency appears to have recognised this.

5.63. A stop and search on 20th August by police proved negative. No further action was taken.

5.64. On 4th September the SHS chronology records that the SNAP service contacted Croydon Reach, having been advised that Duncan no longer had a care coordinator. It was suggested that Changing Lives Housing Trust – a non-commissioned, Housing Benefit Support Exempt Accommodation provider – be considered. No response from Croydon Reach has been recorded by SHS. **Commentary:** the SHS chronology observes that the apparent non-response should have been escalated.

5.65. On 18th September Duncan alleged to police officers that he had been threatened at the hostel where he was staying. This could not be followed up, initially because he could not be found and then because he provided no further information. **Commentary:** people housed in hostel accommodation often report that hostels are experienced as unsafe places, because of pressure from other residents, with the result that they prefer to return to the streets[48]. This might have been an occasion when an adult safeguarding concern could have been referred to the local authority.[49]

5.66. On the 19th September 2018 Duncan attended the Croydon Reach office. It was clear to staff that Duncan's mental health was deteriorating but Duncan declined the suggestion to contact his GP. Duncan told staff that he had been attacked the previous night and had a knife held to his throat. Duncan was becoming aggressive and threatening throughout the conversation. After Duncan had left the office, staff contacted CMHT and raised concerns, suggesting that CMHT do a home visit for a mental health assessment; Croydon Reach staff were advised that Duncan had been discharged back to his GP so a referral would need to come from the GP. **Commentary:** it seems clear that, by this stage, Duncan did not have a GP. This may not have been widely known at the time. The delay that ensued with respect to arranging a mental health assessment raises a question mark about referral pathways into secondary mental health care provision. It is also unclear from the Croydon Reach IMR whether the request was for a mental health assessment or a Mental Health Act 1983 assessment.

5.67. On 1st October according to the SLAM investigation report his then GP discharged Duncan as there had been no contact for one year.

5.68. On 2nd October Croydon Thames Reach expressed concern to SLAM about Duncan's paranoid ideas and agitation. Problems with providing support to address his accommodation needs were also highlighted. The SLAM chronology for the following day records a recommendation that the Croydon Promoting Recovery Team engage in joint working with the START team to work with Duncan. An email response was sent on 5th October regarding this recommendation, to the effect that a referral had to come via a GP. It

[48] See, for example, Manchester Safeguarding Adults Board (2020) *Thematic Review – Homelessness*.
[49] Section 42(1) Care Act 2014.

was also suggested that Duncan had seen his GP in July and subsequently been deregistered. **Commentary:** the SLAM chronology observes that the response ignored the process of easy in and easy out advocated within mental health community teams and that the episode highlights the importance of liaison with a GP prior to discharge and seeking confirmation of their ongoing monitoring. It also appears that on 5th October Croydon Thames Reach had also informed SLAM that Duncan was not registered with a GP. The IMR from GP practice 2 contains no reference to Duncan having been seen by a GP in July. Indeed, that practice had hardly had any face-to-face contact with Duncan.

5.69. On 5th October Duncan called the police alleging that someone was trying to stab him. Both the parties involved at the hostel were spoken to. Later the same day Duncan made four telephone calls to his father. Police were called by security staff in the evening as Duncan had been found seriously injured having fallen from a height. He died at the scene despite the attention of a London Ambulance Service crew and the Helicopter Emergency Medical Service.

5.70. ASC's chronology records receipt of a SAR referral on 2nd November from Crisis Skylight Croydon.

6. Thematic Analysis

6.1. Using the evidence-base as a framework for analysis, themes arising from the chronology, submissions from the services involved and from the learning event are analysed here.

Direct Work

6.2. Person-centred approach and responses to repeating patterns. Research has identified that staff can become inured to or normalise risk when what is being presented is repetitive[50]. The SLAM IMR reports some good practice. Before his final hospital admission he was seen regularly by the mental health team and had a key worker. The team liaised well with hostel staff over concerns about his compliance with medication. The team were responsive to his needs, attempted to make every contact count, and offered Duncan time and support to complete homeless registration forms. During his final hospital admission, the SLAM IMR concludes that staff were tenacious in trying to engage Duncan and responded to his needs, for example relating to nutrition and his preference for a vegan diet. However, substance misuse assessment and motivational work were not commenced on the ward and the IMR concludes that there was little sense of professional curiosity when working with Duncan to review risks and longer-term planning in response to his self-neglect.

6.3. Case closure should not be the automatic response when individuals facing significant challenges do not attend appointments. There are also instances of attempts to maintain contact by offering "more of the same", namely appointments at designated times and places. This is unlikely to prove effective. The Crisis IMR records that the service withdrew at Duncan's request after his final hospital discharge but should review its service offer to ensure a psychologically-informed and person-centred approach. At the learning event, the approach adopted by some services to terminate involvement if an individual missed three appointments was rightly criticised.

6.4. Advice to contact services and signposting to services as single strategies are unlikely to be effective with people experiencing multiple exclusion homelessness and self-neglect. That was the case here. As the CHS IMR comments: "*there is no evidence of communication between services when Duncan was discharged back to the community mental health team for support and in most instances Duncan was asked to contact the community team for follow-up. The [IMR] author could not establish whether Duncan had the resources such as access to a telephone and/or the motivation to follow up instruction given. Given his condition and his non-compliance with his medication, there is limited understanding of how staff understood or addressed the impact on his welfare or escalated concerns identified. Seeking support from services within CHS such as the homelessness team, CHS Lead nurse for mental health nor the safeguarding team could have helped staff to regulate the risk and led to better information sharing and risk management*." The same IMR reinforces the point: "*ED practitioners discharge Duncan back to the community mental health team often with instruction for him to make his own contact the team. However, there is no evidence to show*

[50] Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence. Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

that consideration was given as to whether he had the means to contact them. His clinical records also stated that Duncan was of no fixed abode yet his condition meant that he was expected to comply with medication to keep him safe and proactively access outpatient appointments. Yet there was an over-reliance on Duncan's commitment and ability to follow these instructions. It was not documented in his ED records what role if any, the community mental health team played in supporting Duncan."

6.5. Assertive outreach, including proactively introducing individuals to recommended services, is more likely to be effective. Indeed, the Crisis IMR observes the need to implement a range of different motivational and coaching strategies in order to facilitate engagement. The CHS IMR reiterates this point: "*Staff at CHS fracture clinic failed to establish contact with Duncan for follow up treatment. Given his vulnerability, every effort should have been made to establish contact for follow-up.*" The Crisis IMR states that the service could have been more proactive when Duncan did make contact regarding his temporary accommodation and involvement with other agencies. The GP practice 2 IMR comments that the surgery did not follow-up when Duncan did not attend appointments, for example for his annual health check. It also raises a question, namely how to manage patients who move out of a practice catchment area. Duncan did not register with another GP and the surgery questions whether consideration should be given to allowing patients at risk to remain registered, even if out of the catchment area, to avoid disruption of care or harm to the patient. At the learning event it was observed that patients with complex needs and presentations were difficult for GPs to manage within a framework of ten-minute appointments, and that the way GP practices were organised encouraged reactive practice rather than follow-up of missed appointments. A similar observation was reported at the workshop in October 2020, namely that GP practices are not configured to support different ways of engaging with patients. The expectation is that patients will engage as determined by the service.

6.6. **Recommendation Two: CSAB should consider engaging with the CCG and with NHS England on recommended practice regarding GP registration when patients at risk move across local authority boundaries, and regarding primary care support for patients with multiple and complex (mental health and substance misuse) needs.**

6.7. There are instances when the chronology implies questioning of practitioner attitudes (possible unconscious bias), as in the absence of professional curiosity and making safeguarding personal. The CHS IMR comments that there is no evidence that staff sought to explore who he was, how he was engaging with services and treatment, and what support he might have from next of kin, family and friends. The IMR continues: "*The absence of a sense of belonging for Duncan is evident. There is no evidence of familial and or social support and is not known how this aspect of his health needs were met. To this end, Duncan appeared to be isolated with little evidence of his identity that was beyond his mental illness*."

6.8. Several IMRs observe that Duncan did not want a hostel placement but rather wished to be allocated his own independent living accommodation. Whilst this may not have proved sustainable, at least without additional care and support, this option was not prioritised. Rather, the focus was on moving Duncan from emergency accommodation into a hostel. It is unsurprising, therefore, that Duncan has been recorded as declining offers of 24-hour supported housing. As the SHS IMR records: "*It is not clear from notes if this was an option*

[independent living away from Croydon] explored with Duncan by SNAP / Hestia and SLAM." It is also acknowledged that he had been evicted previously from a hostel because of supplying and using drugs.

6.9. A clear sense emerges from the IMRs that Duncan's hostel accommodation was jeopardised by the process for securing his entitlement to welfare benefits, notwithstanding in-reach welfare rights work when Duncan was in hospital. Whilst not explicitly referred to in the IMRs, poverty impacts on outcomes.

6.10. Lack of <u>understanding of behaviours.</u> Practitioners did not consistently appear to consider why people disengage or are unable to engage with treatment, and not seeing repeated patterns of such behaviours as information to address. There appears to be a need for a better understanding of how to work with people who do not prioritise their own needs, in other words who self-neglect. As the CHS IMR observes: "*Research has shown that whilst it is often difficult to achieve person-centred care in a very busy ED, this can be achievable when appropriate pathways and processes are in place*."

6.11. <u>Risk assessment</u>. Risk assessment and risk management are crucial, with plans preferably co-designed with service users/patients and shared across partners. This component of the evidence-base is clearly acknowledged within IMRs. Croydon Reach reports that there is no record of risk management or a support plan when Duncan reported being attacked in the emergency accommodation. Crisis advises of the need to ensure a clear risk management plan that all agencies are aware of. CHS notes the absence of a shared understanding of risk and the need for clear pathways, as follows: "*there is little evidence of how staff worked together to share and undertake risk assessments about his welfare. Efforts should have been made to share information with Duncan's GP and prioritise his physical health needs. Risk of his non-compliance with his medication and the impact of his homelessness to manage his condition should have been discussed collectively to understand the full extent of his vulnerabilities. Furthermore, evidence … show[s] that the most frequent cause of non-compliance with medication for mental health patients were substance misuse, attitude toward medication, side-effects and cognitive impairment. It is not known if this was explored with Duncan or was a consideration in the care given to him*." The same IMR continues: "*On each attendance to CHS ED, Duncan was assessed, treated, and discharged. Sparse but critical documentation states that Duncan had a diagnosed mental illness, had experienced homelessness and was non-complaint with his medication. There is a need for patients such as Duncan to have clear pathways and better guidance regarding risk assessment during admission to ED.*"

6.12. The SLAM IMR, referring to his final hospital stay, notes that Duncan was obtaining and using cannabis, and that steps were taken to manage this risk, including suspending his leave. Post discharge, the same IMR notes the absence of a holistic risk assessment, for example when SLAM discharged Duncan to the care of his GP, thereby ruling out Hestia housing support. It comments that sharing the risk assessment and care plan with the GP at that time would have been helpful, a point also made in the SLAM Serious Incident report. Since the risk assessment and care plan were not discussed with the GP, a failure to follow established process, risk was unmanaged rather than managed. The IMR concludes with a recommendation, namely: "*Recognition of a systems approach to risk assessment and management, for example actions by one partner agency may impact on risk and this needs*

to be communicated to all in the person's network." The SLAM Serious Incident report also comments that risk assessment was not kept up-to-date.

6.13. Other SARs[51] have remarked that hostels and other forms of temporary and/or supported accommodation can be experienced as unsafe by residents who therefore prefer to return to street-based living. The SHS IMR picks up this theme: "*Generic emergency accommodation settings are not conducive to successful risk management for clients with complex needs, dual diagnosis and histories of non-engagement. Communication and joint working on sharing risk assessment and risk management remains a challenge, particularly around agreed understanding of risk management in these settings. Where an agency has lead responsibility for risk management – in this case [the] … SLAM CPA duty – the care coordinator should be actively leading the risk assessment process with partner agencies roles and responsibilities clearly detailed on the plan*."

6.14. Mental capacity assessment. There were very few references to mental capacity assessment in the chronology, which is perhaps surprising given that the Code of Practice[52] refers to symptoms of alcohol or drug use in the context of disorders of mind or brain.

6.15. At the workshop assumptions about lifestyle choice were challenged. It was recognised that people's behaviours and decisions were often in response to, and an attempt to manage the impact of their life experiences.

6.16. The CHS IMR highlights the complexities when endeavouring to safeguard patients who have been deemed to be making unwise decisions about their care. It concludes that staff gave little consideration to why Duncan was making certain decisions and that there were gaps in practice knowledge regarding mental capacity assessment.

6.17. The SLAM IMR observes that: "*There was an absence of full exploration of mental capacity. Statements such as "he has capacity to keep using" were used … Exploration of his capacity to make decisions and more specifically his executive functioning may have been useful. It could have been the case that his capacity fluctuates just like his mental state did as a consequence of his drug misuse. A formal mental capacity assessment in relation to housing or drug use could not be located in his notes*." The IMR concludes with the following recommendation for action: "*Interaction of mental capacity and executive functioning needs to be considered when making assumptions about capacity in the context of self-neglect, mental ill health and substance misuse, to improve awareness and competency in managing decision-making in people who present with self-neglect concerns*."

6.18. Three questions arise that CSAB should raise with partner agencies as part of its statutory mandate to seek assurance that adult safeguarding services are working effectively in preventing abuse and neglect, including self-neglect. Firstly, is there an understanding of executive capacity? Especially where there are repetitive patterns, it is essential to assess executive capacity as part of mental capacity assessment. Guidance has commented that it can be difficult to assess capacity in people with executive dysfunction. It recommends that

[51] For example, Manchester SAB (2020) Thematic Review – Homelessness.
[52] Department of Constitutional Affairs (2007) *Mental Capacity Act 2005: Code of Practice* (London: The Stationery Office.

assessment should include real world observation of a person's functioning and decision-making ability[53], with subsequent discussion to assess whether someone can use and weigh information.

6.19. Secondly, is sufficient recognition given to the impact of trauma and adverse childhood experiences? Thirdly, is drug and/or alcohol abuse seen as a lifestyle choice and unwise decision-making or possibly invoking considerations of mental capacity and self-neglect?

6.20. Care and support assessment. The absence of requests for an Adult Social Care assessment for care and support is noticeable. Adult Social Care assessment is an essential part of any support plan. Outreach social work is a possible helpful development[54], alongside other practitioners, reaching out and assessing the person in their locations. In Duncan's case, there was no active ASC involvement. The CHS IMR records that the service has been unable to establish whether Duncan's needs for care and support were considered before he was discharged.

6.21. Section 9 Care Act 2014 enables local authorities to assess a person who appears to have needs for care and support, regardless of the level of need. Where the authority is satisfied on the basis of a needs assessment that a person has needs for care and support, it must determine whether any of the needs meet the eligibility criteria (section 13). The eligibility criteria are set out in the Care and Support (Eligibility Criteria) Regulations 2015. An adult's needs meet the eligibility criteria if (a) the adult's needs arise from or are related to a physical or mental impairment; (b) as a result of the adult's needs the adult is unable to achieve two or more of certain specified outcomes; and (c) as a consequence there is, or there is likely to be, a significant impact on the adult's well-being. Thus, such needs may arise from physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury. The specified outcomes include being appropriately clothed, being able to maintain a habitable home environment, and being able to use facilities and services in the community. Where the individual does not have eligible needs, there remains a power in section 19(1) available to the local authority to meet any care and support need where not under a duty to do so. It is at least arguable, both before and after his final hospital admission, that Duncan appeared to have care and support needs, and should have been referred for and received an assessment.

6.22. The statutory guidance[55] identifies that care and support needs arise from or are related to physical or mental impairment or illness. Substance misuse is included here. Thus, CSAB's statutory mandate, to ensure the effectiveness of what partner agencies do, requires that it questions them about how the interface between housing/homelessness and adult

[53] NICE (2018) *Decision Making and Mental Capacity*. London: National Institute for Health and Clinical Excellence.
[54] Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness. A Briefing on Positive Practice. London: LGA and ADASS.
[55] DHSC (2018) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office.

social care is seen. Research elsewhere[56] has found that agencies can be deterred from making referrals to Adult Social Care because of potential volumes and/or that Adult Social Care is operating a higher threshold for care and support assessments than Section 9 (Care Act 2014) permits. CSAB needs to be assured that these factors are not present in Croydon.

6.23. At the workshop unmet care and support needs were seen as not unique to Duncan. Participants reported a struggle to refer people with health and care and support needs. A view was expressed to the independent reviewer that there had been a reduction in "what social work could be". An example was given of a provider being told that an individual did not need a care package and therefore had no eligible needs.

6.24. **Recommendation Three: CSAB should seek assurance about access to care and support assessments, and how ASC meets its responsibilities to promote wellbeing and prevention, and how its power to meet care and support needs is considered alongside its duty to respond to eligible needs.**

6.25. Responses to substance misuse and mental distress. Individuals in the grip of substance misuse do not find change easy to achieve and this realisation should be factored into how services are set up to provide support. This reinforces the commentary on executive decision-making and mental capacity assessment above. It appears that Duncan was known to Turning Point as far back as 2008. Noteworthy, however, is that in the period on which this SAR primarily focuses, there was no active work being undertaken by Duncan with respect to his misuse of alcohol and other drugs. The assumption appears to have been that he did not and would not recognise that his usage was problematic and engage. Indeed, the SLAM IMR observes that: "*It would be reasonable to enquire what prevented substance misuse assessment and motivational work to be initiated on the ward*." The IMR author was unable to locate a recent assessment by a substance misuse specialist.

6.26. There were missed opportunities to consider the interface between mental health and substance misuse. The SLAM IMR, commenting on his final hospital admission, observes that: "*Opportunities to engage with him in a therapeutic and holistic manner may have been lost whilst on the ward. Missed opportunities may have been due to his reluctance to engage, his ongoing use of cannabis, or lack of knowledge or skill in implementing a trauma informed approached to his care. A Trauma informed approach may have led to a perspective of taking a holistic and longitudinal approach to viewing his homelessness. This approach may have been put to one side as the practical aspects of securing accommodation were prioritised*."

6.27. The SLAM Serious Incident report also considers the interface between substance misuse and mental health. The report's chronology states that in February 2018 Turning Point was advised about his cannabis use. The report observes that there was no follow-up discussion with Turning Point. Later in March it appears that his first care coordinator, with a practitioner from Hestia, did discuss drug use and medication compliance with Duncan, who is recorded as being willing to engage with Turning Point but neither Duncan nor his care

[56] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14.

coordinators followed through on this. The report concludes that his second and third care coordinators expected Duncan to engage and did not offer to do more than signpost him. They could have taken Duncan to Turning Point. As noted above, signposting alone is unlikely to prove effective. The report concludes with a recommendation that the interface between SLAM and Turning Point requires improvement.

6.28. As noted further below, only one of Duncan's three care coordinators following his final hospital discharge, had knowledge of dual diagnosis. The SLAM IMR concludes with a recommendation that: "*Opportunity to consult with [a] substance misuse specialist should be standard practice if the use of drugs or alcohol is increasing risk to the individual and evidenced as self-neglect; to raise awareness and competency in working with substance misuse*."

6.29. At the learning event some concern was expressed regarding access to assessments of individuals' substance misuse. There is guidance for referrals to, and joint working between SLAM and Turning Point. It also covers referrals to the social services care management team. First approved in April 2018 and revised in May 2021, an audit would be timely to review its implementation.

6.30. **Recommendation Four: CSAB should consider seeking assurance by means of an audit of the implementation of the guidance on referrals to, and joint working between SLAM and Turning Point.**

6.31. Focusing just on his mental health, GP practice 1 comments that more active involvement of a community psychiatric nurse was needed. The Crisis IMR comments that there is a need to ensure that all agencies are able to notice signs of mental health deterioration, accepting responsibility to feed back any concerns to the service leading on supporting the individual. Training may be necessary here, as the SHS IMR acknowledges: "*Housing and homelessness professionals and partners involved in providing floating support would benefit from induction and training programmes from SLAM on working with clients who self-neglect and disengage from services*."

6.32. On the theme of responses to Duncan's mental health, the SLAM Serious Incident report is critical that he was not reviewed by a doctor when he told the third care coordinator that he was hearing voices and was unhappy with his medication. The report also concludes that the Care Programme Approach (CPA) was not used to good effect in identifying Duncan's complex mental health needs and attendant risks. It is critical also that Duncan's diagnosis was changed in May 2018 from enduring mental illness with comorbid cannabis use to mental and behavioural disorder due to the use of cannabinoids; psychotic disorder. The diagnosis was changed without seeing Duncan in person and without due weight being given to diagnosis when Duncan was on the ward and his response to treatment with anti-psychotic medication while detained under section 3 Mental Health Act 1983.

6.33. The decision to discharge Duncan from the CPA is also commented on in the SLAM Serious Incident report. It does not appear to have been informed by a risk assessment and poor response to a care plan. It was taken when Duncan was making sporadic attempts to engage and the discharge process did not follow operational policy; communication with the

GP was poor, with no agreement secured from the GP to take over his care. The discharge letter was not copied to Duncan and his father was not involved; Duncan only discovered his discharge when he made contact with SLAM in order to see his care coordinator. There are clear messages here regarding shortfalls in person-centred care, discussed above, and in multi-agency collaboration, discussed further below.

6.34. The CPA should be an overarching system for coordinating the care of people with mental disorders, particularly those with the most complex needs requiring multi-agency intervention. Eligibility arises through high clinical complexity, combined with risks such as suicide and self-neglect, dual diagnosis and disengagement[57]. SARs have identified concerns with the implementation of CPA[58].

6.35. **Recommendation Five: CSAB should consider seeking assurance from SLAM regarding the implementation of the CPA.**

6.36. The lack of oversight of his mental health was compounded by Duncan's de-registration by GP practice 2. This was understood by the services witnessing his deterioration that he could not be re-referred to SLAM when in crisis. No advice was given to seek urgent care from the Psychiatric Liaison Service. The SLAM Serious Incident report observes that re-referral should have been seamless but such an approach was not embedded in practice.

6.37. Responses to physical ill-health. The CHS IMR records four attendances at an emergency department between 2013 and 2017 and questions why there was a gap in contact with Duncan between May 2014 and April 2017. This IMR raises an important point about parity of esteem. Thus: "*Research has shown that when considering the health needs of patients with mental health concerns, physical and mental health needs should not be thoughts of as separate. This is because poor physical health can lead to an increased risk of exacerbating mental health diagnosis. There are clear indicators that consideration for Duncan's long-term physical health needs were not prioritised in the same way as his mental health needs when he was being triaged or discharged. Consideration for his physical health needs could have led to wider questions about the impact of non-compliance with his medication. Potentially, homelessness and the diagnosis of paranoid schizophrenic meant that Duncan was at risk of not being able to manage his illness and self-care*." Put another way, it is possible that his physical wellbeing was obscured by his mental health diagnosis. This has been noted in other SARs[59].

6.38. The CHS IMR continues with this theme and implicitly, therefore, also draws attention to the importance of wrap-around support, including meeting his needs for care and support. Thus: "*There is evidence to suggest that Duncan's diagnosis of mental illness and the impact of homelessness could negatively impact on his ability to adequately self-care and maintain his welfare*" and in drawing attention also to the importance of information-sharing, "*It is difficult to establish whether Duncan's non-compliance with this medication*

[57] Braye, S. and Preston-Shoot, M. (2016) *Practising Social Work Law* (4th ed). London: Palgrave.
[58] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.
[59] Tower Hamlets Safeguarding Adults Board (2020) Ms H and Ms I: Thematic Safeguarding Adults Review.

was perceived by staff as self-neglect as there is limited information about this aspect of his care. A thorough review of his assessment records in ED could not establish evidence of any physical presentation of concern which is surprising given his homelessness. At the same time handover accounts from agencies who escorted Duncan to CHS ED did not yield information about his living arrangements." It suggests that: "*A joined-up pathway to ensure the continuity of care for service users such as Duncan will help to address the issues highlighted in this review.*" In summary, there is limited information about his physical wellbeing despite evidence of prescribed medications that suggest that Duncan was living with a long-term condition influenced by substance misuse.

6.39. An additional feature of the evidence-base is "think family." There is little sense in the chronology of the history of family relationships featuring in assessments and planning. The SLAM IMR notes that liaison was attempted with Duncan's father when he was an in-patient but no detail is given. The SLAM Serious Incident report refers to lack of contact with Duncan's father, resulting in missed opportunities to obtain information, for instance about Duncan's history. This might have been especially helpful around the time that his mental health diagnosis was changed. It also meant that there was no exploration of what Duncan's family could offer by way of a circle of support. The report does acknowledge, however, that Duncan may not have consented to such information-sharing and may have asserted his right to private and family life[60].

6.40. Another component of the evidence-base refers to transitions. In the context of this review, transition refers to the point at which people transfer from one service to another. It is a point of movement between, for example, hospital and community services or between community and supported living provision. Hospital discharge is a key transition. Some individuals do not have the skills, resilience and capability, at least not without wrap-around support, to successfully manage transitions, for example into supported accommodation or independent living. What is being highlighted here is the need to consider what wrap-around support was necessary.

6.41. There is NICE guidance about the transition between inpatient mental health or general hospital settings and community settings. For people with serious mental health issues who have recently been homeless or are at risk of homelessness, the guidance[61] recommends intensive structural support to assist with finding and retention of accommodation. This support should begin prior to discharge and continue for as long as necessary. Housing and mental health services should work together to jointly problem solve. Similar guidance for people in inpatient general hospital settings[62] recommends on admission that a person's housing status is established and that, prior to discharge, if a person is likely to be homeless, liaison occurs with the local authority's Housing Options service to ensure that advice and help is offered. Homelessness and safeguarding issues should be addressed by agencies working together to ensure a safe and timely discharge.

[60] Article 8, European Convention on Human Rights and Fundamental Freedoms, incorporated into UK law by the Human Rights Act 1998.

[61] NICE (2016) *Transition between Inpatient Mental Health Settings and Community or Care Home Settings*. London: National Institute for Health and Clinical Excellence.

[62] NICE (2015) *Transition between Inpatient Hospital Settings and Community or Care Home Settings for Adults with Social Care Needs*. London: National Institute for Health and Clinical Excellence.

Those at risk of readmission should be referred to community practitioners prior to discharge for health and social care support.

6.42. The CHS IMR expresses concern about hospital discharge, namely: "*ED practitioners discharged Duncan back to the community mental health team often with instruction for him to make his own contact the team. However, there is no evidence to show that consideration was given as to whether he had the means to contact them. His clinical records also stated that Duncan was of no fixed abode yet his condition meant that he was expected to comply with medication to keep him safe and proactively access outpatient appointments. Yet there was an over-reliance on Duncan's commitment and ability to follow these instructions. It was not documented in his ED records what role if any, the community mental health team played in supporting Duncan.*" This observation harks back to the earlier analysis about the limitations of simply signposting individuals to services, even where appropriate referrals are made, as may have been the case here. It anticipates also the analysis to follow about how services work together. The SLAM IMR records that Duncan's discharge from hospital was delayed due to the challenge of finding him somewhere to live, compounded by his apparent non-engagement.

6.43. At the learning event concern was expressed that GPs were not contacted routinely as part of a hospital discharge process to engage them in planning and to ascertain their level of knowledge and experience of monitoring patients with mental health and substance misuse problems. It was felt that GPs needed to be seen as more active partners in the discharge process.

Team around the person

6.44. Working together. The SLAM IMR refers to "robust liaison" by the housing advice worker with housing providers whilst Duncan was in hospital. Post discharge the IMR is more equivocal. "*The care coordinator was able to convene joint meetings with the Hestia housing support worker, whose role is to provide housing support to mental health service users. There was good evidence of joint working. It was made clear … that Hestia would remain involved on condition [of] joint working with mental health services. It is unfortunate that this was not considered at the point when the team decided to discharge Duncan to the care of his GP*." This discharge effectively ruled out ongoing involvement by Hestia housing support. The SLAM IMR continues to paint a variable picture of how services worked together, namely: "*There were good examples of joint working and acknowledgement of roles as evidenced in the liaison within and between teams. Consultation opportunities may not have been utilised in terms of substance misuse or trauma informed interventions for homeless people.*"

6.45. Other IMRs also identify good practice. The Crisis IMR refers to liaison with other services to resolve Duncan's needs for accommodation and challenges accessing welfare benefits. It observes that concerns about Duncan's mental health were flagged to the care coordinator in July 2017. It is also clear that SHS raised questions with SLAM about that service's involvement with Duncan. The CHS IMR identifies good practice whilst also highlighting concerns about how services worked together. Thus: "*There is evidence that collaborative working between agencies often resulted in the appropriate intervention. For*

example, referral to other agencies and attendance to CHS ED for physical care from Royal Bethlem Hospital resulted in effective treatment and handover of care. The police and London Ambulance Service had encounters with Duncan on other occasions when he was admitted to ED. However, the full extent of handover is unknown due to poor documentation." The concern about recording is reinforced below. The CHS IMR, in reflecting on how services worked together, also flags concerns about information-sharing and the failure to convene multi-agency risk management meetings, also discussed below. Thus: "*There is evidence of collaborative working with the mental health liaison team where he was seen at CHS ED and discharged. However, there is little evidence of how staff worked together to share and undertake risk assessments about his welfare. Efforts should have been made to share information with Duncan's GP and prioritise his physical health needs. Risk of his non-compliance with his medication and the impact of his homelessness to manage his condition should have been discussed collectively to understand the full extent of his vulnerabilities.*"

6.46. However, IMRs also offer critical reflections on how services worked together. Both GP practices observe shortcomings in joint work between GPs and community mental health providers and conclude that there is a need for better communication between primary care and secondary (mental health) care. Crisis has observed that Duncan did not have a single point of contact and has highlighted the importance of nominating a lead worker to coordinate the diverse inputs needed to ensure wrap-around support. The SHS IMR comments that: "*SNAP involvement in response to Hestia emails from January to April 2018 appears to be passive and not pro-active– recording events but not following up. There is also no indication that SNAP service pushed for a multi-agency safeguarding meeting or any records of phone calls following up on emails*."

6.47. Both the CHS and SHS IMRs are critical of the failure to escalate concerns. The CHS IMR highlights the importance of comprehensive recording and of information-sharing, discussed below, when noting the following: "*Evidence from the records show confusion and a lack of clarity amongst practitioners about Duncan's living arrangements. For example, he was often referred to as homeless, when documentation showed that he was living in a hostel. On other occasions, he was described as no fixed abode. Ultimately, this confusion meant that CHS staff had no means of contacting Duncan to arrange an out-patient appointment. When he could not be reached via a mobile number there was no consideration for how he could be reached and there is no evidence to suggest that this triggered concern for escalation or information sharing with his GP*." The SHS IMR notes the absence of escalation when SLAM's care coordinator did not respond to requests for information. It observes that: "*Sending and recording of emails is good practice but is perhaps sometimes a passive exercise, used to demonstrate that an agency is responding to a situation, rather than taking full responsibility for escalating concerns. We need to encourage greater use of pro-active follow up with telephone calls and minuted meetings. Relationships with partner agencies should be sufficiently mature and robust to withstand constructive criticism and challenge practice. There can be a tendency to hold back on this kind of challenge for fear of disrupting positive working relationships*."

6.48. The SHS IMR, reflecting on the use of emergency accommodation, observes that: "*Communication and joint working on sharing risk assessment and risk management remains a challenge, particularly around agreed understanding of risk management in these*

settings." It adds that: "*SNAP service remit was not as broad as current SHS and therefore less leverage was applied from a statutory homelessness perspective. However there <u>were</u> established relationships with SLAM which should have been better utilised by the SNAP service for the benefit of Duncan.*" It concludes that: "*There is a need to review and develop current multi-agency working practices for high risk cases, particularly in relation to decision-making on closing cases for non-engagement and contingency planning for placement breakdown in emergency accommodation*." It recommends that: "*There continues to be inconsistency in communication from SLAM when cases are closed / discharged back to GP. SHS should reiterate the need for SLAM to inform housing officers and support agencies when a case is going to be closed and build this in to a protocol. At the moment this is an 'ask' … rather than an agreed process; this needs to be a formalised agreed process.*"

6.49. IMRs also reflect on the absence of intra-agency collaboration. There were missed opportunities in CHS, for example, to refer Duncan to its homeless team for support to access services that would address his physical health needs, and to a mental health lead nurse or the safeguarding team. The CHS IMR concludes that "*these supports could have made a difference to the quality of care given to Duncan*."

6.50. A mixed picture on working together emerged at the learning event, perhaps reflecting service enhancements since Duncan's death. Some positive changes were reported, for example the establishment of the START team to provide outreach to people experiencing homelessness and mental distress. Co-location of SLAM nurses in GP practices is underway with the aim of improving person-centred care, assessment and support. Bi-monthly meetings are held between SLAM and Turning Point where cases involving dual diagnosis can be discussed. Housing reported a more positive relationship with adult safeguarding.

6.51. A strategic appointment has been made to streamline the communication between SLAM and CHS. Reference was made to the creation of "huddles." Located in GP practices and designed to promote cross-agency, multi-disciplinary assessment and planning with respect to high risk patients, adult safeguarding is now involved. The criteria in use to prompt case discussion are currently being revised. It was observed, however, that Duncan would not have been discussed in a "huddle", had it existed at the time, as he was registered with a GP in Lambeth.

6.52. Nonetheless, concerns were raised at the learning event about communication, joint working and "hand offs", with lack of clarity about which agency was leading on particular cases and who was responsible for different elements of any intervention plan. One specific concern related to a perceived absence of multi-agency risk assessments and mitigation planning. Another concerned lack of clear understanding of referral pathways and having to chase services for a response to referrals. A third, expressed by some commissioned service providers, related to their staff having to hold cases without specialist expertise and the need to consider link workers that would help to open up pathways for individuals and navigate systems.

6.53. The record for the aforementioned workshop refers to fragmentation of services and to a multi-agency approach needing to be more robust, including information-sharing.

6.54. Information-sharing. As the chronology details, particularly during the pre-hospital (January – July 2017) and post-hospital (November 2017 onwards) periods under review, services did sometimes share information in order to try to meet the needs that Duncan presented. Nonetheless, sharing information must have a purpose, as the CHS IMR implies: "*Duncan's clinical record showed that he was non-compliant with this medication. There is no evidence to suggest how this was explored or whether [there were] attempts to assess the impact this might have on his safety and welfare. It was clear that Duncan's non-compliance was shared with the MHT although limited information on how this was used to understand his circumstances*."

6.55. However, there were specific occasions when the law on information-sharing[63] to safeguard an adult at risk may have been misunderstood. The CHS IMR observes that "*It is documented that there was no consent to share information about his admission to ED which meant that vital information was not shared with his GP. There is no evidence that staff considered the potential risk this could pose to the understanding of his welfare nor the implications for keeping him safe. In-depth analysis of staff documentation suggest[s] that it is more likely that staff relied upon historical documentation about his refusal to consent which was dated almost 3 years prior rather than discussing the issue of consent with Duncan.*" The IMR makes explicit connections between information-sharing and, on the one hand, mental capacity assessment, and on the other hand safeguarding literacy, working together and recording. Thus: "*The analysis identified gaps in practice knowledge relating to the issues of consent, mental capacity assessment and safeguarding risk escalation. In this instance, there is limited evidence that the principles of safeguarding were applied or considered when he initially refused to share details of his admission with his GP. However, it is doubtful that consent was sought in the first instance. Agencies and services should have worked together with Duncan to address this issue. There is no evidence to suggest that he lacked capacity to make decisions about his care. However, it could be argued that his refusal to share information with his GP was an unwise decision which he is entitled to make. It is also not known whether he was approached at each admission for consent to share information with his GP or whether staff relied on [a] decision made during previous admissions*."

6.56. Those attending the learning event believed that information-sharing remained an issue, not least because services used different recording and communication systems. It was, however, acknowledged that work is underway to address this concern[64]. Nonetheless, SHS gave one example, namely how its staff are informed when individuals are discharged back to their GP by care coordinators. Those attending the learning event recognised that there were still misapprehensions and misunderstanding regarding when the Data Protection Act 2018 permits proportionate information-sharing to safeguard an adult at risk. This parallels an action recorded as arising from the workshop, namely review of information-sharing practice.

6.57. Multi-agency meetings. Several IMRs offer a critical analysis about this component of best practice. The SHS IMR observes that the SNAP team did not press for a multi-agency meeting. Croydon Reach and Crisis conclude that a multi-agency meeting could have been

[63] Now the Data Protection Act 2018.

[64] For example between SLAM and CHS.

arranged to discuss Duncan's discharge and support plans, and to address concerns about the suitability of proposed accommodation and mental health support in the community. The CHS IMR, reflecting on Duncan's refusal to consent to information being shared with his GP about his attendance at an emergency department, comments that: "*greater efforts should have been made to undertake a multi-agency discussion involving CHS mental health lead, CHS homeless lead and the community mental health liaison team to ensure that the perceived complexities of consent and his welfare were addressed.*" The IMR continues: "*It is accepted good practice to seek consent to share information about a hospital attendance. At the same time practitioners have a duty of care to respect the wishes of the patient even if that decision is unwise and detrimental to their health and wellbeing. There is limited evidence in the clinical record as to how this was managed and discussed amongst the services managing his care*."

6.58. The SLAM IMR, when commenting on some identified areas of good practice, observes the use of a reflective complex care forum where the care co-ordinator could discuss the case. "*Duncan was discussed twice in this forum and at one meeting the pros and cons of discharge were considered*." Whilst multi-disciplinary team meetings are good practice, the advantage of a multi-agency risk management meeting does not seem to have been utilised, for instance to ensure a coordinated approach to his hospital discharge and recovery in the community.

6.59. The record of the workshop noted that a Risk and Vulnerability Management Panel was in place. An action arising from the workshop is recorded, namely to restart the complex case panel.

6.60. **Recommendation Six: CSAB should consider auditing the use of multi-agency panels and meetings.**

6.61. Safeguarding literacy. IMRs offer observations on good practice. The SHS IMR observes that the SNAP service coordinator shared concerns about Duncan possibly being exploited financially with Hestia, Croydon Reach and SLAM. However, it does not appear that this adult safeguarding concern was formally referred to ASC using the criteria in section 42(1), Care Act 2014. The SLAM IMR observes that concerns were raised with ASC following Duncan's altercations with other patients. As steps had been taken to ensure his safety in the hospital, an adult safeguarding enquiry[65] was not undertaken. The same IMR notes, however, that concerns about Duncan's self-neglect were not referred to the local authority at any point. The SLAM Serious Incident report observes that Duncan was not regarded as meeting the safeguarding threshold and so was not referred. However, the three components in section 42(1) Care Act 2014 are not to be seen as a threshold but rather as criteria[66]. It appears that Duncan had care and support needs, was experiencing abuse/neglect (self-neglect) and was unable to protect himself from that abuse/neglect because of his care and support needs. An adult safeguarding referral would have been appropriate.

[65] Section 42(2) Care Act 2014.
[66] Hodson, B. and Lawson, J. (2019) *Making Decisions on the Duty to Carry Out Safeguarding Adults Enquiries*. London: LGA and ADASS.

6.62. There were also other missed opportunities to refer adult safeguarding concerns. The Crisis IMR concludes that it should have been proactive in raising safeguarding concerns. Croydon Reach observes a lack of follow-up when Duncan described being attacked. The CHS IMR concludes that there was a failure to adhere to the Trust's safeguarding policies.

6.63. A view was expressed at the learning event that the interface between SLAM and the local authority with respect to safeguarding adult enquiries was not working as well as it could. In part this was because of the use of different recording systems, rendering difficult the transfer of information. It was stated that this interface would benefit from review.

6.64. **Recommendation Seven: CSAB should consider seeking assurance from SLAM and ASC that a robust process is in place for decision-making regarding referrals of adult safeguarding concerns, and for monitoring the outcomes of adult safeguarding enquiries.**

6.65. An earlier SAR[67] recommended that CSAB be assured that cases that meet the criteria in section 42 Care Act 2014 are progressed. It would be timely for CSAB to review how that recommendation has been implemented.

6.66. Legal literacy. Only the SLAM IMR explicitly refers to legal rules when reflecting on work with Duncan. Thus: "*It was clear that Duncan was reluctant to continue to comply with the medication following discharge. The Mental Health Act 1983 (amended 2007) does provide provision for Community Treatment Order to be considered on discharge from hospital for some patients who have been detained under Section 3. The order is usually reserved for those people who can be seen as "revolving door" patients who have frequent admissions to hospital. It has limited power and does not provide provision for providing treatment against the persons will. It specifies where someone should live but has no power to return a person if they leave. Duncan did not appear to fit criteria of a "revolving door" patient and this is likely to be the reason why a Community Treatment Order may not have been considered on discharge*."

6.67. The SLAM IMR does not reflect on whether guardianship[68] would have been an option at any point during their work with Duncan. The code of practice[69] differentiates between guardianship and a community treatment order. Guardianship is essentially social care led, focused on meeting welfare needs in the community. A community treatment order is suitable when in-patient treatment is not needed but where hospital recall powers remain important.

6.68. Of equal concern, however, is that neither SLAM's IMR nor its serious incident investigation report makes any reference to the absolute duty to provide mental health after-care under section 117 Mental Health Act 1983. This is a major omission. Having been detained under section 3 Mental Health Act 1983, the Trust and the local authority were under an absolute duty to provide mental health after-care, to meet Duncan's needs arising from his mental ill-health and to enable him to remain in the community. It can include healthcare, social care, supported accommodation and skills for independence. After-care

[67] CSAB (2019) SAR – Catherine.
[68] Section 7 Mental Health Act 1983.
[69] Department of Health (2015) *Mental Health Act 1983: Code of Practice*. London: The Stationery Office.

should continue as long as the person's mental health needs continue. It may be discharged if the person disengages but only if they have demonstrated their ability to cope without services[70]. Given this statutory duty, a question mark hangs over the decision by SLAM to withdraw the care coordinator. Other SARs have commented on neglect of the section 117 Mental Health Act 1983 duty, including where SLAM has been the mental health provider[71].

6.69. **Recommendation Eight: CSAB should consider seeking assurance from SLAM and ASC that the absolute duty to provide section 117 after-care plans is met, with a register held of those eligible for after-care and with plans regularly reviewed and maintained for as long as the individuals concerned have needs related to their mental wellbeing.**

6.70. At the learning event it was observed that individual services sought their own legal advice, some provision for which was outsourced. When seeking to manage complex situations, different strands of legal advice should be brought together, for example through the medium of a multi-agency risk management meeting. This point has also been made in other SARs[72].

6.71. Also at the learning event, it was noted that implementation of the Homelessness Reduction Act 2017, including the duty to refer, occurred during the final months of Duncan's life. Of particular concern was the importance of embedding a multi-agency response to people presenting with complex needs when individuals were not owed a main housing duty. It is particularly important that practitioners in Housing and ASC are mindful of the provisions in the statutory guidance[73] regarding the interface between the Care Act 2014 and housing (homeless persons) legislation.

6.72. Recording. Several IMRs are critical of recording standards. ASC has observed that there are gaps in the completion of documentation. Croydon Reach found gaps in recorded information, meaning that it was not possible to account for what work was actually done. GP surgery 1 concluded that contact details must be updated following each patient consultation. CHS found that details about next of kin were missing. "*Triage nurses and medical practitioners rarely recorded personal information about Duncan except for his mental illness and at times conflicting account of his living arrangements.*" The CHS IMR continues: "*The triage assessment documentation at each admission is sparse and the evidence suggests that better record-keeping by ED could have alerted the fracture clinic staff to Duncan's vulnerabilities and prompted them to take more decisive actions to contact him or to share information with his GP when they were unable to reach him.*" The IMR for GP surgery 2 observes that Duncan's contact details were not updated when there was the possibility of him having a different address. It observes that letters from external agencies should be checked to determine whether the patient's address on letter received match the address on the patient's record. This would help to ensure that the taking on of responsibility for managing prescribing is discharged effectively.

[70] R (Mwanza) v Greenwich LBC and Bromley LBC [2010] EWHC 1462 (Admin).
[71] Lewisham SAB (2021) SAR – Adult Z.
[72] For example, Salford SAB (2021) SAR – Kannu.
[73] DHSC (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office.

6.73. Some information has not been retained by agencies, such as DWP, because of policies to purge documentation after an elapse of time. Crisis in its IMR concluded that it would review its approach to recording and case management in order to monitor an individual's progress.

6.74. Points regarding recording that were raised at the learning event have already been mentioned. It was observed that in some London boroughs SLAM has access to GP and hospital records. This assists working together and responses to a patient's physical and mental health needs. Such a facility does not yet exist in Croydon.

Organisational support for the team

6.75. Supervision and management oversight are core components of the evidence-base for best practice. The SHS IMR reflects that, "*Although safeguarding matters are standing agenda items in SHS team meetings and staff 1-1s, more thought should be given to how managers encourage and prompt staff to proactively consider safeguarding across their caseloads. Managers should be asking the right questions of staff to help them see the wood for the trees.*"

6.76. The evidence-base also refers to commissioning. CSAB has a statutory mandate to seek assurance that, in order to prevent and to safeguard people from abuse and neglect, commissioners are responding effectively to meeting the needs of people experiencing homelessness. Research[74] strongly recommends new commissioning approaches that deliver integrated provision and a greater number of specialist multi-disciplinary services.

6.77. The CHS IMR questions whether appropriate pathways and processes were in place to meet Duncan's needs. It has been suggested, for example by SLAM, that there are commissioning gaps, namely concerning assertive substance misuse outreach and a proactive substance misuse rehabilitation service. At the learning event it was observed that SLAM is not commissioned to provide a substance misuse service in Croydon. However, treatment teams do now have access to dual diagnosis specialists.

6.78. The SHS IMR offers a critique of the disparate funding of floating support. It observes that "*Commissioning of supported housing accommodation-based and floating support services is somewhat fragmented and has been cut significantly since 2018. Floating support is a vital link between clients, homelessness / housing services and statutory partners and we should be advocating for these services to continue. In Duncan's case, disparate funding arrangements led to 4 separate support agencies being involved*." On the provision of emergency and hostel accommodation, the SHS IMR is similarly reflective and critical. "*Wellington house remains the main emergency accommodation option for single homeless men and continues to be staffed with [a] security / concierge team who are not professional experienced housing workers with knowledge and experience of mental health and addictions. This is an inadequate setting for people recovering from mental ill health and addictions.*" It continues: "*The council's financial position notwithstanding, as well as the*

[74] Cream, J., Fenney, D., Williams, E., Baylis, A., Dahir, S. and Wyatt, H. (2020) *Delivering Health and Care for People who Sleep Rough: Going Above and Beyond*. London: King's Fund. Weal, R. (2020) *Knocked Back: How a Failure to Support people Sleeping Rough with Drug and Alcohol Problems is Costing Lives*. London: St Mungo's.

above measures implemented since 2018, consideration should be given to commissioning a specialist mental health assessment unit, staffed with an experienced multidisciplinary team."

6.79. IMRs question the suitability of accommodation options for people living street-based lives, the (wrap-around) support that is available and the training provided for staff. Floating support was available at the time through Croydon Reach, Hestia and HAWK but it does not appear to have been that effective in this instance.

6.80. At the workshop held in October 2020, suitability of accommodation was recognised as crucial, accompanied by wrap-around support that included a focus where appropriate on trauma and loss. At the time of the workshop, it was felt that wrap-around support could not be guaranteed for individuals with similar needs to Duncan.

6.81. At the learning event concern was expressed about the continuing use of Wellington House, although the number of residents has reduced. Concerns was also expressed about the availability of drugs in hostels. Some commissioned providers of supported living noted the challenge of moving individuals on. Other resource shortages were noted, including detox facilities and the absence of a hostel locally where alcohol use could be managed in a safe way. A concern expressed particularly by practitioners working in primary care was the difficulty of referring of referring individuals with comorbidities into secondary care services, highlighting a revolving door and arguing for a specific dual diagnosis pathway. Finally, it was observed that placement outcomes after detox are not always positive, even though the local authority and its partners funded placements, highlighting perhaps the need to review the availability of wrap-around support.

6.82. Whilst recognising funding constraints, those attending the learning event questioned the suitability of current emergency accommodation and emphasised the need for smaller, specialist psychologically-informed emergency and hostel accommodation, with appropriately trained staff, for people recovering from mental ill-health and/or substance misuse. Participants felt that there was a good range of supported housing but questioned whether there was sufficient capacity. It was further emphasised that provision of accommodation is only one part of a jigsaw of need; care and support needs also had to be met, along with focused work on harm minimisation, pre-contemplative work and trauma-informed practice to seek to explore what lies behind substance misuse and mental distress.

6.83. Earlier SARs have also recommended development and/or review of policies and procedures, focusing on escalation[75] and on self-neglect[76]. It would be timely for CSAB to review progress here.

6.84. By contrast, the Housing First model, with the availability of practitioners to provide intensive support, was seen as a positive development. So too was the availability of small units where providers offer more personal and tailored care and support. So too was the development of the START Homeless Outreach Team and a new project involving the establishment of a dual diagnosis team. Nonetheless, practitioners, managers and service

[75] CSAB (2019) SAR – Catherine.
[76] CSAB (2020) SAR – VB.

leads talked of having to balance the offer of long-term, trauma-focused, relationship-based practice, with managing the flow and through-put of referrals. Amongst the obstacles to embedding best practice was mention of insufficient mental health resources and the volume of demand reflected in caseloads.

6.85. **Recommendation Nine: CSAB should consider convening a summit of commissioners and providers to explore where there are gaps in policies, procedures and resources with respect to people experiencing homelessness, substance misuse and/or severe and enduring mental ill-health.**

6.86. Workforce and workplace development are other components of this part of the evidence-base. The observations on management oversight shared by SHS in its IMR are accompanied by the reflection that "*this is in the context of staff carrying very high caseloads and teams often firefighting rather than responding to client need in a planned way*." The CHS IMR refers to staffing resources and to how busy the emergency department can be. It is observed that this had an impact on personalisation of care.

6.87. The SLAM Serious Incident report notes that, in the period following his last discharge from hospital, Duncan was the responsibility of three care coordinators, only the first of whom had any knowledge of dual diagnosis. This, the report concludes, meant a loss of uniformity of care and different perspectives on his presentation. After the first care coordinator, who was a dual diagnosis nurse, left, there was no replacement of a dual diagnosis worker to advocate for this aspect of his care as the team did not have a replacement. The report also notes that the third care coordinator was new to post and that caseloads were large, with variable guidance on optimal numbers. As a result of high caseloads, an extra care coordinator post has been created. However, the report also recommended that the Trust's dual diagnosis lead should advise on the level of knowledge and skills on dual diagnosis required in each team.

6.88. **Recommendation Ten**: **CSAB should seek assurance from SLAM that care coordinators have the required knowledge and skills when working with people experiencing severe and enduring mental illness and substance misuse.**

6.89. At the aforementioned workshop, some providers emphasised that Duncan was not a unique case but that, without training and access to specialist advice and support, their staff did not have sufficient skills to support such service users. Training was recorded as one of the actions arising from the workshop, for instance on trauma-informed practice.

6.90. **Recommendation Eleven: CSAB should consider with partners a sequence of webinars to support staff develop the knowledge and skills to work with people experiencing multiple exclusion homelessness.**

Governance

6.91. Getting the governance right is important. Clearly, CSAB holds the statutory mandate for governance of adult safeguarding. However, there is no one model for where governance of multiple exclusion homelessness might reside – the SAB, Health and

Wellbeing Board, Community Safety Partnership or Homelessness Reduction Board may all be appropriate choices for 'holding the ring', for providing strategic leadership and holding partners to account. What works may vary depending on local government structures. Thus, a governance conversation is needed, inclusive of elected members, partnership and board chairs and strategic leaders, where agreement is reached on a common and shared vision, alongside roles and responsibilities for assuring the quality of policies, procedures and practice. Whatever governance arrangements are agreed locally, they must be able to hold relevant organisations and system leaders to account for delivering strategic objectives and service improvement[77]. **Recommendation Twelve: CSAB should consider initiating a governance conversation on adult safeguarding and multiple exclusion homelessness.**

6.92. This review has been commissioned by CSAB using its mandate in Section 44 Care Act 2014. CSAB with its partner agencies should now consider its approach to reviews of cases involving people experiencing homelessness, especially those that appear not to meet the criteria for a mandatory review under Section 44. Haringey SAB has supported the development of homelessness fatality reviews.[78] As with SARs the focus is on implementing learning, for example on making safeguarding pathways and high risk panels more accessible, and providing staff development opportunities on safeguarding and relevant law. As with SARs, fatality reviews remind managers and practitioners of the importance of relationships in people's lives and also of the impact on staff of fatalities, whether or not they were directly involved in the case. This would be one response to the call[79] for a review of every death of an individual while sleeping rough or in emergency accommodation.

6.93. Several IMRs observe that self-neglect does not appear to have been recognised. The CHS IMR, for example, comments that: "*Duncan's non-compliance with his medication was not readily identified by staff as an aspect of self-neglect which could be detrimental to his welfare*." The SHS IMR comments that: "*Housing and homelessness professionals and partners involved in providing floating support would benefit from induction and training programmes … on working with clients who self-neglect and disengage from services.*" The SLAM IMR observes that: "*Defining self-neglect in subgroup of service users who are drug / alcohol dependent versus life style choice raises many questions.*"

6.94. **Recommendation Thirteen: CSAB should consider whether there is a need for further guidance on working with people who self-neglect and/or for dissemination of good practice guidance and the provision of multi-agency training. This could usefully include a risk assessment toolkit.**

6.95. Individual IMRs contains single-agency recommendations and/or record changes to policy and practice that have already been implemented. Crisis now allocates one lead worker for each service user in order to ensure a clear overview and recording of work done. The CHS IMR comments that: "*At the time of completing this review CHS did not have a published mental health strategy in place. Work is currently underway to finalise this. Since*

[77] Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness. A Briefing on Positive Practice. London: LGA and ADASS.
[78] Presentation by Gill Taylor (2019) Homelessness Fatality Review. Reported in Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness. A Briefing on Positive Practice. London: LGA and ADASS.
[79] Weal, R. (2020) *Knocked Back: How a Failure to Support people Sleeping Rough with Drug and Alcohol Problems is Costing Lives*. London: St Mungo's.

the death of Duncan, ED staff received continuous bespoke training from the safeguarding team and the mental health lead within the trust. This case demonstrates the need to strengthen processes of information sharing, risk assessment and escalation as well as strengthening person centred care." The same IMR suggests that further focus should be given to training and supervision covering risk assessment, identifying and referring safeguarding concerns, mental capacity assessments, consent and information-sharing, and review of hospital discharge procedures concerning people experiencing homelessness.

6.96. The SHS IMR observes that many processes have changed since 2018. All placements are now informed by and made according to legislation on homelessness. A designated post holder links SHS with ASC, with fortnightly meetings to flag up safeguarding concerns regarding people in emergency accommodation. An intensive support post has been established to work with people who have complex needs and have experienced street-based lives. A START service has been implemented, a fortnightly task and targeting meeting can focus on safeguarding concerns, and through a link worker role a tailored service is being offered to SLAM. Some of these developments have been possible through short-term funding from central government.

6.97. The SLAM IMR and Serious Incident report advise that risk assessments and care plans should be shared with GPs prior to hospital discharge to ensure continuity of care, that diagnoses should not be amended or changed without reviewing the patient in person to ensure their involvement, and that best practice for working with people experiencing homelessness should be disseminated, including risk assessment checklists, to improve awareness and the provision of multi- agency wrap-around support. The Serious Incident report advises that risk assessment audits have identified significant improvement. Additionally, there is now a pathway for referring patients who are not registered with a GP and that the CPA discharge operational policy has been updated with respect to confirmation from a GP that they accept transfer of care.

6.98. **Recommendation Fourteen: CSAB should seek assurance on the outcomes of these single-agency changes.**

6.99. The SHS IMR also draws attention to one issue as yet unresolved, namely: "*The issue of a shared understanding of non-engagement, when cases are closed and how this is communicated to partners remains an open problem. With all services under extreme pressure and caseloads often unmanageable, staff may not give priority to clients who avoid contact or where they are perceived as being 'safely housed*'."

6.100. **Recommendation Fifteen: CSAB should consider convening a multi-agency summit to agree expectations and procedures to be followed when a service is considering case closure.**

6.101. The IMRs provided for this SAR were of a good standard. The CHS and SHS IMRs were especially comprehensive, containing critical analysis and incisive reflections. The SLAM Serious Incident report and IMR combined similarly offered a reflective and critical analysis of practice and policy.

6.102. At the learning event it was reported that providers are encouraged to engage with the work with CSAB.

7. The National Context

7.1. Whilst this SAR was being prepared, two national inquiries have reported that have direct applicability to reinforcing the learning from this case. The Black report[80] concludes that public provision with respect to substance misuse is not fit for purpose. Amongst its findings and recommendations, it urges government to reverse its disinvestment in treatment and recover services, and provide the resources and whole system approach that provides people with somewhere to live and something meaningful to do. It recognises that addiction is a chronic health condition requiring long-term follow-up, and emphasises the importance of greater coordination at national and local levels. It observes that prevention is ultimately more cost effective and that trauma and/or mental ill-health are drivers of much addiction, with the consequence that commissioners of substance misuse and mental health must ensure that individuals do not fall through the cracks.

7.2. The interim report of the Kerslake Commission[81] also recognises that ultimately investment in prevention is a more cost effective approach. It recommends a combination of government support and collaboration across and between key service providers to build on the lessons learned from the Everyone In initiative. It notes that this response to the COVID-19 pandemic saved lives and enabled many people who had been experiencing homelessness to move on into longer-term accommodation. This report also recommends a whole system approach, recognising that seeing homelessness as a public health rather than simply a housing issue led to better partnership working, understanding and treatment. The report observes the importance of good quality accommodation, food and in-reach multi-agency services but criticises short-term funding. It recommends that government leads on provision of affordable housing, pathways beyond hostels, and welfare support. It too recommends reversal of disinvestment in substance misuse services and retention of welfare changes and the derogation of rules on priority need, local connection and no recourse to public funds.

7.3. These two reports combined reinforce the critique of the government's approach to homelessness contained in other SARs[82] that have focused on homelessness. Foremost here are the legal rules relating to people with no recourse to public funds, policies on welfare benefits, especially Universal Credit, the lack of affordable housing following policies on social housing, and the impact on public services of policies of financial austerity. The budget challenges faced by the council in Croydon cast a shadow across this review.

7.4. The lessons emerging from this SAR find parallels in other SARs of individual cases and in thematic reviews. They and the two reports summarised above also reinforce the message

[80] Black, C. (2021) *Review of Drugs, Part 2, Prevention, Treatment and Recovery*. London: The Stationery Office.
[81] McCulloch, L. with Cookson, E, Currie, H., Kulkarni, D., Orchard, B and Piggott, H. (2021) *The Kerslake Commission on Homelessness and Rough Sleeping: When We Work Together – Learning the Lessons. Interim Report*. London: St Mungo's.
[82] For example, Manchester SAB (2020) Thematic Review – Homelessness; Tower Hamlets SAB (2020) SAR – Ms H and Ms I. See also Preston-Shoot, M. (2020) *Adult Safeguarding and Homelessness. A Briefing on Positive Practice*. London: LGA and ADASS; Preston-Shoot, M. (2021) *Adult Safeguarding and Homelessness: Experience-Informed Practice*. London: LGA and ADASS.

that, whilst SABs can and should demonstrate leadership in the realm of adult safeguarding and homelessness, service improvements and enhancements of the type recommended by the evidence-base and this SAR will be rendered more difficult to achieve if the national context is not aligned with that same evidence-base, creating a legal, policy and financial context within which practitioners, managers and commissioners can sustain best practice.

7.5. Recommendation Sixteen: CSAB should consider working with SAB regional and national networks to use the escalation protocol agreed with the Department of Health and Social Care to draw attention to the consistent findings in SARs and the importance that government policy supports delivery of best practice as codified by the evidence-base.

8. Revisiting the terms of reference: conclusion and recommendations

8.1. This review set out to address six terms of reference, acknowledging how service provision has evolved in the passage of time since Duncan's death. The following conclusions emerge from the written evidence and from reflections offered by practitioners and managers who contributed to the review.

8.2. On provision of mental health services and support, some practitioners and service leads have questioned the extent to which GPs can provide the kind of mental health monitoring and support that Duncan required. They have also highlighted the importance of outreach and of persistence, and of seeking to maintain engagement or to help secondary mental health services re-engage with individuals with whom they are, or have been in contact. These observations reinforce the critique in this review of Duncan's discharge from CPA despite his ongoing mental health needs. Towards the end of his life no-one in either primary care or secondary mental health care was monitoring Duncan's mental wellbeing. The independent reviewer has been told that accessing support to prevent deterioration of, or to promote recovery from mental ill-health represents a "big hurdle" for people.

8.3. On responses to substance misuse, some practitioners and service leads have stressed the importance of outreach and of working assertively, rather than relying on individuals to engage and to maintain motivation for engagement. They have emphasised the importance of "holding hope for people." In that context, it does not appear that any meaningful work was attempted with Duncan regarding his substance misuse following his final discharge from hospital. This would have required outreach and persistence. A recommendation has been offered about how secondary mental health and substance misuse providers work together.

8.4. On responses to homelessness and temporary accommodation, the review has found that Duncan's wish to live independently after his final hospital discharge was not pursued. Practitioners and service leads have referred to shortages of specialist housing for individual with complex needs. The independent reviewer has been told that accessing appropriate accommodation with support is also a "big hurdle" for people.

8.5. On working together to prevent deterioration and to promote recovery, this review has expressed concern and offered recommendations relating to the provision of mental health after-care and liaison between secondary mental health providers and GPs. A recent SAR[83] recommended that SLAM should ensure that discharge policies reflected NICE guidance. It recommended that the CCG should ensure that GPs review the use of letters when an individual does not respond in a context of a mental health history. A subsequent SAR[84] recommended that GP practices should not deregister adults at risk on the basis of non-contact. Recommendations from this review should be seen as reinforcing the importance of monitoring how responses to earlier SAR recommendations have been embedded in policy and practice.

[83] CSAB (2019) SAR – Catherine.
[84] CSAB (2020) SAR – VB.

8.6. On multi-agency case management, some practitioners and service leads appeared unaware of the Risk and Vulnerability Management Panel in a context of working with individuals where it is proving difficult to mitigate or eliminate risk. In that context, some informants for the review observed that in their recent work experience no-one had wanted to take responsibility for working with people where the risks were significant and likely. The outcome was referral bouncing. A recent SAR[85] recommended that use of the Risk and Vulnerability Management Panel be monitored, including audits to measure outcomes. This review also offers a recommendation on auditing the use of multi-agency panels and meetings.

8.7. On partnership working between services, practitioners, managers and service leads have talked positively about developments since Duncan's death, pointing to relational networking between statutory and third sector agencies, and responsive commissioning. Nonetheless, they have also observed the ongoing need for integrated case management, for example between providers of mental health and substance misuse services. As the aforementioned workshop identified, practice has too often been characterised by a lack of consistency to help people. It has also been suggested to the independent reviewer that services should collectively rethink their approach to suicidal ideation. Perhaps also CSAB should question partner agencies whether there remains a culture where the focus is on eligibility and on expecting individuals to engage as determined by services rather than on maximising flexibilities within and between services to promote wellbeing and prevention, and to notice and coordinate responses to escalating needs and risks.

8.8. The following recommendations are offered to CSAB for consideration as a result of the learning that has emerged from analysis of practice with Duncan and subsequent service development.

8.8.1. Recommendation One: CSAB is advised to review its understanding of the mandatory and discretionary criteria for SARs as outlined in Section 44 Care Act 2014 and to assure itself that its decision-making is informed by a referral form that captures essential information and is fully compliant with statutory guidance.

8.8.2. Recommendation Two: CSAB should consider engaging with the CCG and with NHS England on recommended practice regarding GP registration when patients at risk move across local authority boundaries, and regarding primary care support for patients with multiple and complex (mental health and substance misuse) needs.

8.8.3. Recommendation Three: CSAB should seek assurance about access to care and support assessments, and how ASC meets its responsibilities to promote wellbeing and prevention, and how its power to meet care and support needs is considered alongside its duty to respond to eligible needs.

8.8.4. Recommendation Four: CSAB should consider seeking assurance by means of an audit of the implementation of the guidance on referrals to, and joint working between SLAM and Turning Point.

[85] CSAB (2020) SAR – VB.

8.8.5. Recommendation Five: CSAB should consider seeking assurance from SLAM regarding the implementation of the CPA.

8.8.6. Recommendation Six: CSAB should consider auditing the use of multi-agency panels and meetings.

8.8.7. Recommendation Seven: CSAB should consider seeking assurance from SLAM and ASC that a robust process is in place for decision-making regarding referrals of adult safeguarding concerns, and for monitoring the outcomes of adult safeguarding enquiries.

8.8.8. Recommendation Eight: CSAB should consider seeking assurance from SLAM and ASC that the absolute duty to provide section 117 after-care plans is met, with a register held of those eligible for after-care and with plans regularly reviewed and maintained for as long as the individuals concerned have needs related to their mental wellbeing.

8.8.9. Recommendation Nine: CSAB should consider convening a summit of commissioners and providers to explore where there are gaps in policies, procedures and resources with respect to people experiencing homelessness, substance misuse and/or severe and enduring mental ill-health.

8.8.10. Recommendation Ten: CSAB should seek assurance from SLAM that care coordinators have the required knowledge and skills when working with people experiencing severe and enduring mental illness and substance misuse.

8.8.11. Recommendation Eleven: CSAB should consider with partners a sequence of webinars to support staff develop the knowledge and skills to work with people experiencing multiple exclusion homelessness.

8.8.12. Recommendation Twelve: CSAB should consider initiating a governance conversation on adult safeguarding and multiple exclusion homelessness.

8.8.13. Recommendation Thirteen: CSAB should consider whether there is a need for further guidance on working with people who self-neglect and/or for dissemination of good practice guidance and the provision of multi-agency training. This could usefully include a risk assessment toolkit.

8.8.14. Recommendation Fourteen: CSAB should seek assurance on the outcomes of these single-agency changes.

8.8.15. Recommendation Fifteen: CSAB should consider convening a multi-agency summit to agree expectations and procedures to be followed when a service is considering case closure.

8.8.16. Recommendation Sixteen: CSAB should consider working with SAB regional and national networks to use the escalation protocol agreed with the Department of Health and Social Care to draw attention to the consistent findings in SARs and the

importance that government policy supports delivery of best practice as codified by the evidence-base.