2023

Multiple Exclusion Homelessness Safeguarding Adults Review

COLIN SAR

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Contents

1. Introduction

1.1 In mid-2022 Barnet's Safeguarding Adults Board [BSAB] received two referrals for a Safeguarding Adults Review [SAR]. Two men, with care and support needs had died while sleeping rough in the borough, each in very different circumstances. Both men were of white ethnicities.

1.2 This SAR reviews the circumstances of the care and support received by one of those men, Colin[1].

1.3 In May 2022 Colin died from a sustained violent attack while he was sleeping rough in North Finchley. He died on his 55th birthday. The perpetrator of the attack pleaded guilty to manslaughter on the grounds of diminished responsibility. The perpetrator was sentenced with a hospital order. There is nothing to suggest that Colin and the perpetrator knew each other before these tragic events. Consideration is underway as to whether the circumstances of the perpetrator's experience also require a review under any of the statutory review processes. This includes discussions with the Mental Health Trust and NHS England in respect of a Mental Health Homicide Review.

1.4 Colin had many characteristics of what is termed *Multiple Exclusion Homelessness*. That is, that in addition to a history of housing need, he had experienced:

- Physical and mental ill health
- Drug and/or alcohol misuse
- Experiences of institutional care and/or in criminal justice settings

1.5 People who experience multiple exclusion homelessness often have histories of significant exclusion that begun early in their lives, for example in their childhoods. This SAR did not review Colin's early life, but rather focused on the circumstances in the months before his death.

1.6 The purpose of a SAR is not to re-investigate or to apportion blame, nor to carry out a human resources investigation, nor to establish how someone died. The purpose of the SAR is to

- establish whether there are lessons to be learned from Colin's circumstances about the way in which local professionals and agencies work together to safeguard adults;
- review the effectiveness of procedures (both multi-agency and individual organisations);
- inform & improve local interagency practice by acting on learning (developing best practice); and
- prepare a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

[1] The review has chosen pseudonyms to offer some anonymity to the adult and his former partner.

1.7 The SAR focuses on the period January 2021 to May 2022, but also draws on what was learned about Colin's life before then.

1.8 The review Terms of Reference set out some key lines of enquiry, and these are addressed in more detail in the section on Methodology below.

1.9 On 15 July 2021 Barnet's Health and Wellbeing Board approved a Health and Wellbeing Needs Assessment of Rough Sleepers in Barnet. This is a key document which sets out the health needs of people who sleep rough in Barnet. A link can be found at Appendix 5.

1.10 This Health and Wellbeing Needs Assessment sits alongside two other Barnet documents: The borough's Housing Strategy and Homelessness and Rough Sleeping Strategy[2].

2. Colin

2.1 The information the review gathered about Colin was drawn from records, accounts from primary care and mental health clinicians who had worked directly with him, and from his former partner Francesca. Colin's family was invited to contribute to the SAR, but they were not able to take up this offer.

2.2 Colin was born in May 1967. He died on his 55th birthday.

2.3 In recent years Colin was a patient of Barnet, Enfield and Haringey Mental Health NHS Trust (BEHMHT). Records they hold indicate that he had a diagnosis of Paranoid Schizophrenia dating back to 1987. When the reviewer spoke with Francesca, she recalled a time when, as a younger man, he was an in-patient at St Ann's Hospital in South Tottenham; now also part of BEHMHT.

2.4 In recent years, he was treated with anti-psychotic medication via a depot injection[3]. His engagement with this treatment was inconsistent, and although he was offered several different ways to receive his medication, including cold calling at his accommodation and dropping in at a depot clinic, this did not appear to have an impact on his engagement.

2.5 Colin used substances such as cannabis and crack cocaine. The IMR provided by BEHMT is silent about how this impacted on his mental health and behaviours other than to reference challenges with debt and involvement with loan sharks, and an earlier episode of his accommodation being cuckooed by drug dealers.

2.6 The records provided to the review do not evidence the involvement of any dual diagnosis workers in BEHMHT. Colin had some earlier sporadic contact with Change Grow Live [CGL], an alcohol and drug treatment agency, but this did not lead to him taking up their services.

[2] Both documents can be downloaded from https://www.barnet.gov.uk/housing/housing-strategy

[3] A depot injection uses a liquid that releases the medication slowly so that its effects last longer. It is commonly used for anti-psychotic medication.

2.7 Colin had a long-term relationship with Francesca. They had known each other since their late teens. In recent years, Colin had lived with Francesca on and off, sometimes for extended periods of time. He often used her address as his contact address.

2.8 Francesca told the reviewer that many years ago Colin had been admitted to a mental health hospital following a crisis in his personal life. She expressed a wish that when he was clearly unwell more recently, he might have been recalled to institutional care for his safety and that of others.

2.9 Francesca told the reviewer that their relationship was often mutually supportive. BEHMT records identify Colin as being Francesca's carer. However, it was also characterised by episodes of domestic abuse, including some which involved the police.

2.10 Barnet's Multi-Agency Risk Assessment Conference [MARAC] arrangements for domestic abuse had been activated to assess the risks that the couple were experiencing. The MARAC was actively involved in monitoring the couple during 2021. From 9 November 2021, Colin was subject to a restraining order to protect Francesca from harassment.

2.11 During the first part of 2021 Colin was staying with Francesca. This was an informal arrangement. From 9 November 2021 when the restraining order was in place, Colin was homeless.

2.12 When the Court issued the restraining order, the Mental Health Liaison and Diversion Team run by Central and North West London Mental Health NHS Trust provided a report. They noted that Colin had been discharged to his GP by BEHMHT. No actions were recorded in relation to his need for housing, nor indeed any other needs, despite Francesca's address being where he had been living.

2.13 On several occasions Colin breached his restraining order. Some of these came to the attention of the police. The MARAC team identified that there was an escalation of domestic abuse involving Colin and Francesca from December 2021 to March 2022.

2.14 Colin and Francesca were both registered with the same Barnet GP Practice. They were both registered as living at Francesca's address.

2.15 Colin used the drop-in services of a third sector organisation Homeless Action in Barnet [HAB]. In 2021 he was dropping into HAB from time to time requesting help with housing, food, and his dog. HAB noticed a more chaotic pattern towards the end of 2021. The frequency of his attendance increased in 2022.

2.16 In March 2022 attempts were made by HAB to help Colin get support from Barnet Homes, Barnet's housing arm's length management organisation. This led Barnet Homes agreeing

with HAB an immediate plan to assess Colin's needs. Following this through was thwarted by Colin disengaging and not being easily contacted independently by Barnet Homes.

2.17 At this point there is no evidence in the records to suggest that any outreach methods of engagement were explored.

2.18 In July 2021, Colin's community mental health team at BEHMHT decided to discharge him from their services due to his lack of engagement with them. They wrote to his GP to confirm this decision. Colin did drop into his GP once after that. He had dental pain and the practice responded proactively. They also reported that they assisted him to get a Covid vaccination.

2.19 There are many references in Colin's records, and the accounts of working with him, about great difficulties in engaging him in addressing his needs for care, support, and accommodation.

2.20 In January 2022, Francesca's social worker, in discussion with Colin who was present in Francesca's house, referred Colin back to BEHMHT. The referral was picked up and was under consideration. The referral did state that Colin was street homeless and was staying with Francesca. There was no reference in the referral to this being in breach of a restraining order.

2.21 In a reflection session held with Trust staff, the reviewer was told that caseload pressures meant that Colin was not prioritised for allocation. No records were provided of any needs assessment, risk assessment or ongoing monitoring of his referral status by BEHMHT.

2.22 In February 2022 Colin was living on the street. It is likely that this started around the time of the restraining order in November 2021, when he also told HAB that he was homeless.

2.23 Colin died as a result of manslaughter in May 2022 while sleeping rough in North Finchley.

2.24 Tracking people who sleep rough in London

2.25 There are several ways in which Local Authorities in London and the Greater London Authority [GLA] track and respond to people who sleep rough on the city's streets. The most widely used of these is the Combined Homelessness and Information Network (CHAIN).

2.26 During the early period of the pandemic in 2020/2021, the Government's *Everyone In* programme provided accommodation for all people sleeping rough in England. While a very small number of people did not take up the opportunity, they were carefully tracked in London, including in due course to offer the Covid vaccine.

2.27 There are no records whatsoever of Colin being identified as a rough sleeper during that *earlier* 2020 period. This suggests that he was able to secure and maintain accommodation with associates during that time. It is perhaps some evidence of personal and community resilience in nationally difficult times.

3. Thematic Analysis – Direct Work with Colin

3.1 Several issues emerge in the chronologies, IMRs and from a reflective session with practitioners. The BEHMHT team responsible for Colin knew about:

- his housing status (i.e., that he was sofa surfing with his then partner Francesca),
- his history as a perpetrator of domestic abuse towards Francesca who had additional care, support and mobility needs,
- his difficulties in sustaining tenancies,
- his substance misuse with crack cocaine and cannabis and consequent exposure to crime and organised crime,
- his non-engagement and non-compliance with his antipsychotic medication arrangements,
- his GP's view in June 2021 that he might need a mental health assessment in the near future,
- his significant dental health needs,
- his history of physical health needs.

3.2 The judgement reached by this team, when they discharged him to his General Practice, that he did not pose a risk to himself, or others is wholly inaccurate and not based on a rational and comprehensive assessment of the risks he faced personally because of his own needs, or the risks that he posed to Francesca.

3.3 When the reviewer met with Colin's responsible clinician, a psychiatrist, they said that the decision to discharge Colin from BEHMHT was discussed in advance with Colin's GPs. This assertion is not borne out in the BEHMHT's records provided to the SAR, nor in the GP records. If this took place, it was not recorded by either party.

3.4 There is a record of a conversation between Colin's GP and his Care Coordinator on 22 June 2021, following an attendance by Colin at the GP surgery for significant dental needs. The GP recorded that although they did not think that Colin needed a Mental Health Assessment at that time, he might in the near future.

3.5 Colin was a mental health community patient with an earlier history of having been an in-patient in a mental health hospital.

3.6 During much of his time as a BEHMHT patient, the service operated as an integrated health and social care service. Based on what was known, Colin was likely to have had adult social

care and support needs. However, the records provided to the review are silent on whether these were assessed under the provisions of the Care Act 2014.

3.7 The records are largely silent on how Colin's care was being managed under the Care Programme Approach. There is one brief record of a CPA review meeting in the chronology provided dated June 2021. This took place in Francesca's home with Colin present and the plan to discharge Colin from mental health services was discussed with him.

3.8 The notes of the CPA meeting do not reference the risks outlined above, including no references to Colin's housing need as he was living with Francesca informally and was a perpetrator of domestic abuse towards her, monitored by Barnet's MARAC.

3.9 Colin's circumstances established a set of rights under the terms of the Care Act 2014 and the associated Care and Support Statutory Guidance.

3.10 The Care and Support Statutory guidance says this about adult safeguarding: *"Protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances."*

3.11 There is no evidence in the records that a consideration of safeguarding issues informed the decision to discharge him from mental health services – the safeguarding of Colin himself, and the safeguarding of his former partner Francesca. No safeguarding referrals were made to Adult Social Care at this time.

3.12 Normalisation and desensitisation to events in a person's life, and the risks the person may be experiencing, are recognised dangers in safeguarding practice. Practitioners may become so accustomed to patterns of behaviours in an individual that they are no longer startled by events that might shock them if they happened to someone else in different circumstances. To discharge Colin from secondary mental health services to General Practice without making a safeguarding referral betrays an unfounded optimism about the likely outcomes of this decision and indicates a desensitisation to the risks he faced and posed.

3.13 The records provided for Colin are largely silent on issues of his mental capacity. His long use of substances is likely to have had an impact on his decision-making capacity. That meant that consideration had to be given to his decision-making capacity and his executive functioning within the terms of the Mental Capacity Act 2005, its Code of Practice and practice guidance. What is meant by executive capacity is Colin's ability to follow through on stated intentions by planning and actions. Indeed, his inability to comply with his medication

regime or the later restraining order against him, set alongside his substance misuse are highly suggestive of fluctuating capacity.

3.14 There is no assessment of Colin's executive functioning in any of the records provided to the review.

Recommendation 17

Barnet Safeguarding Adults Board: Consider with SAB members whether local services have a sufficient understanding of executive functioning in the context of Mental Capacity Assessments for people with dual mental health and substance use diagnoses and commission further practice guidance and training if required.

3.15 After he was discharged from BEHMHT, staff in his GP Practice did attend to Colin once when he presented at the surgery. A GP also reported observing him begging in the street. It is not clear whether they knew that he might be street homeless and the actions they could have taken to ensure a response from Barnet's rough sleeping services or from Streetlink.[4]

3.16 In January 2022 Francesca's social worker, in discussion with Colin, referred Colin back to BEHMHT. The referral was picked up and was under consideration. The referral did state that Colin was street homeless and was intermittently staying with Francesca. There was no reference in the referral to this being in breach of a restraining order. This was a serious omission both in terms of the urgency of Colin's needs, and the risks that he posed to Francesca.

Recommendation 10

Barnet Adult Social Care: review whether Francesca's safeguarding needs were adequately considered when a) it became apparent that Colin was living with her in breach of his restraining order and b) BEHMHT did not respond rapidly to Colin's referral to their services.

3.17 HAB had many concerns about Colin's wellbeing. As well as being difficult to engage in HAB as well, Colin was adamant that information about him should not be shared with other agencies. They were sufficiently concerned about the risks that Colin was exposed to, to contact adult social care about safeguarding concerns. However, records of this referral were not kept by HAB.

[4] Streetlink is a third sector organisation that can respond to alerts about people sleeping rough. https://www.streetlink.org.uk/

3.18 During the period under review, HAB had virtually no access to mental health advice from BEHMHT or any other specialist health service with the provision to assess, support and intervene in situations of risk related to vulnerable service users. Given the complex nature of homelessness experiences, and the disproportionate prevalence of mental health needs within the homeless population, this gap had a significant impact on their ability to respond effectively to people who accessed their service with these needs. It is common for third sector organisations to experience disconnection and lack of parity of esteem with statutory organisations. That said, in the last five years the provision of specialist integrated homelessness health services who work collaboratively with third sector partners is increasing; BEHMHT has delivered services as part of one such specialist team in the neighbouring London Borough of Haringey since 2020.

3.19 One way of acknowledging the risk picture that Colin presented, and considering what could have been done to mitigate risks further would have been to convene a multi-agency risk assessment panel attended by all the agencies working with him and any agencies that might contribute to potential mitigations.

3.20 The primary responsibility for this would have rested with the BEHMHT care coordination team.

3.21 The London Multi-Agency Adult Safeguarding Policy and Procedures describe this arrangement as follows:

3.22 "*Community Multi-Agency Risk Panels are one type of Multi-Agency working on complex and high-risk cases, often where agencies spend significant amounts of time responding to difficult, chaotic or problematic behaviour or lifestyles that place the person, and possibly others, at significant risk. Panels can be created with all necessary partners, both statutory and third party and will vary depending on local need of the case in question. Any situation calling for Multi-Agency action could be discussed at panel meetings. The panel will support agencies in their work to lower and manage risk for both individuals and the wider community.*

3.23 *Community Multi-Agency Risk Panels are based on the belief that shared decision making is the most effective, transparent and safe way to reach a decision, where there is challenge with the adult at risk and professionals working with them to mitigate the risk; or where there is a highly complex case and the risk needs to be escalated for consideration by such a panel. The purpose of the Panel is to agree a risk reduction plan that is owned and progressed by the most relevant agency with the support of necessary partners."*

3.24 Barnet's Multi-Agency Risk Panel is named the Adult Social Care and Health Panel and has detailed terms of reference.

3.25 The evidence provided to the review indicates practitioners did not benefit from the knowledge, expertise and collaboration provided by a strong multi-agency partnership. Evidence indicates a lack of connection between statutory and voluntary sector partners, ineffective and incomplete information sharing between agencies involved in Colin's care

and desensitisation to risks posed and faced. Although evidence suggests practitioners may have lacked knowledge about the Adult Social Care and Health Panel, no other attempt to convene a multi-agency risk discussion was made, despite this being established good practice across social care and health.

Recommendation 16

Barnet Safeguarding Adults Board: Disseminate clear guidance on convening multi-agency high risk meetings and panels and ensure this is made available to voluntary sector organisations as well as statutory partners. Consider requesting an audit of the existing panel mechanism to understand which populations it is serving, which organisations are making use of the resource and who appears to be underserved.

Recommendation 1

Barnet Enfield and Haringey NHS Mental Health NHS Trust: Undertake an urgent review of the practice that led to Colin's discharge from mental health services with no recorded consideration of a range of risk factors to himself and to his former partner Francesca and no referral to Barnet's high-risk panel. This review should include the quality of record keeping, which consistently failed to detail issues of risk and planned risk mitigation.

Recommendation 5

Barnet, Enfield and Haringey Mental Health NHS Trust: Based on the learning from this SAR, review current policy and practice related to domestic abuse, in particular ensuring that there is adequate provision of information and training for staff about effective safeguarding for vulnerable patients and their family, friends and partners who are at risk of perpetrating or experiencing domestic abuse.

Recommendation 7

Barnet, Enfield and Haringey Mental Health NHS Trust and Barnet Adult Social Care: Review BEHMHT's discharge policies to ensure that Care Act needs are always considered and assessed as part of discharge risk assessments and discharge planning processes.

Recommendation 8

Barnet, Enfield and Haringey Mental Health NHS Trust: Based on the learning from this SAR and SAR Phil, urgently review and update risk management practices, interagency communication, and eligibility criteria related to co-occurring mental health, alcohol and

drug use. In particular, ensure due consideration is given to NICE guidance concerned with homelessness and domestic abuse[5].

4. Thematic Analysis – Team around the Person

4.1 Sadly, the events leading up to Colin's death do not reveal cohesive approaches to practitioners working as a multi-agency team to safeguard him.

4.2 In 1:1 and group meetings conducted as part of the review, the reviewer observed that participants frequently described the difficulties they experience in engaging with professional partners. This included:

- HAB finding mental health services impenetrable and inaccessible to them as fellow professionals working. HAB spoke with candour about the lack of respect they experienced from mental health services when seeking to advocate for individuals whose needs they know well, often over many years.
- Mental health services finding statutory housing services unresponsive to their clients' needs.
- Mental health services finding adult social care distant (especially following a 2021 decision to disaggregate formerly integrated arrangements).
- Adult social care services finding mental health services distant and unresponsible to need.
- General Practice wanting to enhance their housing knowledge and asking for help with this, including and especially for their social prescribers.

4.3 These experiences may not be experienced universally by all professionals and teams working in the borough. However, that a pattern of disconnection, dismissal, lack of knowledge and lack of parity of esteem is observable indicates significant gaps in multi-agency working practices and the desire from practitioners for these to be addressed.

4.4 The reviewer did not hear confident accounts from practitioners and managers about clear governance arrangements that promote locally agreed processes and procedures when dealing with the sorts of circumstances that Colin presented.

5. Organisations around the Team

5.1 The reviewer chaired a large virtual meeting of a wide range of mental health, social care, housing, housing support, commissioning and public health practitioners and managers. This was to consider the arrangements Barnet has, to enable escalation of mental health and substance misuse cases of concern from housing agencies to mental health and substance misuse services.

5.2 Those attending agreed that organisations in Barnet need to come together differently and cohesively to address the needs of individuals experiencing multiple exclusion

[5] https://www.nice.org.uk/guidance/ph50

homelessness. Examples were given of work that is underway to contribute to this which is positive.

5.3 During the review BEHMHT confirmed that they do not have a policy on client housing need and are guided by the relevant Local Authority's Housing policies and protocols. This is simply not an acceptable institutional position and does not reflect how they work in other boroughs they serve.

Recommendation 4

Barnet, Enfield and Haringey Mental Health NHS Trust: Drawing on the NHS Confederation's report *Healthy foundations: integrating housing as part of the mental health pathway* (2022)[6], and examples of good practice such as the work of Sussex Partnership NHS Foundation Trust[7], and aligned with recommendation 9.12, oversee the delivery of a Trust work plan that integrates housing into the Trust's service user pathways in Barnet. This should include:

- Contribution from people with lived experience
- Contribution from relevant third sector organisations
- Contribution from the local authority and their ALMO
- Dissemination of NICE guideline [NG214] *Integrated health and social care for people experiencing homelessness*
- Resource commitments, including ensuring that new resources are deployed in line with current good practice evidence
- Governance arrangements for ongoing oversight

5.4 The circumstances of Colin's unmet care and support needs, leading to him sleeping rough, placing him at severe risk, leading directly to a shortened life. The circumstances provide a window on issues that may be arising for other people in similar circumstances.

Recommendation 5

Public Health and Mental Health Commissioners and Barnet, Enfield and Haringey Mental Health NHS Trust: Review the referral pathways for people with co-occurring mental health and alcohol and drug use to ensure that dual diagnosis services are made available to those who need them and that individuals who pose a risk of violence to others connected with these needs are prioritise for access to services. Ensure that referral pathways and information about what is available from specialist services/teams

[6] https://www.nhsconfed.org/publications/healthy-foundations-integrating-housing-part-mental-health-pathway

[7] https://www.sussexpartnership.nhs.uk/about-us/news-events/latest-news/improving-access-housing-people-mental-health-needs

are communicated clearly to referrers including (but not limited to) Primary Care, Adult Social Care and care homes.

6 Interagency governance by the SAB

6.1 It is notable that there are no housing or homelessness organisations, or senior leaders named as standing members of Barnet SAB, and that during the review period homelessness did not feature in the strategic priorities or annual report of the Board.

6.2 Although this may not have had a direct impact on Colin's circumstances, a focus on housing and homelessness could have provided a platform to explore issues related to safeguarding people affected by rough sleeping and to shed light on the gaps in multi-agency working practices.

Recommendation 11

Barnet Safeguarding Adults Board and Barnet Council: Review the membership of the SAB and appoint a new member or members to provide senior systems leadership on issues of housing and homelessness.

Recommendation 12

Barnet Safeguarding Adults Board and Barnet Council: Oversee the delivery of a work programme, led by relevant senior officers in the local authority where the statutory responsibility for homelessness is held, that reviews, re-designs, delivers, disseminates, and subsequently audits Barnet's pathway for adults who experience Multiple Exclusion Homelessness. This should include:

- Contribution from people with lived experience
- Contribution from third sector organisations working with people with MEH
- Information sharing guidelines
- Dissemination of NICE guideline [NG214] Integrated health and social care for people experiencing homelessness
- Resource commitments
- Governance arrangements for ongoing oversight

Recommendation 13

Barnet Safeguarding Adults Board: related to the above, consider the conclusions and recommendations from this report alongside SAR Phil, to ensure that SAB strategic priorities, local strategies and policies, such as those related to commissioning and safeguarding, effectively consider the lived experience of Multiple Exclusion Homelessness. This would include considering how services identify and manage risk, the case for implementing formal lead professional arrangements and the training available for health practitioners and clinicians about local homelessness services and interventions.

6.3 Since the commissioning of this SAR, led by Public Health, Barnet has taken forward a significant programme of work to address the needs of people who experience Multiple Exclusion Homelessness. This work will contribute to the action plan that the SAB will oversee to address the recommendations in section 9 below.

7 The Wider Legal, Policy and Financial Context

7.1 The appendix on the Evidence Base for Good Practice sets out a range of useful current resources.

7.2 The fact that they were current in 2021 reflects a very significant amount of national work undertaken by the Department for Levelling Up, Housing and Communities, work by NHS England and regional work by the GLA and the then Healthy London Partnership. All of this built on the work of the *Everyone In* programme.

7.3 There is no shortage of policy and practice guidance. However, it is delivered in a context of years of austerity policies which have reduced the availability of housing and support services.

7.4 With reference to housing policy, the London Borough of Barnet has in recent years prioritised the building of new homes and ensuring suitable infrastructure to accommodate the consequent population increases. From a policy perspective, the borough has had less focus on people who sleep rough and experience multiple deprivation.

8 Conclusion

8.1 Colin died a violent death at the hands of another person in May 2022, while sleeping rough in Barnet. In the last few months of his life, his ties with statutory support were almost non-existent, and the voluntary services who supported him were unable to access the advice and support they needed from partners to meet his needs. Except for being able to secure a GP appointment, Colin was not in receipt of any health interventions at the time of his death.

8.2 Despite having a long-documented history of mental health and substance misuse needs, the statutory agency responsible for his care management, BEHMHT, had discharged him to

the care of General Practice with no contingency arrangements in place to manage the many risks that he would face and the risks that he posed to others, primarily to Francesca.

8.3 The decision to discharge him placed both Colin and Francesca at increased risk, and there is no evidence of any safeguarding referrals to address her additional risks, or indeed his.

8.4 There were no recorded attempts to seek an assessment of his care and support needs through a Care Act assessment by Adult Social Care. The decision to discharge Colin from the community mental health team reveals a completely unfounded optimism about the likely outcomes of this decision and/or a desensitisation to the risks he faced and posed.

8.5 The primary responsibility for the discharge decision lay with BEHMHT. However, the General Practice that accepted Colin's discharge and transfer from secondary mental health services to their care was remiss in accepting this decision given the significant needs that Colin had, and the risks he posed to Francesca who was also their patient at the time.

Recommendation 9

Barnet Enfield and Haringey NHS Mental Health NHS Trust & Barnet Primary Care Networks/North Central London Integrated Care Board: undertake a review of relevant information sharing protocols and decision-making practice between primary, secondary and community health services supporting adults with care and support needs. The review should consider how risks are identified, managed and shared between agencies, how decisions about discharging people to primary care are made collaboratively and in what circumstances it is appropriate for primary care clinicians to challenge decisions to discharge people to their care who present significant and unmanageable risks. If such a protocol is not in place, urgently consider implementing one, alongside any training or communications required to ensure staff are aware of what is expected.

8.6 This Safeguarding Adults Review cannot with 20/20 hindsight say what a multi-agency risk discussion or panel might have determined. However, based on established good practice, it is clear that some form of multi-agency discussion should have been convened at any one of the key intervals of change in Colin's life during the review period. This discussion may have considered alternatives to discharging Colin, multi-agency actions to monitor his compliance with medication, actions to enable an assessment of his housing, care and support needs and Colin's own wishes about his life and his health. At a later stage it could have reviewed the implications of the restraining order.

8.7 Colin asked to be re-referred to BEHMHT in January 2022, which was accompanied by a professional referral from Adult Social Care. Some risk factors were identified in the professional referral but the fact that he was subject to a restraining order in relation to Francesca was not mentioned. Despite this, Colin was well known to BEHMHT and so it is reasonable to expect that the re-referral would have been identified as a priority. BEHMHT

were unable to account for why Colin was not re-assessed rapidly, and why by May 2022 no contact had been made with Colin to discuss the referral, other than to cite workload pressures.

Recommendation 2

Barnet Enfield and Haringey NHS Mental Health NHS Trust: Undertake a detailed review of the delay in responding to Colin's professional referral and self-referral back to the Trust made on 17 January 2022, which did not result in any contact with Colin by the time of his death in May 2022, despite the known risk factors and the professional referral citing his street homelessness.

9 Recommendations

Evidence collated as part of the review highlights gaps in multi-agency practice and challenges in relationships between statutory and voluntary sector organisations. The recommendations below identify lead organisations, but it is the perspective of the Reviewer that collaboration and parity of esteem between partners must be at the heart of delivering the change required. As such, each recommendation is an opportunity to collaboratively with partners from all relevant sectors and organisations.

9.1 **Barnet Enfield and Haringey NHS Mental Health NHS Trust:** Undertake an urgent review of the practice that led to Colin's discharge from mental health services with no recorded consideration of a range of risk factors to himself and to his former partner Francesca and no referral to Barnet's high-risk panel. This review should include the quality of record keeping, which consistently failed to detail issues of risk and planned risk mitigation.

9.2 **Barnet Enfield and Haringey NHS Mental Health NHS Trust:** Undertake a detailed review of the delay in responding to Colin's professional referral and self-referral back to the Trust made on 17 January 2022, which did not result in any contact with Colin by the time of his death in May 2022, despite the known risk factors and the professional referral citing his street homelessness.

9.3 **Barnet Enfield and Haringey NHS Mental Health NHS Trust:** Review why the circumstances of Colin's death were not investigated in line with standard Trust and national serious incident review procedures.

9.4 **Barnet, Enfield and Haringey Mental Health NHS Trust:** Drawing on the NHS Confederation's report *Healthy foundations: integrating housing as part of the mental health pathway* (2022)[8], and examples of good practice such as the work of Sussex

[8] https://www.nhsconfed.org/publications/healthy-foundations-integrating-housing-part-mental-health-pathway

Partnership NHS Foundation Trust[9], and aligned with recommendation 9.12, oversee the delivery of a Trust work plan that integrates housing into the Trust's service user pathways in Barnet. This should include:

- Contribution from people with lived experience
- Contribution from relevant third sector organisations
- Contribution from the local authority and their ALMO
- Dissemination of NICE guideline [NG214] *Integrated health and social care for people experiencing homelessness*
- Resource commitments, including ensuring that new resources are deployed in line with current good practice evidence
- Governance arrangements for ongoing oversight

9.5 **Barnet, Enfield and Haringey Mental Health NHS Trust:** Based on the learning from this SAR, review current policy and practice related to domestic abuse, in particular ensuring that there is adequate provision of information and training for staff about effective safeguarding for vulnerable patients and their family, friends and partners who are at risk of perpetrating or experiencing domestic abuse.

9.6 **Public Health and Mental Health Commissioners and Barnet, Enfield and Haringey Mental Health NHS Trust:** Review the referral pathways for people with co-occurring mental health and alcohol and drug use to ensure that dual diagnosis services are made available to those who need them and that individuals who pose a risk of violence to others connected with these needs are prioritise for access to services. Ensure that referral pathways and information about what is available from specialist services/teams are communicated clearly to referrers including (but not limited to) Primary Care, Adult Social Care and care homes.

9.7 **Barnet, Enfield and Haringey Mental Health NHS Trust and Barnet Adult Social Care:** Review BEHMHT's discharge policies to ensure that Care Act needs are always considered and assessed as part of discharge risk assessments and discharge planning processes.

9.8 **Barnet, Enfield and Haringey Mental Health NHS Trust:** Based on the learning from this SAR and SAR Phil, urgently review and update risk management practices, interagency communication, and eligibility criteria related to co-occurring mental health, alcohol and drug use. In particular, ensure due consideration is given to NICE guidance concerned with homelessness and domestic abuse[10].

9.9 **Barnet Enfield and Haringey NHS Mental Health NHS Trust & Barnet Primary Care Networks/North Central London Integrated Care Board:** undertake a review of relevant information sharing protocols and decision-making practice between primary, secondary and community health services supporting adults with care and support needs. The review should consider how risks are identified, managed and shared between agencies, how decisions about discharging people to primary care are made collaboratively and in what

[9] https://www.sussexpartnership.nhs.uk/about-us/news-events/latest-news/improving-access-housing-people-mental-health-needs
[10] https://www.nice.org.uk/guidance/ph50

circumstances it is appropriate for primary care clinicians to challenge decisions to discharge people to their care who present significant and unmanageable risks. If such a protocol is not in place, urgently consider implementing one, alongside any training or communications required to ensure staff are aware of what is expected.

9.10 **Barnet Adult Social Care:** review whether Francesca's safeguarding needs were adequately considered when a) it became apparent that Colin was living with her in breach of his restraining order and b) BEHMHT did not respond rapidly to Colin's referral to their services.

9.11 **Barnet Safeguarding Adults Board and Barnet Council:** Review the membership of the SAB and appoint a new member or members to provide senior systems leadership on issues of housing and homelessness.

9.12 **Barnet Safeguarding Adults Board and Barnet Council:** Oversee the delivery of a work programme, led by relevant senior officers in the local authority where the statutory responsibility for homelessness is held, that reviews, re-designs, delivers, disseminates, and subsequently audits Barnet's pathway for adults who experience Multiple Exclusion Homelessness. This should include:

- Contribution from people with lived experience
- Contribution from third sector organisations working with people with MEH
- Information sharing guidelines
- Dissemination of NICE guideline [NG214] Integrated health and social care for people experiencing homelessness
- Resource commitments
- Governance arrangements for ongoing oversight

9.13 **Barnet Safeguarding Adults Board:** related to the above, consider the conclusions and recommendations from this report alongside SAR Phil, to ensure that SAB strategic priorities, local strategies and policies, such as those related to commissioning and safeguarding, effectively consider the lived experience of Multiple Exclusion Homelessness. This would include considering how services identify and manage risk, the case for implementing formal lead professional arrangements and the training available for health practitioners and clinicians about local homelessness services and interventions.

9.14 **Barnet Safeguarding Adults Board:** Commission a work programme that brings together Barnet Housing, Barnet Homes, Third Sector providers of housing and housing support, and General Practice to design and deliver training for General Practice teams, including their social prescribers, on the role of primary care in supporting good housing outcomes. This training should also address escalation procedures when a GP patient is known to be street homeless or at risk of street homelessness.

9.15 **Barnet Safeguarding Adults Board:** Urgently review the guidance available to Board members about their legal duty to participate effectively in Safeguarding Adult Reviews. Once reviewed, work closely with the North Central London Integrated Care Board to ensure this guidance is communicated with, and understood by, all statutory health partners and all commissioned health service providers working in Barnet.

9.16 **Barnet Safeguarding Adults Board:** Disseminate clear guidance on convening multi-agency high risk meetings and panels and ensure this is made available to voluntary sector organisations as well as statutory partners. Consider requesting an audit of the existing panel mechanism to understand which populations it is serving, which organisations are making use of the resource and who appears to be underserved.

9.17 **Barnet Safeguarding Adults Board:** Consider with SAB members whether local services have a sufficient understanding of executive functioning in the context of Mental Capacity Assessments for people with dual mental health and substance use diagnoses and commission further practice guidance and training if required.

Appendices

Appendix 1 Safeguarding Adults Reviews [SARs]

1.1 Section 44 of the Care Act 2014 places a statutory requirement on the Barnet Safeguarding Adults Board to commission and learn from Safeguarding Adults Reviews (SARs) in specific circumstances, as laid out below, and confers on the BSAB the power to commission a SAR into any other case:

'A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

b) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…, or

c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The SAB may also –

Arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

…Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –

a) identifying the lessons to be learnt from the adult's case, and

b) applying those lessons to future cases.'

1.2 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 to the future (Section 44 (5), Care Act 2014).

1.3 The purpose and underpinning principles of this SAR are set out in section 2.9 of the London Multi-Agency Adult Safeguarding Policy and Procedures. These are reiterated in BSAB's Safeguarding Adults Review Policy & Procedures.

1.4 All BSAB members and organisations involved in this SAR, and all SAR panel members, agreed to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR aims to take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

1.5 This case was referred by Barnet's Case Review Group to the BSAB on 22 September 2022 for their consideration of a SAR.

1.6 The BSAB assessed the case at their meeting on 22 June 2022, where it was agreed that they wished to review the care and support received by Colin and another individual prior to their deaths. The other individual, Phil, is the subject of a separate SAR. Taking this recommendation forward was delegated to the BSAB's Case Review Group who confirmed that the deaths of these two individuals should receive a Safeguarding Adults Review.

1.7 The agencies involved in the Safeguarding Adults Review were approached formally in October 2022; first to provide chronologies of their involvement and then to provide Individual Management Reviews. This was a time when many services were continuing to adjust to the significant ongoing workforce and operational challenges of the Covid-19 pandemic. Against this background context, the review was slow to get underway.

Appendix 2 – Methodology used in this SAR

2.1 This SAR has examined the circumstances of the care and support that Colin received during 2021/2022. To provide some context, this report has also included a little background detail where that was available.

2.2 The Terms of Reference for this review included the following key lines of enquiry:

- How well do partners understand their organisational duties; did they work together (including with VCFS colleagues and Colin himself) to implement effective plans to prevent an escalation of mental health needs and reduce risks of abuse or self-neglect, including through the Care Programme Approach?
- How effective and well-coordinated was multi-agency protection planning, were safeguarding and continuity of care obligations understood and applied?
- Has local strategic project work identified gaps in services or service's thresholds criteria for support to safeguarding adults at risk with experience of MEH and, if so, what are the governance arrangements for strategic overview of implementation of any recommendations.

2.3 The reviewer and author of this report is a retired adult social services and NHS manager with previous experience of reviewing serious untoward mental health incidents, including deaths. She has also managed health and care services for people who sleep rough, including senior roles developing and implementing London-wide policy.

2.4 Accompanied by Barnet Adult Social Care's Principal Social Worker, the reviewer met with Francesca, Colin's former partner.

2.5 The following agencies and organisations were invited to contribute to the SAR:

- Barnet Enfield and Haringey Mental Health NHS Trust

- Barnet's Joint Mental Health Commissioners
- Barnet Public Health
- Central London Community Healthcare NHS Trust
- Change Grow Live
- The GP Practice where Colin was registered
- Homeless Action in Barnet
- London Borough of Barnet Adult Social Care
- London Borough of Barnet Housing (including Barnet Homes)
- MARAC - Barnet's Multi Agency Risk Assessment Team
- Metropolitan Police

2.6 They contributed by submitting chronologies, individual management reviews, key historical documents, by responding to queries and by participating in two review sessions held on MS Teams. As each agency had different levels of involvement, or indeed no involvement, with Colin, each contributed to the SAR in different ways.

2.7 The reviewer chaired two reflection sessions on MS Teams to review:

- The circumstances of Colin's discharge from Mental Health services to General Practice
- The arrangements Barnet has and are being developed to enable escalation of mental health and substance misuse cases of concern from housing agencies to mental health and substance misuse services.

2.8 The purpose of these sessions was to invite participants to reflect on challenges they had experienced as well as any things that they felt that helped in the care of people with multiple exclusion homelessness experiences, and Colin in particular.

Appendix 3 – The Review Process

3.1 The BSAB's intention when commissioning this SAR was to adopt a learning together approach.

3.2 In practice this means that as far as possible, practitioners who worked directly with Colin would be given the opportunity to contribute to the SAR. This has proved difficult to implement. The following issues arose during the review.

3.3 Despite several requests, Colin's GP Practice did not submit an Individual Management Review in relation to their involvement with Colin. This task was then given to the GP representative on the SAB to fulfil and resulted only in the resubmission of chronologies without any reflective commentary. This suggests that the understanding in local General Practice of the requirements of Safeguarding Adults Reviews is insufficient.

3.4 A GP from the Practice did attend a reflective session for practitioners who had worked with Colin, and their contribution was very helpful.

3.5 Local GPs with a specialist interest in mental health and homeless also did not respond to invitations to attend the relevant reflection sessions.

Recommendation 15

Barnet Safeguarding Adults Board: Urgently review the guidance available to Board members about their legal duty to participate effectively in Safeguarding Adult Reviews. Once reviewed, work closely with the North Central London Integrated Care Board to ensure this guidance is communicated with, and understood by, all statutory health partners and all commissioned health service providers working in Barnet.

3.6 The IMRs submitted by BEHMHT revealed a lack of senior contribution to the reflection on practice, and several resubmissions of documents from the Trust were required. The work to complete these submissions was not prioritised by the Trust's senior management and in the event was never completed satisfactorily.

3.7 There was no evidence that the Trust supported first person accounts from practitioners who had worked directly with Colin. Despite several requests via the SAB administration, BEHMHT did not ensure that anyone who had worked directly with Colin attended the relevant reflection session.

3.8 Once this had been escalated with BEHMHT by the Chair of the SAB, the reviewer was able to speak to two clinicians who had been involved in Colin's care.

3.9 When the reviewer met with them individually, she learned that neither clinician had been informed of Colin's death until just before meeting with the reviewer.

3.10 This is clear evidence that none of BEHMHT's own incident reporting and incident review processes were followed at any time, including at the conclusion of the criminal proceedings against the perpetrator of his death.

3.11 It also suggests that BEHMHT did not take any opportunity to correct this omission, when completing their IMR.

3.12 Furthermore, BEHMHT did not take the opportunity to secure the input to the IMR of any of the clinicians who had been involved in Colin's care or had later considered his referral back into mental health services in 2022.

Recommendation 3

Barnet Enfield and Haringey NHS Mental Health NHS Trust: Review why the circumstances of Colin's death were not investigated in line with standard Trust and national serious incident review procedures.

Appendix 4 - The Evidence Base for Good Practice

4.1 Colin's care was organised by the State, and in this context, he had rights as a user of their services. Each agency had responsibilities to ensure that their care and support was steered by relevant practice guidance, regulation, and law.

4.2 On 15 July 2021 Barnet's Health and Wellbeing Board approved a Health and Wellbeing Needs Assessment of Rough Sleepers in Barnet. This is a key document setting out the epidemiological data in relation to people who sleep rough and the borough's policy intentions. A copy can be found at Appendix 5.

4.3 This document highlights national and local characteristics of people with a history of sleeping rough. Violence is a frequent feature in the lives of people with this history, as victims of violence and as perpetrators of violence.

4.4 The report also references the shocking and concerning national data from the Office of National Statistics which shows that men and women who have a history of homelessness die on average at age 46 for me and 43 for women. This is compared to the mean age at death was 76 years for men and 81 years for women in the general population of England and Wales.

4.5 While these figures vary slightly from year to year, the 30+ year disparity in mean life expectancy has been known for many years.

4.6 There are issues of intersectionality that can play out in this context. Each of the organisations that Colin received services from had duties under the Equality Act 2010 requiring attention to be paid to all protected characteristics. The Individual Management Reviews provided by each agency to the review are silent on any issues of equalities, including at the most basic level not referencing his ethnicity. Although this information was recorded in agency client records it was not referenced in the IMRs.

4.7 Colin was a white man.

4.8 Colin was dependent on substances in the period that the SAR reviewed. Colin had a serious mental illness diagnosis of paranoid schizophrenia. The records provided to the SAR including the individual management reviews are largely silent about the experience of mental health related disability that Colin must have experienced.

4.9 It is also of note that the records in relation to Colin do not foreground the risks he posed to his former partner Francesca who has significant mobility issues, and therefore had additional needs for protection in the context of the domestic abuse which occurred in their relationship.

4.10 In March 2020 the Local Government Association [LGA] and the Association of Directors of Adult Social Services published *Adult safeguarding and homelessness: a briefing on positive*

practice.[11] This built on work delivered in a series or regional seminars.

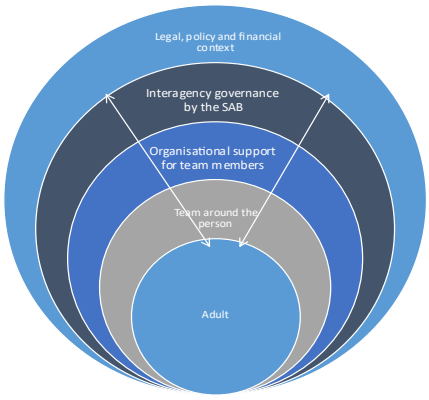
4.11 In August 2021 the Local Government Association developed the work further and published *Examples of positive learning and practice from the different sectors involved, especially housing, health and social care, both statutory and third sector.*[12]

4.12 In February 2022 Dr Adi Cooper OBE and Michael Preston-Shoot published *Adult Safeguarding and Homelessness; Understanding good practice*[13]. This book builds on the work that the LGA had led, and in a series of chapters authored by people with professional and lived experience it outlines:

- Best Evidence on Working with Individuals
- Best Evidence for Multi-Agency and Multi-Disciplinary Teams around the Person
- Best Evidence for Leadership and Strategic Partnerships[14]

4.13 Each of these pieces of work are illustrated by a diagram showing the relationships between each part of the system that interacts to support an individual with multiple exclusion homelessness.[15]

A safe system has alignment of checks and balances between the different layers of the system



4.14 In March 2022 the National Institute for Health and Care Excellence published their guideline [NG214] Integrated health and social care for people experiencing homelessness. The guideline was developed during 2021 and was subject to wide consultation.

[11] https://www.local.gov.uk/publications/adult-safeguarding-and-homelessness-briefing-positive-practice
[12]https://www.local.gov.uk/publications/adult-safeguarding-and-homelessness-experience-informed-practice
[13] Cooper, A. and Preston-Shoot, M. eds., 2022. *Adult Safeguarding and Homelessness: Understanding Good Practice*. Jessica Kingsley Publishers.
[14] The author of this SAR has a chapter in the publication.
[15] With thanks to Professor Michael Preston-Shoot for a copy of the diagram.

4.15 Each of these publications focus on the need to adopt approaches that address all aspects of the safe system illustrated in the diagram above.

4.16 There are several further NICE guidelines that are relevant to Colin and Phil's care:

- Public Health England/National Health Service England (2017) – *Better care for people with co-occurring mental health and alcohol and drug use conditions* (London)
- NICE - NICE Guideline CG120 (2011b) - *Psychosis with coexisting substance misuse,* (London)
- NICE – Public Health Guideline PH50 (2014) – *Domestic violence and abuse: multi-agency working* (London)
- NICE Guideline NG58 (2016) – *Co-existing severe mental illness and substance misuse*, (London).
- NICE Guideline NG108 (2018) *Decision-making and mental capacity* (London).

4.17 In May 2022 the NHS Federation produced a report titled *Healthy Foundations: Integrating housing as part of the mental health pathway.*

4.18 The purpose of listing these documents is to illustrate the wide range of guidance that was available to practitioners and their managers nationally, regionally and in Barnet.

4.19 How these relate to the care and support that Colin received are explored in more detail above.

Appendix 5 - Health and Wellbeing Needs Assessment of Rough Sleepers in Barnet

This document can be found at

https://barnet.moderngov.co.uk/documents/s65859/Barnet%20rough%20sleeper%20HNA%202021%20Final%20050721.pdf