Thematic Safeguarding Adult Review: Homelessness

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Haringey Safeguarding Adults Board
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Contents

1. Introduction

1.1. Mehmet[1] died at the age of 51. His nationality was given in the referral documentation for this review as Turkish Cypriot[2]. He was of no fixed abode at the time of his death.

1.2. Agata died at the age of 60. Her nationality was Polish. She was of no fixed abode at the time of her death.

1.3. Mikolaj was also of Polish nationality. He was residing in a night shelter at the time of his death, at the age of 40.

1.4. Their deaths occurred between August 2019 and January 2020. A homeless fatality review was conducted concerning Mehmet. This resulted in a referral for a safeguarding adult review (SAR) being submitted to Haringey Safeguarding Adults Board (SAB) in October 2019. A homeless fatality review was completed regarding Agata, which also resulted in a SAR referral in November 2019. The referrals were completed by the Strategic Lead – Homelessness and Vulnerable Adults, London Borough of Haringey. The referrals expressed concern about how agencies had worked together and questioned whether policies and procedures may have failed in these cases to safeguard the individuals concerned from abuse and neglect, including self-neglect.

1.5. The homeless fatality review process was also implemented with respect to Mikolaj's case. At the point when this review was conducted a decision had already been taken to commission a thematic SAR and it was decided that his case would be included.

1.6. The Coroner has confirmed the cause of death in all three cases. Mehmet died as a result of left lung pneumonia. Agata died as a result of coronary artery atherosclerosis[3] combined with steatosis[4] of liver pancreatitis. Mikolaj died of combined and dihydrocodeine[5] intoxication. Mikolaj's cause of death was deemed unnatural and an inquest was held on 17th September 2020. Direct cause of death was certified as combined heroin, ethanol and dihydrocodeine intoxication. The inquest conclusion was a drug and alcohol related death.

1.7. Homelessness fatality reviews were formally adopted in Haringey in January 2019, one response to an annual average of ten deaths in the Borough. These reviews do not supersede other statutory review processes, such as SARs, but do aim to learn lessons in a timely manner in order to strengthen multi-agency working and prevent the premature deaths of people experiencing homelessness[6].

[1] Pseudonyms have been used in this report.
[2] However, see section 5.4.1.7 for a corrective to this attribution.
[3] Clogging of the arteries.
[4] Abnormal retention of fat, often affecting the liver.
[5] Analgesic for pain relief.
[6] 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.

2. Safeguarding Adult Reviews

2.1. Haringey SAB has a mandatory statutory duty[7] to arrange a 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. Haringey SAB has discretion to commission reviews in any other 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. It is important to emphasise the distinction between the mandatory and the discretionary criteria because this is not always appreciated[8]. Under current law (Care Act 2014), for the mandatory criteria to be met, a SAB must have reasonable reason to believe that the adult whose case has been referred has/had care and support needs, has/had experienced abuse or neglect, including self-neglect, and there is/was reasonable cause for concern about how agencies have worked together in that case.

2.4. In response to rising concerns and increased visibility of homelessness as an issue across the country, but particularly in big cities, the Government has released its Rough Sleeping Strategy: https://www.gov.uk/government/publications/the-rough-sleeping-strategy

2.5. The Strategy says…

"We agree with the Advisory Panel, who were clear that Safeguarding Adult Reviews are powerful tools, which unfortunately are rarely used in the case of people who sleep rough. We will work with Safeguarding Adult Boards to ensure that Safeguarding Adult Reviews are conducted when a person who sleeps rough dies or is seriously harmed as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. Lessons learned from these reviews will inform improvements in local systems and services".

2.6. The reason for emphasising the distinction between mandatory and discretionary reviews in section 2.3 above is that the Government Strategy appears to fail to recognise that, for the mandatory criteria to be met, the adult must appear to have/have had care and support needs as defined by the Care Act 2014[9].

2.7. The SAR sub-group of Haringey SAB concluded that the circumstances surrounding the deaths of Mehmet and Agata met the mandatory criteria for undertaking a SAR under Section 44 of The Care Act 2014. The sub-group determined that the case

[7] Sections 44(1)-(3), Care Act 2014.
[8] 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.
[9] The Care and Support (Eligibility Criteria) Regulations 2014.

relating to Mikolaj did not meet the mandatory criteria but agreed that this case should be included in the review under the discretionary criteria to contribute to the identification of learning themes.

2.8. The SAR sub-group took the decision on 5th February 2020 to undertake a thematic homelessness SAR in response to three SAR referrals involving the death of homeless adults in the Borough. SABs have discretion regarding the type of review most likely to promote effective learning and improvement action to prevent future deaths or serious harm reoccurring[10].

2.9. 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[11]. 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.

[10] Department of Health and Social Care (2018) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office, paragraph 14.164.
[11] Section 44(5), Care Act 2014.

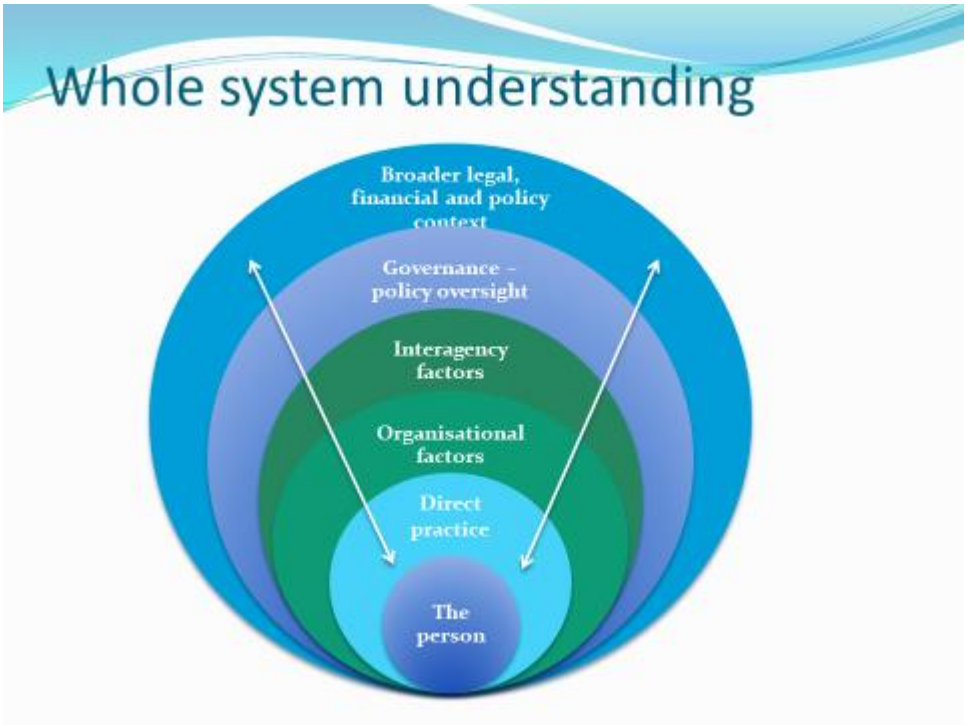
3. Review Process

3.1. Focus

3.1.1. Specific terms of reference were agreed for this thematic review, namely:

3.1.1.1. What learning is there from these cases, in addition to learning already identified by agencies through the homeless fatality reviews, which can inform the work of the Safeguarding Adults Board?
3.1.1.2. What learning themes can be identified across the three cases and how could these shape and change local and national policies and strategies for supporting people who experience homelessness in Haringey?
3.1.1.3. What learning can inform new initiatives for a dedicated homelessness social worker and rough sleeping mental and physical health team?
3.1.1.4. Were clear referral pathways in place across and between agencies to ensure Mehmet, Agata and Mikolaj were appropriately supported?
3.1.1.5. Were appropriate care and support needs assessments and risk assessments undertaken by agencies supporting Mehmet, Agata and Mikolaj?
3.1.1.6. Were hospital discharge procedures followed, and what additional opportunities might discharge planning have presented in supporting Mehmet, Agata and Mikolaj?
3.1.1.7. Were safeguarding concerns raised by agencies, where appropriate, to ensure Mehmet, Agata and Mikolaj were adequately safeguarded?
3.1.1.8. Did organisations communicate within and between agencies to share information and inform decision-making? How far did agencies collaborate in working together? How far do current systems allow or promote collaborative learning?
3.1.1.9. What impact did immigration status have on the housing, care and support that Mehmet, Agata and Mikolaj were able to access? How could the housing and care and support needs of homeless people be better met by agencies where individuals have no recourse to public funds (NRPF) and/or non-settled status?
3.1.1.10. Were legislative duties met by agencies in supporting Mehmet, Agata and/or Mikolaj?
3.1.1.11. How did agencies respond to long-term substance misuse? Did this have any impact on the support received?
3.1.1.12. How were senior managers involved in practitioners' decision-making at key points in the case? What impact did management involvement have? How far do current systems allow or promote management involvement?
3.1.1.13. Can national SAR learning or best practice around homelessness contribute to the learning arising from these cases?

3.1.2. As the terms of reference illustrate, this 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.



3.1.3. The information gleaned about the three cases has been analysed through the lens of evidence-based learning from research and the findings of other published SARs on adults who have experienced multiple exclusion homelessness[12] and on adults who self-neglect[13]. 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. Definitions

3.2.1. To inform the analysis, some terms will be used that require definition.

3.2.1.1. Multiple exclusion homelessness is a form of extreme marginalisation that includes childhood trauma, physical and mental ill-health, substance misuse and experiences of institutional care[14]. Adverse experiences in childhood can include abuse and neglect, domestic violence, poverty and parental mental illness or substance misuse[15]. For many of those who are street sleeping, homelessness is a long-term experience and associated with tri-morbidity (impairments arising from

[12] Preston-Shoot, M. (2020) *Adult Safeguarding and Homelessness. A Briefing on Positive Practice*. London: LGA and ADASS.
[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] 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.
[15] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping)*. London: Public Health England.

a combination of mental ill-health, physical ill-health and drug and/or alcohol misuse) and premature mortality.

3.2.1.2. 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[16].

3.2.1.3. The Mental Capacity Act 2005 requires that there be impairment of mind and/or brain when assessing whether or not a person has decisional capacity. Disorder of mind or brain may include symptoms arising from alcohol or drug misuse[17]. There is evidence[18] that prolonged exposure to trauma affects brain development, especially on its executive, emotional and survival centres. There is also evidence[19] that substance misuse, for example of alcohol, results in cerebral degeneration and cognitive impairment, and that nutritional deficiencies related to chronic alcohol misuse can precipitate cognitive impairment. Thus, whilst language and visual/spatial awareness may be preserved, there may be impairment of executive functioning, the ability to plan, organise and implement decisions.

3.2.1.4. For people from the European Economic Area (EEA) to be eligible for services and benefits, they must be exercising EU treaty rights. To be a qualified person, they must be a job seeker, worker, self-employed, self-sufficient and/or a student. If individuals do not qualify, they will have no recourse to public funds. Worker status is retained if a person is involuntary unemployed or temporarily unable to work due to accident or illness.

3.2.1.5. No recourse to public funds means that individuals have no entitlement to public housing[20] and there are restrictions on most welfare benefits. This includes homelessness assistance.[21] However, access to other publicly funded provision may still be available, including health and adult social care.

3.3. Methodology

3.3.1. A panel was established to support the independent reviewer. Membership was drawn from:

- London Borough of Haringey Adult Social Care (ASC)
- London Borough of Haringey Commissioning
- London Borough of Haringey Public Health
- NHS North Central London Clinical Commissioning Group (CCG)

[16] Care and Support (Eligibility Criteria) Regulations 2014.

[17] Department for Constitutional Affairs (2007) *Mental Capacity Act 2005: Code of Practice*. London: The Stationery Office.

[18] Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M. and Cloitre, M. (2005) 'Complex trauma in children and adolescents.' *Psychiatric Annals*, 35 (5), 390-398.

[19] Restifo, S. (2013) 'A review of the concepts, terminologies and dilemmas in the assessment of decisional capacity: a focus on alcoholism.' *Australasian Psychiatry*, 21 (6), 537-540. Hazelton, L., Sterns, G. and Chisholm, T. (2003) 'Decision-making capacity and alcohol abuse: clinical and ethical considerations in personal care choices.' *General Hospital Psychiatry*, 25, 130-135.

[20] They may also be excluded from private rented housing.

[21] Section 85 Housing Act 1996 and the Allocation of Housing and Homelessness (Eligibility) (England) Regulations 2006.

- Metropolitan Police Service (MPS)
- Homes for Haringey (HfH)
- North Middlesex University Hospital (NMUH)
- Barnet, Enfield and Haringey Mental Health Trust (BEHMHT)
- Department for Work and Pensions (DWP)

3.3.2. The panel was supported by the SAB's Governance and Improvement Officer and its legal advisor.

3.3.3. Chronologies and reflections were submitted by services that had been involved with one or more of the three cases included within the review. Information that had been collected and collated as part of the three homelessness fatality reviews was also included for analysis. This includes referrals and reports, and correspondence between services and with elected members. Services providing information comprised:

- ASC
- London Borough of Haringey Commissioning
- HfH
- BEHMHT
- DWP
- Three GP practices
- MPS
- Whittington Hospital
- St Mungo's Outreach Team and Crash Pad
- All People All Places (APAP)
- Thames Reach
- London Ambulance Service (LAS)
- Mulberry Junction
- Haringey Advisory Group on Alcohol (HAGA)
- Humankind (Drug and Alcohol Service)

3.3.4. The scope of the review covered slightly different but overlapping time periods for the three cases, namely:

- For Mehmet, from January 2019 when he became known to services for people sleeping rough and October 2019.
- For Agata, from November 2018 when she approached HfH for housing assistance to August 2019.
- For Mikolaj, from July 2019 when he became known to Haringey's street outreach team and January 2020.

3.3.5. Agencies were also requested to provide information that they judged significant that fell outside these time periods.

3.3.6. Two virtual learning events were held, using Microsoft Teams, which were attended by practitioners and operational managers from both statutory and third sector agencies, supported by panel members. The observations shared during those learning events have been incorporated into the analysis and recommendations that follow. Additional interviews were conducted virtually with two practitioners and two elected members who had worked with and supported Mehmet.

3.4. Family involvement

3.4.1. There is reference in the submitted chronologies to Mehmet having a daughter and ex-wife, to Mikolaj having a mother in Poland and to Agata having a son. Services involved with Mehmet, Agata and Mikolaj were asked to check their records for contact details of next of kin. MPS provided recorded next of kin contact details for all three people included in this thematic review.

3.4.2. Contact was attempted, with the support of interpreters, with all known next of kin by email and/or telephone. Unfortunately, some telephone numbers were no longer in use; others just rang out without response. There were no responses either to emails that were sent advising of the review and inviting participation.

3.4.3. As part of the homelessness fatality review regarding Mikolaj, a meeting was held with some of his friends and peers. Their contribution has been integrated into this report. An additional interview was conducted with one of Mikolaj's friends and peers.

4. Case Narratives

4.1. Mehmet – a pen picture

Mehmet was a 51-year old Turkish Cypriot[22] man who had moved to the UK in 1998. He was divorced and had a daughter. He carried photographs of his former wife and daughter in his wallet and was devastated when these were lost when his wallet was stolen. He also had an extended family but he does not appear to have asked for help, possibly as a result of fractures between Mehmet and his relatives.

He was evicted from a housing association tenancy in May 2018, which he had held since March 2007, following a change to the documentation required by the DWP to prove eligibility to remain in the UK. Unable to provide this documentation, he subsequently stopped receiving benefits and accrued rent arrears, leading to eviction from his home. At this point he had no recourse to public funds.

Despite significant efforts to secure his immigration status that would then have provided access to temporary or supported housing, this proved very difficult. A passport was finally obtained only in mid-September 2019.

Mehmet was known to rough sleeping services from January 2019 when he was found in the gardens of a housing estate in the Borough. A homeless application was assessed by HfH and he was found to be ineligible for housing. Mehmet spent several months moving between different temporary night shelters, which did not require recourse to public funding.

Mehmet had both antecedent physical and mental health issues, which became aggravated by his homelessness. He had both a head and a shoulder injury. He experienced PTSD, depression, panic attacks and paranoia, probably linked in part to having been attacked and seriously injured in 2007 and again in 2014. He is said to have become fearful of people, as a result disinclined to ask for help and becoming very isolated. Due to a deterioration in his mental health, a Care Act 2014 assessment was carried out in May 2019, but Mehmet was deemed ineligible for support and advised to return to Cyprus where he could access benefits, medical care and accommodation. He was referred for mental health support via a PTSD pathway.

A safeguarding concern was referred in December 2018 but this did not progress under section 42 Care Act 2014, the rationale given being that his needs primarily related to mental health and housing.

He had no convictions but had received a caution, warning notices and fixed penalty fines for cannabis possession. There were several reported incidents of Mehmet having assaulted people. The chronology contains references also to Mehmet presenting as upset, distressed and angry about his situation.

[22] This was according to the original referral documentation but see section 5.4.1.7 for corrective discussion of this attribution.

On 10th October 2019, Mehmet complained of feeling unwell to his support workers. On the following day he was found deceased by a member of the public in a park in the Borough. There were no suspicious circumstances surrounding his death.

4.2. Agata – a pen picture

Agata was a 60-year old Polish woman living in Haringey. She was known to have an adult son. She was alcohol dependent and was suspected to occasionally use other drugs. It was suspected that she had experienced domestic abuse in 2015.

Agata had maintained tenancies and work but was known to be living on the streets from late 2017. Progress was slow to demonstrate habitual residency and to secure settled status, which meant that for some time immigration issues resulted in Agata having very limited housing options.

From late 2017 to mid-2018, Agata was found intoxicated by MPS on five occasions and taken for hospital treatment on four occasions. On some occasions she took her own discharge. In November 2018, Agata approached HfH for housing assistance but was found to be ineligible for housing due to her immigration status in December 2018.

Agata experienced physical ill-health. She had a heart complaint for which she was under cardiology. There is reference to a history of gastric cancer. A shoulder injury necessitated an operation during the period under review here, which took time to heal properly.

Agata was known to rough sleeping services from February 2019 following a referral from NMUH where she was due to be discharged to 'no fixed abode'. She secured a space at a short stay rough sleeping service in March 2019 and later moved to supported accommodation. In July 2019, a Care Act 2014 assessment found that she was eligible for public funding but she did not receive any statutory care and support services. She declined reconnection to Poland and had a history of refusing support offered.

Agata was awarded Personal Independence Payments by DWP and was informed she would receive a back payment of around £5000. Around the same time, safeguarding concerns were raised by the supported accommodation provider regarding financial exploitation and emotional abuse, following incidents involving Agata's male visitors and concerns raised by her son. Agata died before there was a response to the safeguarding referral.

Agata was known to the Police in the West Midlands in 2008 and 2009 for offences of theft, shoplifting and being drunk and disorderly.

On 7th August 2019, MPS found Agata intoxicated in a squat and took her to NMUH. She was reported missing from her accommodation on 9th August and was subsequently found deceased following a cardiac arrest outside a GP surgery on 21st August.

4.3. Mikolaj – a pen picture

Mikolaj was a 40-year old Polish man who had family in Poland and had volunteered in the kitchens of a Polish church in Stamford Hill. He was known to the Haringey Street Outreach Team from July 2019 when he was found sleeping rough in the courtyard of a housing estate in the Borough. There were occasions when he declined to engage with practitioners who found him sleeping rough.

On 25th November 2019, Mikolaj attended the Mulberry Junction Single Homelessness Resource Centre. He was referred to the Cranwood Somewhere Safe to Stay night shelter. He stayed overnight at the shelter. Following this, he did not return as the service would not accommodate his friend who was also a rough sleeper. Once again, he declined to engage when found street sleeping.

Mikolaj had physical health needs and alcohol misuse issues. He is said to have used drugs previously and may have been using cannabis during the period under review. He was a regular attender at A&E, often for upper gastric pain and excessive alcohol intake. He sometimes left before being treated. His earlier medical history included a peptic ulcer, Hepatitis C, methadone dependence and associated knee pain.

There is no reference to either a care and support assessment (section 9 Care Act 2014) or to any referral of safeguarding concerns (section 42).

Mikolaj was known to the Police, mainly for theft, and had received cautions, penalty notices, conditional discharge and a fine, including for possession of a controlled drug.

In late 2019/early 2020 he had admissions to Whittington Hospital and NMUH. He was admitted to NMUH on 6th January 2020 and later discharged. According to his peers, Mikolaj still felt unwell after he was discharged. He returned to the Cranwood Hub on the night of 15th January 2020 and again on 16th January 2020. On the night of 16th January 2020, he was found unresponsive outside of the Cranwood Somewhere Safe to Stay night shelter. In the early hours of 17th January 2020, he was pronounced dead. There were no suspicious circumstances surrounding his death.

4.4. Premature mortality is a significant risk for people experiencing homelessness. The average age of deaths for men is 44 and for women is 42 who are homeless and sleeping on the streets[23]. Only Mikolaj exactly fits this pattern, demonstrating that there are diverse routes into homelessness.

4.5. Referring back to the components of multiple exclusion homelessness, drawing on the information supplied by the services involved:

4.5.1. There is evidence of physical health concerns in all three cases.

[23] ONS Deaths of homeless people in England & Wales 2013-2017 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2013to2017#deaths-of-homeless-people-have-increased-by-24-over-five-years

4.5.2. All three individuals were known to the Police.
4.5.3. Mehmet and Agata were victims of assault.
4.5.4. Both Mehmet and Agata faced immigration issues and fell within the ambit of no recourse to public funds.
4.5.5. Alcohol misuse features in two cases (Agata and Mikolaj).
4.5.6. Mehmet experienced mental ill-health.

4.6. However, there are no references in the initial information supplied by agencies to institutional care or to adverse childhood experiences. None received services under the Care Act 2014, either in response to safeguarding concerns or referrals for care and support. There are no references to assessment of mental capacity or to multi-agency risk management meetings or complex case discussions in the documentation provided by the services that had contact with them.

4.7. At least two of these cases (Mehmet and Agata) illustrate how unanticipated incidents can spiral individuals into homelessness. Agata had worked until suffering a shoulder injury. Mehmet had maintained a tenancy until changes in the documentation required to demonstrate eligibility for housing benefit. Other SARs[24] have also highlighted the apparent absence of a safety net for certain individuals when events conspire to increase their vulnerability to becoming locked and entrenched in homelessness.

[24] See for example Oxfordshire Safeguarding Adults Board (2020) Thematic Review – Homelessness.

5. Findings

5.1. Reference was made earlier (section 3.1.3) to research[25] and findings from SARs[26] that enable a model of good practice to be constructed in relation to adults who experience multiple exclusion homelessness and/or 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 across services and agencies 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.

5.2. A fifth domain has been added to this evidence-base, namely the legal, policy and financial context within which the work to safeguard adults at risk and to counteract homelessness occurs. That context will be included in the analysis that follows.

5.3. Information and reflections provided by the practitioners and managers involved in the three cases, coupled with the reports from the services engaged with Mehmet, Agata and Mikolaj, will be analysed thematically. The purpose is to explore what facilitated and what impeded positive practice.

5.4. The domain of direct practice with individuals who are homeless and/or who self-neglect has several components.

5.4.1. A person-centred approach 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.[27] Contact should be maintained rather than the case closed so that trust can be built up; use of advocacy services where that might assist a person to engage with assessments, service provision and treatment.

5.4.1.1. Agency reports note that in all three cases interpreters were made available to assist with assessments and treatment planning. However, interpreters were not always arranged or available when actually needed, resulting in delays in service provision. There were occasions when practitioners did not speak to individuals in the language of their choice or in settings comfortable to them, and where arrangements for interpreters were not secure. However, there are also references to

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

[26] 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.

[27] 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.

practitioners building positive relationships, for example with Agata and Mehmet.

5.4.1.2. Significant support was given, especially to Mehmet and Mikolaj, to enable them to obtain passports and other documentation to prove their eligibility for support from public funds, and to attend appointments, access services and/or submit claims. There were occasions when sensitivity and flexibility were shown, such as when Mikolaj was given a shelter space even though he was intoxicated at the time and when he was enabled to make contact with his mother in Poland.

5.4.1.3. However, contact was not always maintained. The report from BEHMHT, for example, observes that there were only three attempts to make contact with Mehmet between June and October 2019, and that more could have been done to reach out and link him with his support worker. When he did not attend the PTSD pathway, greater efforts could have been made to follow this up, working with other services that were also involved, such as APAP and St. Mungo's, where he was engaging with staff. Correspondence seen by the independent reviewer questions whether assumptions were made that Mehmet would not engage but, with appropriate language support, it is clear that some of those who were advocating for him were able to identify his wishes and his level of frustration regarding his circumstances.

5.4.1.4. Agata fell out of contact with Thames Reach in April 2018 to the extent that her case was closed. There does not appear to have been any follow-up when she self-discharged or failed to attend cardiology outpatient appointments between April and July 2019. She was discharged by physiotherapy when she missed three scheduled appointments. She was at the time, however, attending follow-up appointments at the NMUH fracture clinic. With people who experience homelessness and/or self-neglect, their lives may be too chaotic, unpredictable and complicated to enable them to keep to appointment schedules, at least without outreach support[28].

5.4.1.5. Appointing advocates to help individuals to engage was either not considered or not followed up. This is despite evidence to suggest, not least as a result of language barriers, that Mehmet, Agata and Mikolaj qualified for advocacy. A view was expressed by some of those who advocated for Mehmet, as a person in need of assistance, that their involvement was not welcomed by statutory services and that they were regarded as too emotionally attached.

5.4.1.6. **Recommendation One:** Haringey SAB conducts audits of the use of interpreters and advocates, with particular focus on cases involving people who are homeless or threatened with homelessness.

[28] Preston-Shoot, M. (2020) *Homeless: A Thematic Review*. Manchester Safeguarding Adults Board.

5.4.1.7. A core requirement of best practice, underpinned by the Equality Act 2010 and the Human Rights Act 1998, is to counteract discrimination. Unfortunately, SARs often fail to consider whether sufficient consideration was given to a person's race, culture, religion, language, ethnicity and heritage[29]. In the initial documentation provided for this review, Mehmet was described as Turkish Cypriot. In fact, as explained by one of the elected members who knew Mehmet, he was Roma Cypriot. A practitioner also acknowledged his Roma heritage and added that he would describe himself and his given name as Ottoman and his former wife as Roma.

5.4.1.8. The apparent failure by services to accurately identify Mehmet's heritage is an example of cultural insensitivity. In the view of some of those who contributed to this review, assumptions were made about certain communities, including the community to which Mehmet belonged. This included assumptions about literacy and ability to access services. Support for his daughter, and advocacy for cultural sensitivity and dignity in death, were required to ensure that Mehmet's body was repatriated to Cyprus where he could be buried.

5.4.1.9. A further aspect of a person-centred approach relates to acknowledging and addressing gender-specific risks. In panel discussions it was noted that there appears to be a gap for women who are homeless and who have experienced domestic/sexual abuse, as they often don't 'fit' into traditional Violence against Women and Girls services.

5.4.1.10. Research[30] has found that the causes of homelessness are multi-faceted and impact differently on men and women. Routes into homelessness can have a gendered dimension, founded in abuse and violence in close relationships. Support is often fragmented, available across separate agencies, with budget cuts intensifying this picture. The research has found positive appreciation of keyworker and women only provision but frustration at having to engage with multiple services at the same time and with provision that was not personalised to their needs. Adverse childhood experiences have resulted in women who are homeless experiencing a complex range of social and health needs and their situation exposes them to risk of further abuse.

5.4.1.11. At the learning events, some of those attending questioned whether there is unconscious bias against homeless people and those with alcohol and drug misuse issues, with consequent missed opportunities to use professional curiosity to explore people's situation in depth. They suggested that there was a need to support these user groups better. At the time of these cases, there had been no mental health and substance misuse outreach provision. There was optimism that recent service enhancements would make a positive difference, namely the

[29] 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.

[30] Cameron, A., Abrahams, H., Morgan, K., Williamson, E. and Henry, L. (2016) 'From pillar to post: homeless women's experiences of social care.' *Health and Social Care in the Community*, 24 93), 345-352.

appointment of a Social Worker in the First Response Service with a dedicated focus on homelessness, and the development of dedicated mental health and physical health care service for people sleeping on the streets. Outreach services have been regularly in contact with St Mungo's and are working in creative ways with flexibility. For the first time, the Mental Health Service has been able to come out to St Mungo's to work with clients. There remains no substance misuse outreach service but the availability of a Dual Diagnosis Navigator had been experienced as helpful.

5.4.1.12. **Recommendation Two:** Haringey SAB should track the impact and effectiveness of recent service enhancements for working with people experiencing homelessness, identifying positive outcomes and any gaps in provision.

5.4.1.13. Also at the learning events it was stated that male clients had their own barriers to accepting services. Mehmet felt that he couldn't cope with his mental health or with dormitory style shelter accommodation as a result of his mental health. Mikolaj had been known to services for years but was initially allocated a hostel place in South London but had no means to get there. All People All Places (APAP) managed to arrange a paid taxi there but he had to make his own way back to access APAP services and this impacted on his relationship with services. APAP had accommodated both Mehmet and Mikolaj but both had been reluctant to access dormitory style night shelters. There seemed to be different barriers for both men and their expectations could not be met by the service that had been commissioned. It was emphasised that this work is relational and maintaining these relationships can be complex.

5.4.1.14. Those attending the learning events were clear that Making Every Contact Count[31] was essential. Every time that people ask for help and don't get the help needed, they are much less likely to ask for help again. Therefore access to information at the point people do make contact is one important key; another is meeting people with respect.

5.4.2. 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;[32] it is helpful to build up a picture of the person's history, and to address this "backstory"[33], 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.

[31] Public Health England and Health Education England (2018) *Making Every Contact Count (MECC): Implementation Guide*. London: Public Health England.

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

[33] 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.

5.4.2.1. Only limited glimpses are given in the chronologies and reports from services about the three individuals. People who knew Mikolaj talked of him as a good person who volunteered in the kitchen of a Polish Church. When living in a Crash Pad Agata seemed happy and excited, building positive relationships with staff and other residents. She was described as kind, warm, caring, and relational in her approach.

5.4.2.2. However, Mehmet was fearful of people, probably as a result of two serious assaults, as a result of which he was very isolated. He was angry, unsettled and unhappy about his circumstances. A psychology assessment in March 2019 identified that he felt depressed and upset, and afraid much of the time. He was struggling with the impact of traumatic experiences compounded by the psychological impact of homelessness and immigration difficulties. He was referred for the PTSD pathway.

5.4.2.3. Those who worked closely with Mehmet were clear that many people were trying to support him but that the traumas he had experienced meant that he trusted very few. They described how he would attach himself to a few staff members but otherwise could present as angry. In some moments when traumas were very real for him, he would shout at the sky. He was volatile when unhappy and could be cantankerous and rude. However, those who knew him well also felt that he was looking for belonging and slowly he began to trust those staff members with whom he could build some continuity. He was very unhappy when APAP services contracted owing to funding.

5.4.2.4. Agata was a regular attender at NMUH from March 2009, attendances often related to alcohol excess or injury following alcoholic intake. Between 2017 and 2019 there was a repetitive pattern of MPS and LAS becoming involved as a result of her self-neglect, rough sleeping, intoxication and sustained injuries. When in the Crash Pad, however, Agata maintained her accommodation and managed her drinking; she felt more stable and kept health appointments. She was focused on moving forward and keen to live independently. Yet, she could not maintain this. She began to miss appointments, declined to engage with staff and refused help. After a period of not using her Crash Pad accommodation and not responding to staff attempts to make contact with her, her bed space allocation was closed.

5.4.2.5. Mikolaj also declined to engage or enter night shelters when found sleeping rough on several occasions. He also declined support to access drug and alcohol services and he missed some appointments for blood tests. He did not attend HAGA's Polish speaking harm reduction group. Two days before he died staff noted that he had received and was worried about a negative health report. It is not clear whether that recognition was followed up with concerned curiosity.

5.4.2.6. Those attending the learning events recognised the impact of loss and trauma on people's lives, and observed that considerable work was

necessary to embed a trauma-informed approach across all services. Those attending the learning events did, however, recognise that some services, for example the PTSD provision worked in very trauma-informed way. That said, those who worked closely with Mehmet were clear that to expect him to navigate homelessness without support was unrealistic.

5.4.2.7. When people do not remain in treatment or do not keep appointments, the role of the GP is pivotal as they hold all the health information about that person. However, when people who are homeless do not have a GP, a potential gap arises regarding coordination of all their health information. Hospital Trusts, especially Emergency Departments, should ask if the person has an address and whether they have a GP. The Health Service for people who are homeless could be considered to have a coordinating role for health information in future.

5.4.2.8. Other SARs[34] have identified how loss and trauma can resurface to undermine a person's determination to move forward. Moreover, a person may be at greater risk when their situation is beginning to improve. It is equally important to recognise that the presenting problem is not the problem so much as a way of coping[35]. However dysfunctional there is a logic behind behaviour, a positive function. Attempting to change someone's behaviour without understanding its survival function will prove unsuccessful. It is responding to symptoms and not causes. Put another way, individuals may be caught in a "life threatening double bind, driven addictively to avoid suffering through ways that only deepen their suffering."[36] What is being highlighted here is the need to explore beyond the presenting problem and to consider what wrap-around support was necessary in order to support those who were trying to recover from the impact of trauma and adverse experiences and endeavouring to manage their emotional responses. People's lives may be too chaotic and complex to enable them without support to routinely keep appointments at designated times and places.

5.4.2.9. **Recommendation Three:** Haringey SAB reviews with commissioners and providers where there are gaps to be filled in the availability of holistic, wrap-around support for people experiencing multiple exclusion homelessness.

5.4.2.10. Overall, then, little was known about Mehmet, Agata and Mikolaj. This might suggest that the focus of work had been on accomplishing tasks rather than people seeking to understand. Panel members noted that when a person is in supported housing, extensive assessment is carried out, which reveals more information about the person, whereas people in crash pad or night shelter accommodation are not assessed as extensively and, therefore, less is known about them. Equally, when

[34] For example, Tower Hamlets SAB (2019) Ms H and Ms I – Thematic Review; Oxfordshire SAB (2020) Thematic Review – Homelessness.
[35] Satir, V., Banmen, J., Gerber, J. and Gomori, M. (1991) *The Satir Model*. California: Science and Behaviour Books.
[36] David Bishop, personal communication.

people who are homeless have no recourse to public funds, they can be wary of revealing information about themselves as they believe it could be passed on to other agencies and affect their access to services. Panel members from Acute Trusts also noted that they tend to learn more about people when they are very unwell, as there is a deeper analysis of their histories. Agencies need to look for repeating patterns in those presenting for help, as this could indicate that there could be an entrenched problem, even if the issue they are presenting with can be dealt with swiftly.

5.4.3. Thorough mental health and mental capacity assessments are advised, 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[37].

5.4.3.1. Both Mikolaj and Agata appear to have been dependent on alcohol. Mehmet appears to have sustained a head injury as a result of one or both of the serious assaults that he experienced. Yet there do not appear to have been any formally recorded concerns about or assessments of mental capacity.

5.4.3.2. 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 assessment should include real world observation of a person's functioning and decision-making ability[38], with subsequent discussion to assess whether someone can use and weigh information.

5.4.3.3. SARs[39] have also highlighted the importance of thorough mental capacity assessments, including a focus on executive dysfunction, when individuals demonstrate addictive and compulsive behaviours, possibly indicative of impulse control disorder or alcohol dependence syndrome. The latter syndrome is explicitly mentioned in Mikolaj's health records.

5.4.3.4. Moreover, although there were concerns in the run-up to her death about whether Agata was being exploited by male acquaintances, which coincided with her going missing and aggravated substance misuse, the impact of coercion on her decision-making does not appear to have prompted consideration of a mental capacity assessment. St Mungo's staff did raise a safeguarding concern in July 2019, which was not picked up before Agata died, but there were also missed opportunities to refer concerns[40].

[37] 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.
[38] NICE (2018) *Decision Making and Mental Capacity*. London: National Institute for Health and Clinical Excellence.
[39] For example, Teeswide SAB (2017) SAR – Carol; Isle of Wight SAB (2019) SAR – Howard; Tower Hamlets SAB (2019) Ms H and Ms I – Thematic Review.
[40] This point is discussed further in section 5.5.4.1.

5.4.3.5. Mehmet's mental health was periodically a focus of concern, at least following the first serious assault. Indeed, one practitioner who worked with Mehmet described how he would say that "attacks had made him crazy in the head" and how medication had made him feel vulnerable because of the risk of abuse when in a deep sleep that the treatment induced. From 2008 there are references to trauma focused therapy, Care Programme Approach (CPA) reviews, depression, anxiety and PTSD. It is not clear from documentation available to the independent reviewer how sustained a focus there may have been between 2009 and 2018 on mental health provision for Mehmet. At the end of December a referral to the First Response Team included mental health amongst the risks outlined, following which a senior practitioner then concluded that his needs were primarily mental health related. It has been suggested that there was a missed opportunity to respond to his mental health needs at this point. A psychological assessment in March 2019 concluded that he had emotional dysregulation and difficulty with tolerating frustration. A CPA review in April 2019 did not find any psychotic symptoms or abnormality in cognition. He was discharged from the CPA in June 2019 with support planned through the PTSD pathway. One practitioner who knew Mehmet well wondered whether, as a result of her observations of how he interacted with people, he was on the autistic spectrum. A more sustained approach to attempting to work with Mehmet on his mental wellbeing would have been helpful.

5.4.3.6. Other SARs[41] have reported access issues in relation to mental health assessments and treatment, especially when individuals are not experiencing a psychotic crisis, with views expressed that more resource here is necessary to meet demand, for example for outreach, and to respond to mental distress and trauma.

5.4.3.7. Those attending the learning events observed the need for greater consistency in considering the impact of coercion on mental capacity and the legal options available. Those representing Emergency Services observed that knowledge regarding mental capacity amongst staff was variable.

5.4.3.8. At the learning events a view was communicated that mental health pathways had been difficult to navigate, with referrals from GPs needed. Since March 2020, however, Haringey sought and were awarded funding to develop a mental health outreach service as part of a dedicated homelessness health service. Mental health assessments and input from a Psychologist were now available to people living on the streets.

5.4.3.9. **Recommendation Four:** Haringey SAB works with relevant partners to develop guidance on the interface between mental health and mental capacity, with particular reference to the impact of trauma and adverse life experience, substance misuse and the potential for impairment of executive capacity.

[41] 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.

5.4.3.10. **Recommendation Five:** Haringey SAB convenes a summit to review pathways into mental health provision, and to strengthen strategic relationships and operational practice between primary care, social care, third sector agencies working with people experiencing homelessness and mental health providers.

5.4.4. 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[42]; thorough assessments, care plans and regular reviews, comprehensive enquiries into a person's rehabilitation, resettlement and support needs[43]; taking into account the negative effect of social isolation and housing status on wellbeing[44].

5.4.4.1. Mikolaj does not appear to have received (or been referred for) a care and support assessment (section 9 Care Act 2014). Mehmet's care and support needs were assessed but no services were offered despite apparent evidence that he had some eligible needs. Agata's care and support needs were also assessed but no care package appears to have been offered.

5.4.4.2. Both Mehmet and Agata were advised by ASC to return to their countries of origin. This advice has been strongly criticised by some of those who contributed to the review, seeing it as an example of the "hostile environment" that the Borough has formally rejected. They did not feel that their challenge to this practice had any demonstrable effect.

5.4.4.3. As identified in section 3.2.1.2, care and support needs can arise from physical and/or mental conditions and/or substance misuse. All three individuals whose cases form the basis for the review appear to have had care and support needs, which is the entry point for assessment. Even if assessment had concluded that there was no duty to provide services, on the basis of inability to achieve two or more of certain specified outcomes (section 13 Care Act 2014), there remains a power to meet care and support needs, for example where a person has no settled residence (section 19(1)).

5.4.4.4. At the learning events there was an expectation that the newly appointed Social Worker with responsibility for working with people experiencing homelessness would be carrying out Care Act 2014 assessments and safeguarding enquiries on the streets and liaising with the Care Authorisation Panel to secure the appropriate support. It was also acknowledged that, on some occasions, people are given support when they do not meet at least two of the eligible needs as codified by

[42] 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.

[43] Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.

[44] 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.

the Care Act 2014[45]. For example, accommodation has been provided to clients who have NRPF and Human Rights Act 1998 assessments carried out for greater flexibility. This is good practice.

5.4.4.5. **Recommendation Six:** Haringey SAB requests a report from the local authority on how the provisions in the Care Act 2014 relating to care and support are being implemented with respect to people who are homeless. This report to include initial outcomes from the work of the newly appointed Social Worker whose role is to work with people experiencing homelessness.

5.4.4.6. There is good evidence of thorough assessments and treatment of physical ill-health. For example, medical review and planning for Mikolaj with respect to gastroenterology, liver functioning and detox; referral for Agata by St Mungo's to HAGA for alcohol misuse, and her treatment in NMUH for chest palpitations and for a shoulder injury. Mehmet was actively supported by third sector service staff to attend clinics with respect to pain and weakness resulting from the injuries sustained when he was attacked. Mehmet was also well supported by the GP surgery. Between June 2018 and October 2019 he was seen a total of 13 times. This is high intensity GP care[46], with some consultation times longer than the normally allocated 10 minutes. Nonetheless, Mikolaj's friend and peer who was interviewed felt that he was not given enough medical help when he visited hospital with extreme stomach pains and nose bleeds. His perception was that Mikolaj had only been treated with pain relief. That apart, he could not see how anyone else could have helped Mikolaj more than they did.

5.4.4.7. On housing/homelessness assessment, there is no reference to HfH involvement with Mikolaj. Agata received a not eligible decision in December 2018. Her case was not referred back to HfH until June 2019 even though it appears that documentation was available shortly after the original decision to demonstrate that she could have recourse to public funds, with her also passing the habitual residency test in May 2019. There was a further delay in allocating her case for re-assessment. Attempts then at contacting her failed so the plan for securing long-term supported housing was not achieved before she died.

5.4.4.8. It is clear that Mehmet's Housing Benefit position was resolved very shortly after he had been evicted for rent arrears in May 2018. It appears that his passport and other papers were lost or destroyed after he was evicted and his property cleared. It took until September 2019 for a replacement passport to be available for collection, despite considerable support and advocacy by third sector practitioners, after which he could apply for settled status. During this time he was homeless and subsisting on a low level of benefits. ASC records for late December 2018 contain reference to a housing/homelessness

[45] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office.

[46] On average, patients see their GP about twice a year.

assessment that Mehmet was not medically vulnerable. There are references in early January 2019 to him being "intentionally homeless" and to an omission in not contacting HfH to request a review of previous decision-making.

5.4.4.9. Dismay has been expressed to the independent reviewer that greater efforts appear not to have been made to prevent his eviction and to reinstate his tenancy when the Housing Benefit position was resolved. Apparently, Mehmet would walk past his former tenancy and wanted to return there. Some practitioners have challenged the assumption that he could read and understand letters that were sent to him about his housing and benefit position, and have questioned how many other individuals may be in a similar position.

5.4.4.10. The Housing Act 1996 and subsequent case law have established that a person would be in priority need if vulnerable as a result of mental illness, learning disability or physical disability. Medical assessments have been questioned in decided cases. In one case involving a person who was homeless with post-traumatic stress disorder of moderate severity and depression, impacting on his cognitive functioning, activities of daily living and social interaction, the assessment that he was not in priority need despite evidence of disability because of mental illness was overturned.[47] In determining whether Mehmet was vulnerable, the comparator is the ordinary person if made homeless and not an ordinary actual homeless person[48].

5.4.4.11. HfH has provided information relating to the number of non-priority decisions between April 2018 and August 2020. In comparison with other London Boroughs the number, 120, is low and is believed to be the result of effective prevention work. Only 32 of these decisions proceeded to statutory review and of these only 5 decisions were overturned on independent review, primarily because of new information becoming available that was not known at the time of the original decision.

5.4.4.12. For people experiencing multiple exclusion homelessness, such as Agata and Mehmet, the support that is available to request statutory review of decision-making will be important.

5.4.4.13. **Recommendation Seven:** Haringey SAB should receive from HfH regular reports on the outcome of decision-making regarding housing applications from people experiencing multiple exclusion homelessness.

5.4.4.14. NMUH in its contribution to this review has observed that there were missed opportunities to explore patients' accommodation situation and occasions when Mikolaj, for example, was discharged to no fixed abode and Agata was identified as homeless but discharged, without escalation of concern or completion of the duty to refer[49].

[47] Cherry v Tower Hamlets LBC [2018].
[48] Hotak v Southwark LBC [2015] UKSC 30.
[49] Homelessness Reduction Act 2017.

5.4.4.15. The BEHMHT contribution to the review observes that, when Mehmet was evicted from his tenancy in March 2018 there should have been a greater emphasis on work to prevent his homelessness, including working closely with housing providers. He appeared to be vulnerable and to require support. He had not responded to concerns about rent arrears, accruing because his Housing Benefit had been withdrawn. Had there been outreach efforts based on an understanding of his mental distress and his language needs, it is possible that the label of "intentional homelessness" might have been avoided and his accommodation needs resolved.

5.4.4.16. Since the Homelessness Reduction Act 2017 came into force in April 2018, any applicant who is homeless or threatened with homelessness and eligible for assistance will be owed some duty regardless of priority need. Their case must be assessed, and the authority must seek to agree a personalised housing plan (section 198A). If the applicant is homeless and eligible for assistance, the authority is required to take reasonable steps to help the applicant secure accommodation (section 189B). If the applicant is threatened with homelessness, the authority is required to take reasonable steps to help the applicant to secure that accommodation does not cease to be available (section185).

5.4.4.17. **Recommendation Eight:** Haringey SAB should receive reports from partner agencies on implementation of the Homelessness Reduction Act 2017 and to consider whether further training is required regarding, for example, the duty to refer.

5.4.4.18. A previous SAR completed by Haringey SAB[50] recommended that a homeless protocol be developed and disseminated. It would appear timely, given the implementation of the Homelessness Reduction Act 2017 and the issues raised by the three cases in this thematic review, to consider whether any revisions are necessary to the protocol and any further work on its dissemination to ensure its impact on services and decision-making.

5.4.4.19. At the learning events it was stated that operational policies are in place, with services working together through a Making Every Adult Matter approach[51] and supported housing pathways. It was felt that there needed to be flexibility in seeing people on the streets and working with people in a person-centred, trauma-informed way, for example when conducting care and support needs assessments and mental health crisis interventions. Put another way, some of those attending felt that there is a gap between the expectations of operational policies and how these are actually delivered.

5.4.4.20. **Recommendation Nine:** Haringey SAB reviews the homeless protocol and considers whether further revisions and/or training are

[50] Haringey SAB (2017) SAR: Robert.
[51] The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.

required to enhance the responsiveness of services to the needs of people who experience homelessness.

5.4.4.21. All three individuals had experienced abuse/neglect and/or were at risk that included, alongside self-neglect, financial abuse and possibly sexual exploitation (Agata), and physical abuse (Mehmet). However, despite some staff being able to establish positive relationships with them, there was no shared risk management strategy. Indeed, a CPA review regarding Mehmet in later April 2019 did not identify any risks.

5.4.5. The final component of the evidence-base relating to direct work with individuals focuses on points of transition. Hospital discharge features significantly in the cases of Mikolaj and Agata, and has already been referenced in relation to the importance of enquiring about people's accommodation needs, recognition of the vulnerabilities of homeless attendees at A&E departments, and the duty to refer people who are homeless or threatened with homelessness.

5.4.5.1. In their contribution to this review Mikolaj's friends questioned whether he had been discharged too soon by NMUH when he was still experiencing stomach pains. In Agata's case there is evidence of planned discharges to a Crash Pad but also lack of follow-up when she self-discharged or failed to attend out-patient appointments.

5.4.5.2. Panel members noted that there is an over-reliance on self-referral, as patients are often advised to contact other services (for example, Drug and Alcohol) upon discharge. There is more success when there is a professional to professional referral. Indeed, SARs and research[52] have identified that people with chaotic lives benefit not just from professional to professional referral but also outreach services that support them to access services.

5.4.5.3. At the learning events it was emphasised that Whittington Hospital and NMUH encourage staff in Emergency Departments to ask attendees if they are homeless or at risk of homelessness. Discharge plans from Emergency Departments do not necessarily work effectively if the person is homeless because they have no address[53]. Some A&E Departments often keep people who are homeless in during the day and provide them with food but are then having to release them at night back to the streets. A view was expressed that Hospitals should be able to release people who are homeless to night shelters without worrying which local authority has the responsibility for housing the person. The challenge of "ordinary residence" has been previously addressed by a SAR undertaken by four SABs in London[54].

5.4.5.4. In the learning events it was noted that, in the last year, NMUH, DWP and Outreach Workers have worked closely together in response to

[52] Preston-Shoot, M. (2020) *Adult Safeguarding and Homelessness. A Briefing on Positive Practice.* London: LGA and ADASS.
[53] See paragraph 5.4.2.6 above also.
[54] City of London and Hackney SAB, Islington SAB, Lambeth SAB and Newham SAB (2019) Mr YI – SAR.

someone who might be otherwise discharged to no fixed abode. The purpose has been to support people to navigate and engage with services. Nonetheless, keeping hospital discharge under review would appear appropriate.

5.5. The second domain focuses on the services around the individual and how they worked together.

5.5.1. The first component of this domain is inter-agency communication and collaboration, working together[55], coordinated by a lead agency and key worker in the community[56] to act as the continuity and coordinator of contact, with named people to whom referrals can be made[57]; the emphasis is on integrated, whole system working, linking services to meet people's complex needs[58].

5.5.1.1. There are examples of positive practice. For example, the GP provided detailed information for NMUH when Mikolaj was referred to the hospital. A GP provided detailed information on Mehmet, also for a mental health provider. MPS and LAS worked together when Agata was found intoxicated, unwell and at risk on the streets. BEHMHT was in contact with St Mungo's in an effort to support Mehmet, for whom immediate B&B accommodation was found when an elected member raised concerns about his homelessness in mid-January 2019. There was also effective and regular communication between commissioned outreach and crashpad/night shelter services delivered by Thames Reach and St Mungo's and the local authority rough sleeping lead.

5.5.1.2. In NMUH and Whittington Health the Safeguarding Team meet regularly with the Emergency Department Team to identify frequent attenders and potential safeguarding issues. This is good practice. The Council has funded and implemented service developments, including the co-location of Homelessness Officers in services such as Mental Health, DWP, Drug and Alcohol agencies and the MASH.

5.5.1.3. However, in none of the cases was a lead agency and key worker appointed. Whilst individual services worked to meet their needs, there is little sense in any of the cases of a coordinated plan. The homelessness fatality reviews identified, for example as a result of Agata's case, the need to improve collaboration between Hospital Trusts

[55] 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.

[56] 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.

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

[58] 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.

and the local authority regarding people who present as homeless, and between DWP and statutory and third sector organisations supporting people experiencing homelessness, especially those additionally at risk from exploitation.

5.5.1.4. BEHMHT could have worked more closely with Mehmet's support workers in an effort to secure his participation in the PTSD pathway. Earlier there should have been greater collaboration between the Housing Association, his Care Coordinator and the local authority when Mehmet was facing eviction in an effort to prevent him becoming homeless.

5.5.1.5. At the learning events more recent developments in terms of co-location and collaboration between services were mentioned. For example, HfH has a presence in job centres that was experienced to have been crucial to many cases in opening the door for more dialogue and swifter resolutions. Housing Needs staff are based at Mulberry Junction, in job centres and at St Ann's hospital (BEHMHT). This co-location has worked well in identifying homeless clients to be referred into housing needs services. A further example of co-location was the placement of a Paramedic on the Rough Sleeping Team, which will prove helpful where people who are homeless cannot access a GP.

5.5.1.6. Since the deaths being reviewed in this SAR occurred, the Rough Sleeping Mental Health Team has been established. This team is flexible in its approach; for example, people do not have to be registered with a GP or have a postal address. Regular weekly meetings are held with partners, including the GP Federation and Street Outreach Services. This has improved multi-agency working. Another example given at the learning events concerned Whittington Hospital. Here a homelessness steering group meets on a monthly basis, joint chaired by a Consultant and attended by one Director of Operations. All patients who are homeless or at risk of homelessness are signposted to Housing Services and a flag is put on the electronic patient record system for future attendances.

5.5.1.7. A further example given at the learning events focused on Community Alcohol Services. An address is not required to access drug and alcohol services and there is a Polish and Eastern European Worker. Outreach is also provided through Hospital Liaison Workers. Job Centre Plus staff have been trained to be able to identify drug and alcohol misuse and to provide basic advice. A direct referral route is available from third sector agencies.

5.5.1.8. Nonetheless, some frustrations were expressed at the learning events. For example, St Mungo's have operational procedures relating to safeguarding concerns and mental health referrals but had found that there was a tendency for other agencies to say that there is nothing that they can do because the person doesn't meet the threshold for services. It would be an improvement, it was suggested, to have one agency coordinating high needs cases where the person is not eligible for

services as everyone had been working independently. Similarly, NMUH staff observed that Hospitals can be stuck between a rock and a hard place, making safeguarding, care and support, and mental health referrals but often not experiencing a satisfactory solution for patients who are homeless and having to discharge them back into the community. This feels really uncomfortable for staff having to discharge vulnerable people back on to the streets. Often when the duty to refer is completed, NMUH staff receive a set response that the person is not entitled because of NRPF or that the Care Act 2014 assessment comes back as ineligible.

5.5.1.9. This is clearly a fast moving environment with recent service enhancements. A view was expressed at the learning events that services are working together better, with the right people in place. However, a view was also expressed that information about the roles and responsibilities of different teams and services would be helpful, and that the architecture of service provision was not entirely clear, meaning that practitioners would not necessarily know who to contact. Recommendation Two above is therefore designed to ensure that Haringey SAB is clearly sighted on the impact and outcomes for people experiencing homelessness of the services now in place.

5.5.2. Part of a collaborative approach is a comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture.

5.5.2.1. As already noted, Mikolaj's GP provided a very detailed letter for NMUH, setting out his medical history. However, although he was discharged by NMUH on 6th January 2019, the discharge summary was not completed until 15th. The local authority was unaware of the involvement of MPS with Agata as no safeguarding alerts had been raised when she was found intoxicated and at risk on the streets. Neither Thames Reach nor St Mungo's had this information either. It has also been suggested that communication could have been enhanced regarding the risks she faced of interpersonal violence and exploitation.

5.5.2.2. Chronologies reflect that there was good communication between services when Mehmet crossed Borough boundaries, and between BEHMHT and his GP. Chronologies are critical, however, of poor information-sharing and missed opportunities to liaise with other agencies when the First Response Team was considering his case in January 2019.

5.5.2.3. At the learning events examples were given of where enhanced information-sharing would be helpful. For example, DWP staff referred to implementing a more holistic approach if a person does not attend a work capability assessment, including undertaking a safeguarding visit to the address to identify if there are any mental health or other issues. However, DWP can only act on the information sent to it, for example, about someone's mental health background, that would indicate the need for a compassionate and holistic approach.

5.5.2.4. As DWP observed at the learning event, information-sharing about the risks to Agata of financial exploitation might have assisted in decision-making regarding the large payment she was due[59].

5.5.3. One mechanism for improving how services work together and share information is the use of 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[60].

5.5.3.1. In none of the three cases did all the services and agencies involved meet together. In Mikolaj's case a partnership meeting between HAGA and Mulberry Junction was planned but did not take place before his death. In Mehmet's case a meeting was proposed between BEHMHT and St Mungo's but any outcome is not recorded in the chronologies. Overall, there is no sense that all the services involved were working to an agreed plan concerning the mitigation of risks.

5.5.3.2. Mixed views were expressed at the learning events. Some of those attending felt that the use of multi-agency meetings had improved considerably, partly as a result of more embedded joint working and case coordination. Others felt, however, that not all services were routinely involved in multi-agency meetings and that further clarity about the roles and responsibilities of different services was necessary.

5.5.3.3. **Recommendation Ten:** Haringey SAB reviews the use of multi-agency meetings in cases where there adult safeguarding concerns, including cases involving homelessness and self-neglect, and considers the implications of the findings for revision of policies and procedures, and for the commissioning of multi-agency training.

5.5.4. Another mechanism that can facilitate multi-agency collaboration and also address risks of abuse and neglect is the use of the duty to enquire (section 42, Care Act 2014), sometimes referred to as safeguarding literacy.

5.5.4.1. There were missed opportunities to use adult safeguarding enquiries to coordinate prevention and mitigation of abuse and neglect, including self-neglect. In Agata's case, no safeguarding alert was raised when she was probably victim of partner assault in November 2015. Neither MPS nor LAS raised safeguarding alerts on the three occasions in 2017, one occasion in 2018 and two occasions in 2019 when she was found intoxicated, sometimes with injuries and always with evidence of self-neglect. No Acute Trust raised alerts either, particularly when she self-discharged. St Mungo's did raise a safeguarding alert regarding financial abuse but this was not picked up before she died. The delay in

[59] Those attending the learning event were informed of DWP's wider work to protect its most vulnerable customers. The Department is looking at what more it can do when claimants are due large back payments and there are concerns that receiving a full payment could cause harm.

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

responding to the alert was outside expectations set out in the local authority's guidance and procedures.

5.5.4.2. Panel members suggested that MPS Officers may have assumed that LAS Crews would have referred the concerns once Agata had been transported to Hospital, possibly coupled with concern also to avoid duplication of referrals. It was observed too that Acute Trusts are more likely to raise a safeguarding concern where a homeless person is an in-patient as opposed to coming to the a Place of Safety Suite, as homelessness and safeguarding risk is more likely to be picked up where people are being discharged back into the community. It was also observed that it can be difficult for Hospitals to identify homelessness, as some of the addresses given on discharge are for B&B or hostel accommodation but are not flagged as such.

5.5.4.3. It was also noted by panel members that there can be a reluctance to make safeguarding alerts for people who are homeless as they are perceived as difficult to engage or contact. It was suggested that safeguarding concerns for people experiencing homelessness are often only progressed once the person's situation has become worse. More positively, work has been done to ensure that staff working in Acute Trusts, including in Emergency Departments, are asking whether a person has somewhere safe to go on discharge.

5.5.4.4. In Mehmet's case, although his situation met the three point criteria in section 42(1) Care Act 2014, one referral in late December 2018 was not progressed. Chronology submissions remark that enquiries at the time could have explored his circumstances in greater detail and that there were missed opportunities to identify Mehmet as vulnerable by Housing before his eviction and by ASC when a safeguarding concern was received. Although a safeguarding social worker spoke to the referrer, reflections in the documentation are critical of practice. No feedback was given to the referrer. There was no safeguarding plan that was outcome focused or that met his needs. His needs were seen as primarily related to his mental health but no checks were conducted to see if a referral had been made, which would have required his consent.

5.5.4.5. Moreover, he seems to have been seen as someone taking unwise decisions by making unrealistic demands regarding choice of accommodation. It is by no means clear on what evidence this judgement had been reached. Practitioners in APAP described their investigation of multiple options for Mehmet, which were either unsuitable or which he rejected. He was understandably frustrated by the lack of a permanent location where he could reside and by his inability to return to his former tenancy.

5.5.4.6. In Agata's case too, the question has been asked as to whether she was always taken seriously due to her abuse of alcohol. Thus arises the question of conscious or unconscious bias, of attitudes towards people who are experiencing homelessness, who are distressed, whose behaviour may be a response to the adverse events they have

experienced, and who may be misusing alcohol or other drugs. Indeed, an elected member has questioned how conclusions had been reached, especially given the language and dialect issues in Mehmet's case.

5.5.4.7. Earlier in Mehmet's case, on 14th March 2018, the BEHMHT chronology refers to a safeguarding concern having been received from Housing. Other than the GP being asked to review his situation, no outcome of this referral is recorded.

5.5.4.8. There is reference in the documentation submitted for Mehmet's case to safeguarding case audits being conducted to evaluate the quality of practice.

5.5.4.9. At the learning events reference was made to adult safeguarding concerns being "pushed back" because the person had no settled accommodation and/or had no recourse to public funds. The criteria for adult safeguarding enquiries are clearly outlined in section 42 (1) Care Act 2014. It is only necessary to demonstrate that a person appears to have care and support needs, is at risk of abuse and neglect (including self-neglect) and, as a result of care and support needs, is unable to protect themselves from that abuse or neglect.

5.5.4.10. Nor should any practitioner place an expectation on other services to refer adult safeguarding concerns. Thus, LAS is clear that, should crews identify concerns, they should complete any safeguarding referrals. It was helpfully suggested by MPS that if their Officers had a better understanding of homelessness, safeguarding referrals might have been made alongside passing people to health services. It was further suggested that a reminder to identify risks and vulnerabilities would be helpful, as Police Officers should not rely on health services to report safeguarding concerns. It was noted that interactions with the subjects were often when they were intoxicated and so it would have been very difficult to assess their mental capacity.

5.5.4.11. **Recommendation Eleven:** Haringey SAB should receive reports and consider the implications for further work of safeguarding case audits and scrutinise decision-making about which cases progress from section 42(1) to section 42(2).

5.5.4.12. **Recommendation Twelve:** Haringey SAB should remind all practitioners and services of their responsibility to refer adult safeguarding concerns and not to rely on others to do so.

5.5.5. The focus on section 42(1) is one part of an evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy.

5.5.5.1. The submission of information by NMUH observes that the duty to refer in the Homelessness Reduction Act 2017 was not used in Mikolaj's case in January 2020. In Agata's case NMUH did refer her when she was due to be discharged to no fixed abode in February 2019. There is no

reference to the provisions of the Homelessness Reduction Act 2017 having been considered in Mehmet's case. There was at least one missed opportunity to use these provisions, namely when the First Response Team was referred his case. Submissions for this review note that he could have been referred in late December2018 or early January 2019 to the rough sleeping task force.

5.5.5.2. Decisions that neither Mehmet nor Agata qualified for rehousing as homelessness persons under the provisions of the Housing Act 1996 were not challenged.

5.5.5.3. People experiencing multiple exclusion homelessness often have care and support needs, which should be assessed (section 9 Care Act 2014). Mehmet's case in particular illustrates the importance of complying with this provision. No assessment appears to have been completed when one had been requested from the First Response Team in January 2019. A care and support assessment was completed in May 2019 according to the BEHMHT chronology but this did not result in any immediate service provision or plan to promote his wellbeing.

5.5.5.4. For individuals with no recourse to public funds, in particular, there is no evidence of a Human Rights Act 1998 assessment. Such an assessment may be required to determine whether support is necessary to prevent a breach of their human rights, especially the right to live free of inhuman and degrading treatment (Article 3, European Convention on Human Rights). In the context of homelessness, this might require consideration of whether the decision to withhold accommodation-based support, social care or health care would result in actual bodily harm or intense mental suffering and physical harm[61].

5.5.5.5. Some panel members were under the impression that a Human Rights Act 1998 assessment had been contemplated with respect to Mehmet but appeared not to have taken place. Some panel members were either unaware of the obligation to consider human rights assessments or had experienced difficulty in securing assessment and believed that they were not commonly utilised. Panel members were clear that human rights assessments should be standard practice where a person experiencing homelessness has no recourse to public funds, as the assessment will identify whether or not there are qualifying needs. However, there may be some resistance because of the potential resource implications. Panel members noted the enormous pressure to reduce costs in Adult Social Care and felt that this was likely to be affecting practitioners' responses.

5.5.5.6. A further feature of legal literacy relates to entitlement to welfare benefits. DWP advised the panel that Mehmet was in receipt of Employment and Support Allowance (ESA) and yet was regarded by agencies as having no recourse to public funds. People can be ineligible

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

for housing but eligible for certain benefits, which may cause differences in perception. Welfare benefit knowledge supports the work of staff in tackling poverty and homelessness, and preventing further physical and mental ill-health.

5.5.5.7. Legal literacy was a focus at the learning events. DWP staff were clearly aware of their responsibilities under the Homelessness Reduction Act 2017 but might not always be informed of the outcome of their referrals[62]. For DWP staff also, there was a general challenge that NRPF status can change during their involvement with someone; it can be hard to establish this information from other agencies and to explain the implications of this to clients. With links to information-sharing and multi-agency working together, there was a felt need to be clear who the key contacts are within each agency.

5.5.5.8. Not all agencies were aware of the importance of Human Rights Act 1998 assessments with respect to people with no recourse to public funds. Similarly, there was some lack of clarity about what action to take, including escalation, when it had proved difficult to access support through provisions in the Care Act 2014.

5.5.5.9. **Recommendation Thirteen:** Haringey SAB should review the provision of training on legal literacy and the availability of guidance on law relating to immigration status, human rights and welfare benefits for staff across Housing, Health and Social Care services.

5.5.6. One feature of positive inter-agency practice is when detailed referrals from one agency request the assistance of another in order to meet a person's needs.

5.5.6.1. Good practice was demonstrated by Mikolaj's GP in referral to NMUH and also to the community alcohol team. Good practice was also demonstrated in the referral information provided by Mehmet's GP for a secondary mental health provider. Indeed, in all three cases there were referrals to other services, often to respond to an accommodation crisis. As already observed, however, there were also missed opportunities to refer and examples of an absence of a timely response. In Mehmet's case, practitioners in third sector services commented that referral information was often inaccurate and/or incomplete. What is missing in all three cases, again as already observed, is a coordinated response to promote wellbeing and to prevent (further) abuse and neglect.

5.5.6.2. One example was highlighted at the learning events, namely a referral pathway for Emergency Services and Emergency Departments direct to

[62] There is no legal requirement for feedback to be given to the referrer. Consent given by the service user is also limited to making a referral and does not include to information-sharing about the outcome of referrals. There is, however, no obstacle on referrers asking for consent from the service user to receive notification about referral outcome. If consent is given, it should not be a burdensome exercise to inform both the service user and the referrer of the outcome, and information-sharing may assist with case coordination and planning.

third sector organisations providing temporary accommodation. Such a pathway would increase the possibility of discharge to a safe provision.

5.5.6.3. The use of different languages can mean that concerns being referred are lost in translation. Panel members suggested, for example, that there may be gaps in the language used by Housing practitioners when making safeguarding referrals, and that reference to the Section 42 criteria and definitions of abuse and neglect need to made to ensure referrals are accepted.

5.5.6.4. Research[63] has also spotlighted the challenge of different workforce sectors understanding the powers and duties available to different statutory agencies. Thus, Adult Social Care staff have the challenge of exploring the fit between vulnerability as defined by the Housing Act 1996 and subsequent case law with the duty in the Care Act 2014 to assess anyone who appears to have care and support needs. Staff working directly with homeless people similarly have to know about how the Care Act 2014 conceptualises wellbeing and eligible needs, and to map people's stories and needs accordingly to secure access to Adult Social Care.

5.5.6.5. **Recommendation Fourteen:** Haringey SAB should consider with Adult Social Care whether revision to the referral pathway for safeguarding concerns would be helpful to explicitly advise referrers to address the three criteria contained within Section 42(1) Care Act 2014.

5.5.7. The final component of this domain emphasises the importance of clear, up-to-date[64] and thorough recording of assessments, reviews and decision-making; recording should include details of unmet needs[65].

5.5.7.1. In Mikolaj's case, an incorrect spelling of his name meant that records relating to him were not joined up. In Mehmet's case, the BEHMHT chronology comments that there is no record of his support worker being contacted to assist him accessing the PTSD pathway. It is also unclear from the records whether a head injury assessment was completed as a plan had indicated in March 2019. Recording of the First Response Team's involvement in late 2018 and early 2019 has been described as poor. Conclusions that there were no concerns regarding his mental capacity, for instance, were not formally recorded.

5.6. The third domain focuses on the organisations around the team. Within the documentation submitted by agencies for the review, there is little reference to this domain.

5.6.1. There are five components to this domain, namely:

[63] 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.

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

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

5.6.1.1. 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;
5.6.1.2. Access to specialist legal, mental capacity, mental health and safeguarding advice;
5.6.1.3. Case oversight, including comprehensive commissioning and contract monitoring of service providers;
5.6.1.4. Agreed indicators of risk that are formulated into a risk assessment template that will guide assessments and planning;
5.6.1.5. Attention to workforce development[66] and workplace issues, such as staffing levels, organisational cultures and thresholds.

5.6.2. At least some of the staff involved with Agata participated in a debriefing exercise after her death, which is good practice.

5.6.3. The analysis of the involvement of the First Response Team concludes that there was a lack of management oversight of the work and that management sign-off of case closure was inappropriate because no Making Safeguarding Personal outcomes had been established and it remained unclear whether a referral had been made for mental health intervention. At that point Mehmet had not really been engaged and there was no documentary evidence that tasks claimed to have been undertaken had been completed.

5.6.4. At the learning events, representatives of some individual services recognised that more could be done by way of development of procedures and/or training to support their staff. Thus, LAS representatives observed that the service did not have specific policies and procedures for people experiencing homelessness and a greater focus on this client group would be helpful. MPS representatives observed that the service had policies on recognition of vulnerability but that officers needed a more informed understanding of homelessness.

5.6.5. At the learning events references were made to workloads. It was acknowledged that the First Response Team were struggling to meet demand at the time of these cases. Further staff are being recruited to meet the demand.

5.6.6. Also at the learning events it was observed that commissioning of services for people experiencing homelessness is informed by service users and service providers. Commissioners responsible for different services do come together but operational services may not always be aware of how to engage with strategic commissioners or of recent commissioning to enhance provision. It has also been observed that staff in third sector services, working to support individuals with highly complex needs and challenging behaviour, and the residents/service users themselves, would benefit from in-house psychological expertise and support.

[66] 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.

5.7. The fourth domain focuses on the SAB. One component here is ensuring that multi-agency agreements are concluded and then implemented with respect to working with individuals at risk of significant harm, abuse and neglect. This includes clear pathways into multi-agency risk management meetings and other multi-agency panel arrangements.

5.7.1. Other features in this domain include:

5.7.1.1. Development, dissemination and auditing of the impact of policies and procedures regarding self-neglect and multiple exclusion homelessness;

5.7.1.2. Reviewing the interface between housing/homelessness and adult social care, mental health, and adult safeguarding, and including housing in multi-agency policies and procedures[67];

5.7.1.3. Working 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;

5.7.1.4. Providing or arranging for the provision of workshops on practice and the management of practice with adults who self-neglect and/or experience multiple exclusion homelessness.

5.7.2. At the time when these cases were active, the Pan-London Adult Safeguarding Procedures did not include a section on homelessness. This has been recently added as an appendix.

5.7.3. **Recommendation Fifteen:** Haringey SAB, with its partners and with other governance Boards and partnerships, should consider the implications of the briefing now added to the Pan London Adult Safeguarding Procedures on homelessness for local policies, procedures and practice.

5.7.4. Haringey SAB has strongly supported and endorsed the homelessness fatality review process that has been developed locally. This is a rapid review process, the outcomes of which are reported annually to the SAB. This thematic review arose from two referrals from this rapid review process.

5.7.5. **Recommendation Sixteen:** Haringey SAB reviews the interface between the homelessness fatality review process and its mandate to conduct mandatory and discretionary reviews (section 44 Care Act 2014).

5.7.6. Getting the governance right is important. Clearly the SAB 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.

5.7.7. At the learning events it emerged that there are several partnerships and Boards into which commissioners report. Reference was made to the Making

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

Every Adult Matter Strategic Board, the Rough Sleeping Strategic Board, and the Homelessness Reduction Board, the latter being under development and which may replace the Rough Sleeping Strategic Board. Commissioners also report into Adult and Health and/or Housing Priority Boards. This is a complex governance architecture. Whilst coordination is the responsibility of one team, the test will be how discrete and overlapping priorities are determined, planned and implemented at a strategic level. Moreover, since the SAB has a mandate to seek assurance about the effectiveness of adult safeguarding in Haringey, it is important to clarify how the SAB and its partners are included in these governance arrangements. The SAB should be represented and adult safeguarding personnel should also attend regularly.

5.7.8. 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[68].

5.7.9. **Recommendation Seventeen:** Haringey SAB should initiate that governance conversation by convening a summit of system leaders across the Borough to agree how the effectiveness of services for people experiencing homelessness is assured, and the role of the SAB in this process.

5.8. The fifth and final domain focuses on the legal, policy and financial context within which adult safeguarding is situated in England. In several respects this national context does not support local services to achieve best practice with respect to preventing and counteracting homelessness.

5.8.1. Government policy with respect to "no recourse to public funds" undeniably presents challenges to those working with people who are homeless with care and support needs, as the cases of Mehmet and Agata highlight. The processes to secure settled status and habitual residency are slow and complex. Vulnerable people can find it difficult to apply for settled status, especially if they have limited ability to speak and understand English, limited access to online technology, and difficulty in obtaining documentary evidence from High Commissions and/or Embassies.

5.8.2. That was certainly the case for Mehmet. Practitioners in third sector services working with him were clear that the lengthy wait for documentation to resolve his immigration status proved a major obstacle. Practitioners supported him to keep appointments. He would not involve his daughter to assist with his claim for residence because of the shame he felt. When he did have sufficient documentation, he hesitated to act, which one practitioner who knew him well put down to his disabilities. It has been suggested to the independent reviewer that Mehmet's case is emblematic of a "Cypriot

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

Windrush", government placing unrealistic demands on individuals for documentation to prove status and entitlement.

5.8.3. The difficulty of securing documentary evidence from High Commissions has been found in other cases too[69]. The impact of this policy, the hostile environment, has left individuals isolated and destitute, and added considerable difficulty to finding a long-term means of helping these individuals. There are other people in Mehmet's position in Haringey alone, some 77% of people sleeping on the streets, many of whom are mentally unwell, with alcohol and/or drug dependence, isolated and at risk of exploitation[70].

5.8.4. Research[71] has also shone the spotlight on the financial context, noting the impact of financial austerity on the capacity of all agencies (not just Adult Social Care) to absorb the workload arising from recognition of the care and support needs, and safeguarding concerns of people sleeping on the streets. The documentation provided for this thematic review includes the observation that the closure of a day centre hit Mehmet hard since it meant that he lost friendships, care and solace.

5.8.5. The Homelessness Reduction Act 2017 is silent with respect to two of the main contributing factors towards homelessness, namely the lack of supply of affordable housing and affordability of available accommodation. Welfare reforms have had a negative impact by creating landlord mistrust of Universal Credit and by failing to assist people into the private sector due to the rise in rents not being matched by the level of assistance available. Reducing support for people to help them maintain tenancies[72] and changes in Housing Benefit have rendered some people homeless[73]. It is not unusual to remark that the achievement of one government policy, namely here the prevention of homelessness, is undermined by another, namely here welfare benefit changes[74].

5.8.6. That said, it is important to acknowledge what has been achieved with respect to people experiencing homelessness as a result of the response to the Covid-19 pandemic. Derogation of legal rules and the injection of financial resources has made a marked difference for people previously homeless. It has demonstrated what can be achieved when the financial, legal and policy context changes, and supports good practice locally. It has demonstrated

[69] Redbridge Safeguarding Adults Board (2019) *Annual Report 2018-2019*.
[70] Chain Annual Report (2020) *Haringey April 2019-March 2020*.
[71] 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. Cornes, M., Mathie, H., Whiteford, M., Manthorpe, J. and Clark, M. (2016) 'The Care Act 2014, personalisation and the new eligibility regulations: implications for homeless people.' *Research, Policy and Planning*, 31 (3), 211-223.
[72] Pleace, N. (2013) *Measuring the Impact of Supporting People: A Scoping Review*. Cardiff: Welsh Assembly Government
[73] *The Impact of Welfare Reform on Homelessness in London*. Undated report, accessed 23rd August 2020 at https://www.london.gov.uk
[74] Butler, I. and Drakeford, M. (2005) *Scandal, Social Policy and Social Welfare* (2nd ed). Bristol: Policy Press.

what recent research[75] has advised when outlining five principles – find and engage people, build and support the workforce to go beyond existing service limitations, prioritise relationships, tailor local responses to people sleeping rough and, finally, use the full power of commissioning to meet people's health, housing and social care needs.

[75] 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.

6. Revisiting the Terms of Reference

6.1. At the learning events a sense of frustration was expressed by some practitioners and managers present that cases like those of Mehmet, Agata and Mikolaj could reach "stalemate", with no apparent way forward because of the application of thresholds and eligibility criteria, and decision-making with respect to powers and duties contained in statute. Some of those attending the learning events questioned whether greater use should have been made of escalation and whether there was sufficient clarity about the procedures and pathways to follow.

6.2. At the learning events it was recognised that Mehmet, Agata and Mikolaj were all in touch with outreach teams and support services almost immediately after they were homeless. They were known. Their needs were not unknown. They were not under the radar. The outcomes in all three cases were ultimately the result of a lack of alignment across the systems that are designed to prevent and protect people from abuse and neglect, including self-neglect, and to meet their housing, health and social care needs. At the forefront here is legislation regarding immigration and no recourse to public funds that directly cuts across the legislative and moral imperative to safeguard adults.

6.3. That said, it is difficult to discern in these three cases a whole system, coordinated response to needs relating to housing, physical and mental health care, substance misuse and care and support. Powers and duties in legislation were not drawn upon to the fullest extent possible. Whilst there were examples of information-sharing and collaboration between services, what was missing was any sense of all agencies, including mental health and substance misuse services, working to an agree risk management plan. Indeed, this had been reflected in recommendations from the fatality reviews, namely to improve collaboration between Council and Acute Trust services regarding homeless people, and to improve connections between DWP and organisations supporting people who are homeless.

6.4. The question for the SAB, and for its partner agencies, is whether the creation of new posts, such as the Social Worker with direct responsibility for homelessness, and of new teams, such as the Rough Sleeping Mental Health and Physical Health Team, will promote a more coordinated response to people with a complex and challenging range of needs.

6.5. There is, as this thematic review has highlighted, an evidence-base for positive practice with respect to adults who self-neglect and/or experience multiple exclusion homelessness[76]. It draws on research and SAR findings. Recent research[77] has captured this evidence succinctly in five shared principles – find and engage people, build and support the workforce to go beyond existing service limitations, prioritise relationships, tailor local responses to people sleeping rough and, finally, use the full power of commissioning. The SAB can continue to seek assurance that service developments are promoting practice that mirrors that evidence-base.

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

[77] 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.

6.6. However, Mehmet, Agata and Mikolaj should not be seen solely through a lens of people experiencing homelessness. Agata and Mikolaj had worked as volunteers and/or contributed to the wellbeing of others residing with them in temporary accommodation. Mehmet was personally proud, taking care of his personal appearance, and a talented creative artist who contributed to the environment of the third sector service that offered him shelter. Despite the attention he demanded and the multiple needs with which he presented, he was “a good guy.”

7. Recommendations

Recommendation One: Haringey SAB conducts audits of the use of interpreters and advocates, with particular focus on cases involving people who are homeless or threatened with homelessness.

Recommendation Two: Haringey SAB should track the impact and effectiveness of recent service enhancements for working with people experiencing homelessness, identifying positive outcomes and any gaps in provision.

Recommendation Three: Haringey SAB reviews with commissioners and providers where there are gaps to be filled in the availability of holistic, wrap-around support for people experiencing multiple exclusion homelessness.

Recommendation Four: Haringey SAB works with relevant partners to develop guidance on the interface between mental health and mental capacity, with particular reference to the impact of trauma and adverse life experience, substance misuse and the potential for impairment of executive capacity.

Recommendation Five: Haringey SAB convenes a summit to review pathways into mental health provision, and to strengthen strategic relationships and operational practice between primary care, social care, third sector agencies working with people experiencing homelessness and mental health providers.

Recommendation Six: Haringey SAB requests a report from the local authority on how the provisions in the Care Act 2014 relating to care and support are being implemented with respect to people who are homeless. This report to include initial outcomes from the work of the newly appointed Social Worker whose role is to work with people experiencing homelessness.

Recommendation Seven: Haringey SAB should receive from HfH regular reports on the outcome of decision-making regarding housing applications from people experiencing multiple exclusion homelessness.

Recommendation Eight: Haringey SAB should receive reports from partner agencies on implementation of the Homelessness Reduction Act 2017 and to consider whether further training is required regarding, for example, the duty to refer.

Recommendation Nine: Haringey SAB reviews the homeless protocol and considers whether further revisions and/or training are required to enhance the responsiveness of services to the needs of people who experience homelessness.

Recommendation Ten: Haringey SAB reviews the use of multi-agency meetings in cases where there adult safeguarding concerns, including cases involving homelessness and self-neglect, and considers the implications of the findings for revision of policies and procedures, and for the commissioning of multi-agency training.

Recommendation Eleven: Haringey SAB should receive reports and consider the implications for further work of safeguarding case audits and scrutinise decision-making about which cases progress from section 42(1) to section 42(2).

Recommendation Twelve: Haringey SAB should remind all practitioners and services of their responsibility to refer adult safeguarding concerns and not to rely on others to do so.

Recommendation Thirteen: Haringey SAB should review the provision of training on legal literacy and the availability of guidance on law relating to immigration status, human rights and welfare benefits for staff across Housing, Health and Social Care services.

Recommendation Fourteen: Haringey SAB should consider with Adult Social Care whether revision to the referral pathway for safeguarding concerns would be helpful to explicitly advise referrers to address the three criteria contained within Section 42(1) Care Act 2014.

Recommendation Fifteen: Haringey SAB, with its partners and with other governance Boards and partnerships, should consider the implications of the briefing now added to the Pan London Adult Safeguarding Procedures on homelessness for local policies, procedures and practice.

Recommendation Sixteen: Haringey SAB reviews the interface between the homelessness fatality review process and its mandate to conduct mandatory and discretionary reviews (section 44 Care Act 2014).

Recommendation Seventeen: Haringey SAB should initiate that governance conversation by convening a summit of system leaders across the Borough to agree how the effectiveness of services for people experiencing homelessness is assured, and the role of the SAB in this process.