Northamptonshire Safeguarding Adults Board

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Safeguarding Adults Review

Jonathan

2020

Executive Summary

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Introducing this summary

This summary provides an accessible overview of a Safeguarding Adults Review (SAR) report completed in respect of Jonathan and pulls together key messages and opportunities for improving practice. This summary is not a substitute for reading the full report and should not be used as such. Its primary goal is to share findings to inform and improve local inter-agency practice by acting on learning in order to reduce the likelihood of similar harm occurring again. The full report can be read here.

1. Context

1.1 In 2019, 778 deaths in England and Wales were attributable to homelessness, an increase on the previous year by 7.2% and the highest estimate since statistics on homeless mortality rates began in 2013[1]. These statistics tell us that among homeless people, the mean age at death was 45.9 years for males and 43.4 years for females in 2019; in comparison the mean age of death in the general population which was 76.1 years for men and 80.9 years for women.

1.2 Against this background, including the increased worry that homelessness was on the rise across the country, growing by 169 per cent since 2010[2]. The Government has highlighted the potential relevance of adult safeguarding procedures for people experiencing homelessness in its Rough Sleeping Strategy (2018)[3]. Other responses from leading homelessness charity St Mungo's[4] and the Mayor of London[5], for example, have questioned how well people who rough sleep are being served by agencies with duties to protect them from abuse and neglect, including self-neglect.

1.3 In 2018, the Rough Sleeping Strategy made a clear link between homelessness and adult safeguarding in relation to the deaths of people sleeping rough. 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" (chapter 3, page 31).

1.4 It is, however, important to highlight that mandatory criteria needs to be met for a Safeguarding Adult Review to be triggered under section 44 of the Care Act 2014. Such mandatory criteria are not recognised within the Government's Rough Sleeping Strategy, 2018. It is perhaps timely to revisit the existing evidence-base of positive practice[6], including the emerging themes from SAR research[7] as much is already known about what works in safeguarding and homelessness. The challenge remains, however, for system leaders and practitioners to effect a change in practice to bridge gaps that span across sector disciplines and geographical boundaries.

[1] Office for National Statistics. Deaths of homeless people in England and Wales (2019)
[2] Fitzpatrick, S., Pawson, H., Bramley, G., Wilcox, S., Watts, B. & Wood, J. (2018) The homelessness monitor: England 2018. London.
[3] Rough Sleeping Strategy (2018). Ministry of Housing, Communities and Local Government.
[4] Dying on the Streets: The case for moving quickly to end rough sleeping (2018)
[5] Mayor of London, Rough Sleeping Plan of Action (2018)
[6] A positive practice briefing by Michael Preston-Shoot (2020) 'Adult safeguarding and homelessness A briefing on positive practice' - LGA. This briefing outlines what works in homelessness and safeguarding with a focus on those who experience multiple exclusion homelessness.
[7] 25 SARs in the national analysis (11%) contain references to homelessness, majority published: - Michael Preston-Shoot et al (2020) *'Analysis of Safeguarding Adult Reviews April 2017 – March 2019 Findings for sector-led improvement'.* LGA. **And** research by Kings College London provides an analysis of 14 SARs where homelessness was a factor: - Martineau, S et al (2019) *Safeguarding, Homelessness and Rough Sleeping: An Analysis of Safeguarding Adults Reviews. London*: NIHR and Kings College London.

2. Objectives

2.1 This SAR was commissioned following the death of Jonathan in December 2019; a 46-year-old white British male who was living in a hotel at the time of his death. Jonathan had care and support needs and experienced abuse and neglect, including self-neglect. There were also concerns about how agencies worked together to safeguard Jonathan. It was therefore decided by Northamptonshire Safeguarding Adults Board (NSAB) that a SAR[8] should be undertaken.

2.2 The aim of a SAR is not to apportion blame or responsibility, but to highlight ways in which agencies can improve how they work together and singly. Each member of the Safeguarding Adults Board must co-operate in and contribute to the review to identify the lessons to be learnt with a view to apply those lessons to future cases[9].

2.3 The combined chronology showed over 700 individual entries recorded by several agencies within a 12-month period. Jonathan had over 40 attendances at emergency departments in this time, often resulting in treatment and admission as an inpatient. He also had a high level of contact with both statutory and community-based services, including police officers, probation workers, housing and homelessness professionals and social workers. This represented a high level of involvement from agencies and the records showed an elevated degree of concern for Jonathan's wellbeing, including risk to life.

2.4 This summary also highlights the experiences of Jonathan and illustrate the degree to which his life course exemplifies that of an adult facing multiple exclusion homelessness. In the context of this SAR, multiple exclusion homelessness is defined as:

"People who have been 'homeless' (including experience of temporary/unsuitable accommodation as well as sleeping rough) and have also experienced one or more of the following additional domains of deep social exclusion – 'institutional care' (prison, local authority care, psychiatric hospitals or wards); 'substance misuse' (drug problems, alcohol problems, abuse of solvents, glue or gas); or participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work)." Fitzpatrick, et al (2011)[10]

2.5 Finally, this summary seeks to place the views of Jonathan's relatives at the forefront of learning, so that practice improvements are made, and agencies work better together to safeguard adults in Northamptonshire and beyond with similar experiences and challenges to those of Jonathan's. The family have made it clear that 'seeing the person and not just the problems' is key to securing better wellbeing outcomes for homeless adults with complex needs, or, at the very least, it would provide adults like Jonathan with an opportunity to be 'seen and heard', so that their presenting needs, risks and behaviours are better understood.

3. Summary of findings

3.1 Opportunities to protect Jonathan were often missed, often as a result of professional preconceptions of care and support needs and risk, including a narrow interpretation of policy and the legislative framework. In their reflective discussions with the Independent Overview Report Author and at the practitioners' event, several agencies commented on the lack of planning, communication and co-ordination between agencies whereby Jonathan's repeating pattern of crises were rarely acknowledged and understood.

[8] Sections 44(1)-(3), Care Act 2014
[9] Section 44(5), Care Act 2014
[10] Fitzpatrick, S., Johnsen, S. and White, M. (2011) 'Multiple exclusion homelessness in the UK: Key patterns and intersections', Social Policy and Society, 10(4), pp. 501–12.

3.2 Jonathan's presenting issues and risks are categorised as themes in this report. These were derived from reading the combined chronology, a practitioner's event and from the additional information supplied by the agencies involved in the review. Alongside the full SAR report, NSAB partners and other agencies involved with Jonathan are encouraged to read a briefing on positive practice for adult safeguarding and homelessness delivered by the LGA in collaboration with ADASS.

3.3 Four main themes were identified in relation to Jonathan which are described below as a summary:

3.4 Housing and Homelessness

3.4.1 The review found that Jonathan's problems were increasingly restricting his mobility, his continence and his ability to concentrate, and remembering appointments were increasingly affected. Given what was known at the time, it is surprising that Jonathan was judged as not more vulnerable than an ordinary person faced with homelessness, and at a much earlier stage. The review found limited evidence and understanding of the application of the Equality Act 2010, including the duty to make adjustments for individuals with difficulties arising from disabilities, which would have applied in Jonathan's case. It would not be reasonable to expect Jonathan to physically attend all appointments given his health issues, financial troubles and having no means of contact without substantial support.

3.4.2 The review identified concerns from Housing[11] that Jonathan would not be able to hold down a tenancy without substantial support given his physical and mental health conditions. It was identified that Housing had concluded that Jonathan lacked mental capacity to make a homelessness application on the basis that he did not understand the consequences that not meeting the conditions of a tenancy would have on his wellbeing, including managing and maintaining a home safely. Housing were rightfully concerned that Jonathan would not be able to hold down a tenancy given his physical and mental health conditions without substantial support. However, having the ability to live independently and having capacity to make a homelessness application are arguably different issues and therefore decisions.

3.4.3 The review illustrates a lack of understanding around the relationship between mental capacity guidance and decisions to make a homelessness application. Jonathan's ability to manage a home is not necessarily evidence of a lack of capacity to make a homelessness application. Jonathan's behaviours, erratic engagement with services and difficulties remembering appointments were likely to be as a result of his physical disabilities and communication difficulties. The case records indicated that Jonathan would not be able to achieve certain tasks without substantial support and this was a source of frustration and distress for Jonathan. The review has therefore concluded that the mental capacity assessment was not carried out in the way required by the mental capacity code of practice and there is learning for all local housing agencies in this respect.

3.4.4 The case records revealed a lack of review of previous exclusions from emergency night shelters, meaning that Jonathan was continuously unable to seek respite from the streets, and there was a sense of Jonathan being permanently excluded. This also highlighted a failure to recognise repeating patterns of homelessness and joined up messaging between agencies, including making better use of out-of-hours responses to street homelessness.

3.4.5 The review found no evidence of the Local Authority exercising discretionary powers under section 19 (3) of the Care Act 2014. Local authorities are permitted to exercise its power to meet care and support needs, including for accommodation, prior to completion of an assessment if there appears to be an urgent need.

[11] Housing within this summary refers to East Northants Council, however there is learning for all local housing agencies within this SAR.

3.5 Hospital discharges

3.5.1 The case records identified that Jonathan attended two hospitals (16 miles apart) on at least 40 occasions in 2019. The review recognised a repeating pattern of unplanned hospital visits which were rarely acknowledged or understood. There was a distinct lack of professional curiosity about why Jonathan was frequently visiting emergency departments, apart from concluding that he was seeking shelter. There were several examples of the hospitals not activating the duty to refer under the Homelessness Reduction Act 2017 as well as raising safeguarding concerns, and a repetitive approach to addressing his circumstances by booking him a taxi to take him to a night shelter where he had been excluded from.

3.5.2 The review identified concerns about Jonathan's stated wishes taken at face value without further checks and balances. He often stated that he had been assaulted and was fearful of rough sleeping, but when he gave assurances that he was okay or if he left abruptly, this would often be accepted at face value with no further lines of enquiry being explored based on professional curiosity – an aspect of practice which would have helped guard against practitioners placing undue confidence on Jonathan's ability to care for himself.

3.5.3 It was possible to discern from the case records a 'more of the same' approach, in that Jonathan would attend an emergency department, receive treatment (occasionally leave or self-discharge), be referred to the mental health team for assessment resulting in 'no further action', a taxi would be booked and sometimes not long after he would return to hospital, often with the same complaints that led him there previously. The review found that, such was Jonathan's frustration and distress, that he would deliberately commit offences so that he could be arrested and 'helped' off the streets.

3.5.4 A case record showed an alert dating back several years remained set against his patient record to 'not refer' Jonathan to the hospital mental health team unless his presentation had 'significantly changed'. The review identified how Jonathan's circumstances had been normalised with clear omissions of the mundane and obvious risks he was facing, and would face, as a street homeless person.

3.5.5 It is possible to establish that Jonathan was well known to Emergency Departments in Northamptonshire, however, there was a lack of understanding of his needs and a repeat failure to plan hospital discharges in a meaningful and purposeful way. This was most apparent in December 2019, when Jonathan was identified as having 'no care and support needs' following observations that he was independently managing his personal care and mobilising safely on the ward and that these could be sustained in the community. This presents an interpretation of the Care Act outcomes and the person's 'ability to achieve' that would not be in line with statutory guidance.

3.5.6 The case records revealed that a referral to medical rehabilitation could not proceed because there was no discharge destination. It can be concluded that Jonathan's homelessness or lack of housing was a barrier to him achieving full recovery potential. As no accommodation was sourced for Jonathan, the default pathway was to 'signpost' Jonathan back to the local Housing authority without arrangements in place for meeting his wider care and support needs. It is important to highlight that excluding those with nowhere suitable to live could be a breach of the Equality Act 2020.

3.6 Care assessments and safeguarding

3.6.1 Multiple notifications of concern were submitted by agencies throughout the review period to adult Northamptonshire County Council's adult social care and adult safeguarding teams. These highlighted the risks Jonathan faced and areas where he required support, in addition to the safety issues made worse by homelessness. On one occasion, a case record noted significant concerns that Jonathan would die if agencies did not intervene and help him.

3.6.2 The review found an absence of feedback from adult social care and adult safeguarding with regards to the outcome of notifications raised by agencies. Equally, the review also found that there was a lack of agencies checking whether referrals or notifications had been received, including understanding the status of concerns raised.

3.6.3 The review highlighted a pattern which indicated that Jonathan's care and support needs were not being sufficiently acknowledged, with each referral or notification being seen in isolation. The records highlighted that Jonathan did not have any care and support needs to trigger a safeguarding adult enquiry under section 42 of the Care Act 2014. On one occasion it was noted that 'eligibility' for a social care assessment had not been satisfied which denied Jonathan of his right to an assessment. This review therefore questions the degree to which statutory and non-statutory agencies understand the statutory criteria for a section 42(1) enquiry and the section 9 of the Care Act 2014 needs assessment duties, particularly when set against challenging circumstances linked to multiple exclusion homelessness and repeating patterns, like Jonathan experienced.

3.6.4 On the occasion where Jonathan was being assessed, the review identified how his request to be given information in 'plain English' had been ignored. The statutory guidance accompanying the Care Act 2014 requires local authorities to give the person being assessed advance notice of the questions so that they can prepare for the assessment. In addition, the review found that Jonathan would have likely qualified for an Independent Advocate under section 67 and/or section 68 Care Act 2014, but this was not considered.

3.6.5 The review also found that no safeguarding enquiries occurred throughout the period under review, nor did any multi-agency meetings with a focus on risk and risk mitigation occur. There was one solitary professionals meeting in September 2019, however, this lacked structure and a purposeful agenda and insufficient notice was given to secure the relevant agency involvement. This is a significant omission and given the risks faced by Jonathan, it would have required a proactive investigative response under a multi-agency framework to make lines of accountability and responsibility much clearer.

3.7 Inter-agency collaboration, leadership and coordination

3.7.1 The review found that confidence levels amongst agency workforces were relatively low when working with people experiencing multiple exclusion homelessness. This applied to understanding the risks that Jonathan faced, identifying his care and support needs and poor coordination of interventions. Notwithstanding the inherent challenges in managing complex cases, especially in resource scarce contexts, the review identified how a narrow interpretation of the legal framework resulted only in short-term relief from operational pressures. Jonathan's case demonstrated an escalation of his needs and repeating patterns of harm resulting in numerous interactions with blue light services, for example.

3.7.2 There was a clear lack of purposeful and meaningful planning with each encounter seen in isolation. The practitioners' event identified how the workforce felt they didn't always understand how the relevant legislative powers and duties could have been applied in the case of Jonathan. Understanding the risks that adults like Jonathan may face, including a significant increased risk of serious abuse, exploitation and neglect, as well as an escalation of their health and care needs and a reduction to their life expectancy will help practitioners to objectively define risks and needs.

3.7.3 The review has found that local procedures, such as Northamptonshire's multi-agency Adult Risk Management (ARM) processes, was not embedded in practice. There were diverging views from agencies in terms of the utilisation of the ARM process for complex cases like Jonathan, ranging from a lack of awareness of the aims and purposes of the ARM process, to perceptions that it was not compatible with practice. Individual reflective discussions and the practitioners' event highlighted that practitioners are not confident in arranging multi-agency meetings through the ARM process, or indeed otherwise seeking to arrange alternative risk management meetings, as there is a sense that the right agencies would not 'turn up'.

3.7.4 Case notes revealed a lack of understanding about each other's roles and responsibilities, including lack of consensus, or indeed discussions, as to how a professionals meeting with a focus on risk mitigation could be beneficial. However, as the review has found, there is a clear requirement to secure more timely responses when working together, to facilitate communication across sector boundaries and to promote earlier interventions for people experiencing multiple exclusion homelessness. The review has found that agencies should focus on the timeliness for carrying out the ARM process, or an equivalent multi-agency meeting, and the use of lead agencies to coordinate services and risk management plans.

4. Summary of SAR Recommendations – (reproduced in full in section 9 of the SAR overview report)

Arising from the analysis undertaken within this review, the Independent Overview Report Author recommends that the Northamptonshire Safeguarding Adults Board:

1	Receive from the Chief Housing Officers Group a review of practice and decision-making regarding priority need for housing applications.
2	Receive from Adult Social Services and Housing, a joint multi-agency protocol on assessment and service provision with respect to homeless people with care and support needs.
3	Conduct a multi-agency case file audit of section 42 enquiry threshold decisions where homelessness or risk of homelessness is a factor and to agree proposals for service development based on the findings.
4	Receive from Adult Social Services a review of their professional oversight and management of safeguarding alerts to ensure that they are compliant with agreed standards. This should include assessment of risk, appropriate recording which captures professional judgement and collective agreement where a person's wellbeing is influenced by multiple agencies.
5	Receive assurance and evidence from relevant agencies involved in this review that processes are sufficiently robust that ensures the 'duty to refer' under the Homelessness Reduction Act 2017 is being activated when the responsibility arises.
6	Receive from the Chief Housing Officers Group (CHOG) the local homelessness strategy/strategies together with assurances that the strategy/strategies addresses those experiencing multiple exclusion homelessness.
7	Receive from Northamptonshire Adult Social Care, NHS Northamptonshire Clinical Commissioning Group, Northampton General Hospital and Kettering General Hospital a review of co-operation regarding hospital discharges and proposals to improve communication, assessment and service provision with an emphasis on joint assessments for homeless people.
8	Receive from Northampton General Hospital and Kettering General Hospital suggestions for how the safeguarding teams inside a hospital can be made aware of homeless people in a timely and effective manner.
9	Conduct a multi-agency case audit to answer the question of how embedded in practice is the ARM procedure, with particular focus on the timeliness for carrying out an ARM and the use of lead agencies to coordinate services and risk management plans, with proposals brought forward to address the findings. The findings should include proposals from agencies with regards to establishing more regular meetings where information can be shared, and decisions made for people experiencing multiple exclusion homelessness.
10	Receive assurance and evidence from all agencies involved in this review *that* risk management processes have been reviewed and amended where necessary in relation to people experiencing multiple exclusion homelessness. Assurance should evidence that structures are sufficiently robust to ensure agencies understand each other's roles and responsibilities and include mechanisms that allow for effective operational relationships to develop across practice disciplines.
11	Receive assurance and evidence from all agencies involved in this review that training and knowledge gaps in respect of multiple exclusion homelessness, referrals and thresholds for section 42 Care Act 2014 enquiries and section 9 care assessments, Mental Capacity Act 2005 assessments and the Homelessness Reduction Act 2017 have been addressed.

5. Conclusions

5.1 While numerous examples of positive practice were revealed throughout the review including many examples of determined efforts to support Jonathan, the review has concluded that there was a lack of purposeful and effective multi-disciplinary working to address Jonathan's complex issues. There was a clear failure to implement a personalised plan of action and a failure to assess his social care needs so that these were not merely confined to just a housing issue.

5.2 The review explored the extent to which professionals working with people that are experiencing multiple exclusion homelessness like Jonathan, need to be prepared to exercise their professional judgement and in ways which incorporates the law, ethics and rights based-thinking.

5.3 The SAR has provided eleven recommendations, to be understood in the context of Northamptonshire and to act as a catalyst for change so improvements can be made to reduce the chances of further tragedies occurring.

5.4 The Independent Overview Report Author and all members of Northamptonshire Safeguarding Adults Board are grateful to Jonathan's relatives who felt able to contribute to the review. The family were clear in their wish to see agencies across Northamptonshire learn lessons from their tragic loss, so that agencies work better together to safeguard adults in Northamptonshire and beyond with similar experiences and challenges to those of Jonathan's.