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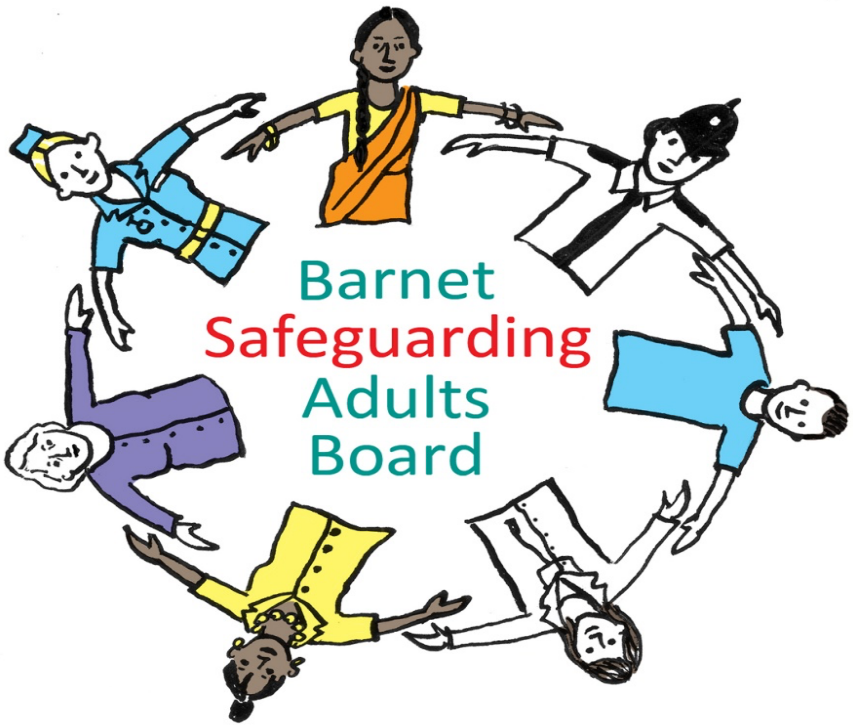

Multiple Exclusion Homelessness Safeguarding Adults Review

PHIL SAR

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Contents

1. Introduction

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

1.2 This SAR covers the circumstances preceding Phil's[1] death.

1.3 Phil went missing from his residential care home on 31January 2022. In April 2022, his decomposed body was found in a rough sleeping site in woodlands near to the North Circular. He was 64 when he died. The Coroner's Inquest was unable to establish a specific cause of death; however, the police investigation ruled out any third-party involvement.

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

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

1.5 This SAR focuses on the period January 2021 to April 2022.

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

2. Phil

2.1 The information the review gathered about Phil was drawn from a range of organisational records from 2021 onwards, and a meeting with a GP from the practice where Phil was registered in 2021 and 2022. A member of Phil's family was invited to contribute to the SAR, but they did not respond to this offer.

2.2 Phil was born in July 1957.

2.3 In July 2021 he had a hospital admission in Barnet where he received a diagnosis of Wernicke-Korsakoff syndrome. The cause of the disorder is thiamine (vitamin B1) deficiency, usually a consequence of chronic alcohol dependence.

[1] The review has chosen a pseudonym to offer some anonymity to the adult.

2.4 Symptoms include confusion, memory loss, altered mental state and consciousness, peripheral neuropathy, and gait disturbances. These symptoms make people living with Wernicke-Korsakoff syndrome vulnerable to exploitation, abuse and neglect and the condition presents challenges around mental capacity and self-advocacy.

2.5 Before his hospital admission Phil had no fixed abode and had been living with friends.

2.6 Phil lacked the mental capacity to make decisions about where to live and he was placed in a care home in Barnet. An Independent Mental Capacity Advocate [IMCA] was involved in supporting Phil and the services supporting him to make that decision on a best interests' basis.

2.7 An application for a Deprivation of Liberty Safeguards authorisation [DoLS] was begun while Phil was in hospital, before he moved into the Care Home. The application was in progress but hadn't been concluded at the time of his death. This would have enabled the home staff to stop him leaving the establishment to manage the risks he faced in the community.

2.8 From Phil's conversations with professionals, it is believed he may have had a history of serving in the armed forces. The review was unable to find any confirmation of this. A search of the "Find my past" commercial database with Phil's full name and date of birth does not reveal any service record.

2.9 There were several occasions when Phil went missing from the Care Home. Based on a risk assessment, the home put some additional support and mitigations in place to address this. These mitigations included additional one-to-one support and ensuring that the front door to the home was securely locked.

2.10 Around the turn of the year 2021 to 2022, Phil's behaviours in the home were causing further concern. Other residents and staff were deemed to be at risk because of his aggressive behaviour. He is reported to have threatened staff with a knife.

2.11 Following referral from his GP, he was seen twice by teams at Barnet, Enfield and Haringey Mental Health Trust [BEHMHT]. Doctors who saw him confirmed the diagnosis of Wernicke-Korsakoff's psychosis and discharged him back to the care of his GP with several recommendations. These are detailed later in the report.

2.12 Later in January 2022 Phil went missing from the Care Home and didn't return.

2.13 A police-led Missing Person's investigation was begun immediately. This included leaflet drops and distribution, social media posts, checking with local hospitals whether he had been admitted, enquiries with local homelessness agencies, and visiting former addresses. There was regular communication between Adult Social Care and the police.

2.14 In April 2022 Phil's body was found in woodlands near the North Circular. He had been dead for some time. There was evidence around his body of a disused rough sleeping site.

2.15 Those who worked with Phil in 2021/2022 knew very little about his life story. The SAR reviewer has not been able to make contact with any of his friends or associates. There are some reports of him living with others indoors at times. No records have been found of his registration with a GP before his admission to the Care Home.

2.16 During a previous hospital admission relating to a leg injury in 2019, he declined to provide contact or follow-up details when he was discharged.

2.17 It was reported for the Coroner's Inquest that the police had seen him sleeping rough in 2019, in the same woodland area where his body was found. He is reported to have said that he had been living in a tent for 10 years. It is not clear whether this was continuous or intermittent.

2.18 Phil's disappearance was followed up as a Missing Person, but it does not appear that there was any early intelligence available to consider searching deep in the woodland area where his body was eventually found. Shortly before he was found, an aerial search of the woodland area was being considered, but the police Air Support Unit were unable to prioritise this due to competing demands on their resources.

Tracking people who sleep rough in London

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

2.20 However, if Phil's rough sleeping site was in woodlands, then it is less likely that he would come to the attention of statutory or third sector outreach teams as they tend to focus on urban rough sleeping sites and are required to consider the risk to their staff when approaching sleep sites in abandoned, isolated or potentially dangerous locations.

Recommendation 10

Barnet Housing: Review the approach to identifying isolated rough sleeping sites and people who use them. Consider a joint approach with Parks Teams and police to improve communication on people or areas of concern and to identify areas that would benefit from regular periodic joint visits.

2.21 The review has found no evidence that Phil was known to rough sleeping services in Barnet, or those operating pan-London that are commissioned by the GLA. This is unusual, but not unheard of, for people who have an established pattern of rough sleeping over many years.

2.22 The reviewer therefore thinks that it is unlikely that Phil was living in a tent in woodland in London for extended periods of time, but rather that this may have occurred intermittently.

2.23 During the early period of the pandemic in 2020/2021, the Government's *Everyone In* programme provided accommodation for all people sleeping rough in England. In London, while a small number of people did not take up the opportunity, if they were known to rough sleeping services, they continued to be offered support, including in due course to offer the Covid vaccine.

2.24 There are no records that Phil was identified as rough sleeping during that period. This suggests that he was able to secure and maintain some form of accommodation with friends or other associates during that time. The nature of this accommodation is unknown, but it is hoped this indicates that Phil had relationships that were able to endure the challenges presented by the pandemic.

3. Thematic Analysis – Direct Work with Phil

3.1 In terms of law and regulation, Phil's care and support was assessed and commissioned within the terms of the Care Act 2014 and his needs to be deprived of his liberty were assessed under the provisions of the Mental Capacity Act 2005. He also had assessed needs for the management of his Wernicke-Korsakoff's psychosis.

3.2 Very little was known by Adult Social Care or the Care Home about Phil's previous life, including experiences of sleeping rough.

3.3 At the time that Phil moved to the Care Home, those working with him had observed that his capacity to make decisions was compromised, particularly in terms of deciding where to live. This led to the convening of Best Interests meetings and the appointment of an Independent Mental Capacity Advocate [IMCA]. The decision to seek a Deprivation of Liberty Safeguards [DoLS] authorisation built on the understanding of the impact of his Wernicke-Korsakoff's psychosis on Phil's decision making.

3.4 When Phil was admitted to hospital in 2021, the social work team assessing his need did have some limited information about and contact with some friends and acquaintances. It is regrettable that more work was not undertaken to understand Phil's background. There is no record of agencies involved at this time learning of his history of rough sleeping. This was a key piece of Phil's life story that needed to be taken account of in planning for his needs.

3.5 While in hospital he had been prescribed Thiamine, to address his thiamine (vitamin B1) deficiency, a consequence of heavy alcohol use over time. Phil's GP practice continued to prescribe this for Phil following his discharge from hospital.

3.6 The application for a DoLS authorisation was begun while Phil was in hospital before he moved into the Care Home.

3.7 Phil was first placed in the Care Home for a trial period in August 2021. The placement was reviewed in September 2021 and the following month his long-term placement in the Care Home was confirmed. Phil's IMCA was involved in this process.

3.8 There is some evidence in the records that Phil liked the Care Home and at some level understood that they were trying to help him. He was able to talk about his sense of how he was feeling - "my brain is messed up"; "I get confused"; "I like it here, they do help".

3.9 During the autumn of 2021 Phil's symptoms of Wernicke-Korsakoff's psychosis became more problematic for others, as well as potentially causing him increased distress. His behaviours became more challenging towards others, and he occasionally went out unaccompanied from the Care Home.

3.10 It is important to note that the delay in the DoLS authorisation prevented the Care Home from mitigating some of the risks with Phil's placement, including him leaving the building without accompaniment.

3.11 This issue was explored in one of the practitioner reflection sessions. Barnet has since taken steps to introduce additional scrutiny regarding the timely completion of DoLS authorisation assessments and implementation.

Recommendation 2

Barnet Adult Social Care: Review the current system for triaging and prioritising high-risk Deprivation of Liberty Safeguards assessments and expediting authorisations to seek assurance that people at high risk are safeguarded appropriately and lawfully.

3.12 There is no evidence in the documentation provided that the home addressed Phil's wandering risks by putting a Herbert protocol in place. This is a simple risk reduction tool to help the police in their search for vulnerable people who go missing.[2]

[2] https://www.met.police.uk/advice/advice-and-information/missing-person/missing-persons/vulnerable-people-at-risk-of-going-missing/dementia-missing-risk-herbert-protocol/

3.13 As Phil's behaviours were causing the home concern, the GP for the Care Home referred him to BEHMHT, who reviewed his needs and recommended that the GP prescribe an antipsychotic, Olanzapine. This was actioned.

4. Thematic Analysis – The Team around Phil

4.1 Residents at the Care Home were registered with a local General Practice.

4.2 Once residents were registered, the practice would arrange a weekly virtual ward round with the Care Home staff and Barnet's Onecare community health team which includes community matrons and community pharmacists.[3]

4.3 Residents who needed additional community or secondary health care services were prioritised for discussion. The Onecare team are then able to facilitate rapid referral to appropriate services. The GP practice would also arrange for practice staff to see patients and carry out their general health checks.

4.4 As Phil's behaviours were causing concern to the home, at their request, the GP referred Phil to BEHMHT. Phil was reviewed by the Barnet Intensive Enablement Team in December 2021 and by the Barnet Crisis and Resolution Home Treatment Team in January 2022.

4.5 One of the records of BEHMHT's assessment by a psychiatrist says that Phil was drinking up to ten cans of lager a day. This information is unsubstantiated by any other agency involved in the review and it is unclear if the psychiatrist attempted to confirm this with care home staff. Nonetheless, the psychiatrist recommended that the Care Home support Phil to engage with Change Grow Live [CGL], an alcohol and drug treatment agency commissioned to provide support to relevant Barnet residents.

4.6 No other records provided to the review refer to Phil having resumed drinking, or to this extent, and Phil's GP is clear that they were not informed of this.

4.7 Addressing alcohol dependency is challenging and long-term work, often made more difficult for people living without the support of family and friends. It is especially difficult in a care home setting when someone's capacity to make decisions is fluctuating and deteriorating. There has been recent case law examining these issues in a similar context.[4] This Safeguarding Adults Review cannot say whether a different approach to Phil's drinking would have averted his untimely death, however it would certainly have been likely to have had a positive effect on the behaviours arising from his Wernicke-Korsakoff syndrome.

[3] The One Care Home team is a clinical in-reach model delivers an integrated community based proactive health care support offer to residents in care home settings. This is delivered in partnership working with Public Health, Barnet Integrated Care Board, the wider Central London Community Healthcare NHS Trust workforce and the Care Quality team in Barnet Adult Social Care.

[4] London Borough of Tower Hamlets v PB [2020] EWCOP 34

4.8 The extent of Phil's alcohol use whilst living in the care home is unclear. If Phil had resumed drinking at the level that the psychiatrist reported, then the Care Home would have known this as he would have been drinking throughout the day and there would have been evidence of this in his room, and observations about how and when the alcohol was procured. If this was the case, it has not appeared in any of the records supplied to the review.

4.9 In the reflection session considering the care and support that Phil had received, there was uncertainty about how CGL work with people living in care homes. This requires clarification and action to communicate the position to relevant agencies and practitioners.

4.10 Records show that other professionals were concerned about the suitability of Phil's placement at the care home. The police, who had responded to incidents involving Phil, questioned the suitability of the placement but there is no record that this was communicated to Adult Social Care.

4.11 At the time that Phil was placed by Barnet's Adult Social Care, the Care Home was not providing the quality of care expected and was under scrutiny by the Care Quality Commission [CQC] and Adult Social Care [ASC], as well as receiving additional support from ASC to improve practice.[5] The level of concerns, however, did not reach the stage where the commissioners were actively planning for alternative placements for residents.

4.12 Subsequently the manager left. Although Adult Social Care report that the care provided was improving, the organisation who ran the Care Home decided to close it. It closed finally at the end of October 2022.

4.13 The additional scrutiny and support from Adult Social Care included weekly visits to review the implementation of quality improvement measures. Adult Social Care confirmed that at no point during these weekly visits did the Care Home raise any concerns about Phil or highlight any challenges with getting appropriate support to manage his behaviour.

4.14 That said, Phil had gone missing from the Care Home several times, resulting in the involvement of the police and safeguarding referrals to Adult Social Care. This was discussed at Phil's placement review meeting and was therefore known to ASC. ASC staff had a responsibility to identify and explore a pattern of regular wandering and work assertively to ensure this was being addressed as part of the support provided by the care home. There is some evidence in the records that this was happening. However, the records do not reveal that this had any impact on the prioritisation of the DoLS assessment and authorisation.

[5] An inspection of the home carried out by the Care Quality Commission in early 2022 is published at https://www.cqc.org.uk/location/1-109825493/inspection-summary

4.15 There is also evidence in the records that information shared with Adult Social Care was not responded to promptly. There was a lack of clarity about who was responsible for overseeing Phil's placement, which appears in part to be because of Phil's care moving between Adult Social Care teams.

Recommendation 3

Barnet Adult Social Care: Review the current system for case closures and transfers between teams. The aim of this is to ensure that responsibilities are clear at handover points and to minimise the risk that concerns are 'lost' and appropriate and timely action is not taken to safeguard vulnerable adults at risk.

4.16 Whether or not the Care Home was the appropriate placement for Phil is difficult to determine with hindsight. What is clear, however, is that Phil's behaviours were causing considerable concern, and this led both the police and BEHMHT to comment on the suitability of the placement. BEHMHT record that social services were aware of these issues, however, there is no record of BEHMHT communicating directly with Adult Social Care about this.

4.17 Phil's decision-making capacity was severely compromised and his placement in the Care Home was made by Adult Social Care on a best interests' basis. It is therefore concerning that BEHMHT did not communicate the outcome of their assessment, or subsequent concerns directly to Adult Social Care, the organisation responsible for the placement.

4.18 The records of BEHMHT's assessment of Phil make no reference to any assessment of his mental capacity nor his executive functioning.

4.19 In the earlier placement decisions, Phil had been supported by an IMCA. There was no reference in the BEHMHT actions following assessment of the contribution that an IMCA might usefully offer in supporting Phil at this crucial time in his placement.

4.20 The totality of the actions and recommendations set out by BEHMHT in the two assessments are as follows:

- Recommendation to review Phil's placement, which they believe the social worker has been contacted about.
- Prescription instructions in relation to beginning low dose Olazapine and titrating up, including physical health monitoring by the GP and advice to Phil to prevent metabolic syndrome.
- Encourage Phil to engage with CGL.
- Call the police when he becomes threatening and unpredictable.
- A second steer to get the placement reviewed.

4.21 Phil's GP reported their concerns to Adult Social Care on 20 January 2022. Records show that the Care Home was also attempting to discuss the placement with Adult Social Care.

4.22 This GP report was received by the Multi-Agency Safeguarding Hub [MASH] on 21 January 2022. The referral was screened by a MASH worker. BEHMHT's Rio[6] record showed that Phil was open to the Crisis and Resolution Home Treatment Team who had assessed him the day before. The MASH worker made an entry on the adult social care client database MOSAIC and closed the safeguarding referral with no further action, on the basis that Phil's case was open to an appropriate service and the referral did not meet thresholds for safeguarding. The MASH team did not communicate directly with BEHMHT. There is no information in the Adult Social Care records or the GP records that were provided to the review that anyone in the MASH team responded to the GP.

4.23 Had the MASH team communicated directly with BEHMT they would have learned that Phil's case as not open to the Trust, and they would therefore have needed to consider alternative actions in response to the concerns raised by the GP.

Recommendation 4

Barnet Adult Social Care: Review the current approach to conducting safeguarding enquiries and related decision-making, to ensure that decisions are made based on accurate evidence and that referrers are informed of the conclusions of enquiries (to an appropriate and lawful level of detail).

4.24 BEHMHT did not communicate with Adult Social Care, the commissioners of Phil's placement, when they closed Phil's case.

Recommendation 5

Barnet Enfield and Haringey NHS Mental Health NHS Trust and Barnet Adult Social Care: undertake a review of relevant information sharing protocols and practice between the two organisations, particularly in relation to identifying and managing risk, communicating key care planning and diagnostic decisions, and identifying lead professional arrangements. If a protocol is not in place, urgently consider implementing one, and any training or communication required to ensure staff are aware of what is expected.

4.25 At the end of January 2022, the IMCA who had previously supported Phil in relation to his accommodation and care decisions, also raised concerns about the suitability of Phil's placement in the Care Home.

4.26 Although several agencies involved with Phil had concerns about his behaviours, they did not communicate effectively or comprehensively with each other. No agency convened a

[6] The electronic patient record used by BEHMHT.

multi-agency review to establish a rapid comprehensive multi-agency plan of action to support Phil. His experience of living with Wernicke-Korsakoff's psychosis was deteriorating, in the context of possible resumed alcohol consumption, periods of going missing and lack of clarity about his medication management.

4.27 There are no references in the evidence provided to the review that the care home attempted to engage Phil in trying to understand or manage his alcohol intake, address his nutrition, or adhere to his medication regimen.

4.28 Phil's need for safety in his accommodation, both in terms of his own risks and the risks he posed to others, should have been engaged with more directly and rapidly by all agencies involved in his care.

4.29 It is wholly regrettable that Phil was able to walk out of the Care Home on 31 January 2022, something he had done several times before.

4.30 This should also have resulted in an immediate safeguarding referral. The records indicate that safeguarding procedures were not invoked straight away, but sometime later.

4.31 Phil found his way to an isolated rough sleeping site that was familiar to him. It was there that his life ended, at some point that winter and some weeks before his body was found.

4.32 The events leading up to Phil's death reveal a lack of effective multi-agency working to manage risk and inconsistent communication between practitioners regarding changes in Phil's care and support needs.

5. Organisations around the Team

5.1 It appears that Phil had led a life with very little contact with statutory agencies. Yet when he most needed safeguarding, the way agencies responded to his developing Wernicke-Korsakoff's psychosis was sluggish and insufficient to protect him from the known risk of wandering. This ultimately meant he was able to travel to an isolated rough sleeping site where he later died.

5.2 The agencies working with Phil, in particular the Care Home, do not appear to have ensured that Adult Social Care, the commissioners of the placement, understood the unfolding pattern of missing episodes, apparent increases in alcohol consumption and aggressive behaviour that placed others at risk. The agencies involved in his care should have convened a multi-agency meeting to put in place a clear plan to address the risks to Phil, as well as to other residents and to staff.

5.3 While conducting this SAR, the reviewer encountered confusion amongst practitioners and managers about pathways for assessing and monitoring individuals with Wernicke-Korsakoff's syndrome. There was confusion about which aspects are the responsibility of with BEHMHT and which aspects with CGL, and how all agencies involved ought to work together to ensure clear lines of accountability for risk assessment and management.

Recommendation 1

Public Health and Mental Health Commissioners: Along with the service providers, review the referral pathways for people diagnosed with Wernicke-Korsakoff's syndrome, including making provision within service specifications for appropriate flexibility for people who experience frailty at a younger age due to homelessness and other traumatic life events. Ensure that referral pathways and information about what is available from specialist services/teams are communicated clearly to referrers including (but not limited to) Primary Care, Adult Social Care and care homes.

Recommendation 7

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

5.4 In this context, Phil's GP told the reviewer that one of most challenging aspects of working with BEHMHT was the slow communication from BEHMHT about the outcomes of referrals. The reviewer understood this to be a general comment as well as a comment about how this had impacted on decisions about Phil's care, particularly given the high-risk nature of Phil's situation.

5.5 When BEHMHT assessed Phil on Thursday 20 January 2022, they took the decision that there was no ongoing role for the service that assessed him, and closed Phil's case. A record of this decision does not appear to have been visible on the Rio record on Friday 21 January 2022 when the MASH team checked it. Records provided to the review indicate that the Trust's decision to close the case was communicated to the GP on Monday 24 January 2022. It is the absence of a timely BEHMHT record which contributed to the MASH team deciding to take no further action, because based on the Rio record visible on 21 January 2022, the MASH team believed Phil was in receipt of services appropriate to his needs.

5.6 Although BEHMHT's Rio patient database indicates that they sent a letter with the outcome of their assessment to Phil's GP on Monday 24 January 2022, the GP record for Phil indicates that as of Thursday 27 January 2002 the practice had not received a letter.

Recommendation 6

Barnet Enfield and Haringey NHS Mental Health NHS Trust & Barnet Primary Care Networks/North central London Integrated Care Board: undertake a review of relevant information sharing protocols and practice between primary, secondary and community health services supporting adults with care and support needs. The review should consider how risks are identified, managed and shared, how information about key care

planning and diagnostic decisions are communicated between BEHMHT and primary care clinicians and any lead professional arrangements in place for patients with complex health, care and housing situations. If a protocol is not in place, urgently consider implementing one, alongside any training or communication required to ensure staff are aware of what is expected.

5.7 Despite Phil's history, diagnosis and behaviour, securing a psychiatric assessment was complex and convoluted. A GP referral to the Trust's 'Older Adults Mental Health Team' in September 2021 was declined because Phil was 64 and therefore did not meet the team's criteria. Given Phil's history of homelessness and chronic alcohol dependence, it is reasonable to assume given the evidence base[7], that he experienced frailty akin to someone much older, and at the time of referral was only a year younger the service criteria. There is no evidence that any flexibility was considered. The consequent delay meant that Phil did not get service he needed in a timely manner.

Recommendation 9

Barnet Safeguarding Adults Board: Consider the conclusions and recommendations from this report alongside SAR Colin, to ensure that local policies and related activity, such as commissioning and care planning, effectively consider the lived experience of Multiple Exclusion Homelessness[8]. This would include considering the earlier onset of frailty, lead professional arrangements for people with complex multi-agency involvement and the provision and availability of appropriate advocacy.

5.8 The events leading up to Phil's death reveal a lack of effective multi-agency working to manage risk and a pattern of poor communication between agencies. Further, the review reveals a lack of consideration for the complex needs of adults with histories of long-term alcohol use and limited implementation of the relevant guidelines for people with these needs.

[7] https://www.nice.org.uk/guidance/ng214/chapter/Recommendations#improving-access-to-and-engagement-with-health-and-social-care, and
Rogans-Watson, R., Shulman, C., Lewer, D., Armstrong, M. and Hudson, B. (2020), "Premature frailty, geriatric conditions and multimorbidity among people experiencing homelessness: a cross-sectional observational study in a London hostel", *Housing, Care and Support*, Vol. 23 No. 3/4, pp. 77-91. https://doi.org/10.1108/HCS-05-2020-0007

[8] In addition to a history of housing need, people who experience Multiple Exclusion Homlessness have

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

These experiences are likely to have begun early in their lives.

5.9 Phil's life history had remained opaque to the agencies working with him and with that his history of rough sleeping. Had this been known, agencies could have drawn on further practice evidence-based guidance.

6. The Wider Legal, Policy and Financial Context

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

6.2 The fact that many of them were current in 2021 reflects a very significant amount of national work undertaken to address the needs of people in need of care and support because of their substance use over many years.

6.3 This was a time when many services were continuing to adjust to the significant ongoing workforce and operational challenges of the Covid-19 pandemic.

6.4 Nevertheless, Phil's needs were well known. It was the inability of local systems to come together to develop and implement clear treatment and safeguarding plans that led to Phil being able to leave the home and return to a familiar rough sleeping site where he met his death.

7. Conclusion

7.1 There is an overall lack of effective and comprehensive record-keeping identified by this review, and a significant gap where Phil's own voice should be in the archive of notes and assessments about his life. Some of this could have been mitigated by more determined follow up with his former friends and acquaintances, perhaps leading to more information about his history of sleeping rough.

7.2 Relatedly, key agencies have not engaged consistently or promptly in the Safeguarding Adult Review itself, resulting in gaps in evidence available to the review and concerns that patient deaths are not being given the consideration they deserve. Combined, these issues have resulted in unsubstantiated evidence (such as that related to Phil's drinking patterns and levels) that is highly relevant to the safeguarding risks under consideration, and significant gaps in evidence about when and how agencies communicated with each other.

7.3 Despite Phil's needs being known by the agencies involved in his care, and despite a decision that he did not have the mental capacity to decide where to live, he was able to leave his care home unsupervised on several occasions with seemingly ineffective measures put in place. When this happened again at the end of January 2022, he did not return, and weeks later was found dead in an isolated piece of woodland where he had been rough sleeping.

7.4 Agencies involved in Phil's care did not work together collaboratively to avert this outcome, despite a pattern of missing episodes in the year prior to his death and evidence from a psychiatric assessment that he was drinking heavily again. There were no multi-agency risk management meetings in the months prior to his death and limited evidence of effective

information sharing between key agencies and no lead professional identified to coordinate communication with and between agencies. This leads to the conclusion that the multi-agency risk management measures at the time were ineffective.

7.5 Phil's presenting needs for care and support arose from his diagnosis of Wernicke-Korsakoff's syndrome, a condition arising from long-term dependence on alcohol and managed by BEHMHT as part of their dementia provision. However, Phil did not receive the care he needed from BEHMHT, neither in the form of up-to-date record-keeping, timely communication between BEHMHT and Phil's GP, communication with Adult Social Care who were responsible for Phil's placement, flexibility relating to his frailty history and nor in alerting other professionals to his suspected level of alcohol consumption. It is therefore reasonable to conclude that this had a detrimental impact on the support provided by other agencies.

7.6 Agencies involved did not know the appropriate support pathways for people living with Wernicke-Korsakoff's syndrome, nor about the treatment options available for people living with alcohol and/or substance dependency in residential care facilities. Further, the connections between frailty, alcohol dependence and homelessness appear not to feature in service eligibility, multi-agency risk management practices or decisions made as a result of safeguarding alerts.

7.7 Some of the issues identified above meant that Adult Social Care, were not enabled to remain at the centre of safeguarding Phil. However, at least two safeguarding alerts were brought to their attention relating to his wandering and they were sufficiently aware of concerns at an early stage to have initiated a DoLS assessment/authorisation. As such, it is reasonable to conclude that further action could have been taken to respond rapidly and robustly to concerns about Phil and the suitability of his placement.

8. Recommendations

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

8.1 **Public Health and Mental Health Commissioners:** Along with the service providers, review the referral pathways for people diagnosed with Wernicke-Korsakoff's syndrome, including making provision within service specifications for appropriate flexibility for people who experience frailty at a younger age due to homelessness and other traumatic life events. Ensure that referral pathways and information about what is available from specialist services/teams are communicated clearly to referrers including (but not limited to) Primary Care, Adult Social Care and care homes.

8.2 **Barnet Adult Social Care:** Review the current system for triaging and prioritising high-risk Deprivation of Liberty Safeguards assessments and expediting authorisations to seek assurance that people at high risk are safeguarded appropriately and lawfully.

8.3 **Barnet Adult Social Care:** Review the current system for case closures and transfers between teams. The aim of this is to ensure that responsibilities are clear at handover points and to minimise the risk that concerns are 'lost' and appropriate and timely action is not taken to safeguard vulnerable adults at risk.

8.4 **Barnet Adult Social Care:** Review the current approach to conducting safeguarding enquiries and related decision-making, to ensure that decisions are made based on accurate evidence and that referrers are informed of the conclusions of enquiries (to an appropriate and lawful level of detail).

8.5 **Barnet Enfield and Haringey NHS Mental Health NHS Trust and Barnet Adult Social Care:** undertake a review of relevant information sharing protocols and practice between the two organisations, particularly in relation to identifying and managing risk, communicating key care planning and diagnostic decisions, and identifying lead professional arrangements. If a protocol is not in place, urgently consider implementing one, and any training or communication required to ensure staff are aware of what is expected.

8.6 **Barnet Enfield and Haringey NHS Mental Health NHS Trust & Barnet Primary Care Networks/North central London Integrated Care Board:** undertake a review of relevant information sharing protocols and practice between primary, secondary and community health services supporting adults with care and support needs. The review should consider how risks are identified, managed and shared, how information about key care planning and diagnostic decisions are communicated between BEHMHT and primary care clinicians and any lead professional arrangements in place for patients with complex health, care and housing situations. If a protocol is not in place, urgently consider implementing one, alongside any training or communication required to ensure staff are aware of what is expected.

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

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

8.9 **Barnet Safeguarding Adults Board:** Consider the conclusions and recommendations from this report alongside SAR Colin, to ensure that local policies and related activity, such as commissioning and care planning, effectively consider the lived experience of Multiple

Exclusion Homelessness[9]. This would include considering the earlier onset of frailty, lead professional arrangements for people with complex multi-agency involvement and the provision and availability of appropriate advocacy.

8.10 **Barnet Housing:** Review the approach to identifying isolated rough sleeping sites and people who use them. Consider a joint approach with Parks Teams and police to improve communication on people or areas of concern and to identify areas that would benefit from regular periodic joint visits.

Appendices

Appendix 1 - Safeguarding Adults Reviews [SARs]

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

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

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

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

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

The SAB may also –

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

[9] In addition to a history of housing need, people who experience Multiple Exclusion Homelessness have

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

These experiences are likely to have begun early in their lives.

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

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

b) applying those lessons to future cases.'

1.2 Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons to the future (Section 44 (5), Care Act 2014).

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

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

1.5 This case was referred by Barnet's Case Review Group to the BSAB on 22 September 2021 for their consideration of a SAR.

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

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

Appendix 2 – Methodology used in this SAR

2.1 This SAR has examined the circumstances of the care and support that Phil received during 2021 and January2022. To provide some context, this report has also included a little background detail where that was available.

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

- How well do partners understand their organisational duties; did they work together (including with VCFS colleagues and Colin and Phil) to implement effective plans to prevent an escalation of mental health needs and reduce risks of abuse or self-neglect,

including through the Care Programme Approach/ NHSE's 'Well pathway for Dementia'?
- How effective and well-coordinated was multi-agency protection planning, were safeguarding and continuity of care obligations understood and applied?
- Has local strategic project work identified gaps in services or service's thresholds criteria for support to safeguarding adults at risk with experience of Multiple Exclusion Homelessness and, if so, what are the governance arrangements for strategic overview of implementation of any recommendations.

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

2.4 The following agencies and organisations were invited to contribute to the SAR

- Barnet Enfield and Haringey Mental Health NHS Trust
- Barnet's Joint Mental Health Commissioners
- Barnet Public Health
- Central London Community Healthcare NHS Trust
- Change Grow Live
- The GP Practice where Phil was registered
- Homeless Action in Barnet
- London Borough of Barnet Adult Social Care
- London Borough of Barnet Housing (including Barnet Homes)
- Metropolitan Police

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

2.6 The reviewer chaired two reflection sessions on MS Teams to review

- The arrangements Barnet has and are being developed to enable escalation of mental health and substance misuse cases of concern from housing agencies to mental health and substance misuse services.
- The circumstances of accessing mental health input for Phil as his mental health deteriorated during his placement at the Care Home.

2.7 The purpose of these sessions was to invite participants to reflect on challenges they had experienced as well as any things that they felt that helped in Phil's care with due consideration to his history of sleeping rough.

Appendix 3 – The Review Process

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

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

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

3.4 After an intervention by the Integrated Commissioning Board's Safeguarding Lead, the reviewer was able to speak to a GP who had worked with the Care Home and with Phil. This was helpful to the review.

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

3.6 The Care Home had closed since Phil's stay there, and therefore did not contribute from their experience. If the Care Home had still been operating, they would have been asked to provide a detailed chronology of their care and support for Phil and an Individual Management Review reflecting on their work. This was mitigated in part by Adult Social Care carrying out a thorough review of all relevant records and participating fully in the relevant reflection sessions.

3.7 The fact of their closure as a stand-alone home, explains why there are no recommendations for them.

3.8 The IMR submitted by BEHMHT revealed a lack of senior contribution to the reflection on practice, and several resubmissions of documents from the Trust were required. The work to complete these submissions was not prioritised by the Trust's senior management.

3.9 There was no evidence that the Trust supported first person accounts from practitioners who had assessed Phil. Despite several requests, BEHMHT did not ensure that anyone who had worked directly with Phil attended the relevant reflection session. Invitations to meet one to one with the reviewer were not taken up. Furthermore, no one at all represented BEHMHT at the session that considered how agencies had worked with Phil when his behaviours in the home were causing concern.

Recommendation 9

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

Appendix 4 - The Evidence Base for Good Practice

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

4.2 On 15 July 2021 Barnet's Health and Wellbeing Board approved a Health and Wellbeing Needs Assessment of Rough Sleepers in Barnet[10]. This is a key document setting out the epidemiological data in relation to people who sleep rough and the borough's policy intentions.

4.3 This document highlights that there is strong evidence of premature aging in the homeless population. People who experience homelessness begin to also experience the characteristics of older age early in their mental and physical health.

4.4 A relevant publication provides more detail: Rogans-Watson, R., Shulman, C., Lewer, D., Armstrong, M. and Hudson, B. (2020), "Premature frailty, geriatric conditions and multimorbidity among people experiencing homelessness: a cross-sectional observational study in a London hostel", *Housing, Care and Support*, Vol. 23 No. 3/4, pp. 77-91. https://doi.org/10.1108/HCS-05-2020-0007

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

4.6 Phil was a white English man.

4.7 Phil was dependent on alcohol in the period that the SAR reviewed. Phil had been diagnosed with Wernicke-Korsakoff's syndrome, a consequence of his alcohol dependency. We know that Phil had some mobility issues because of previous injuries.

4.8 The records provided to the SAR including the individual management reviews are largely silent about the experience of mental health related disability that Phil must have

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

experienced.

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

- Public Health England/National Health Service England (2017) – *Better care for people with co-occurring mental health and alcohol and drug use conditions* (London)
- NICE - NICE Guideline CG115 (2011a) - *Alcohol-use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence*, (London) This guideline includes some content about the management of Wernicke-Korsakoff's syndrome
- NICE - NICE Guideline CG120 (2011b) - *Psychosis with coexisting substance misuse,* (London)
- NICE – NlCE Guideline NG58 (2016) – *Co-existing severe mental illness and substance misuse*, (London).
- NICE Guideline NG108 (2018) *Decision-making and mental capacity* (London).

4.10 In September 2021 Alcohol Change UK published *How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales*. This document, authored by Professor Michael Preston-Shoot and Mike Ward, sets out a range of legal options, as well as suggested governance structures to support people who are vulnerable because of their significant alcohol dependence. Although this Alcohol Change UK report was published late in the year that Phil had moved into the Care Home, it does reference legislation and guidance that was in place and widely used at that time.

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

4.12 How these relate to the care and support that Phil received were explored in more detail above.