Lewisham
Safeguarding Adults Board
A working partnership to prevent abuse

SAFEGUARDING ADULT REVIEW

Tyrone Goodyear

MAY 2020

CONTENTS

1.	INTRODUCTION	3
2.	SAFEGUARDING ADULT REVIEWS	3
3.	BRIEF SUMMARY OF CHRONLOGY AND CONCERNS	5
4.	THE EVIDENCE BASE FOR THE REVIEW	6
5.	THEMATIC ANALYSIS AND FINDINGS	9
6.	CONCLUSIONS	13
7.	RECOMMENDATIONS	16
8.	APPENDIX 1	18
9.	APPENDIX 2 & BIBLIOGRAPHY	19

SAFEGUARDING ADULT REVIEW – Tyrone Goodyear

Lewisham Safeguarding Adults Board

1. INTRODUCTION

1.1 Tyrone Goodyear (TG) was a very gentle 24-year-old man who had a strong religious faith and loved animals. He worked at the bakery in Tesco's, often in the early hours of the morning, and had ambitions to be a 'Manga' artist (Japanese comic books). TG had a strong sense of what was right and what was wrong and distanced himself from acquaintances whose behaviour he disliked, and therefore had few close friends.

1.2 TG had contact with mental health services when he was 15 years old and had been assessed to have Autism Spectrum Disorder (ASD), learning difficulties and Obsessive-Compulsive Disorder (OCD), which took the form of intrusive religious and sexual thoughts.

1.3 TG then came into contact with adult mental health services in 2018 and 2019 when he was 24 years old. He had lived for the past four years with his mother and five of his six siblings, aged 18 – 26 years old, in four-bedroom temporary accommodation. TG had been using the front room as his bedroom and had found the lack of his own room unsettling. Tensions had built between TG and his siblings, and he felt unable to share a room with them. TG's mother had tried to be rehoused but larger properties were not available.

1.4 TG overheard a conversation during which he learned that his mother's bid for a larger home had been turned down, and a week before Christmas 2018 he left the family home to stay in hotels around London. He had been using money he had saved during the period he had been working.

1.5 TG had approached Lewisham Council for housing and had eventually been offered the prospect of sheltered accommodation in 4 to 6 weeks' time. He would have been housed sometime in February 2019.

1.6 On 21st February 2019, TG was found dead in a hotel room in Enfield. He had taken his own life via an overdose.

1.7 The report writer and the Lewisham Safeguarding Adults Board (LSAB) Business Manager met with TG's mother and a friend to find out more about TG, and to obtain his mother's views about the way that services responded to his needs. TG's mother also suggested recommendations. This information has been incorporated into the SAR report.

1.8 The reviewer is an experienced adult social services and health services manager with previous experience of a serious case review involving death by suicide.

2. SAFEGUARDING ADULT REVIEWS

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

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

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

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

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

The SAB may also –

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

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

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

b) applying those lessons to future cases.

2.2 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).

2.3 The purpose and underpinning principles of this SAR are set out in section 2.9 of the London Multi-Agency Safeguarding Adults Policy and Procedures: London Multi-Agency Adult Safeguarding Policy & Procedures - April 2019

2.4 All LSAB 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 will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

2.5 This case was referred to the LSAB on 13th April 2019 for their consideration of a Safeguarding Adult Review by London Borough of Lewisham – Adult Social Care – Safeguarding & Quality Assurance Team.

2.6 The LSAB delegates these decisions to a Case Review Sub-Group who assessed the case on the 3rd May 2019, where it was decided that they would like to review the care and support received by Mr TG prior to his death.

2.7 The group advised that this case did not meet the criteria for a mandatory Safeguarding Adult Review as in Section 44 of the Care Act 2014. But the care and support provided by Lewisham Agencies to Mr TG prior to his death would benefit from review. The group further advised they would like to exercise their option under Section 44 (4) to review 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).

3. BRIEF SUMMARY OF CHRONLOGY AND CONCERNS

3.1 TG was known to mental health services since the age of 15 (2010). TG had diagnoses of ASD, OCD with obsessional and intrusive thoughts of a religious and sexualised nature, and insomnia. TG was one of eight siblings, five of which he was living with, along with his mother. TG was one of six children in the family living with a disability.

3.2 Lewisham Council Housing were made aware of the need to rehouse this family due to overcrowding[1] in November 2012, with specific instruction that TG and one other family member required their own rooms due to the nature of their diagnosis. Despite this, the family were moved to a four-bedroom property in September 2014.

3.3 TG complained to Lewisham Council's Social Care Advice and Information Team (SCAIT), and Single Homeless Intervention and Prevention (SHIP) in January and February of 2016 that he was living in an overcrowded[1] property, and would like the assistance of a social worker with regards to his housing situation.

3.4 SHIP undertook an assessment in February 2016, which included the information that TG had attempted to take his own life in January 2016, with the cause being mental health crises in relation to housing issues. He had attempted to overdose with unknown tablets. A referral to Child and Adolescent Mental Health Services (CaMHS) was made by SHIP, although there is no record of any assessment by Mental Health Services at this time.

3.5 TG next contacted services in December 2018. This was first via the Accident and Emergency Department at University Hospital Lewisham and then via SHIP.

3.6 TG had worked at Tesco's since 2016 but he resigned on 14th December 2018.

3.7 During December 2018 TG's mother was struggling to cope with TG's behaviour in the family home and asked him to leave.

3.8 TG's GP made a referral to South London and Maudsley NHS Foundation Trust (SLaM), the local mental health service provider) on 21st December 2018, which made several attempts to make contact including a "home visit" to the family home. TG's eldest sister made SLaM aware that TG posed a threat to his family and was not welcome back in the family home. SLaM notified the police of their assessment of risk and closed the case.

3.9 TG was at this point staying in hotels using savings from his work at Tesco's and not living in the family home.

3.10 A second referral was made to SLaM by TG's GP in January 2019. TG's family reiterated their concern of a change in TG's behaviour, including expressions of violence toward others and himself.

3.11 An assessment on 18th January 2019 concluded that TG was not at risk of harm to himself and / or others. At this point SLaM offered TG some support and pressed SHIP to provide housing for TG from 6th February 2019 onwards.

3.12 TG took his own life via an overdose on the 21st of February 2019.

---

[1] TG and his family's housing circumstances did not meet the statutory definition for overcrowding in the Housing Act 1985. See section 5.28 and Appendix 2 below

3.13 There is evidence that throughout the time that the identified agencies were involved with TG, they were aware of his previous history of suicidal ideation.

4. THE EVIDENCE BASE FOR THE REVIEW

4.1 Preston-Shoot (2019) argues that, "*Drawing on existing evidence about effective practice would mean that reviewers are not starting out with a blank canvas. What is proposed here is that SARs begin explicitly with the available evidence-base, using it as a lens with which to scrutinise case chronology and explore through panel meetings, interviews and learning events with practitioners and managers what facilitates good practice and what presents barriers to effective practice.*"

4.2 The advantage of this approach is that, *"The emphasis then is less on description and more on immediate reflection and systemic analysis of facilitators and barriers, across nationally determined policy, legal and financial systems as well as local arrangements and staff values, knowledge and skills*" (Preston-Shoot, 2019).

4.3 Consequently, a study was made of both the research evidence and practice evidence.

Evidence for suicide and the autism spectrum

4.4 A recent SAR ("Ms C", London Borough of Tower Hamlets, 2019), highlighted that there was a small but growing body of research into suicide risk in adults with autism spectrum conditions. A more comprehensive literature review (see appendix 1 for details) was conducted for this Lewisham SAR and the following factors were identified:

4.5 People with autism spectrum conditions have a higher rate of mortality and of suicide than the general population does.

4.6 People with autism spectrum conditions have a different risk profile for suicide compared with the general population. This includes:

- **A history of self-harm but not of alcohol use**
- **Negative life experiences including:**
  - Adversity and conflict, being victimised or bullied
  - Physical or sexual abuse
  - Repeated failures to develop relationships
  - Depression and other mental health problems
  - Isolation due to lack of social support.
- **Having difficulties coping with these experiences including:**
  - Behaviour problems (oppositional, aggressive, angry, explosive, and impulsive behaviours)
  - Having restricted patterns of thinking and lack of imagination
  - Having unmet support needs

- o “Camouflaging” of autism spectrum conditions.

4.7 “Camouflaging” refers to attempts to conceal autism spectrum conditions in order to fit in to social situations and associated with suicidal behaviours even when no mental health difficulties has been identified (Cassidy et al, 2018).

4.8 People with autism spectrum conditions have an increased likelihood of experiencing the risk factors for suicidality outlined above (Pelton and Cassidy, 2017) compared with the general population.

4.9 People with autism spectrum conditions also find developing coping strategies to deal with these and other life stressors more challenging due to difficulties in imagination and in thinking flexibly (Segers and Rawana, 2014).

4.10 People with autism spectrum conditions who attempted suicide (Kato et al, 2013):

- Had persistent rather than spontaneous stressors
- Used more lethal means, and
- Were less connected to psychiatric services than people who attempted suicide but did not have autism spectrum conditions.

4.11 This increased risk of suicide is also present in people who show symptoms of, but do not have diagnosed autism spectrum conditions (Richards et al, 2019).

4.12 No diagnostic assessment for risk of suicide has yet been validated on people with autism spectrum conditions (Cassidy, 2018b).

4.13 In summary and in terms of TG, there is evidence that people with autism spectrum conditions are:

- At a greater risk than the general population are of suicide.
- Have a different risk profile which includes previous attempts at self-harm and a number of life experiences including physical abuse, feelings of isolation and lack of support, having restricted patterns of thinking and lack of imagination, having unmet support needs and camouflaging/ concealing autism.

Evidence for housing practice

4.14 Homeless Link published a briefing for front line practitioners in 2015 on working with people with autism: Autism and Homelessness Briefing for frontline staff.

4.15 This included the following advice:

- Allow time for the individual to process what you are asking or telling them
- Ask one very clear and direct question at a time then just stop talking
- Reduce the amount of choice you are offering
- Provide images to illustrate what you are telling them (e.g. a picture and description of you, pictures of a hostel)
- Give very clear, minimal rules (visually if possible)
- Be aware of the potential of sensory challenges. Prepare them for this (e.g. there is an extremely bright wall as soon as you walk in the hostel, will they need black-out curtains or different bedding)

- Be aware of possible anxieties they may have and consider ways of reducing these
- Find ways to make your support part of their routine e.g. regular meetings at a fixed time and place that they are familiar with.

4.16 These points of advice provide a useful reference guide for housing officers working with people with autism spectrum conditions and for the analysis of the interactions with TG about housing.

4.17 Autism and homelessness is a relatively recent and active area of research. In what appears to be the first study of its kind, Churchard et al (2019) found initial evidence that, "*autistic traits are over-represented among homeless people and that autistic homeless people may show a distinct pattern of characteristics and needs*". This pattern includes being more socially isolated and being less likely to use drugs.

4.18 Building on this work, Homeless Link has co-produced a new Homelessness and Autism Toolkit that offers evidence-based guidance for staff working in homelessness and supported housing: Homelessness and Autism Toolkit

4.19 This includes:

- Adapt how you build relationships
- Be consistent in approach
- Slow down
- Reduce choice and minimise demands
- Make communication clearer and use images
- Use strengths-based approaches.

Local housing policy

4.20 The Statutory Guidance for Local Authorities and NHS organisations to support implementation of the Adult Autism Strategy (2015) Statutory Guidance for Local Authorities and NHS organisations to support implementation of the Adult Autism Strategy emphasises the importance of housing in ensuring that the needs of adults with autism (including autism spectrum conditions) are met. It also identifies the function of housing in meeting duties under the Care Act (2014) to prevent, reduce and delay needs for social care services.

4.21 Lewisham has a Lewisham Housing Allocations Scheme (dated 10th April 2017), which covers access to social housing and the priorities given to certain groups of people in certain circumstances. The scheme also provides guidance on topics such as housing options, overcrowding, eligibility and restrictions.

4.22 The scheme includes the circumstances in which anyone will be given emergency priority for rehousing. The most relevant of these to TG are that this will only be given to people whose:

- Life will be in serious danger
- Will suffer from a severe physical or mental illness unless they are rehoused.

4.23 The scheme does not make any special reference to clinical diagnoses.

5. THEMATIC ANALYSIS AND FINDINGS

Using this research and practice evidence-base it is possible to identify a number of analytical themes. These include the presence of predictive factors for suicide in TG's life, the interaction between TG and housing, including the national and local housing context, and the response of different agencies to TG.

Theme 1: Predictive factors for suicide for people with autism spectrum condition were present in TG's case

5.1 The research that links autism spectrum conditions with suicide is relatively new and was not widely known in the fields of housing, homelessness and general mental health during the time that TG was in contact with these services. Consequently, the following four predictive factors were present but were not necessarily all recognised at the time. They are examined here to support learning.

Predictive factor 1: There was evidence of suicidal thoughts and behaviours and of behaviour problems

5.2 There are several references to at least one suicide attempt and to thoughts of suicide, troubling and intrusive thoughts, and also to thoughts and expressions of physical violence.

5.3 TG experienced obsessional and intrusive thoughts and had received some support with these in 2011 from the Child and Adolescent Mental Health Service in Bromley. After 12 sessions of Cognitive Behavioural Therapy, TG had reported that he felt less anxious and that the intrusive thoughts were less frequent.

5.4 There were references to suicidal behaviours recorded in, for example, the initial assessment of TG by SHIP on 9th February 2016 and information received by SHIP on 10th March 2016.

5.5 There was evidence of thoughts of suicide, for example, in a GP appointment on 20th December 2018 and when SLaM contacted TG's mother on 11th January 2019 and was told that TG, "*had told his sister that he had thoughts to jump off a bridge but feared that he may not die and that seagulls may eat him*".

5.6 There were, however, also references to the risk of harm to others. For example, at the GP appointment on 20th December 2018 it was noted that TG was seeing distressing images of his family being stabbed. On 28th December 2018, TG's sister explained to SLaM that TG had been making threats to his family when he had been living at home, had been watching violent videos about stabbing and researching how to get a gun.

5.7 It appears that the risk of harm to others became the main concern. On 31 December 2018 SLaM referred TG back to his GP and closed his case since he presented with antisocial behaviours rather than with mental ill-health problems. An email was sent to the police to make them aware of this.

5.8 This same concern about TG being a risk to others led TG's GP to urgently re-refer TG to SLaM on 11th January 2019, since TG, *"…had violent thoughts about how he would hit someone in the head*". In addition, the Pathway Universal Assessment and Referral form completed on 10th February 2019 by a SHIP worker also mentions that immediately prior to

leaving the family home, TG had hidden two kitchen knives within his clothes. There is no indication that this was followed up. The police and SLaM should have been notified.

5.9 In summary, SHIP, SLaM, TG's GP and the Police had, or were aware of, concerns that TG was a risk to himself or to others, however, it appears that towards the end of TG's life the concern was about risks to other people rather than to himself. The mental health assessment on 18th January 2019 did not identify any risks requiring an assertive response. If a further assessment had been carried out at a later date it is possible that the outcome of the assessment might have been different. After 18th January 2019, direct contacts by services with TG were rare.

5.10 One of the problems that mental health services faced was that TG moved frequently. Whilst there are arrangements between mental health trusts to intervene with whomever is in their area even if they do not live there, the frequency with which TG moved prevented this from happening. If TG had been in more stable accommodation, for a period of a week for example, then further assessment and an intervention might have been possible.

Predictive factor 2: Changes in routine

There were a number of significant changes in TG's routines.

a) Homelessness

5.11 Between 18th December 2018 and 21st February 2019, TG is known to have stayed in seven different hotels in Crystal Palace, Penge, Sidcup, Croydon and Edmonton, spending a maximum of 4 days in each and finally stayed in a hotel in Enfield.

5.12 In addition to the obvious disruption and difficulties that this lifestyle caused, TG was paying for the hotels out of his savings which were depleting since he was not working. TG's mother explained (meeting on 11th December 2019) that TG moved from hotel to hotel since he felt embarrassed about being asked why he was there by other guests and was, "…*ashamed of living in a hotel at such a young age*."

b) Resignation from work and social networks

5.13 TG had worked at Tesco's in Surrey Quays since 2016. Tesco's confirmed TG's resignation from his job there on 17th January 2018. TG had previously been absent without authorisation on 13th December 2018.

5.14 TG also had a limited social network. On 11th January 2019, his mother described how he had, "…*no friends and tends to walk around central London*".

Theme 2: The response to TG's housing needs in the context of the guidance provided by Homeless Link and the Lewisham Housing Allocations Scheme

5.15 Whilst the refresh of the guidance by Homeless Link was not published until after TG's death, there was guidance prior to this (see 5.2 above). Many of the best practice points in this guidance refer how to manage the interaction between a housing officer and a person who has an autism spectrum condition, but others emphasise the need to make the interaction regular, predictable and less challenging.

5.16 Concerns about TG's housing situation had been clearly identified by SHIP, SLaM and TG's GP. Efforts were made to meet TG's housing needs, but these were protracted, having started in 2016 and not having been concluded before TG's death in February 2019.

5.17 There was no evidence of follow up for 2 years and 10 months between TG's initial assessment on 9th February 2016, when his mother said that she was not willing or able to accommodate him, and his next approach to SHIP on 19th December 2018 when TG explained that his mother had excluded him.

5.18 TG was included in his mother's application for housing but since his mother had stated that she did not want to accommodate him, a separate follow up of TG would seem to have been appropriate rather than to have relied on TG to come back.

5.19 The housing assessment and information gathering process seemed to involve multiple stages, assessments and requests for information. For example, TG was asked to come back for further appointments and assessments on 19th December 2018, 24th December 2018 and on 7th January 2019 and there did not appear to be a particular plan for these. The appointments were not set at regular times as the guidance suggests.

5.20 It would also appear that TG had started to disengage by the final appointment with housing on 7th January 2019 since he left when the housing officer went to seek advice. This was the last time that he was seen in person by SHIP.

5.21 There were requests by SLaM for the process to be sped up on 6th February 2019 and 11th February 2019 but these do not appear to have influenced events.

5.22 There were also delays in being seen. TG's mother explained that she and TG had waited for five hours for a housing meeting on 19th December 2018. Following this, she and TG went to A&E at Lewisham Hospital due to concerns about TG's mental ill-health, where they were told that they would have to wait for a further four hours. They could not wait that long and so left.

5.23 In the context of the guidance provided by Homeless Link (section 7.6), the response to TG does not appear to have been influenced by the information received about him in 2016. This may have been due to the time lapse between the receipt of information and the next contact with TG in 2018. Consequently, there seems to have been a lack of awareness of how TG's background and conditions may have required special adaptations to have been made for him.

5.24 There were a number of organisational practice and contextual factors that influenced the response to TG's housing needs as follows:

Practice factors

5.25 The experience of staff in SHIP is that they often work with people who are distressed and who, when told that they are not eligible for housing, make threats that they will harm themselves or that they will even attempt suicide. This may have resulted in a reduced sensitivity but, despite this, the SHIP team did liaise with mental health services about the concern that TG might harm himself. Even after assessment, however, TG was considered not to be at high risk of suicide.

Contextual factors

5.26 There is a well-recognised and chronic shortage of housing specifically in London and the South East of England, commonly referred to as a “crisis” (see regular articles in sources as diverse as the Guardian and the Daily Telegraph for more information if necessary). This puts pressure on both housing providers and commissioners to find suitable accommodation for the growing number of homeless people. The Homelessness Reduction Act 2017 placed new duties on housing authorities to intervene earlier to prevent homelessness and to take reasonable steps to relieve homelessness for all eligible applicants, not just those that have priority needs. The Act brings new duties and aims to:

- Prevent more people from becoming homeless in the first place by identifying people at risk and intervening earlier with evidenced solutions
- Intervene rapidly if a homelessness crisis occurs, so it is brief and non-recurrent
- Help more people recover from and exit homelessness by getting them back on their feet.

5.27 Whilst these aims are welcome and laudable, they depend on the availability of suitable housing. See https://www.crisis.org.uk/ending-homelessness/housing/housing-supply for details.

5.28 In terms of the Lewisham Housing Allocations Scheme and the definition in the Housing Act (1985), TG’s household with his mother and brothers and sisters was not overcrowded and so TG was not priority for emergency rehousing.

5.29 Emergency accommodation itself is also problematic since it often takes the form of hostels or Bed and Breakfast accommodation in hotels exclusively used by homeless people placed there by local authorities. The understanding of SHIP was that the accommodation that TG was obtaining for himself was higher quality than that which it would offer to him. In fact, TG did spend one night in a hostel (8th January 2019-9th January 2019) and based on his experience did not want to do it again. TG’s mother stated that TG, “…*struggled to stay in a bedroom with one of his brothers due to his autism and OCD, so living with 30 strangers was just impossible as he felt threatened there*”. TG was able to, at least temporarily, afford and source accommodation himself and so his housing needs were met.

5.30 The supported housing offer available from SHIP was not the same as specialist learning disabilities supported living accommodation commissioned by adult social care. Access to the latter would require an assessment of need under the Care Act 2014. Instead the supported housing that can be accessed by SHIP is a more intensive type of housing management support involving both regular checks and prompts for tenants who find it difficult to sustain their tenancy. In the absence of a Care Act assessment of TG’s needs it is not possible to determine which type of accommodation would have been most suitable for him.

Summary of themes

5.31 A number of factors were present that the published research evidence links with an increased likelihood of suicide or suicidal behaviour. For example, TG had persistent stressors (about housing) and irregularly connected with mental health services, was isolated (living in hotels with no friends) and may have had unmet needs (based on his

assessments as a young person). He had once attempted suicide, his behaviour was changing and he experienced violent thoughts. TG also may not have had the coping skills to manage these problems. A picture develops of TG facing considerable challenges without the necessary support to overcome them.

5.32 Despite this, the mental health assessment carried out on 18th January 2019 by SLaM did not identify any concerns about suicide. It is too deterministic to conclude that TG's suicide was a direct and predictable result of these predictive factors, but the presence and persistence of a number of them does suggest that there were warning signs.

5.33 There is also a question of the extent to which TG's autism spectrum condition was identified and responded to in practice. There is little evidence that any agencies adapted their approach to TG based on an awareness that his understanding of information and his reaction to events might have been influenced by his autism spectrum condition.

5.34 No agencies used escalation processes such as Merlin's (this is the informal but most frequently used name for the Metropolitan Police system used to record "Adult Come to Notice" reports, which are completed by the police when they encounter an adult who they believe is 'vulnerable'), safeguarding concerns or requests for a Care Act assessment.

5.35 No questions were raised about TG's mental capacity to understand, predict and manage his situation.

5.36 The response to TG and his mother's requests for rehousing took place over an extended period of time and seemed to be reactive rather than planned. There does not appear to have been a clear recognition of the impact of delays on TG and there was an assumption that the temporary accommodation that TG was finding and paying for himself was better than that which SHIP could provide to him. Whilst this was true in terms of its physical quality, the emotional impact of the disruption and isolation upon TG, mediated by his autism spectrum condition, was not recognised.

5.37 The events took place within the context of the housing crisis. TG came from a very large family and very large social housing properties are hard to find. Re-housing the whole family so that each person would have their own bedroom was difficult, but the type of accommodation available to a single homeless person like TG was generally of poor quality.

6. CONCLUSIONS

The impact of TG's autism spectrum condition does not seem to have been sufficiently recognised

6.1 Despite the evidence available that TG had an autism spectrum condition and learning difficulties, it does not appear that adaptations were made to facilitate TG's contact with housing services. This may have been because TG's autism spectrum condition was not recognised in practice.

6.2 The response by mental health services and A&E at Lewisham Hospital also does not seem to have been adapted in recognition of TG's autism spectrum condition. TG and his mother attended A&E on 19th December 2018 but left because they were told that there was a four hour wait. This was a potential missed opportunity to re-engage with TG and respond to his concerns.

No referral was made for an assessment of need under the Care Act 2014

6.3 On 24th December 2018 TG's GP wrote to SHIP since he was concerned that TG might harm himself, was homeless and needed accommodation where he could be watched. This should have resulted in a referral to adult social care either through the safeguarding route or for a Care Act assessment. These referrals could have been made by the GP or by SHIP. The SHIP team did not have direct access to the type of accommodation that the GP thought was appropriate, whereas it fits within the category that adult social care might commission.

6.4 TG may have had care and support needs, relying for example, on his mother to provide him with fresh clothes on a regular basis, he was going through a stressful time of great uncertainty and there were concerns about the risk of violence to himself and to others. Despite this there does not appear to have been a recognition that an assessment under the Care Act 2014 might have been appropriate. Whilst it is not possible to determine what the outcome might have been, the assessment may have supported TG's request for housing.

No adult safeguarding concern was raised

6.5 No adult safeguarding concern was raised. Practitioners involved with TG did not believe that there were safeguarding concerns and so did not notify the local authority (the lead authority for adult safeguarding under the Care Act). A local authority must act when it has "reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)":

- Has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from the risk or experience of abuse or neglect

6.6 There was no suggestion that TG was being abused by anyone else, but there could have been concerns about whether or not TG was neglecting himself.

6.7 Furthermore, the Care Act Statutory Guidance makes provision for non-statutory adult safeguarding enquiries (s42.2, commonly known as "other" enquiry) and interventions where the three-part test is not met but where there is sufficient concern that someone may come to harm. It is likely that TG met at least the criteria for a non-statutory adult safeguarding enquiry.

6.8 There is no evidence that a Merlin was received by Lewisham Adult Social Care following the police contact with TG on 18th December 2018.

6.9 Vulnerability in this case is determined using the Vulnerability Assessment Framework, which the Metropolitan Police introduced in 2014. This requires that concerns be identified in any three of the five listed factors for an entry on the Merlin database to be made. These factors are: Appearance; Behaviour; Communication/capacity; Danger; Environment/circumstances.

6.10 It is inappropriate to speculate too far about whether or not TG met three of these factors on the evening of 18/12/18. The police account of the meeting was that, TG "…*said he was fine but just needed some time away from his family. He would be going to the council for housing. He didn't express any suicidal thoughts but said he did have depression and autism. He said he would attend his GP in the morning*".

6.11 If an entry had been recorded on the Merlin system, however, and had been sent as an adult safeguarding concern to Lewisham Council, it would have increased another statutory agency's awareness of the situation. Whether or not this would have made a difference to the course of events cannot be determined.

No referral for a carer's assessment was made

6.12 TG's mother was a carer, yet there is no evidence that a Carer's Assessment was offered or that she was advised to ask for one under the Care Act (2014) (or prior to its implementation in 2015, under the NHS and Community Care Act (1990) or the Carers (Recognition and Services) Act 1995). This is despite having come in to contact with several professionals in the time period covered by this review.

No assessment of mental capacity was made

6.13 No assessment of TG's mental capacity was made. The Mental Capacity Act (2005) requires both a presumption of mental capacity to make decisions and that the presence of a diagnosis of a mental disorder is a necessary but not a sufficient condition to conclude a lack of capacity from. TG's complex background and presentation described throughout this SAR could have raised concerns about whether or not TG was making capacious decisions and was able to fully understand and use the information that he was given.

Lack of involvement with the family

6.14 Whilst there was contact with TG's mother, this was largely on a transactional basis for the exchange of information about housing. References to TG's needs or to changes in his behaviour or emotions took place within this context. As a result, important information about TG's thoughts and feelings such the pressures that he faced whilst living in hotels or his thoughts of suicide do not seem to have been sought. The only two examples of a discussion about TG with a member of his family outside of contact about housing, was when representatives from SLaM visited him at home to find he had left and so spoke to his sister (28th December 2018) and when a duty clinician spoke to his mother (11th January 2019).

6.15 TG's mother explained to the review writer that when TG overheard that her application for rehousing the whole family had not been approved, he changed. Prior to this TG had been positive and motivated. Afterwards he tore up his Manga artwork and became resigned to a belief that they would never be rehoused. TG planned to travel to the USA to hunt animals with people he had met on the internet. This was out of character, and more direct family engagement might have revealed this and other potentially useful information.

6.16 This would also require listening to what the family members said. On 14th January 2019 TG's mother notified SHIP that TG had, "*recently made threats to harm himself*" but was told that TG had not disclosed this during the assessments meetings.

Linking homelessness with anxiety

6.17 The prevailing belief behind the housing and the mental health service responses to TG was that TG's mental ill-health needs would be met if he was rehoused. Whilst this accurately described the way that TG's needs were presented at the time, it also seems to have meant that not enough attention was given to TG's background of suicidal thoughts which included at least one suicide attempt, social isolation (for example, his lack of friends), and his complex family situation (living with several siblings who themselves had a range of social and mental ill-health needs).

6.18 Additionally, it seems that the effect of the extended timescale over which TG's requests for rehousing took place was not recognised, and that this might have an impact on TG's beliefs about the future and that he would ever be rehoused.

Good practice

6.19 There were persistent efforts by SHIP and SLaM to remain in contact with TG and to attempt to provide services to him.

6.20 SHIP did refer TG for a mental health assessment because of the concern that he might harm himself.

6.21 SHIP tried to be flexible in providing housing for TG but the lack of suitable accommodation hampered this.

7. RECOMMENDATIONS

Domain 1: direct practice with individuals

7.1 South London and Maudsley NHS Trust should increase staff awareness of the risk of suicide amongst people with autism spectrum conditions, and how to identify predictive factors in assessments. This should include identifying autism spectrum condition symptoms and camouflaging. This may include liaison with Guys and St Thomas NHS Foundation Trust, who provide a specialist Mental Health in Learning Disabilities Service in Lewisham.

In the "Mrs C" Tower Hamlets SAR, the report writer recommended that the local mental health trust keep itself updated on the development of research in this area. The report writer for this SAR in Lewisham conducted a wider literature review so that the current research could be better understood by a wider audience.

7.2 Lewisham SHIP should provide its staff with autism awareness training that covers identifying and recognising the needs of people who are not receiving services.

7.3 Lewisham SHIP should implement the Homeless Link guidance on working with people with autism who are homeless, and Lewisham SHIP and SLaM should develop tools that can help people with autism to describe their feelings of distress. This should also include how to ensure that people know how their housing applications are progressing.

In response to this SAR, the following actions are already in progress:

- Lewisham Council Housing is introducing a housing customer portal so people can keep track of how their housing case is progressing on-line.

- Changes have been made to speed up how quickly people are seen by the Mental Health Liaison Service at University Hospital Lewisham.

Domain 2 and 3: Agency and interagency cooperation

7.4 SHIP and SLaM should use opportunities for joined up working, including liaison meetings and having named contacts to increase multi-agency understanding of processes, services, structures and timescales. This could also include having a mental health liaison worker in the housing team.

Domain 4: Board level

7.5 LSAB to highlight the conflict between housing legislation and autism, and raise the difficulties caused by inadequate funding for services and the housing crisis at a national level.

7.6 LSAB should promote safeguarding and mental capacity literacy amongst the Police, GP Practices, Housing and Mental Health professionals.

Patrick Hopkinson
LSAB Independent Reviewer

8. APPENDIX 1

The literature reviewed

The author of the “Mrs C” SAR noted that the National Confidential Inquiry into Suicide and Homicide by people with mental illness (NCSIH, 2017) had drawn attention to the number of suicides by people with autism spectrum conditions between 2005-2015, which, though relatively low in number, were slowing increasing year on year. The author also reported on recently published research (Cassidy et al, 2018a), which had identified differences in the risk profile for suicide between people with autism spectrum conditions and the general population.

Neither of the NCSIH reports for 2018 or for 2019 included explicit data on the number of suicides of people with autism spectrum conditions, so it was not possible to provide an update on the trend suggested in the 2017 report.

However, two reviews of previous research had been published in 2014 (by Richa et al and by Segers and Rawana). These identified 25 clinical studies and case studies (theoretical articles were excluded) published between 1999 and 2013. Seven of these were common to both reviews, leaving 18 discreet clinical studies. These consisted of studies involving children and young people as well as adults. Not all studies included a comparison group (of either the general population or of people who used mental health services). Some studies focused on people who had committed suicide, others on people who had attempted suicide or had harmed themselves significantly and others on people who had contemplated suicide or who thought regularly about it. With the exception of two studies, approximately three-quarters of the participants were male. A further eight studies published between 2017 and 2020, including the one referred to in the “Ms C” SAR, and a number of other related articles were also included in the literature review.

Of note was Richards et al (2019) who found a high prevalence of autism spectrum condition symptoms using the Autism Spectrum Quotient test in a (unusually) predominately female, self-selected sample of 245 adults who reported that they had attempted suicide. This high prevalence of autism spectrum conditions was especially the case for people who attempted suicide more than once and whose communication and imagination subscale scores were most indicative of autism spectrum conditions.

The literature was accessed through three means using key words of “Autism”, “Suicide”, “Autistic Spectrum Disorder“, “Autism Spectrum Condition(s)”, ASD” or “ASC” in multiple combinations

1) An internet search using Google to find open access journals and articles

2) A search of the Royal Society of Medicine’s on-line journals and related sources

3) A search of the British Psychological Society’s on-line journals and related sources

9 Appendix 2

Definition of overcrowding

The statutory definition of overcrowding is based on the number, gender and age of persons who must sleep in one room and the maximum number of people who may sleep in a dwelling of a particular size. Please see:

Shelter.org.uk_what is overcrowding

and

The House of Commons Library Briefing Paper 1013, 31st March 2020 “Overcrowded housing (England) for full details and an exploration of this topic.

BIBLIOGRAPHY

The articles reviewed for this SAR are not all referenced directly, but for completeness they are:

Bejerot, S. and Nylander, L. (2003) Low prevalence of smoking in patients with autism spectrum disorder. *Psychiatry Research*, 119(1-2), 177-182

Cassidy, S., Bradley, P., Robinson, J., Allison, C., McHugh, M. and Baron-Cohen, S. (2014) Suicidal ideation and suicide plans or attempts in adults with Asperger's syndrome attending a specialist diagnostic clinic: a clinical cohort study. *Lancet Psychiatry* 1(2), 142–7

Cassidy, S. and Rodgers, J, (2017) Understanding and prevention of suicide in autism. Lancet Psychiatry, 4, e11

Cassidy, S., Bradley, L., Shaw, R. and Baron-Cohen, S. (2018a) Risk markers for suicidality in autistic adults. *Molecular Autism*. https://doi.org/10.1186/s13229-018-0226-4

Cassidy, S., Bradley, L., Bowen, E., Wigham, S. and Rodgers, J. (2018b) Measurement properties of tools used to assess suicidality in autistic and general population adults: A systematic review. *Clinical Psychology Review* 62, 56-70

Churchard, A., Ryder, M., Greenhill, A. and Mandy, W. (2019) The prevalence of autistic traits in a homeless population. *Autism* 23(3), 665-676

Hooijer, A. A. T. and Sizoo, B. B. (2020) Temperament and Character as Risk Factor for Suicide Ideation and Attempts in Adults with Autism Spectrum Disorders. *Autism Research* 13,104–111

Lalanne, L., Weiner, L., Trojak, B., Berna, F. and Bertschy, G. (2015) Substance-use disorder in high-functioning autism: clinical and neurocognitive insights from two case reports. *BMC Psychiatry*, 15, 149-153

Mayes, S. D., Gorman, A. A., Hillwig-Garcia, J., & Syed, E. (2013). Suicide ideation and attempts in children with Autism. *Research in Autism Spectrum Disorders*, 7, 109–119

NCISH (2017), Annual Report from the National Confidential Enquiry into Suicide and Homicide by People with Mental Illness, University of Manchester

Pelton, M. K. and Cassdy, S. A. (2017). Are Autistic Traits Associated with Sucidiality? A Test of the Interpersonal-Psychological Theory of Suicide in a Non-Clinical Young Adult Sample. *Autism Research*, 10, 1891-1904

Preston-Shoot, M. (2017) On self-neglect and safeguarding adult reviews: diminishing returns or adding value? *Journal of Adult Protection*. 19(2) 53-66

Richa, S., Fahed, M., Khoury, E. and Mishara, B. (2014) Suicide Disorders in Autism Spectrum Disorders. *Archives of Suicide Research*, 18, 327-339

Richards, C., Oliver, C., Nelson, L. and Moss, J. (2012) Self-injurious behaviour in individuals with autism spectrum disorder and intellectual disability. *Journal of Intellectual Disability Research*, 56(5), 476–489

Rothwell, P. E. (2015) Autism Spectrum Disorders and Drug Addiction: Common Pathways, Common Molecules, Distinct Disorders? *Frontiers in Neuroscience*, 10, 1-12

Segers, M. and Rawana, J. (2014) What Do We Know About Suicidality in Autism Spectrum Disorders? A Systematic Review *Autism Research* 7, 507–521

Wood, A. (2016), "*Wood report: review of the role and functions of Local Safeguarding Children Boards*", The Stationery Office, London