# MS: A Safeguarding Adult Review

City of London and Hackney Safeguarding Adults Board
Report Author: Professor Michael Preston-Shoot
11/11/20

# 1. Introduction

1.1. MS died, aged 63, on 30th July 2019. The Coroner found that MS died of natural causes, so no formal inquest has been held. Cause of death was acute myocardial infarction[1], coronary artery atherosclerosis[2] and aspiration pneumonia. MS died at a bus stop in the London Borough of Hackney where he had been living and sleeping for several weeks. He was found by Council Enforcement Officers, and Police Officers and a London Ambulance Service crew attended. Contemporaneous records refer to a strong unpleasant smell associated with death. MS was beneath blankets, with assorted bags around him. He had soiled himself and had been in the same dirty clothes for some time.

1.2. MS was Turkish[3] with limited understanding of English and a history of homelessness, self-neglect and substance abuse. It is thought[4] that he understood English more than he was able to speak it. He had returned to the bus stop where he eventually died at the end of May 2019, having spent the previous five months in a nursing home. When that placement came to an end he was offered a hotel room but declined. He is reported as having said that "something brings [me] back to the bus stop."

1.3. MS had previously spent time sleeping at the same bus stop, in the Autumn and early Winter of 2018, surrounded by his possessions. MS's death was widely reported by the local media and his living situation had previously been raised as a serious concern by local residents.

1.4. In the final two months before he died, considerable efforts were made to persuade him to accept hotel, temporary accommodation and/or hostel placement but he refused all offers. His engagement, especially with a Street Outreach Worker well known to him, was variable and he refused support for his "rapidly declining physical health."

1.5. There were discussions between practitioners and services on whether and how to use anti-social behaviour powers, and mental capacity and mental health legislation, in order to safeguard MS's health and wellbeing, and to address expressed concerns from local residents about MS's situation and the impact on the community. No effective means of resolving the situation was found before MS died.

[1] Heart attack.
[2] Hardening of arteries carrying blood to the heart muscle.
[3] He is recorded as being of Kurdish ethnicity.
[4] Observation in the Safeguarding Adult Review referral from Hackney Adult Social Care.

# 2. Safeguarding Adult Reviews

2.1. City of London and Hackney Safeguarding Adults Board (CHSAB) has a statutory duty[5] to arrange a Safeguarding Adult Review (SAR) where:

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and
- There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

2.2. CHSAB has discretion[6] to commission reviews in circumstances where there is learning to be derived from how agencies worked together but where it is inconclusive as to whether an individual's death was the result of abuse or neglect. Abuse and neglect includes self-neglect.

2.3. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future[7]. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

2.4. The referral for consideration of the case for a SAR was sent by Hackney Adult Social Care (ASC) on 22nd October 2019. The referral observed that MS was known to several agencies who were attempting to address his accommodation and health needs. The referral provided an initial chronology of MS's involvement with services between September 2018 and July 2019. The referral noted that MS had significant mental health and physical health needs. In the days immediately prior to his death the referral observed that he was defecating and urinating in his clothes, was in pain and was unable to move the lower part of his body.

2.5. Specifically, the SAR referral commented that there appeared to have been no overall agreement between services prior to MS's death regarding whether his verbal refusals of support were capacitous, in other words whether he had decisional capacity[8] with respect to his health and welfare. It questioned whether, given his presentation, MS had executive capacity, namely whether he could protect himself and put into action his preferred way of dealing with his situation. The referral suggested that there would be several areas of learning and questioned whether he had been afforded dignity and treatment.

2.6. In summary, the referral identified MS as an adult at risk, with severe self-neglect. It suggested that the practitioners and services involved did not collectively recognise and respond appropriately in a coordinated way.

2.7. CHSAB determined that the case met the mandatory criteria for a SAR. The independent overview report writer was commissioned to undertake the review in December 2019. A panel was established to oversee the conduct of the review. The panel was chaired by the Service Manager for Adults, City of London Corporation. Senior managers attended from City and Hackney CCG, London Borough of Hackney ASC, ELFT, St. Mungo's, the Advocacy Project

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[5] Sections 44(1)-(3), Care Act 2014

[6] Section 44(4).

[7] Section 44(5), Care Act 2014

[8] Mental Capacity Act 2005.

and the Westminster Drug Project. The independent reviewer attended all meetings of the panel.

2.8. The following agencies which had commissioned or provided services to MS contributed to the review alongside the independent overview report writer.

- Independent overview report writers:
  - Michael Preston-Shoot
- CHSAB Business Manager
- Metropolitan Police Service (MPS)
- London Borough of Hackney – Adult Social Care (ASC)
- London Borough of Hackney – Street Enforcement Team
- London Borough of Hackney - Benefits and Housing Needs Service
- City and Hackney Clinical Commissioning Group (CCG)
- Whittington Health NHS Trust
- East London Foundation Trust (ELFT)
- Thames Reach
- London Street Rescue
- Hackney Recovery Service (HRS)
- London Ambulance Service (LAS)
- St. Mungo's
- Enabling Assessment Service London (EASL)
- Murrayfield Nursing Home

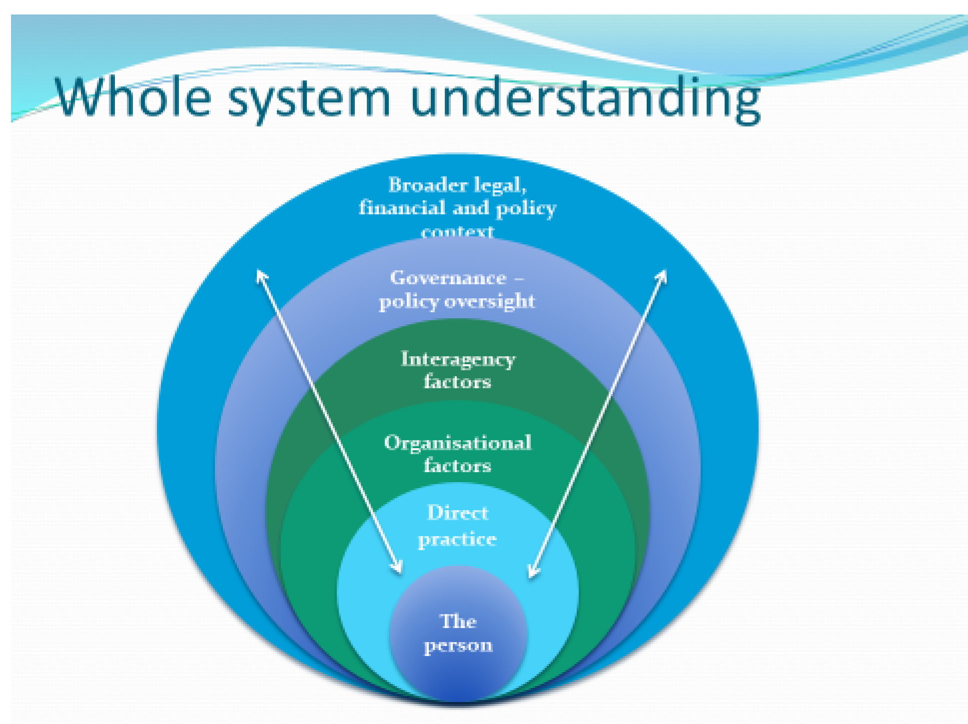
2.9. An agreed schedule of work began with requests for reflective chronologies in January 2020. The process, however, was paused in March 2020 as a result of the Covid-19 pandemic, recommencing in July 2020.

## 3. Review Process

### 3.1. Focus

3.1.1. The case has been analysed through the lens of evidence-based learning from research and the findings of other published SARs on adults who experience homelessness[9] and self-neglect[10]. Learning from good practice has also been included. By using that evidence-base, the focus for this review has been on identifying the facilitators and barriers with respect to implementing what has been codified as good practice.

3.1.2. The review has adopted a whole system focus. What enables and what obstructs best practice may reside in one or more of several domains, as captured in the diagram. Moreover, the different domains may be aligned or misaligned, meaning that part of the focus must fall on whether what might enable best practice in one domain is undermined by the components of another domain.




3.1.3. Specific lines of enquiry, or terms of reference, were identified as follows:

3.1.3.1. What was the multi-agency response to multi-exclusionary homelessness?
3.1.3.2. How were Mental Capacity Assessments executed, specifically:

- Frontline staff understanding of higher executive functioning?
- Who is best placed to undertake Mental Capacity Assessments?

3.1.3.3. What continuing healthcare provision was in place for MS and how was this delivered?
3.1.3.4. What were the discharge processes in place at Whittington Hospital?

[9] Preston-Shoot, M. (2020) *Adult Safeguarding and Homelessness. A Briefing on Positive Practice*. London: LGA and ADASS.
[10] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

3.1.3.5. To what extent were London Borough of Hackney Adult Social Care and Benefits and Housing Needs Service involved in MS's care?
3.1.3.6. What reasonable adjustments were made to support MS?
3.1.3.7. Legal literacy with specific reference to whether any legal options to support MS were considered.
3.1.3.8. To what extent was consideration given to ensuring that MS was treated with dignity, particularly at the end of his life?
3.1.3.9. Whether there was a positive approach to information sharing.

## 3.2. Methodology

3.2.1. It was agreed that the timeframe for the review would cover the period from 1st September 2018, when MS was evicted from a St. Mungo's hostel, to the date of his death on 30th July 2019. However, information from outside this timeframe has been included when significant for understanding learning from this case.

3.2.2. Agencies were requested to provide a chronology and reflective review of their involvement with MS within the agreed timeframe. They were advised to also include anything that they judged significant that fell outside the agreed timeframe for the review.

3.2.3. The individual chronologies were combined and analysed by the independent reviewer and discussed with the panel, along with the submitted individual management reports (IMRs).

3.2.4. A learning event with practitioners involved in MS's case was planned in order to explore key episodes and events within the timeframe being reviewed based on issues and concerns emerging from the combined chronology and reflective agency accounts. However, the Covid-19 pandemic interrupted this plan. In the event a virtual learning event was held, using Microsoft Teams. The outcomes of this learning event have been included in the subsequent analysis of the case.

3.2.5. Thus, a hybrid methodology has been used, designed to provide for a proportionate, fully inclusive and focused review.

## 3.3. Family involvement

3.3.1. The SAR referral noted that MS had a niece with whom services had intermittent contact. It was also noted that a sister had died around one year before MS's own death.

3.3.2. Several attempts were made to contact MS's niece. Using the telephone number available, messages were left for MS's niece to make contact. Unfortunately, no response was received to these messages. The reviewer was unable to obtain contact details for any other family members or friends of MS.

3.3.3. Invitations to contribute to the review were also extended to community organisations with which MS may have had contact. Again, no response to these invitations was received.

## 3.4. Parallel processes

3.4.1. No inquest has been held as it was determined that MS had died of natural causes.

3.4.2. ELFT completed a serious incident review at the end of October 2019 in relation to the involvement of mental health services between 3rd June 2019 and the date of MS's death. No family involvement had proven possible with that review as the niece did not respond to messages that had been left for her. No recommendations were recorded from the review. Observations contained within the review have been included in the subsequent analysis here.

# 4. The Evidence-Base

4.1. Reference was made earlier (section 3.1.1) to research and findings from SARs[11] that enable a model of good practice to be constructed in relation to adults who self-neglect. The model comprises four domains. In line with Making Safeguarding Personal, the first domain focuses on practice with the individual. The second domain then focuses on how practitioners worked together. The third domain considers best practice in terms of how practitioners were supported by their employing organisations. The final domain summarises the contribution that Safeguarding Adults Boards can make to the development of effective practice with adults who self-neglect. The domains are summarised here.

4.2. For the purposes of this thematic review, evidence has been integrated into these domains regarding best practice drawn from research and SARs on multiple exclusion homelessness[12] and substance misuse.

4.3. It is recommended that direct practice with the adult is characterised by the following:

4.3.1. A person-centred approach that comprises proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes; work to build motivation with a focus on a person's fluctuating and conflicting hopes, fears and beliefs, and the barriers to change[13];

4.3.2. A combination of concerned and authoritative curiosity appears helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills; early and sustained intervention includes supporting people to engage with services, assertive outreach and maximising the opportunities that encounter brings[14];

4.3.3. When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage; failing to explore "choices" prevents deeper analysis;[15]

4.3.4. It is helpful to build up a picture of the person's history, and to address this "backstory"[16], which may include recognition of and work to address issues of loss and trauma in a person's life experience that can underlie refusals to engage or manifest themselves in repetitive patterns;

4.3.5. Contact should be maintained rather than the case closed so that trust can be built up;

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[11] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

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

[13] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[14] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK. Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

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

[16] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

4.3.6. Comprehensive risk assessments are advised, especially in situations of service refusal and/or non-engagement, using recognised indicators to focus work on prevention and mitigation[17];

4.3.7. Where possible involvement of family and friends in assessments and care planning[18] but also, where appropriate, exploration of family dynamics, including the cared-for and care-giver relationship;

4.3.8. Thorough mental health and mental capacity assessments, which include consideration of executive capacity; assumptions should not be made about people's capacity to be in control of their own care and support[19];

4.3.9. Careful preparation at the point of transition, for example hospital discharge, prison discharge, end of probation orders and placement commissioning;

4.3.10. Use of advocacy where this might assist a person to engage with assessments, service provision and treatment;

4.3.11. Thorough assessments, care plans and regular reviews, comprehensive enquiries into a person's rehabilitation, resettlement and support needs[20]; taking into account the negative effect of social isolation and housing status on wellbeing[21].

4.4. It is recommended that the work of the team around the adult should comprise:

4.4.1. Inter-agency communication and collaboration, working together[22], coordinated by a lead agency and key worker in the community[23] to act as the continuity and coordinator of contact, with named people to whom referrals can be made[24]; the emphasis is on integrated, whole system working, linking services to meet people's complex needs[25];

4.4.2. A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture;

4.4.3. Detailed referrals where one agency is requesting the assistance of another in order to meet a person's needs;

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[17] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

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

[19] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

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

[21] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[22] Parry, I. (2014) 'Adult serious case reviews: lessons for housing providers.' *Journal of Social Welfare and Family Law*, 36 (2), 168-189. Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.

[23] Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

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

[25] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.

4.4.4. Multi-agency meetings that pool information and assessments of risk, mental health and mental capacity, agree a risk management plan, consider legal options and subsequently implement planning and review outcomes[26];

4.4.5. Use of policies and procedures for working with adults who self-neglect and/or demonstrate complex needs associated with multiple exclusion homelessness, with specific pathways for coordinating services to address such risks and needs as suitable accommodation on discharge from prison or hospital[27];

4.4.6. Use of the duty to enquire (section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy;

4.4.7. Evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy;

4.4.8. Clear, up-to-date[28] and thorough recording of assessments, reviews and decision-making; recording should include details of unmet needs[29].

4.5. It is recommended that the organisations around the team provide:

4.5.1. Supervision and support that promote reflection and critical analysis of the approach being taken to the case, especially when working with people who are hard to engage, resistant and sometimes hostile;

4.5.2. Access to specialist legal, mental capacity, mental health and safeguarding advice;

4.5.3. Case oversight, including comprehensive commissioning and contract monitoring of service providers;

4.5.4. Agree indicators of risk that are formulated into a risk assessment template that will guide assessments and planning;

4.5.5. Attention to workforce development[30] and workplace issues, such as staffing levels, organisational cultures and thresholds.

4.6. SABs:

4.6.1. Ensure that multi-agency agreements are concluded and then implemented with respect to working with high risk individuals; this will include the operation of MAPPA, MARAC, MASH[31] and other complex case or multi-agency panel arrangements, responding to anti-social behaviour, domestic abuse, offending (community safety) and vulnerability[32]; strategic agreements and leadership are necessary for the cultural and service changes required[33];

4.6.2. Develop, disseminate and audit the impact of policies and procedures regarding self-neglect;

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

[27] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE.

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

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

[30] Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.

[31] Multi-Agency Public Protection Arrangements (MAPPA), Multi- Agency Risk Assessment Conferences (MARAC), Multi-Agency Safeguarding Hub (MASH)

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

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

4.6.3. Review the interface between housing/homelessness and adult social care, mental health, and adult safeguarding, and include housing in multi-agency policies and procedures[34];

4.6.4. Establish a system to review the deaths of homeless people and/or as a result of alcohol/drug misuse;

4.6.5. Work with Community Safety Partnerships, Health and Wellbeing Boards and partnership arrangements for safeguarding children and young people, to coordinate governance, namely oversight of the development and review of policies, procedures and practice;

4.6.6. Provide or arrange for the provision of workshops on practice and the management of practice with adults who self-neglect.

4.7. This model enables exploration of what facilitates good practice and what acts as barriers to good practice. The analysis that follows draws on information contained within the chronologies, IMRs and group discussions during the learning event. Where relevant, it also draws on available research. It follows the whole system framework for analysis presented above, beginning with the components of direct work with individuals and moving outwards to the legal, policy and financial context within which adult safeguarding and work with people who are homeless are situated.

4.8. The analysis begins, however, with a summarised chronology with accompanying commentary on good practice and on concerns about how practitioners responded to the needs and risks that MS presented with and how services worked collaboratively to attempt to address those needs and mitigate the risks.

4.9. Some key definitions underpin the analysis. Multiple exclusion homelessness refers to extreme marginalisation that includes childhood trauma, physical and mental ill-health, substance misuse and experiences of institutional care.[35] Adverse experiences in childhood can include abuse and neglect, domestic violence, poverty and parental mental illness or substance misuse.[36] For many of those who are rough sleeping, homelessness is a long-term experience and associated with tri-morbidity (impairments arising from a combination of mental ill-health, physical ill-health and drug and/or alcohol misuse) and premature mortality.[37]

4.10. Care and support needs arise from or are related to physical or mental impairment or illness. This can include conditions as a result of physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury (Care and Support (Eligibility Criteria) Regulations 2014.

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

[35] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14.

[36] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping)*. London: Public Health England.

[37] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14.

# 5. Case Chronology and Initial Commentary

5.1. Some background information about MS has been made available by agencies to the review. What follows has been provided by the Hackney Recovery Service (HRS) and Enabling Assessment Service London (EASL), by St Mungo's and by the Metropolitan Police Service (MPS).

5.2. MS had a long history of opiate and alcohol dependency as well as problematic crack cocaine use. His case records show that he had been involved with Substance Misuse Services in Hackney since 2001 and was receiving opiate substitute medication methadone. It was recorded in the case records that between 2001 and 2017 MS had a significant problem with high levels of crack cocaine and occasional use of heroin. His use of Class A drugs had also been recorded by MPS in 2010 and 2014, with one day detention on the first occasion and an adult caution on the second.

5.3. MS had indefinite leave to remain in the UK. Old GP records indicate that he received a polio vaccination in 1970. He was working in a restaurant in 2002 and living above a public house in Stoke Newington. The records indicate that he served a sentence in Brixton Prison in 2007. When he became homeless, he slept initially behind a Mosque in Stoke Newington. He was first known to be rough sleeping in Hackney in 2009. He had stayed in various hostels in Hackney and had been evicted from five, each time returning to live on the streets.

5.4. MS had been accessing treatment at Hackney Recovery Service with WDP since 2015 when he was transferred from the previous substance misuse provider. His treatment was provided by the GP Shared Care Scheme based at the Greenhouse Surgery. He was seen fortnightly by a Hackney Recovery Service Recovery Practitioner and a GP with special interest in addiction. He was maintained on 50mg methadone daily throughout his treatment at Hackney and collected his methadone daily from the Pharmacy.

5.5. Initially MS engaged well and attended appointments regularly; however, his promptness for appointment waned significantly when he reported that his sister was admitted hospital in July 2017. MS became less reliable, was often late for appointments and often terminated the sessions prematurely, stating that he had to leave to visit his sister.

5.6. **Commentary:** the evidence-base (section 4.3.4) advises that due regard is given to loss and trauma when these feature in a person's lived experience since they can impact on engagement and on recovery[38]. It is not clear what efforts were made to engage MS in discussion about his relationship with his sister but, as the SAR referral from Hackney ASC implies, her death appears to have impacted significantly on him. The evidence-base also recommends a focus on a person's history since this may shed light on a person's journey to the problems with which they are now presenting and the decisions they are taking.

5.7. In terms of substance misuse, MS reportedly used crack cocaine occasionally and disclosed low levels of alcohol use around 2-3 cans of 5% larger two or three times weekly. There was some difficulty in establishing accurate levels of substance misuse due to the language barrier and his reluctance to provide urine samples or to be breathalysed. There were some concerns raised by one of the GPs at the Greenhouse Surgery in January 2018 that there may have been some physical dependency on alcohol and that MS was under reporting levels of

[38] For example, see Preston-Shoot, M. (2020) *Thematic Review – Ms H and Ms I*. Tower Hamlets SAB.

use. It was noted within the case records that he often smelled strongly of alcohol when he attended the Greenhouse Surgery for key work sessions.

5.8. **Commentary:** it may have been helpful to consider whether, indeed, a diagnosis of alcohol dependence syndrome would have been appropriate, and for detailed assessment of his mental capacity with respect to decision-making about alcohol consumption.

5.9. There was a consistent theme throughout his treatment at HRS that, when encouraged to consider his alcohol use, a methadone reduction or engage in any dialogue relating to his substance misuse MS often disengaged from the process and asked to leave the session early. It was regularly noted within the case records that MS consistently avoided any attempts from the clinical team at the Surgery or his Key Worker to participate in any medical intervention or procedures, including blood pressure and urine drug screens; he generally became agitated when asked and made excuses to leave. It was regularly recorded throughout the case records that MS presented unkempt, smelling of body odour and urine and it was noted that he largely appeared unconcerned about his hygiene as well as his physical health.

5.10. **Commentary:** it would have been appropriate to have considered CHSAB's self-neglect policy and procedures, specifically with respect to whether a safeguarding concern should have been referred and/or a multi-agency meeting convened to explore the development of a collaborative plan to address the needs and risks evident in the case.

5.11. MPS records contain references to non-compliance with a dispersal notice for street drinking in 2014. When challenged about street drinking in 2016, he struck a Police Officer but no prosecution followed. In March and again in August 2018, MPS raised MERLINS as a result of street drinking, urinating in the street and concerns about his physical health. However, the concerns were not shared as MS was unable to consent to the information being shared.

5.12. **Commentary:** the Data Protection Act 2018 does permit information to be shared without consent when proportionate to the need to safeguard an individual at risk.

5.13. Both HRS and St Mungo's have reported that MS was not engaging with treatment for his physical ill-health, including not taking medication reliably for his heart condition and hypertension. He was difficult to engage in any key work, was at times unkempt and malodorous, and under-reporting his substance misuse. St Mungo's records include references to liaison with HRS and with his GP but he missed appointments and was generally dismissive of concerns. His GP had suspected that MS had COPD but this could not be confirmed because MS would not undergo necessary tests. Referral to a Turkish speaking counsellor was considered at one point, and efforts to engage him with a Turkish interpreter also.

5.14. St Mungo's issued MS with a warning letter about his non-engagement in September 2017. He was also in arrears for service charges and needed assistance to clean his room and wash soiled clothes. In May 2018 St Mungo's issued MS with another written warning for non-engagement but this did not produce any significant improvement in his willingness to address his engagement with treatment for his physical health concerns and substance misuse, or with necessary activities to sustain daily living. He was served also with a health and safety notice due to the condition of his room. St Mungo's and his GP liaised but MS's

engagement remained inconsistent. He was served a final notice about the terms of his hostel stay in June 2018.

5.15. **Commentary:** a pattern of non-engagement, including in response to attempts at enforcement was as embedded by September 2018 as was his physical ill-health and substance misuse. Indeed, the ELFT Serious Incident Report dates various concerns – ischaemic heart disease (2012), methadone (1999), hypertension (2016) and alcohol dependence syndrome (2014). It appears that he had not been known to Mental Health Services. The report observes that it is unclear whether he understood the gravity of his situation and how self-neglect was impacting on his mental and physical health. This observation points to two omissions at this point, namely a detailed mental capacity assessment, with particular focus on his executive functioning, and a care and support assessment with respect to his need for assistance with aspects of daily living.

5.16. The formal period under review in this SAR begins on 3rd September 2018 when MS was evicted from a hostel run by St Mungo's. He had been there for just under two years[39]. He was evicted because of non-engagement with services, the intended work being designed to help him move on, and an incident of spitting at a staff member[40]. The hostel is recorded as having had a very high tolerance threshold of disruptive behaviour.

5.17. **Commentary:** there is no reference in any IMR or chronology to whether there were any multi-agency meetings or discussions prior to his eviction. There is no reference either to whether there was any reference to the provisions in the Homelessness Reduction Act 2017. Given MS's history of evictions, rough sleeping and substance misuse problems, the Act's provisions relating to prevention of homelessness might have been considered relevant. His history of self-neglect might have indicated consideration of a multi-agency adult safeguarding response.

5.18. The combined chronology for September and October 2018 records that MS declined to engage with Street Outreach and refused help to find him temporary accommodation and support for his alcohol abuse. When on one occasion he appeared to accept an offer of temporary accommodation, he subsequently declined transport to get him there. MPS have a record for October that MS was urinating in the street by a bus shelter in front of children.

5.19. During this time his self-care was poor. He appeared to spend most of each day at the bus stop, with bedding stored under a tree on the opposite side of the road. On one joint visit by an EASL Social Worker and a Thames Reach staff member, it is recorded that he could engage in conversation despite intoxication and a language barrier. He seemed to have developed a warm relationship with a local resident. A very limited assessment concluded that he showed no overt signs of mood disorder or psychosis. His alcohol use and homelessness were his main problems[41].

5.20. **Commentary:** up to this point no assessment of his decisional capacity and executive functioning appears to have been undertaken. No consideration of CHSAB's self-neglect procedures is evident. More positively the combined chronology has recorded liaison between Street Outreach and Council services and joint visits to see MS.

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[39] The chronology from the London Borough of Hackney Housing Needs Team states that he had been admitted to the hostel on 29th September 2016.

[40] Reported in the EASL chronology.

[41] Reported in the EASL chronology.

5.21. On 29th October London Borough of Hackney Enforcement Officers were requested to provide assistance to secure MS's engagement with services. Complaints had been received of anti-social behaviour, principally urinating in the street. MS was advised to attend the Housing Needs Team to secure temporary accommodation. MS said that he intended to seek a hostel placement and to consult a GP as he was feeling sick due to the cold weather.

5.22. On 30th October London Street Rescue raised a safeguarding concern, citing his alcohol misuse and health issues, and his refusal of three offers in recent days of temporary accommodation. The concern noted his self-neglect – poor hygiene, very dirty clothes, and refusal to accept transport to A&E and clean clothes. A Senior Practitioner in ASC asked for further information on the same day regarding MS's motivations and what was important to him, and whether there was any concern about his mental health. This request for further information from the referrer was renewed on 2nd November to enable a decision regarding the referral to be made.

5.23. Meanwhile, MS had refused to attend Hackney's Housing Needs Team to secure pre-booked temporary accommodation. When visited at the bus stop and asked why he had not engaged with housing. MS said he would go the following week, which was the same answer he gave when spoken to previously. MS was told that he needed to engage so he could get out of the bus shelter and into somewhere warm. He appeared to have some pain in his lower back area but did not want an ambulance. MS said that he would see his own doctor once he had spoken to Housing. MS was possibly reluctant to leave all of his belongings in the bus stop for any length of time to go to the HSC.

5.24. On 1st November, alongside but separately from the visit described immediately above, an EASL Social Worker and Thames Reach staff member saw MS. There were concerns about mental capacity owing to his three-time refusal of temporary accommodation without apparent reason and his resistance to move-on work. His self-care had deteriorated since the last joint visit. His clothes were dark and stiffened by dirt. He had mucous on his moustache and he smelt of urine. He appeared unable to stand because of pain in his hips. He seemed initially interested in the option of temporary accommodation but quickly changed his mind, responding to questions with "tomorrow" or "no English." He did say that someone was about to pick him up to take him to his sister; however, his sister had died some time previously.

5.25. The EASL chronology has recorded the plan arising from this visit. A medical summary had been obtained from the GP. There was no history of mental illness but MS had numerous physical health problems (hypertension, heart disease, forgetfulness, gout and arthritis). He had a long history of opiate misuse (heroin, methadone, codeine and morphine). The GP was planning to assess MS with a Kurdish interpreter present, to discuss what MS wanted and options about hygiene, clean clothes and showers, and to set boundaries about use of services. The St Mungo's hostel, from where MS had been evicted, was to be contacted for an assessment of whether MS's decline was reflective of a long-term pattern.

5.26. The combined chronology for 2nd November also records a complaint from a member of the public, unable to use the bus stop to shelter from wet weather. He did not move on from the bus stop when Enforcement Officers spoke with him. Another member of the public, who described himself as MS's friend, suggested that an interpreter would be needed as MS would not understand what was being said to him. This friend said that he has been following MS's progress of being rehabilitated by the Council but had always been let down. He also added that MS had been a good member in the community, always willing to help

others, but was deserted by all when he got into this position. The friend went to bring someone to interpret and also said that he was ready to assist in any capacity. While Enforcement Officers were there, MS was drinking alcohol and smoking underneath a no smoking bus shelter. A member of the public handed him two cans of strong lager. He had littered the bus shelter but he was not moved as people had started gathering. A referral to Street Link was sent.

5.27. Also on 2nd November the ASC Senior Practitioner spoke with the London Street Rescue worker who had made the safeguarding referral. The ASC and EASL chronologies record that the plan was to gather information from St Mungo's to establish a baseline against which to measure any subsequent deterioration. A decision about the formal response to the safeguarding concern would then follow.

5.28. **Commentary:** joint visits and discussion between services to formulate a plan represent good practice. However, there is a repetitive pattern of MS declining or deferring engagement and support and it is unclear what contingency plan was envisaged if he did not engage and how the approach being taken would mitigate the risks to his physical health of self-neglect. At this point no formal mental capacity assessment has been completed in respect of any of the decisions that MS was being invited to consider. There has been no suggestion of an assessment of his care and support needs despite evidence of physical ill-health and substance misuse. There was no apparent consideration of whether it was reasonable to expect MS to attend appointments at Council Offices, at least without being taken there in person, or whether staff should complete assessments and written procedures on site at the bus stop.

5.29. On 6th November an EASL Social Worker contacted HRS to establish the level of support being offered and MS's engagement. In their submission to this SAR, HRS observe that, following his eviction from St Mungo's Hostel in September 2018, MS's presentation deteriorated quite rapidly and there were some questions raised by the GP with Special interest at the Greenhouse Surgery[42] about his suitability for the GP shared care scheme, due to the change in his behaviour and lack of self-care. The last face to face contact between Hackney Recovery Service and MS was on the 25th October 2018.

5.30. On the same day MS was seen by a GP and Thames Reach staff member at the GP's surgery. His self-care was very poor and he was not dressed appropriately for the cold weather. His hands were swollen and red. There were holes in his shoes. He refused a shower and a change into clean clothes that the Thames Reach worker had brought for him. He was given a methadone prescription to 14th November, so that he would have to return then. He undertook to have washed and changed by then. He was given contact details of a Turkish Mosque close to his sleep site. The GP thought that MS had decisional capacity regarding accommodation but the EASL Social Worker and Thames Reach worker were not sure that he understood the physical health risks of his homelessness or that he needed to wash and change in order to access temporary accommodation. It was not clear to them what information he was weighing up in his decision to sleep at the bus shelter. He mentioned family bereavements but would not speak about these. The GP wondered whether his references to relatives dying were a way of avoiding conversations about treatment. On checking MS's medical records the GP noted that seven years had elapsed since his last mental health assessment; a referral was made to HRS requesting a psychiatric assessment.

[42] A walk-in centre for people experiencing homelessness.

5.31. **Commentary:** joint appointments represent good practice since they promote coordination and collaboration. There is also the first mention of a professionals' meeting, planned for 14th November. Bringing agencies together is good practice in order to share information and develop a risk management plan with clear roles and responsibilities. If an interpreter was present at this joint appointment, it has not been recorded. As yet there has been no specified consideration of advocacy to help MS engage. Doubts about whether MS had decisional capacity have begun to emerge, which would indicate the need for a formal assessment and, depending on the outcome, referral to the Court of Protection if capacity was fluctuating or if MS would not engage in assessment or if there was uncertainty about how to act in his best interests.

5.32. On 9th November MS saw a GP at the Greenhouse Centre but declined other offers of support. He did however take clean clothes away with him. Further joint outreach was planned. There was further communication between the Senior Practitioner in ASC, St. Mungo's and the Thames Reach/London Street Rescue Outreach Worker.

5.33. On 10th November LAS attended MS following a 999 call. He refused assessment and transportation to A&E, although it was possible to take vital observations. He was "deemed" to have capacity for declining assistance and worsening advice was given. The LAS chronology and IMR observes, correctly, that this was a missed opportunity to complete a formal mental capacity assessment, using the LAS mental health capacity tool. There is no evidence as to how the crew came to a decision about his mental capacity, especially when considering the language barrier. There is no evidence that language line was considered.

5.34. **Commentary:** in addition to the critique from LAS regarding mental capacity assessment, no safeguarding concern was submitted following this episode.

5.35. Practitioners from different services saw MS on 11th and 12th November. On the latter date, someone describing themselves as a friend told the practitioner that MS was kicked out of everywhere because he did not behave. On 14th November, the Outreach Worker from London Street Rescue/Thames Reach saw MS. He had not changed into the clean clothes he had been given. Since the Outreach Worker could not collect MS's script, as he had requested, he went to the Greenhouse Surgery for this. Once again he refused to engage regarding his housing need.

5.36. Also on 14th November a decision was reached about the safeguarding concern that had been referred. The decision was made not to commence an adult safeguarding enquiry (section 42(2) Care Act 2014) because MS did not have care and support needs. The chronology submitted by ASC adds that MS had been "living an itinerant lifestyle for a decade" and had "clear tendencies towards poor self-care." The chronology further observes that, whilst work needed to occur to try to support MS into making wiser choices for himself, the matter did not require a safeguarding intervention. Professionals were working collaboratively around his case. He was stated to be engaging with Greenhouse Surgery and was interested in pursuing a housing application. It is further stated that he had no identified long-term health needs but would require an interpreter.

5.37. **Commentary:** the referrer was informed about the decision regarding the safeguarding referral, which is good practice. It does not appear that the professionals' meeting, which had been requested for this date, took place. It is not referred to in any of the information submitted by the agencies involved. The decision regarding the safeguarding referral is very

questionable. The criteria regarding adult safeguarding enquiries are laid out in section 42(1), namely that a person has care and support needs, is experiencing abuse and/or neglect (including self-neglect) and, as a result of the care and support needs, is unable to protect themselves from that abuse and/or neglect. In relation to self-neglect, the statutory guidance[43] adds a further condition, namely that the individual cannot control their own behaviour. Using the aforementioned definition of care and support needs (section 4.10) and the information about the entrenched nature of MS's self-neglect and his non-engagement with services and refusals of support, it seems clear that the criteria laid out in section 42(1) were met. The reasons given for not progressing to an adult safeguarding enquiry appear flawed. It is the criteria in section 42(1) that should guide decision-making.

5.38. In the late evening of 14th November or early hours of 15th November, a member of the public called the emergency services because MS looked unwell, was unkempt and was not communicating. Both MPS and LAS attended. The LAS chronology records that MS was non-compliant. There were no obvious injuries, and he was able to weight bear but not walk. He complained of back pain. The LAS crew were unable to obtain more details or history. LAS commentary adds that MS seemed unconcerned about his health. He stated that he had fallen two weeks previously and his back was sore but otherwise he was fine; he was recorded as having no insight into his condition. When asked about incontinence, he stated that he had been deliberately soiling himself because he was homeless and had no access to a toilet. He was taken to the Whittington Hospital Emergency Department, from which he was admitted with a chest infection.

5.39. **Commentary:** it is not clear from the combined chronology whether MS agreed to be transported to hospital or whether this was a best interest decision following an assessment under the Mental Capacity Act 2005. The LAS individual chronology does not mention attendance by the LAS crew that resulted in MS being transported to hospital.

5.40. In the Emergency Department MS was able to communicate that he lived on the streets. He denied having a fever, urinary problem or diarrhoea. He presented as unkempt, alert and not in pain. He had multiple, very large and necrotic pressure ulcers. A safeguarding referral was sent to the London Borough of Islington, because it was believed that he lived on the streets close to the hospital. The referral described the unkempt, soiled and confused state in which MS had been found and references that he had been homeless since family members had passed away and he had liquidated his business. The Hospital had identified that an interpreter would be necessary. He was admitted onto a ward with health problems that included malnutrition. A referral for review by a Tissue Viability Nurse was made.

5.41. **Commentary:** the safeguarding referral was good practice as was the identification of the need for an interpreter. It is not recorded whether an advocate was considered at this stage and whether MS had capacity to agree to treatment decisions, including admission onto a ward, or whether decisions were taken in his best interests. It is recorded that MS had no insight into his condition but it is unclear whether a formal mental capacity assessment followed.

5.42. MS remained in Whittington Hospital until 3rd January 2019. Information about his hospital stay is drawn largely from the Hospital's chronology[44]. In the days immediately following his admission, even with an interpreter present, MS allowed minimal medical

[43] Department of Health and Social Care (2018) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office.
[44] Whittington Health NHS Trust IMR.

examinations only, and refused to engage with a Tissue Viability Nurse and with a Speech and Language Therapist. He required assistance to mobilise. He would not discuss his injuries and could not recall how he had acquired them. He was only able to answer basic verbal questions in English and did not appear to understand information given to him. The initial treatment plan was made in his best interests as he did not have capacity to consent to investigation or treatment. Some of his health needs were life-threatening[45], which meant that treatment could not wait. At this point the Hospital noted that he had no next of kin.

5.43. **Commentary:** the Hospital appears not to have known about MS' niece who was resident in the UK. The treating clinicians recognised the urgency of treating MS's symptoms and that his decisional capacity might change in the future.

5.44. In later November MS did not engage with assessment by a Speech and Language Therapist, on one occasion becoming agitated, shouting and raising his arm. Information was requested from and sent by Thames Reach. This highlighted that he had declined support, including with accessing accommodation. A mental health assessment and, several days later a mental health review, concluded that there was a high risk of self-neglect but no current suicidal thoughts or known history of psychiatric problems, a pattern of drug and alcohol misuse and that he was vulnerable to exploitation. It observed that MS minimised his social circumstances and that his time and place orientation was poor. It appeared that he was experiencing some form of memory impairment, being unable to retain information, leading to a conclusion that he lacked capacity.

5.45. On 30th November when mental health review was concluding that he lacked capacity, a nursing note recorded that he had capacity with regards refusal of night-time medication and became agitated when approached. Nonetheless a speech and language assessment eventually proved possible, with a plan developed regarding nutritional intake and hydration. A Physiotherapist was also able to assess his mobility and he appears to have cooperated with instructions. Although apparently medically fit for discharge the plan was for MS to remain in hospital pending a placement that could address his care needs. He had apparently agreed to such a placement. He remained confused and further cognitive assessment was recommended in the presence of an interpreter. He had also attempted to leave the ward to visit his sister who, he said, was ill (she had in fact died some time before). This triggered discussions about whether the deprivation of liberty safeguards should be used.

5.46. **Commentary:** there were persistent efforts to engage with MS and to complete assessments of his needs. This is good practice. His mental capacity was clearly considered but there are also references to the difficulty in completing formal capacity assessments and to references to mild small vessel disease. However, up to this point there does not appear to have been any consideration of involving an advocate, alongside an interpreter, to enable MS to participate in assessments. Information was shared between services involved, which again is good practice. He is recorded as having been reticent to talk about how he felt or to enlarge on his background but it appears that he had two sons living in Turkey, that he had worked in a café and in the rag trade, and may have served a short prison sentence three or four years previously following a fight[46].

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[45] Sepsis; ischaemic foot; osteomyelitis; hypoactive delirium secondary to infection and chlordiazepoxide, and upper gastro-intestinal bleed are all mentioned.

[46] The only specifically recorded prison sentence was found during the SAR process and is referenced in section 5.3 above.

5.47. On 2nd December MS was doubly incontinent whilst in his hospital bed, refusing to be changed and becoming very aggressive. The following day a cognitive assessment was attempted but proved very difficult to complete, even with an interpreter present. There was some evidence of orientation but cognitive impairment could not be ruled out. No acute mental illness was apparent. Referral to a memory clinic was suggested.

5.48. **Commentary:** it may have been the case that MS's mental capacity fluctuated. It is not clear whether his executive functioning or capacity was included in assessment.

5.49. By 4th December MS was again recorded as being medically fit for discharge but an application for Continuing Health Care was completed in his best interests as he lacked capacity, presumably regarding decision-making about placement or accommodation post discharge. The following day an urgent Deprivation of Liberty was completed, to expire on 18th December. Thereafter, up to the point of his hospital discharge, there were occasions when MS refused wound dressing and personal care but his gastric ulcer was healing. The plan, to which he apparently consented, to discharge him to a care home, was pursued, with two care settings visiting him in hospital to consider his suitability. He appears to have regained mental capacity with respect to consent to treatment and to next steps regarding accommodation, but concerns remained about cognitive impairment and it was recognised that a best interest meeting and referral for an Independent Mental Capacity Advocate would be needed if he lost capacity to make decisions regarding accommodation and responses to his self-neglect. A referral to Hackney Memory Service was envisaged via his GP. There was a recorded delay because of the absence of an interpreter to consideration of whether or not to extend his deprivation of liberty.

5.50. MS was discharged to a care home on 3rd January 2019, having been treated for upper gastrointestinal bleeding, sepsis secondary to cellulitis of the legs, peripheral vascular disease with multiple leg ulcers, and malnutrition secondary to self-neglect. The rationale for the nursing home placement was based on the high risk of falls and further self-neglect. A nursing home would provide for all his personal and nutritional needs and, since MS remained at times confused and disorientated, he could be monitored and safeguarded. In other words, the placement would safeguard his current and future welfare[47].

5.51. **Commentary:** throughout MS's hospital stay there was liaison between the services involved, including Camden and Islington NHS Foundation Trust for mental health liaison, Hackney ASC, EASL and Thames Reach. The discharge appears to have been well planned, with two nursing homes having assessed MS's suitability for placement whilst he was on a ward at Whittington Hospital, and with a comprehensive discharge summary. It appears towards the end of his hospital admission that MS was requesting accommodation, was at times orientated to time, place and people, able to retain information and with decisional capacity about accommodation. This appears to have been the reason why appointment of an Independent Mental Capacity Act Advocate was not pursued at this time.

5.52. MS remained at Murrayfield Nursing Home (London Borough of Enfield) from 3rd January until 28th May 2019. He resided in the dementia unit. An initial query was raised as to whether, given ongoing cognition issues, use should be made of the deprivation of liberty safeguards. It was also confirmed by Whittington Hospital that empty methadone bottles found amongst MS's belongings should be returned to a pharmacy and that MS was not

[47] EASL IMR.

being prescribed methadone. His niece was informed of the placement on 8th January[48]. The IMR and chronology from the Nursing Home observes that MS was admitted with multiple category 3 pressure wounds on his right hip , right thigh and right lower leg , scabs on multiple locations of his body, with very dry skin, and very unkempt with his beard and hair overgrown and not trimmed. Throughout his placement Tissue Viability Nurse assessments, treatment and review took place regularly. Sometimes MS would refuse changes to his dressings but, over several months, his condition improved. A Tissue Viability Nurse made a GP referral for vascular assessment and possible claudication, following this up when an initial response had not been forthcoming. It was noted that he gained weight but was in some pain. As a result of significant improvement, he was discharged from the Tissue Viability Service on 29th April.

5.53. **Commentary:** the IMR from the Nursing Home does not record the involvement of any family member, raising a question as to whether next of kin and family details were shared with care home staff. It would also appear that the niece had not been aware of his hospital admission and stay, raising questions as to which service might have had responsibility to engage with her.

5.54. **Commentary:** the condition in which MS appeared at the nursing home raises a question about pressure ulcer and personal care prior to Hospital discharge. The involvement of Tissue Viability Nurses upon referral from the Nursing Home followed a treatment plan and secured improvement in his condition. This was good practice.

5.55. Later in January an assessment for Continuing Health Care funding was completed and concluded that MS did not meet the criteria. Nor did he meet the criteria for Full Nursing Contribution. This assessment outcome prompted telephone and email conversations about the need to arrange a housing assessment, with the care home being prepared to assist with transport to the Greenhouse Centre to facilitate this.

5.56. MS's behaviour was very challenging with respect to personal care, with recorded denials of needing care, incidents with continence and reports of him refusing to come out of his room and not washing. He presented himself as unable to speak English, although at times he appeared to understand and communicate in English. Sometimes he threatened the nurses and care staff in order not to be approached for personal care. There were reports of him getting access to the kitchen, drinking milk, eating cereals and leaving the area very unsafe. Some days he would not allow himself to be washed[49]. He assaulted a female resident on 11th January, an incident notified to CQC and an adult safeguarding concern referred to the London Borough of Enfield. As a result a protection plan was in place and supervision to manage his behaviour and safeguard other users of the service.

5.57. **Commentary:** the referral of a safeguarding concern was good practice but does not appear to have elicited an enquiry or multi-agency and/or cross-borough meeting. The IMR/chronology from Hackney ASC has recorded that the London Borough of Enfield intended to refer MS to mental health services but there is no indication that this happened. Convening a multi-agency and cross-borough meeting would have been helpful at this point,

[48] EASL IMR and ASC IMR, noting that the niece was informed by MPS after she had filed a missing person report as she had not seen MS for some time. The MPS chronology records that the niece reported that she had not seen MS for some time. MPS sent a MERLIN to Hackney ASC on 8th January regarding the contact made by the niece,

[49] This detail comes from the Murrayfield Nursing Home IMR and chronology.

both to nominate a lead agency and key worker but also to coordinate a response to meeting MS's accommodation, health and care and support needs.

5.58. By early February 2019 MS was indicating in a conversation with a Social Worker that he wished to return to the area in the London Borough of Hackney with which he was most familiar. He also expressed a desire not to return to the street. It has been recorded that MS appeared to have mental capacity with respect to these expressed wishes and that he was mobile and able to care for himself[50]. It was understood that the Nursing Home was prepared to accommodate MS until temporary accommodation in Hackney could be found for him. Despite liaison between a Social Worker and Housing staff, no appointment had been facilitated before the Nursing Home gave 28 days' notice to quit at the beginning of April. An urgent appointment at the Greenhouse centre was requested. On 5th May MS barricaded himself into a room at the Nursing Home and refused to attend the housing appointment. This appointment should then have taken place on 14th May in the presence of an interpreter but MS refused to attend. A case discussion the same day raised once again the question of whether an IMCA should be appointed. On 28th May MS was offered temporary accommodation under the provisions of the Housing Act 1996 as amended and enhanced by the Homelessness Reduction Act 2017. This was a hotel room. MS accepted the offer. However, by 30th May he had returned to the same bus stop where he had bedded down previously and was refusing to engage with an Outreach Street Worker and other services. MS was offered temporary accommodation again on 3rd June but refused. On 5th June a request for a new temporary accommodation referral was made as the previous allocation had been cancelled when MS returned to the bus stop; temporary accommodation was booked on 5th June and offered again on 6th June but MS did not attend an appointment on 10th June and temporary accommodation was cancelled.

5.59. Whilst efforts were being pursued to move MS on from the Nursing Home, at the beginning of May a care and support assessment was completed.[51] This assessment concluded that MS had mental capacity and that he was independent and had, therefore, no eligible needs. The Hackney ASC IMR/chronology questions whether MS's ability to manage his financial affairs was considered, including his mental capacity in this respect. The EASL IMR/chronology comments similarly but also observes the lack of contact with MS's known relative and omission by assessments with respect to considering the impact of his time in Whittington Hospital and Murrayfield Nursing Home.

5.60. **Commentary:** the outcome of the care and support assessment has been criticised in two IMRs/chronologies. In addition the history in this case would highlight possible doubts regarding his ability to manage key aspects of activities of daily living, including the ability to sustain his accommodation, and there are questions regarding the degree to which key behaviours regarding activities of daily living were observed, such as the ability to ensure he could manage his nutritional needs.

5.61. **Commentary:** whilst at the Nursing Home his behaviour had, at times, been aggressive towards staff and residents. He demonstrated an ability to be independent and to self-care, with the Nursing Home believing that he had decisional capacity. At times he was non-compliant with tissue viability treatment. It appears that he was regarded as having capacity regarding decisions about his accommodation needs but no formal mental capacity assessment took place with respect to any of the decisions that MS was taking. There were no multi-agency discussions regarding how to address and respond to his health and care

[50] Hackney ASC IMR and chronology.
[51] Section 9 Care Act 2014.

and support needs in the light of non-compliance and the imminent discharge from the Nursing Home. In the light of repeating patterns and his ultimate return to the streets, no consideration appears to have been given to referring the case to the Court of Protection.

5.62. **Commentary:** the Nursing Home IMR/Chronology criticises the lack of response to the notice to quit and comments that care staff were left to manage his challenging behaviour. A further assault on a female resident was reported to the London Borough of Enfield on 8th April. The protection plan was reviewed by the Home but no other (multi-agency) response is noted. The Nursing Home IMR/chronology also records that legal advice was sought regarding how to move MS on.

5.63. **Commentary:** there is a repetitive pattern in respect of MS engaging and not engaging with services and with the support being offered. This was not factored into multi-agency risk management and contingency planning. Whilst recognising the danger of hindsight bias, it is possible to suggest that insufficient attention was paid to history in this case and to whether, in fact, MS had the executive functioning necessary to sustain himself independently in the community.

5.64. From the end of May until 30th July, when MS died, he lived on the streets. He is reported as having said, on 3rd June, that "something brings [me] back to the bus stop." There were regular welfare checks day and night by Street Outreach Workers. MS declined temporary accommodation, the combined chronology explicitly recording that this was offered on 5th, 6th, 7th and 10th June, and he was once again reported as reluctant to engage. One entry in the combined chronology[52] records that a Social Worker had stated that Social Services had discharged their care. On 5th June a Street Outreach Worker discussed MS's case with London Borough of Hackney Benefits and Housing Needs Service in order to arrange temporary accommodation and with Community Safety and Enforcement Officers and, if necessary MPS, to attempt to get MS off the streets. His case was also to be presented at a Street Users Operational Meeting. Once again, the need for a Turkish speaking interpreter or staff member to be present was recognised. EASL referred MS to City and Hackney Primary Care Mental Health Services. EASL was told that MS had been de-registered from the Greenhouse Centre Surgery due to his placement in the Nursing Home.

5.65. **Commentary:** it is not clear what was meant by Social Services having discharged their duty of care. There is no reference to this in the IMR/chronology from Hackney ASC. It would be a surprising position to adopt, not least because the Care Act 2014 is clear that care and support assessment can take place where an individual lacks capacity to refuse and assessment is in their best interests, or the individual is experiencing or at risk of abuse and neglect, including self-neglect[53]. It is unclear how soon MS's case was discussed at the Street User Operational Meeting. One record in the combined chronology lists discussion on 2nd July and notes that there was an action plan but its contents are not apparent in any chronology or IMR documentation submitted for the review. A second record comes in the Hackney Recovery Service IMR/chronology, for 11th July, and no details are given of the outcome of that discussion. Whilst there clearly were exchanges of information and discussions between agencies, no multi-agency risk management meeting at which everyone involved was present had yet been held. The pattern was repeating itself. No one agency has taken the lead in coordinating the response. The need for such a meeting, not least to promote information-sharing, is highlighted by a contribution to the combined chronology where in

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[52] London Street Rescue. Also noted in the EASL IMR/chronology.

[53] Section 11(2).

early June it is stated that some staff involved with the case were unaware that MS had vacated the temporary accommodation that had been arranged for him in late May.

5.66. There were attempts to procure adult safeguarding involvement. On 6th June Hackney ASC received a MERLIN from MPS that reported a bad smell at the bus stop because MS was urinating and defecating himself. He was drinking heavily again. He had declined Ambulance support. On 18th June an Outreach Worker referred MS's case to adult safeguarding at Hackney ASC and continued to undertake regular welfare checks. The combined chronology records that the adult safeguarding referral was declined on the basis that MS was of no fixed abode. The ASC response is also recorded as observing that MS did not have any eligible care and support needs and had made himself intentionally homeless. A referral for mental health assessment via a GP was suggested. This decision was immediately challenged by EASL, whose staff knew MS well and where the focus was attempting to prevent further rapid deterioration.

5.67. **Commentary:** this is a crucial moment in the case. The decision, effectively saying that there was no role for adult safeguarding, is highly questionable. As previously indicated, section 42(1) is clear that, for an adult safeguarding enquiry, the only criteria are that an adult has care and support needs, is experiencing abuse and neglect (including self-neglect) and, as a result of their care and support needs, is unable to protect themselves. Using the definition of care and support needs[54], it is clear that the criteria are fully met in this case. If in any doubt, at least an urgent assessment of his care and support needs following the adult safeguarding referral should have been undertaken. However, one IMR/chronology[55] records that around 24th June, Hackney Social Services had responded to indicate that they did not consider self-neglect with homeless people as a concern (presumably meaning an adult safeguarding enquiry concern) and that MS had made himself intentionally homeless with capacity. That MS was of no fixed abode at the time was an irrelevant consideration when deciding not to progress to an enquiry under section 42(2) Care Act 2014.

5.68. **Commentary:** the Hackney ASC IMR/chronology is clear, reflecting on the decision regarding the adult safeguarding referral, that "this is not the response that we would expect." That analysis suggests that the decision was influenced by a failure to see the situation as escalating or new but rather was overly reliant on historic case notes and a record on MOSAIC that there was an allocated Hospital Social Worker who could, presumably, pick up the issues identified. The Hospital Social Worker did discuss the case with EASL but it is hard to detect a plan that was designed to prevent further deterioration in MS's health and wellbeing. Thus, the decision represents a significant missed opportunity to bring all the services involved together and to coordinate a plan in an attempt to prevent further deterioration.

5.69. ELFT picked up the mental health referral. The referral appears to have been treated as non-urgent for which the time frame for response was 28 days.

5.70. **Commentary:** the triage of the mental health referral highlights the importance of all referrers providing the maximum amount of relevant information, including indicating the urgency (or otherwise) of the request for assessment. It is also important to be clear whether the request was for mental health assessment or Mental Health Act 1983 assessment.

[54] Section 4.10 in this SAR.
[55] EASL submission for the SAR.

5.71. By 20th June a referral had been sent to the St Mungo's hostel from which MS had previously been evicted. There was also an elected member enquiry, asking what steps were being taken to safeguard MS's life. MS continued to decline engagement with the Street Outreach Worker and refused support to address his "rapidly declining physical health." He refused to engage with regular welfare checks from the Night Outreach Team. On both 26th June and 1st July he refused to go to the hostel to which he had been referred. On 2nd July he refused temporary accommodation and hostel placement, and to attend A&E.

5.72. **Commentary:** there were joint visits to see MS involving Thames Reach, EASL and Hackney Enforcement Officers, one of whom was able to converse with him in Turkish. Persistence and the continuity of practitioners involved represents good practice. However, it appears clear that there was uncertainty about how to proceed. An email contained in the combined chronology states that MS had been deemed not to have sufficiently high mental health needs and was not responding when told that MPS would become involved if a solution was not found. Members of the public were unable to use the bus stop, triggering concern for MS's wellbeing. The email recognises that, although Outreach Workers and Enforcement Officers would keep trying, this approach was clearly not working. It would have been timely to have sought advice from mental capacity specialists and from legal practitioners on potential ways forward, and to have convened a multi-agency risk management meeting to agree a strategy.

5.73. On 3rd July 2019 Community Safety authorised MS to be served with a Community Protection Notice[56]. This provision, which appears to have been served the following day and assumes that MS was able to read and understand the provision and its implications, is designed to prevent unreasonable behaviour that is having a negative impact on the community. Failure to comply can result in a fine.

5.74. On 3rd July Transport for London referred the case to the Safer Transport Inspector. On 4th July the decision regarding the adult safeguarding referral was again challenged on the basis that MS's mental and physical health were deteriorating, his clothes were soaked with urine and soiled, and he was refusing all offers of support and services. This may have been the prompt behind email exchanges between the Hospital Social Worker, Adult Safeguarding Senior Practitioner and the Rough Sleepers Coordinator about options, which appear to have raised the first explicit consideration of a mental capacity assessment, with options of seeking the involvement of the Court of Protection or High Court (Inherent Jurisdiction), and referral to a High Risk Panel.

5.75. **Commentary:** the Hackney ASC IMR/chronology rightly notes that the involvement of the Senior Practitioner is good practice, representing acquisition of specialist advice. However, the options that were discussed were not immediately progressed, possibly because of the absence of key staff on annual leave. Given the increasing urgency of the situation, this delay is regrettable. Meanwhile it appears that MS was assumed to have mental capacity with respect to the decisions he was taking.

5.76. In parallel, EASL referred MS for mental health assessment. The referral was not accepted by the Urgent Assessment Team as MS was "not in immediate crisis". The referral was redirected to the Primary Care Mental Health Liaison Service. The ELFT Serious Incident Report records that the case was opened on 10th July, triaged on 12th July, with a referral

[56] Anti-social Behaviour, Crime and Policing Act 2014.

meeting held on 17th July. MS was not seen until 26th July for mental health assessment and in the meantime continued to refuse to engage with services and support offered.

5.77. **Commentary:** it is unclear from the submitted IMRs and chronologies whether the referral to mental health services was for assessment or for a Mental Health Act 1983 assessment. If the latter, one outcome may have been the use of Guardianship under the Act.

5.78. Members of the public continued to raise concerns with MPS. Services involved also pressed MPS to take action. MPS did submit a MERLIN but also advised that their assessment was that MS had mental capacity, because he always engaged with the Police when spoken to, and that he was not at risk, nor in immediate danger, and did not have any injuries or illnesses that MPS was aware of. He was in their assessment choosing to sleep rough.

5.79. **Commentary:** MPS decision-making was questioned on the grounds that MS might have been committing a public order offence by urinating and defecating in public. A request was made that the decision be referred to a Senior MPS Officer and advice given about how the Council and MPS could work together to resolve the situation. This was good practice. However, at this point, no multi-agency risk management meeting has been convened and it appears that the CHSAB procedures on self-neglect have not been drawn upon. No specialist legal advice has been sought and nor has a thorough mental capacity assessment been completed. It has to be questioned as to whether MPS was the appropriate service to conduct a mental capacity assessment in respect of the accommodation and treatment decisions that MS was facing. Moreover, Hackney ASC was only partially correct in stating to Housing colleagues that the Court of Protection could only be accessed in respect of people lacking capacity; referrals may also be made where capacity is uncertain and/or has proved difficult to assess. No up-to-date assessment had been completed other than by MPS.

5.80. **Commentary:** it is also apparent that some services and practitioners involved were unclear regarding the pathway to access the High Risk Panel. It also appears that, from ASC, the key input was seen as needed from Mental Health and Housing, alongside the involvement of EASL, London Street Rescue and Transport for London. Arguably, it would have been preferable for an agreed approach to have emerged from a multi-agency discussion.

5.81. On 10th July an adult safeguarding referral was received from a member of the public. This included the following statement:

> "This man … is literally laying in a pile of his own urine and faeces in the sheltered bus stop (I've never seen him get up) … worryingly with children about as there is a school round the corner. The smell is becoming unbearable every time I walk past. The bus stop has become a huge pile of rubbish, he clearly has had multiple strokes from drinking too much as he doesn't look like he knows what he is doing. It's not the first time he has appeared as he did it last year as well."

5.82. **Commentary:** no change in approach is evident as a result of this expression of public concern. It is not apparent what consideration was given to this referred concern. Hackney ASC IMR/chronology observes that no response to the referrer has been recorded. This is poor practice. MS was still refusing to engage with day and night Outreach Workers.

5.83. On 10th July also Hackney ASC's IMR/chronology records that the Hospital Social Worker closed down his involvement. The closure summary repeats the view that MS was making informed decisions, as assessed by MPS and Street Enforcement Services. The commentary in that IMR/chronology observes that no clear transfer episode could be located on MOSAIC, suggesting that it was unclear what ASC community team would pick up the case, if any. The same IMR notes an assumption that Community Safety staff were leading on the case, with MPS and Mental Health involvement, with ASC having a monitoring role.

5.84. **Commentary:** there is no evidence that this assumption was warranted. It does not appear to have been an agreed multi-agency decision. Indeed, a reflection in Hackney ASC's own IMR/chronology refers to "unclear transfer protocols" and the lack of recorded acceptance by community teams in ASC of this monitoring role. There does not appear to have been any direct involvement by ASC in this case after 15th July 2019.

5.85. A Community Protection Notice was served on MS on 11th July. This required him to not loiter in a public place, to desist from urinating and defecating in public, to stop harassing and threatening members of the public, to engage with Outreach Workers and to remove his belongings.

5.86. **Commentary:** it is doubtful whether MS had the executive capacity to comply with the terms of the Community Protection Notice. No thorough mental capacity assessment accompanied the decision to serve the Notice and in the event of non-compliance the contingency plan is unclear.

5.87. He is recorded on 15th July as declining to engage with the Street Outreach Worker. By this time an EASL Social Worker had provided advice on the law regarding making contact with MS's niece without his consent. On 19th July the Street Outreach Worker spoke with the niece to arrange a joint visit to MS. It is recorded that the niece reported that MS had had "significant difficulties in his life and with relationships." In the event the niece did not attend on the arranged date (24th July) with the Outreach Worker and once again MS declined to engage. By this time a Community Behaviour Order[57] was being considered in the event of a breach of the Community Protection Notice, with the support of Transport for London.

5.88. **Commentary:** the reported observation made the niece is potentially significant given that loss and trauma often lie behind self-neglect[58]. It is not clear whether the niece was asked to elaborate and whether this information was shared subsequently or factored into assessment of mental capacity.

5.89. A visit to assess MS's mental health was eventually made on 26th July. Present were an EASL Mental Health Social Worker, a practitioner from the Primary Care Mental Health Liaison Service, with the Police, Council Enforcement officers and Ambulance Crew also in attendance. MS proved difficult to engage, telling those present to go away. An Approved Mental Health Practitioner Manager was consulted who advised immediate hospital treatment for poor physical health. MS refused to go to hospital. MS was assessed as lacking mental capacity to make the decision to refuse medical treatment by the practitioners from the Primary Care Mental Health Liaison Service. Paramedics disagreed. Police stated they had no grounds to forcibly remove MS. As a result a plan was forged to return with a

[57] Anti-social Behaviour, Crime and Policing Act 2014.

[58] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

Consultant Psychiatrist to assess MS with aid of a Turkish interpreter. MS was left at the bus stop.

5.90. **Commentary:** this is a significant episode and, arguably, a missed opportunity to safeguard MS's health and wellbeing. The LAS IMR observes that MS was severely unkempt, his clothes soiled. He was unable to move his left foot, which was dark in colour and without sensation. He refused to be examined. The Ambulance crew deemed him to have capacity to refuse to attend hospital and the Police could not persuade him to do so and did not feel that they could force the issue using the life and limb provision in the Police and Criminal Evidence Act 1984, or mental health provision in Section 136 Mental Health Act 1983. The LAS IMR comments that an opportunity to complete the mental health capacity tool was missed and it was unclear how the crew had deemed him to have capacity. There was no evidence that the language line was consider to assist with assessment. These comments parallel those made when analysing the LAS involvement in November 2018.

5.91. **Commentary:** it is clear that no mechanism appeared available to the practitioners present at the bus stop to resolve the disagreement regarding MS's mental capacity.

5.92. When practitioners visited MS at the bus stop subsequently he continued to refuse support and services. A further mental health assessment visit was arranged for 30th July but MS died that day before the assessment could take place.

## 6. Analysis

6.1. From the foregoing commentary on the chronology, themes were extracted for further analysis. Discussion and reflection on these themes have taken place at a learning event, involving practitioners and operational managers who worked with MS or had involvement at the time with his case, and at the panel overseeing the conduct of the review.

### 6.2. Responses to non-engagement

6.2.1. MS was evicted from a St Mungo's Hostel in September 2018 because of an incident of aggression towards staff, disruptive behaviour and persistent non-engagement. Advice was apparently sought from Housing Advice but nothing further. No multi-agency meeting took place prior to his eviction. This has been recognised as a significant omission and practice has now changed as a result. Multi-agency meetings are now requested in similar situations when residents at the hostel are not engaging with their own recovery, with commissioners also informed of possible evictions. This is underpinned by a St Mungo policy on non-engagement.

6.2.2. Hostel staff felt that language may have been a barrier, a theme that appears throughout the chronology. Qualified interpreters were used on occasion but on other occasions Turkish speaking members of staff employed by several of the agencies involved were called upon to translate. It was pointed out at the learning event that workers who speak a service user's first language are not qualified interpreters and that a worker's fluency in a language is not necessarily accompanied by skills in interpretation.

6.2.3. It was also observed at the learning event that third sector organisations at the time of this case did not have access to Language Line. Apparently, this situation regarding access has changed since that time. **Recommendation One:** CHSAB to seek assurance as to the availability and use of interpreters when an adult at risk's first language is not English.

6.2.4. Advocacy should also have been considered throughout the period under review. The appointment of Independent Mental Capacity Advocates and Care Act Advocates would have been appropriate at various points, not least when MS was approaching eviction from the St Mungo's Hostel, to help him to engage with assessments. Reflections from ASC have included the need to raise awareness regarding advocacy and to increase the number of referrals. There are legal duties[59] to consider whether a person might require support from an independent advocate in order to engage in assessments of care and support needs, safeguarding, mental capacity, medical treatment and mental health. It would appear that these legal duties were not met in this case. **Recommendation Two:** CHSAB to seek assurance on the use of advocacy to assist service users to engage in assessments and decision-making about care planning and interventions to mitigate risk.

6.2.5. At the learning event it was suggested that ideas could be shared about how to engage with people who are reluctant to accept support. One mechanism for discussing options on how to attempt engagement is discussed next, namely practitioners and operational managers meeting together from across the services involved.

[59] Sections 67/68 Care Act 2014, Section 35 Mental Capacity Act 2005 and Section 130A Mental Health Act 1983.

## 6.3. Multi-agency meetings

6.3.1. ASC in its reflections on the case chronology observed that the High Risk Panel had not been used. A reminder to staff about the role of the panel was felt necessary.

6.3.2. It appears that MS's case may have been discussed at the Street Users Operational Meeting (SUOM) but records that confirm this have not been found.

6.3.3. At the learning event it was observed that cases could be re-referred to the High Risk panel on several occasions, with the aim of ensuring that consistent support is offered. The panel has been in place for several years and it remains unclear why MS's case was not referred for discussion and action. It was suggested at the learning event that smaller agencies may not know about this panel, and other referral pathways, and therefore may be unclear about how to voice their concerns.

6.3.4. At the learning event the existence of the Adult Social Care and Housing Liaison Meeting was also discussed. This meeting includes representatives of Estate Management, ASC and ELFT. Complex cases involving housing issues are discussed with the aim of developing individually tailored plans. Its primary purpose is to address risks relating to housing and accommodation, and includes cases where people are homeless. This meeting was also in place before MS died and it is unclear why his case was not discussed there.

6.3.5. Some operational staff attend both the Liaison Meeting and the High Risk Panel. It is quite possible that cases could be discussed in both locations, raising the prospect of duplication of effort and confusion in terms of agreed forward planning. The Liaison Meeting was described as internal, so other agencies involved in a case are not routinely invited to attend.

6.3.6. SUOM runs parallel to the Liaison Meeting and the High Risk Panel. Cases may be discussed here when liaison with Mental Health Services, including Mental Health Outreach, and with Street Outreach Workers has not enabled effective risk mitigation or resolution. Referral onwards to the Liaison Meeting and/or the High Risk Panel is possible.

6.3.7. Three issues emerge from this analysis given that MS's case was only discussed at SUOM. The first is awareness amongst different services of the meetings and panels where cases can be referred for discussion. The second is how the different meetings and panels fit together to provide a coherent response to complex cases. The third is whether an escalation route exists to senior managers when risks in complex cases are not mitigated as a result of agreed plans. As one person attending the learning event expressed it: "all the meetings muddle me." **Recommendation Three:** CHSAB requests a review of the architecture of multi-agency meetings with respect to people experiencing homelessness to ensure a staged approach to attempts to engage with service users and to mitigate risks.

## 6.4. Multi-agency coordination

6.4.1. It has already been noted that there were no multi-agency meetings to share information and to agree a risk management plan and a contingency plan. Also clear from the chronology was that liaison took place between practitioners and services

involved but such liaison did not result in an overarching approach to which all those involved were committed.

6.4.2. At the learning event it was confirmed that ASC (Adult Safeguarding) now attends SUOM to ensure adult safeguarding issues are picked up. St Mungo's also attends SUOM, so all potential partners should now be represented.

6.4.3. Nonetheless, at the learning event some concerns were expressed about referral bouncing rather than a whole system response, and about lack of clarity regarding which agency would take responsibility for coordinating the sharing of information, ensuring collaboration between services and appointing a key worker. Housing colleagues stated that the aforementioned Liaison Meeting had been established partly as a result of referrals to access mental health assessment and support being knocked back. Similarly, in its reflective analysis on the chronology, ASC observed that relationships between it and Street Homeless practitioners were not well developed and improved liaison was needed. ASC's attendance at SUOM was designed in part to address this[60]. In the same reflective analysis ASC observed that communication with GPs, District Nurses and other Health Services about his health needs could have been better, for example when he was admitted to Hospital and then when he entered the Nursing Home.

6.4.4. More positively, Thames Reach staff commented positively on relationships with the Council's Street Outreach Team. Those attending the learning event felt that access to Mental Health provision was good, the Rough Sleeping Mental Health Project was observed to be accessible, and a pilot was planned for co-locating Social Workers in both Housing and Mental Health Services. Since the learning event, the independent reviewer has been told that "the Benefits and Housing Needs Service identified a gap in service provision via the joint working protocol and meetings, and successfully bid for non-recurrent funding for a year's pilot. Mental Health and Social Work professionals are to be embedded within the Benefits and Housing Needs Service to support staff to work with residents with increasingly complex needs. Two Social Workers, one with a background in mental health, will support staff to ensure that the most vulnerable residents receive an appropriate and safe service that addresses their holistic needs. Three prototype interventions are in progress."

6.4.5. What was missing in this case was a formalised coordinated approach to responding to MS's needs and the risks to which he was exposed. A formalised plan that built on the collaboration between services would have sharpened the focus on how to best safeguard MS, the options for which are reviewed again in section 6.7 below. A formalised approach could have been constructed around parallel processes, namely two (or more) sets of plans running side by side. In MS's case, one track could have been the use of enforcement powers, whether in anti-social behaviour and/or mental health

[60] Since the learning event, the independent reviewer has been informed that "quarterly joint working meetings between the Benefits and Housing Needs Service, ASC, ELFT, Neighbourhoods and Housing Departments was set up in 2017 by the Director of Customer Services to monitor the joint working protocol. This protocol was devised to reduce the number of crisis situations for individuals with an identified medical, psychological or behavioural condition that have a housing need through early intervention and better information sharing between service areas. There was an absence of a clear planned process to mitigate problems and avoid reactive situations to prevent 24 or 48-hour notice to re-house individuals into sustainable long term accommodation. This meant that often homeless individuals were presenting to the Benefits and Housing Needs Service just prior to discharge from hospital mental health wards without support identified from either ELFT or ASC."

legislation; a second could have been attempting to use more supportive provisions within the Care Act 2014 and the Homelessness Reduction Act 2017. Regular multi-agency meetings could have reviewed these parallel tracks and determined which appeared more appropriate to pursue at given points. **Recommendation Four:** CHSAB to conduct an audit of cases involving people experiencing long-term homelessness with a focus on how effectively services are working together.

### 6.5. Mental capacity assessments

6.5.1. The chronological account includes commentary on missed opportunities to conduct mental capacity assessments and on unresolved disagreements about whether or not MS had mental capacity with respect to particular decisions. It is clear that assessment of his mental capacity was rendered more complicated by the language barrier and his alcohol consumption. It is also clear that his mental capacity was assessed as fluctuating and/or that he had mental capacity with respect to some decisions but not others.

6.5.2. ASC's reflections within its contribution to the combined chronology observes that assessment of MS's executive functioning had been omitted and suggested that further training was necessary to highlight the importance and significance of assessing executive capacity. The same contribution also observed that deprivation of liberty safeguards appeared not to have been considered towards the very end of MS's hospital stay, or when in the Nursing Home. This, it was observed, would have triggered a formal mental capacity assessment and consideration of the need for an Independent Mental Capacity Advocate. It was suggested that Hospital-based Social Workers needed to be reminded about this aspect of their work.

6.5.3. At the learning event several observations were offered to explain why mental capacity assessments had not been completed when that would have been appropriate. It was suggested that staff across agencies lacked confidence, especially in complex and challenging cases, and especially in respect of assessing executive capacity. This meant that assessors tended to rely on what people said rather than to explore what they did and/or were actually able to do, and to feed this into conversations, specifically to explore whether individuals could use or weigh information.

6.5.4. With specific reference to executive capacity, little was known about the losses and traumas that MS had experienced and the impact of these on his decision-making. The Mental Capacity Act 2005 requires that there be impairment of mind and brain when assessing whether or not a person has decisional capacity. Disorder of mind or brain may include symptoms arising from alcohol or drug misuse[61]. There is evidence[62] that prolonged exposure to trauma affects brain development, especially on its executive, emotional and survival centres. There is also evidence[63] that substance misuse, for example of alcohol, results in cerebral degeneration and cognitive impairment, and that nutritional deficiencies related to chronic alcohol misuse can precipitate cognitive

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

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

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

impairment. Thus, whilst language and visual/spatial awareness may be preserved, there may be impairment of executive functioning, the ability to plan, organise and implement decisions. If this is observed, can the individual understand and use or weigh when such observations are shared with them? Assessment of executive function is, therefore, especially important[64].

6.5.5. Especially where there are repetitive patterns, it is essential to assess executive capacity as part of mental capacity assessment. Guidance has commented that it can be difficult to assess capacity in people with executive dysfunction. It recommends that assessment should include real world observation of a person's functioning and decision-making ability[65], with subsequent discussion to assess whether someone can use or weigh information, and understand concern about risks to their wellbeing.

6.5.6. It was suggested that staff did not know who to approach when assessments were proving complex and/or were uncertain how to proceed in the event of a dispute or disagreement. On the final occasion when a mental capacity assessment was attempted, and when there were disagreements amongst the practitioners as to whether MS had mental capacity with respect to decisions about his health, there was no clarity about who, ultimately from amongst those present, was the lead decision-maker. As a result the assessment was not completed and MS was left. Those attending the learning event felt that a resolution procedure was also needed so that practitioners had a framework to act within when there were disagreements about a person's mental capacity.

6.5.7. Even if, on that occasion in July 2019, it had been determined that MS did not have mental capacity regarding his health and/or his living situation, it may not have been straightforward to determine what was in his best interests and/or to implement a best interest decision. Those attending the learning event clearly recognised the dilemma, movingly verbalised by Lord Justice Munby: "what good is it making someone safer if it merely makes them miserable?"[66] The counter argument, however, is that increasingly the situation in which MS found himself deprived him of his dignity and compromised his wellbeing. To help practitioners resolve the dilemma, risk and mental capacity assessments are key.

6.5.8. Also important in just such a context is consideration of referral to the Court of Protection or, in some instances the High Court for exercise of its inherent jurisdiction. It was felt at the learning event that such a consideration was easier when someone was holding lead responsibility for the case. Another barrier could be lack of confidence in this aspect of using legal rules. Another barrier could be access to legal advice. It was noted at the learning event that lawyers seldom attended multi-agency meetings. Normally a form has to be completed to request their engagement. For some staff obtaining legal advice had been slow.

6.5.9. It was also acknowledged that staff could feel uncomfortable depriving someone of their liberty, that trying to balance self-determination with protection could be "tricky" and that exercising professional curiosity when people were refusing to engage was difficult.

[64] Hazelton, L., Sterns, G. and Chisholm, T. (2003) 'Decision-making capacity and alcohol abuse: clinical and ethical considerations in personal care choices.' *General Hospital Psychiatry*, 25, 130-135.
[65] NICE (2018) *Decision Making and Mental Capacity*. London: National Institute for Health and Clinical Excellence.
[66] Re MM (An Adult) [2007] EWHC 2003 (Fam)

A further complicating factor in MS's case was understanding the impact on mental capacity of prolonged substance misuse.

6.5.10. Those attending the learning event made several suggestions to address the issues surrounding mental capacity assessment. These included the provision of training, for example on executive functioning and on the impact of alcohol misuse on mental capacity; the provision of case law updates; the development of a toolkit, and encouragement to seek legal advice and consideration of referral to the Court of Protection. **Recommendation Five:** CHSAB to undertake an audit of mental capacity decision-making in cases involving homelessness and/or substance misuse, and to consider the implications of the findings for the provision of training. **Recommendation Six:** CHSAB to promote with partner agencies the development of trauma-informed practice and the assessment of mental capacity, with specific reference to executive decision-making.

## 6.6. Assessment of need and risk

6.6.1. When in the Nursing Home an assessment was completed of MS's care and support needs[67]. This concluded that he needed prompts to take his medication and that he was unable to manage meal preparation. Otherwise it concluded that he had little or no difficulty with personal hygiene, continence, nutrition and hydration, managing his money or moving around.

6.6.2. This assessment was not revisited once he had left the Nursing Home. Nor does it appear that "real world observation" was included in the assessment; in other words his care and support needs were not assessed in what was planned to be the "moving on" location from the Nursing Home, namely temporary accommodation. In that context it is important to note that it was recognised that he was potentially still vulnerable; equally it is unsurprising that, in the Nursing Home, he was not assessed as at risk of falls and self-neglect.

6.6.3. It is also important to note that, when in Hospital, he was assessed as having needs relating to nutrition, continence, personal hygiene, keeping appropriately clothed, managing a home environment and using facilities in the community. Awareness of case history is important when completing care and support assessments. It is clear from the chronology provided by St Mungo's that, when living in the Hostel, MS demonstrated difficulties maintaining a safe living environment for himself and managing his personal hygiene.

6.6.4. ASC's analysis within its contribution to the combined chronology observes that the Nursing Home was not commissioned to develop MS's independent living skills and that these were not adequately assessed before he left. Thus, there was no plan for wrap-around care and support that would meet his needs with respect, for example, to provide assistance with meals, managing his money and ensuring he kept appointments with his GP. It comments that the Occupational Therapy Service would have had a useful contribution to make to assessment of his care and support needs and the development of a care plan.

[67] Section 9 Care Act 2014

6.6.5. This contribution to the analysis highlights the importance of considering different options at points of transition which, in MS's case, were eviction from St Mungo's Hostel, discharge from Hospital, and moving on from the Nursing Home. It has already been made clear that there was no multi-agency consideration of options when he was approaching eviction from the Hostel. The only option that appears to have been considered around Hospital discharge was admission to a Nursing Home. A critique has been offered of planning when that placement was ending. MS had multiple difficulties, long embedded, which practitioners had always found it challenging to address because of his variable engagement. It would be timely, however, to review the availability of provision that can meet a person's accommodation, health and social care needs. What is envisaged here is a range of provision, dependent on the level of a person's needs, beginning with support to access private sector accommodation and rising through floating support, housing-related support and a Housing First approach[68]. Recommendation eleven, below, is designed to provide an opening for such consideration.

6.6.6. With respect to MS's health needs, during the discharge process from Whittington Hospital it was suggested that MS should be referred to Hackney Memory Service. It is not clear whether he was referred and seen. It was also noted that a repeat endoscopy should be undertaken after six weeks but there is no evidence that this was carried out. The ELFT Serious Incident Report accepts that there were delays in arranging mental health assessment in June and July 2019.

6.6.7. More positively, there was exemplary focus on treating pressure ulcers in the Hospital and subsequently the Nursing Home. There was some oversight of his physical health and substance misuse by the GP Surgery. Nonetheless, there does not appear to have been a whole system multi-disciplinary team conversation that focused on his health care needs, particularly when significant decline was observed.

6.6.8. ASC's analysis also observes that, when it was clear that MS would be leaving the Nursing Home, different Housing options were not considered, such as Housing with Care. Equally, the risk of MS returning to the street was not identified and a multi-agency risk mitigation plan was not in place. There was a suggestion that MS might be re-referred to the St Mungo Hostel where he had resided previously but this suggestion was not followed through. It is unclear why but perhaps is the outcome of a case where there was no lead agency or nominated key worker.

6.6.9. At the learning event a recent innovation was discussed, namely a RAG rating system in order to provide greater focus and consistency when managing risks with respect to people experiencing homelessness. Nonetheless concerns were expressed about the lack of a whole system approach in situations of clear risk. Whilst it was recognised that the aforementioned Liaison Meeting and High Risk Panels were proving useful in seeking agreements about how to manage risks, there did not appear to be awareness of a formalised escalation route to senior managers when all attempts to mitigate risk had been unsuccessful. In fact CHSAB published an escalation protocol in 2016[69]. It would be timely to review the protocol and then to actively disseminate and promote the revision version. **Recommendation Seven:** CHSAB to consider with senior strategic managers the need to revise and then actively disseminate an escalation pathway to ensure multi-agency senior management oversight and decision-making with respect to high

[68] Homeless Link (2016) *Housing First in England: The Principles*. London: Homeless Link.

[69] CHSAB (2016) Escalation Protocol.

risk cases where earlier attempts to mitigate risk and alleviate the risk of significant harm have proved unsuccessful.

## 6.7. Safeguarding and legal literacy

6.7.1. Whittington Hospital, to which MS was admitted, falls within the London Borough of Islington. Although adult safeguarding concerns were recorded after his admission, MS is not recorded as known to the London Borough of Islington.

6.7.2. On 11th January 2019, as noted in the earlier chronology, the Nursing Home referred an adult safeguarding concern to the London Borough of Enfield as a result of MS's assault on another resident. This was not logged in MS's name, although the information does appear to have been shared with the London Borough of Hackney. By the time a second assault had been referred by the Nursing Home to the London Borough of Enfield, MS had already moved on.

6.7.3. Two issues arise from these observations. The first is the question of how information is shared when people are placed, or admitted to Hospital, "out of Borough". At least one other SAR in London[70] has focused on the challenges posed by Ordinary Residence and on agency responses when people move across geographical boundaries. The second is that the London Borough of Enfield recorded the referred adult safeguarding concerns in the name of the victims. This could result in an omission of consideration of the needs of, and risks posed by the perpetrator.

6.7.4. The commentary on the chronology above seriously questions the decisions that were taken in ASC in response to the adult safeguarding concerns that were referred. No safeguarding enquiry was conducted with respect to MS and, it is argued, insufficient regard was paid to the three criteria in Section 42(1) Care Act 2014 that should result in an enquiry being undertaken. **Recommendation Eight:** CHSAB to consider what responses are indicated by the findings of previous audits of Section 42 decision-making and of this review, to be assured that the local authority fully complies with its statutory duties regarding referred adult safeguarding concerns and subsequent enquiries.

6.7.5. The provisions of housing legislation, most especially the Homelessness Reduction Act 2017, and associated guidance[71] do not appear to have been actively considered at key points of transition, namely MS's eviction from the St Mungo's hostel and his discharge from Whittington Hospital and subsequently the Murrayfield Nursing Home. Particularly at these transition points, as the guidance advises, suitability of accommodation should have been considered by reference to his medical and physical needs, and any social considerations. Similarly, such consideration should have taken place alongside the Care Act 2014 duty to promote a person's wellbeing, which includes consideration of the suitability of living conditions and enhancement of an individual's emotional wellbeing, personal dignity and control over their daily life.

6.7.6. At various points, especially towards the end of MS's life, an enforcement approach was adopted in an attempt to move him on from the bus stop where he had settled. This approach was unsuccessful, partly because it was not accompanied by a multi-agency plan designed to address his multiple needs. At the very end of his life a mental health

[70] City of London and Hackney SAB, Islington SAB, Lambeth SAB and Newham SAB (2019) Mr YI – SAR.
[71] Ministry of Housing, Communities and Local Government (2018) Homelessness Code of Guidance for Local Authorities. London: The Stationery Office.

assessment was planned, which might have led to use of the Mental Health Act 1983. It is important to note here, however, that alcohol dependence is not regarded as a mental disorder for the purposes of the Act although conditions that arise from alcohol dependence may be considered mental disorders for the purposes of either Guardianship (section 7) or Hospital admission (Section 2).

6.7.7. When in a public place MPS might have explicitly considered Section 136 Mental Health Act 1983. As has already been noted there were occasions when the Mental Capacity Act 2005 featured in practitioners' considerations of how to intervene if MS did not consent. At the learning event it was recognised that knowledge of case law can be helpful. For example, the case of *London Borough of Croydon -v- CD [2019] EWHC 2943 (Fam)* has demonstrated that a chronic dependent drinker can be viewed as lacking capacity with regard to decisions about his care. The judge determined that the individual lacked mental capacity to understand the risks he was living in, namely extremely neglected accommodation and self-neglect. Orders in his best interest were made. In *Tower Hamlets v A and KF [2020] EWCOP 21* practitioners were reminded in the case of a woman with Korsakoff Syndrome that domains of capacity are individual or issue specific. Someone may not have capacity with respect to their care but may (or may not) have capacity regarding a place of residence. In cases of fluctuating capacity, for example with respect to alcohol misuse, the courts have advised the adoption of a longer-term perspective on someone's capacity rather than simply assessing a person's mental capacity at one point of time[72].

6.7.8. Nonetheless, as those attending the learning event recognised, it can be difficult for practitioners to keep abreast of case law, even when the organisational culture is supportive of applications to the Court of Protection. This highlights again the importance of accessible legal advice but also of regular opportunities for continuing professional development of legal literacy. **Recommendation Nine:** CHSAB to consider how best to ensure that practitioners maintain their legal literacy, with particular reference to the Care Act 2014, Mental Capacity Act 2005, Mental Health Act 1983/2007 and the Homelessness Reduction Act 2017.

### 6.8. Family and community involvement

6.8.1. In its Serious Incident Report ELFT observes that he had no known relatives. However, both MPS and a Street Outreach Worker had contact with MS's niece. ASC's reflection on its chronology observes that there was no follow-up with the niece when she reported MS as missing (when he was in fact in Hospital). It suggests that this was an oversight and a missed opportunity to assess when the niece could be part of a supportive network.

6.8.2. The death of his sister does appear to have affected MS but, if anyone who knew him inquired about his family relationships, the outcome does not appear in the combined chronology. This may be another example of a missed opportunity to demonstrate professional curiosity.

6.8.3. When MS was resident at the St Mungo's Hostel it was known that he associated with members from his Turkish community. There were also local residents who expressed concern about MS when he had returned to the bus stop. It does not appear that

[72] Greenwich RLBC v CDM [2019] EWCOP 32 and Cheshire West and Chester Council v PWK [2019] EWCOP 57.

community groups were approached to explore what support they might be able to offer. This might also have assisted with developing an understanding of his cultural background and responding positively in relation to his ethnicity. **Recommendation Ten:** CHSAB to seek assurance that next of kin details are routinely recorded and that active consideration is given to assessment of whether relatives and community groups can contribute to a circle of support for adults at risk.

### 6.9. Procedural guidance and management oversight

6.9.1. Considerable resilience and persistence was demonstrated by some practitioners, for example the Street Outreach Worker and staff in the St Mungo's Hostel prior to his eviction. To maintain involvement with individuals who consistently reject offers of support requires management support and oversight of decision-making, not least to avoid the risk that practitioners can become desensitised to what they observe. Also important is that practitioners have a framework within which to locate their practice.

6.9.2. Staff in Thames Reach hold case management meetings every three weeks and more frequently in high risk cases. However, it was suggested at the learning event that not all services provide an operational procedural framework for practitioners to follow. It was suggested also that more guidance would be useful for practitioners across statutory and third sector agencies on how to work with people who are homeless and with complex comorbidities.

6.9.3. An appendix has recently been added to the Pan-London Procedures on Adult Safeguarding and Homelessness. This draws on a briefing with the same focus[73]. A view was expressed at the learning event that it would be beneficial to have greater clarity about the contribution of each service to meeting the needs of people experiencing homelessness. In that context it was noted that the London Borough of Hackney is moving to a system of neighbourhood teams that, it was hoped, would address the build-up of referrals and clarify the relationship between Hospital and Community Social Work and Social Care. This reflects, in part, a critique from ASC that a Hospital Social Work had retained MS's case after he had been discharged from Whittington Hospital. **Recommendation Eleven:** CHSAB to convene a summit involving all agencies working with people experiencing homelessness, including commissioners alongside providers, the purpose being to map current service provision for adults who self-neglect and/or have complex needs/or misuse substances and/or are homeless or threatened with homelessness and consider what refinements, resources and further developments are advisable in light of learning from this SAR in order to deliver an integrated and collaborative system for meeting people's complex needs.

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

## 7. Conclusion and Recommendations

7.1. The commentary in section 5 of this report and the analysis in section 6 has sought to address explicitly the terms of reference for the review. Particular attention has been paid to how services responded to MS who was experiencing multiple exclusion homelessness, which included their approach to decision-making about mental capacity, and to assessment and risk assessment. The report has considered how services worked together, including how they shared information. It has reviewed decision-making around safeguarding concerns and considered the legal rules that were used and legal options that were not employed.

7.2. Reference was made earlier to the observations that MS was recorded variously as Turkish and Kurdish. Accurate recording of a person's ethnicity is a key component of best practice, as is follow-on consideration of how to counteract discrimination when providing services[74], to respect a person's heritage and to practise in culturally appropriate ways. The provision of interpreters is just one component of anti-discriminatory practice.

7.3. Cases of self-neglect, including those where people are experiencing multiple exclusion homelessness and/or appear dependent on substances such as alcohol, not infrequently uncover stereotypical assumptions about lifestyle choice or, put another way, unconscious bias. How practitioners, managers and services respond to the person in the here and now needs to be informed by a profound and humane understanding of the individual's journey and the impact of it on how a person presents today.

7.4. The timeframe under review in this case predates the Covid-19 pandemic. It is important to acknowledge what has been achieved with respect to people experiencing homelessness as a result of the response to the Covid-19 pandemic. Derogation of legal rules and the injection of financial resources has made a marked difference for people previously homeless. It has demonstrated what can be achieved when the financial, legal and policy context changes, and supports good practice locally. It has demonstrated what recent research[75] has advised when outlining five principles – find and engage people, build and support the workforce to go beyond existing service limitations, prioritise relationships, tailor local responses to people sleeping rough and, finally, use the full power of commissioning to meet people's health, housing and social care needs. **Recommendation Twelve:** CHSAB to reflect with partner agencies on what has been learned and achieved from the support provided in response to the pandemic to people who were experiencing homelessness, and what can be built into provision in the future.

7.5. The recommendations are addressed to CHSAB. They are repeated here, having first been embedded in the textual analysis at the point where they appeared most relevant.

**Recommendation One:** CHSAB to seek assurance as to the availability and use of interpreters when an adult at risk's first language is not English.

**Recommendation Two:** CHSAB to seek assurance on the use of advocacy to assist service users to engage in assessments and decision-making about care planning and interventions to mitigate risk.

[74] Equality Act 2010.

[75] Cream, J., Fenney, D., Williams, E., Baylis, A., Dahir, S. and Wyatt, H. (2020) *Delivering Health and Care for People who Sleep Rough: Going Above and Beyond*. London: King's Fund.

**Recommendation Three:** CHSAB requests a review of the architecture of multi-agency meetings with respect to people experiencing homelessness to ensure a staged approach to attempts to engage with service users and to mitigate risks.

**Recommendation Four:** CHSAB to conduct an audit of cases involving people experiencing long-term homelessness with a focus on how effectively services are working together.

**Recommendation Five:** CHSAB to undertake an audit of mental capacity decision-making in cases involving homelessness and/or substance misuse, and to consider the implications of the findings for the provision of training.

**Recommendation Six:** CHSAB to promote with partner agencies the development of trauma-informed practice and the assessment of mental capacity, with specific reference to executive decision-making.

**Recommendation Seven:** CHSAB to consider with senior strategic managers the need to revise and then actively disseminate an escalation pathway to ensure multi-agency senior management oversight and decision-making with respect to high risk cases where earlier attempts to mitigate risk and alleviate the risk of significant harm have proved unsuccessful.

**Recommendation Eight:** CHSAB to consider what responses are indicated by the findings of previous audits of Section 42 decision-making and of this review, to be assured that the local authority fully complies with its statutory duties regarding referred adult safeguarding concerns and subsequent enquiries.

**Recommendation Nine:** CHSAB to consider how best to ensure that practitioners maintain their legal literacy, with particular reference to the Care Act 2014, Mental Capacity Act 2005, Mental Health Act 1983/2007 and the Homelessness Reduction Act 2017.

**Recommendation Ten:** CHSAB to seek assurance that next of kin details are routinely recorded and that active consideration is given to assessment of whether relatives can contribute to a circle of support for adults at risk.

**Recommendation Eleven:** CHSAB to convene a summit involving all agencies working with people experiencing homelessness, including commissioners alongside providers, the purpose being to map current service provision for adults who self-neglect and/or have complex needs/or misuse substances and/or are homeless or threatened with homelessness and consider what refinements, resources and further developments are advisable in light of learning from this SAR in order to deliver an integrated and collaborative system for meeting people's complex needs.

**Recommendation Twelve:** CHSAB to reflect with partner agencies on what has been learned and achieved from the support provided in response to the pandemic to people who were experiencing homelessness, and what can be built into provision in the future.