Executive Summary: Daniel Safeguarding Adults Review (SAR)

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Summary

Daniel died by suicide at an incident in 2023 in Havering, aged 36 years. During the 12 months prior to his death, Daniel became increasingly mentally unwell. After a fire at his home address, (housed by Newham Council in Essex) where he had been living alone, he experienced accommodation instability followed by homelessness and rough sleeping, which affected the continuity of the care and treatment he received. He began presenting at his GP practice, to hospital accident and emergency departments and mental health services with suicidal ideation, paranoia and apparently fixed delusional beliefs.

A particularly prominent belief was that he needed to be placed on the Sex Offender Register because he had committed a sexual offence (of which there was found to be no trace in the records of any agency) or in order to protect himself from people he was afraid of. He visited Police Stations in the Metropolitan Police and Essex Police areas on numerous occasions in connection with this belief but partner agencies were unable to obtain hard evidence to confirm his fears. Decisions were made to admit him to mental health beds as an informal patient on 2 occasions but on neither occasion was he actually admitted which meant that his complex needs went largely unaddressed. There are suggestions that perhaps he was a victim of Criminal Exploitation, which might explain his extreme fears and pattern of international travel in the months leading up to his death.

Methodology

A collated multi-agency chronology was produced looking in detail at the last two years of Daniel's life. Practitioner meetings were held and a multi-agency panel involving agencies across LBs Havering and Newham, and Essex took place to develop learning. Daniel's family contributed to the review following delays with the Inquest, which concluded in December 2025.

Terms of reference questions

- Where there is suggestion of suicide risk or self-harm, how do agencies work together to ensure a shared understanding of risk and a joined-up approach to risk management? – information sharing, multi-agency meetings etc.

- Identify learning from this SAR to share with Public Health in Essex and the London Boroughs of Havering and Newham, in order to inform their suicide prevention programmes.
- In Daniel's situation, what would best practice have looked like?

Criminal Exploitation

During a 7 week period Daniel travelled to France twice, Brazil returning via Portugal, Finland twice, Italy and Norway. Sometimes he would be 24 hours or less in a location and on one occasion he flew into the UK, and flew out of another airport on the same day.

Daniel's pattern of international travel may be indicative of some form of exploitation, although no hard evidence has been shared. However, Daniel's persistently expressed wish to be placed on the Sex Offender Register could be construed as an action, that would result in his passport being removed, which would have curtailed his opportunities to travel abroad and have prevented any form of exploitation, which necessitated international travel.

There is no indication that any professional who came into contact with Daniel considered whether he might be a victim of, or at risk of, criminal exploitation. Home Office guidance on Criminal Exploitation of children and vulnerable adults here sets out signs to look out for.

- *Professionals should not expect victims to report their exploitation as they may not identify or be able to express that they are being exploited. They may also be too afraid to tell professionals what is happening for fear of retaliation by their exploiter.* (Daniel did not directly report exploitation. He does not appear to have been asked by any professional if he was being exploited)
- *Sudden changes in the victim's lifestyle* (There were 2 sudden changes in Daniel's lifestyle. Firstly when he left Brentwood and appeared very reluctant to return following the house fire; secondly when he began to rough sleep after a period of intense foreign travel).
- *Going missing from home, an unwillingness to explain their whereabouts and/or being found in areas they have no obvious connections with (out-of-area)* (Daniel was reported missing twice. He constantly travelled around Essex, Havering, Newham and Redbridge. He travelled to a range of international destinations, often spending very short periods there).
- *Self-harm or significant changes in emotional well-being, personality or behaviour.* (There was a marked change in Daniel's presentation from October 2022).
- *Possession of tickets for unusual journeys.* (The frequency and destinations of Daniel's international travel in the final year of his life was unusual, and included Colombia. His family did not know about these trips).
- *Possession of a rucksack or a bag that they are very attached to or will not put down.* (Daniel carried his possessions around in a rucksack when he began rough sleeping. He discarded the rucksack by throwing it in to a garden, shortly before his death).
- *Isolation from usual peers or social networks.* (Little is known about Daniel's social networks. However, it is clear that he became very isolated from his family and his friends).
- *Suspicion of physical assault/unexplained injuries – these tend to be visible but minor injuries which are issued as a threat, such as cigarette burns or small cuts, but can also be much more serious life-threatening injuries, such as stab wounds.*
- *Appearing anxious or secretive about their online activities and who they are communicating with.* (Daniel reported an historic fall for which he had not previously sought medical attention. He provided lists of names of the people he said he was in fear of twice).

- *Signs of a cuckooed property include the presence of unfamiliar individuals coming and going from the property at all hours or an increase in key fob activity; damage to the property, such as broken windows or doors* (The SAR has received no evidence that Daniel's home was being cuckooed prior to the housefire although on the evening of the day on which the house fire took place Daniel reported fearing that 2 men were going to kill him by hitting him with concrete. A more effective Police response to that incident may have clarified whether the threat to Daniel was real or imaginary).

Suicide and Self-Harm

Staying Safe from Suicide here promotes evidence-based practice, drawing on the latest research and understanding of population-level risk trends.
With the benefit of hindsight there were several known antecedents of suicide, highlighted by research, present in Daniel's life:

- Daniel was a homeless man. There were an estimated 741 deaths of homeless people registered in England and Wales in 2021. 99 of those deaths were attributed to suicide (13.4% compared to around 1% of deaths by suicide per year in the general population). Most homeless deaths registered in 2021 were amongst men (87.3%)
- Daniel was unemployed and was experiencing economic problems.
- Daniel was affected by bereavement.
- He had become isolated from his family.
- He had reported sexual abuse.
- He had been treated by his GP for anxiety.
- Although there was no mental health diagnosis, Daniel had recently been assessed as experiencing an acute psychotic episode, for which he did not receive treatment.
- His apparent delusional beliefs were becoming more acute in that he began to express fears that his life was at risk.

Nine recommendations were made

Recommendation 1

That Havering and Essex Safeguarding Adult Boards jointly obtain assurance from the North East London NHS Foundation Trust that they have robust systems in place to ensure that discharge summaries and assessments are sent to a patient's GP practice.

Recommendation 2

That Havering and Essex Safeguarding Adult Boards obtain assurance from the hospital trusts involved in Daniel's care that they have taken action to improve the quality and content of discharge summaries where this has been found to be necessary.

Recommendation 3

Given the significant demand in mental health beds, providers of mental health services should provide assurance to Havering and Essex Safeguarding Adults Boards on how they address the issue of high demand for admission including their clinical prioritisation process. In addition, Havering and Essex Safeguarding Adults Boards should share this report and recommendation with NHS England as it is of national relevance.

Recommendation 4

That Havering and Essex Safeguarding Adult Boards jointly request EPUT to update them on the implementation of staff training proposals contained in their Safety Action Plan and jointly request NELFT to update them on progress against their Action After Review action plan.

Recommendation 5

That when Havering and Essex Safeguarding Adult Boards disseminate the learning from this SAR they draw attention to the missed opportunities for professionals to consider whether Daniel was at risk of criminal exploitation.

Recommendation 6

That Essex Safeguarding Adults Board requests Essex Police to review the process by which they refer concerns about a person's mental health to their GP Practice to ensure that there is managerial oversight of repeat referrals.

Recommendation 7

That Havering and Essex Safeguarding Adults Boards requests NHS North East London Integrated Care Board (ICB) (Havering) and the NHS Integrated Care Systems (ICS) for Mid and South Essex, Suffolk and North East Essex and Hertfordshire and West Essex to work with local GP practices to encourage them to hold complex patient MDT meetings so that there is a forum for discussing adult patients about whom there are safeguarding concerns.

Recommendation 8

The adoption and use of Staying Safe from Suicide is being supported across relevant local systems, including health, social care and community services. It is recommended that Havering and Essex Safeguarding Adult Boards are formally consulted during any local implementation of Staying Safe from Suicide, to ensure that potential safeguarding implications are identified and addressed within the wider system response (This recommendation should be directed to those responsible for the local Suicide Prevention Strategy).

Recommendation 9

That Havering and Essex Safeguarding Adult Boards share the learning from this SAR, particularly

- *the elevated risk of suicide amongst homeless people*
- *the need to recognise that repeat presentations may require escalation*
- *the need to look holistically at the person's needs and be professionally curious about other risks such as criminal exploitation*
- *the requirement for a Mental Capacity Act Assessment when a person is or could be experiencing an acute psychotic episode*
- *the continuing shortage of mental health beds*

with those responsible for suicide prevention in Havering and Essex.

You can find the report here