Safeguarding Adults Review for 'Daniel'

Independent Reviewer: David Mellor

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1.0 Introduction

1.1 The purpose of a Safeguarding Adults Review (SAR) is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. The SAR can also provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases[1].

1.2 Daniel (a pseudonym) died in an incident at a railway station located in the London Borough of Havering during October 2023. At the time of his death he was 36 years old. During the 12 months prior to his death, Daniel became increasingly mentally unwell. After a fire at his home address, 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 area 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.

1.3 After considering a referral from Essex Police, the London Borough of Havering Safeguarding Adults Board decided to commission a discretionary Safeguarding Adults Review jointly with Essex Safeguarding Adults Board on the grounds that Daniel had died, that he had care and support needs and there was reasonable cause for concern about how partner agencies had worked together to safeguard him.

1.4 David Mellor was appointed as lead reviewer for the SAR. He is a retired chief officer of police and has 13 years' experience of conducting statutory reviews. He has no connection to any agency in Havering or Essex. Membership of the SAR Panel which oversaw the review and the methodology by which the review was conducted is shown in Appendix A.

1.5 An inquest concluded in December 2025, that Daniel died by suicide due to injuries sustained in a collision with a train.

1.6 Havering and Essex Safeguarding Adults Boards wish to express their sincere condolences to the family and friends of Daniel.

[1] Retrieved from https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

2.0 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.

- In Daniel's situation, what would best practice have looked like?

- Identify learning from this Safeguarding Adults Review to share with Public Health in Essex and the London Boroughs of Havering and Newham, in order to inform their suicide prevention programmes.

3.0 Chronology of key events

3.1 Daniel was born in 1987 and he and his elder sister were brought up by their parents in a London Borough of Newham property in Brentwood, Essex. He attained all milestones during his childhood years and was educated to college level where he studied painting and decorating. He was employed in the construction industry until 2020 or 2021 which it is believed he left following an argument with a colleague. Daniel used Cannabis and Cocaine and may have been a heavy drinker, disclosing drinking 25 pints of beer per weekend during a 2018 hospital attendance.

3.2 Daniel's father died in 2012 and his mother in 2016. Daniel successfully applied to take over their tenancy. At that time his elder sister and her children were also living in the property.

3.3 On 8th August 2020 Daniel reported a sexual assault by a male who was known to him which was investigated by Essex Police. Daniel disclosed that the assault had taken place on 31st December 2019. The alleged perpetrator was arrested. Daniel and the alleged perpetrator's recollections of the incident varied. In the absence of any independent evidence, the Police decided to take no further action. There is no indication that Daniel was offered or signposted to any support.

3.4 On 7th July 2022 Daniel visited Romford Police Station to share a list of people he believed to be spreading rumours that he was a paedophile. When asked to provide any evidence that this was the case, Daniel replied "it just is, I know". The officer who spoke to Daniel was concerned that he may be suffering from anxiety or paranoia. Daniel was advised of civil remedies in respect of slander and defamation of character. He was not considered to present a risk to self or others. The matter was transferred to Essex Police who referred Daniel to his GP practice who contacted Essex Adult Social Care to raise a concern for Daniel's mental welfare. Adult Social Care wrote to Daniel requesting him to contact them. After no contact was received, the case was closed.

3.5 On 5th October 2023 Daniel contacted Basildon Mind's[2] helpline to self-refer following thoughts of self-harm. He said he had been feeling very low since March 2023 and wanted to speak to someone urgently. He said he was available at any time, which meant that Basildon Mind could offer an appointment within a week. Daniel was advised to call 111 option 2 or go to A&E if his thoughts of self-harm got stronger. He was also advised to making an urgent appointment with his GP and signposted to Samaritans[3].

3.6 Daniel attended appointments on 12th, 19th and 29th October 2022. During his first counselling session he confirmed that he was distressed when he first contacted Basildon Mind but was now feeling better. He said that he believed his low mood was due to his sister "moving out" and he said he was also still grieving for the loss of his parents. Basildon Mind noted that Daniel struggled to talk during sessions. There were long silences and he said that he was shy and found it difficult to open up. Daniel did not attend appointments on 2nd and 9th November, and Daniel cancelled his 23rd November appointment with less than 24 hours notice. After he did not attend an appointment on 30th November 2022, the service was withdrawn due to 4 failed appointments.

3.7 On 19th December 2022 Daniel flew from London Heathrow to Madrid. This is the first of 2 departures from the UK during the period under review for which there is no corresponding return journey recorded. It is assumed that Daniel's visit to Madrid was fairly brief as he had returned to the UK by 22nd December 2022 at the latest.

3.8 On 21st December 2022 Daniel contacted Essex Police to report that an unknown suspect had hacked multiple devices and email accounts belonging to him. Daniel was documented to have reported the incident to Action Fraud[4] who decided not to investigate the matter. Essex Police was informed of, and agreed with, this decision. Essex Police forwarded the case to Essex Cyber Protect officers who provided advice to Daniel. The case was then filed.

3.9 Shortly after noon on Thursday 22nd December 2022 Essex Fire and Rescue Service (FRS) responded to a fire at Daniel's home. The fire was extinguished and was considered to be accidental. The cause was documented to be either a candle or cigarette left alight in a bedroom. The first item ignited was stated to be 'furniture' and 'bedding' was documented to be mainly responsible for the spread of the fire. Daniel was not present and was therefore not spoken to by the FRS. Essex Police was initially notified of the fire but later informed that it was not necessary for them to attend.

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[2] Basildon Mind is an independent mental health charity affiliated to the national Mind charity. Basildon Mind aims to reach out to all people in need of mental health support in the communities they serve. Basildon Mind offers 12 sessions of counselling to Adults at a discounted rate of £5.

[3] Samaritans is a registered charity aimed at providing emotional support to anyone in emotional distress, struggling to cope or at risk of suicide throughout the United Kingdom and Ireland, often through its telephone helpline.

[4] Action Fraud is the UK's national reporting centre for fraud and cybercrime where people can report fraud if they believe that they have been scammed, defrauded or experienced cyber crime. The service is run by the City of London Police working alongside the National Fraud Intelligence Bureau (NFIB) who are responsible for assessment of the reports and to ensure that fraud reports reach the right place. The City of London Police is the national policing lead for economic crime.

3.10 On the same date Newham Residents Services (NRS) was informed of the fire and urgently attempted to contact Daniel by phone, leaving a voicemail, text and email but received no response. NRS were able to contact Daniel's sister who visited the property later the same day to collect items which belonged to her. She advised NRS that she had been unable to contact Daniel for some time.

3.11 On the same date Daniel's sister reported him as a missing person to Essex Police who documented that there had been a fire at his home earlier in the day, that he had not been present and that he had last been seen in a park and that his state of mind was unknown as he had been going through some mental health issues.

3.12 During the same evening Daniel contacted the Met Police to report that two men were outside his door and that they were going to kill him by hitting him with a lump of concrete. He gave his address as a hostel in Ilford. An officer spoke to Daniel at length and came to the conclusion that there was no immediate threat to life. No Met Police unit was available to respond and it appears that Daniel was advised to attend Ilford Police Station to report the incident. Daniel re-contacted the Met Police around 2 hours later and provided the same information. There is no indication that Daniel attended Ilford Police Station.

3.13 During the early hours of the following day (Friday 23rd December 2022) Essex Police notified the Met Police that Daniel had been reported missing from home. Around an hour later, Daniel re-contacted the Met Police to ask if Ilford Police Station was open for 24 hours each day as he had visited that Police Station earlier "but no one would take his statement". Following a conversation with the Met Police call handler, Daniel said that he would go to Forest Gate Police Station.

3.14 Daniel then attended Forest Gate Police Station (London Borough of Newham) to inform the Police that he thought they were looking for him and so he had gone to the nearest Police Station. (It is understood that Daniel's sister had texted him to let him know that she had reported him missing). He said that he did not wish to speak to the Police about where he had been but had not come to any harm. The Police were said to have 'assessed' Daniel's mental health and concluded that he was not 'sectionable'. The Met Police later received a phone call from Daniel's aunt (who was also documented to be Daniel's Appropriate Adult[5]) to report him missing. She said she had been informed by Essex Police that Daniel had visited Forest Gate Police Station during the night but appeared to be worried that no one knew where Daniel was.

3.15 On Friday 23rd December 2022 Essex Adult Social Care (ASC) received an email from Newham Residents Services (NRS) who advised that they had been unsuccessfully trying to contact Daniel following a fire at his home the previous day. NRS went on to advise that they had spoken to Daniel's sister who had explained that her brother was not mentally well and that she had been trying to "get him sectioned" as she had a lot of concerns for his wellbeing and personal safety.

[5] The role of the Appropriate Adult is to safeguard the interests, rights, entitlements and welfare of children and vulnerable adults who are suspected of a criminal offence, ensuring that they are treated in a fair and just manner, and are able to participate effectively.

Daniel's sister also said that her brother had been exhibiting signs of severe anxiety and paranoia more recently. She described him as "creeping around", acting very strangely and that he had been in a "dark place" since the death of their parents. His sister also advised that Daniel had been receiving support from a bereavement counsellor but she believed that this support had recently ended which she felt had contributed to Daniel's decline. NRS said that Daniel's sister had reported him missing and that Daniel had later visited a Police Station to state that he was not a missing person. NRS also advised that his sister was unaware of Daniel's current whereabouts and was very worried about her brother because he was very isolated. NRS said they would appreciate any help and support Adult Social Care could provide.

3.16 On Saturday 24th December 2022 attended King George Hospital[6] emergency department (ED) following a referral from the co-located Partnership of East London Co-operatives (PELC)[7] walk-in centre. Daniel reported a history of suicidal ideation for the past 6 months. He said he was anxious, unable to look after himself but had no plans to end his life. Daniel stated that he needed to be sectioned and was assessed by the hospital psychiatric liaison team[8]. He was discharged to his GP for follow-up with a view to his GP completing a referral to local Psychological Services. The Hospital made a safeguarding referral 'for ongoing support' for Daniel the following day. It is not known where the safeguarding referral was sent and there is no information about any outcome. However, if the referral was for 'ongoing support' it may not have been a safeguarding referral.

3.17 On Tuesday 27th December 2022 Daniel flew from London Heathrow to Bogota in Columbia.

3.18 On 29th December 2022 Essex Adult Social Care closed the contact from the Newham Residents Services as they were unable to assess Daniel's needs as his whereabouts were unknown. They advised NRS to seek Police and Mental Health support.

2023

3.19 On 6th January 2023 Daniel's sister reported him as a missing person to Essex Police. She advised that she normally heard from her brother every couple of days but had not heard from him since 25th December 2022. She added that he would not

[6] King George Hospital is located in Ilford in the London Borough of Redbridge. The provider is the Barking, Havering & Redbridge University Hospitals NHS Trust.

[7] The Partnership of East London Co-operatives is a not-for-profit social enterprise delivering NHS healthcare services in Outer North East London. PELC provides four Urgent Treatment Centres, two co-located with Emergency Departments and two on community sites.

- Queens Hospital in Romford,
- King George Hospital in Goodmayes,
- Barking Hospital in Barking, and
- Harold Wood Polyclinic in Harold Wood

[8] King George Hospital mental health team provided by North East London NHS Foundation Trust (NELFT). NELFT provides an extensive range of integrated community and mental health services for people living in the London boroughs of Barking & Dagenham, Havering, Redbridge and Waltham Forest along with Essex and Kent

say where he was staying and had called her from a private number. She informed the Police about the fire at Daniel's home. The Police later visited this address and noted that it was 'burned out' and boarded up. Police checks later established that Daniel was in Colombia and so the Police concluded that he was no longer a missing person.

3.20 On 14th January 2023 Daniel returned to London Heathrow from Bogota.

3.21 On 16th January 2023 Daniel contacted NRS in relation to his property. He had a new mobile phone number and email address. He said that he had been staying at lots of different addresses. A meeting was arranged which took place at the Stratford Hub 2 days later. When asked where he was at the time of the fire, Daniel declined to answer, saying that he needed to speak to his sister first. He said that he did not work and was not in receipt of Housing Benefit, adding that his sister helped him to pay the rent. The option of downsizing was discussed with Daniel as he was living alone in a 3 bedroomed house.

3.22 On 18th January 2023 Daniel had a telephone consultation with his GP during which he reported ongoing 'problems with housing' and said that he was living in temporary accommodation. Symptoms of anxiety were noted and he was referred to Vitaminds (Improving Access to Psychological Therapies (IAPT)[9]. There is no reference to any discussion of Daniel's assessment by the psychiatric liaison team at the King George Hospital on 24th December 2022. (The SAR has been advised that a discharge letter was not completed by the King George Hospital which triggered an incident report).

3.23 On 23rd January 2023 Daniel attended an initial appointment with Vitaminds. During the assessment Daniel disclosed fleeting thoughts of "thinking about taking tablets and better off not being there" and said he felt he may be unable to keep himself safe whilst waiting to access a service from Vitaminds. As Vitaminds are not commissioned or resourced to provide urgent risk support, they referred Daniel to the Crisis Response Service (CRS)[10] to whom he reported experiencing anxiety, low mood and mental health issues over the past year. He went on to say that he was having thoughts of overdosing once or twice a week and experiencing paranoia but denied any current suicidal intent at the time of the call. The CRS referred Daniel back to Vitaminds on the grounds that he had no active suicidal thoughts, and although he was hearing voices, he was considered able to keep himself safe. Additionally, the plan formulated by the CRS was for his GP to consider treatment for low mood and anxiety, a referral to the Crisis Sanctuary[11], to download the CALM app[12] and to call CRS if experiencing a mental health crisis. It was noted that Daniel

[9] The NHS Talking Therapies, for anxiety and depression programme (formerly known as Improving Access to Psychological Therapies, IAPT) was developed to improve the delivery of, and access to, evidence-based, NICE recommended, psychological therapies for depression and anxiety disorders within the NHS.

[10] The CRS is provided by Essex Partnership NHS Foundation Trust (EPUT) and is a 24/7 single point of contact for people facing a mental health crisis. People can self-refer by calling NHS 111 Mental Health and selecting the option for mental health crisis and the call centre.

[11] Crisis Sanctuary is provided by Thurrock and Brentwood Mind.

[12] The CALM app free application to download on mobile phones or tablets for support in managing stress and anxiety, get better sleep and to feel more present in life.

had had no previous contact with Essex Partnership NHS Foundation Trust (EPUT) mental health services.

3.24 On 24th January 2023 Daniel had a telephone consultation with his GP and was prescribed Citalopram[13] for symptoms of mild to moderate depression.

3.25 On 25th January 2023, following Daniel's referral back to them from the CRS, the Vitaminds Duty Lead spoke to Daniel and established that the voices he reported hearing could be thoughts, and that the voices or thoughts did not tell him to harm himself. The voices or thoughts did not appear to be a symptom of psychosis. Daniel went on to say that he occasionally had thoughts of not wanting to be here but said that he had no plans or intent to take his own life. He cited his family as his reason for not ending his life. Daniel was deemed suitable to engage with Vitaminds and he agreed to try the Worry Webinar (a group based online intervention). However, Daniel did not attend the Webinar sessions and did not respond to correspondence requesting him to make contact and was discharged back to the care of his GP on 15th February 2023.

3.26 Following the referral to the Crisis Sanctuary, a Crisis Sanctuary outreach worker phoned Daniel to introduce himself and say that he would be working with him. Daniel said that he was feeling much better than when he contacted the Crisis Response Service (CRS). He said that he would prefer in-person contact as he "couldn't explain much on the phone". He confirmed that he was staying in a Barking hotel. He reported feeling much better and re-iterated a preference for in-person contact as he was staying in a hotel and didn't want other residents to "know his business' (If Daniel was staying in a Barking hotel, this accommodation had not been arranged by NRS. Daniel had advised NRS that he didn't require temporary accommodation as he was staying with friends and also planned to "go away" for a period of time).

3.27 On 27th January 2023 Daniel met NRS and a removal company at his home address to select items for storage.

3.28 On 30th January 2023 Daniel did not attend the scheduled in-person meeting with the Sanctuary outreach worker. He phoned to explain that he was unable to make the appointment as the Council had not sorted out his hotel arrangements. The in-person appointment was rearranged for 3rd February 2023.

3.29 On the same day Daniel had a telephone consultation with his GP during which he said that he had decided not to take the Citalopram as he preferred to see if the therapy would work. He reported his mood to be stable and denied any suicidal thoughts.

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[13] Citalopram is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). It's often used to treat low mood (depression) and also sometimes for panic attacks. It helps many people recover from depression and has fewer side effects than older antidepressants. It usually takes 4 to 6 weeks for citalopram to work, although the patient should start to feel better after 1 to 2 weeks. Side effects such as tiredness, feeling nervous, dry mouth and sweating are common. They're usually mild and go away after a couple of weeks.

3.30 On 3rd February 2023 the sanctuary outreach worker phoned Daniel to check if he was on his way to the scheduled in-person meeting. Daniel replied that he had "totally forgot" about the appointment and apologised. He declined the offer of a telephone discussion and the appointment was rearranged for 6th February 2023. Daniel confirmed that he was able to keep himself safe.

3.31 On 6th February 2023 Daniel did not attend the in-person appointment and when phoned by the Sanctuary outreach worker, apologised and explained that he was having issues with housing and needed to speak to the council as he said he was unsure if he had somewhere to stay that night. It was agreed that future contact would be by phone so that Daniel had more time available to sort out his accommodation. Daniel requested a telephone appointment for the following day. However, when the Sanctuary outreach worker attempted to phone Daniel several times on 7th February 2023, the calls went straight to voicemail. Following a multi-disciplinary team (MDT) discussion, it was decided to discharge Daniel.

3.32 On 13th February 2023 NRS emailed Daniel with an offer of a temporary decant property which was located close to his home, which was under repair following the fire. On 17th February 2023 Daniel met NRS at the decant property and accepted it and was allocated the keys on 27th February 2023.

3.33 On 3rd March 2023 Daniel had a telephone consultation with his GP practice, during which he reported feeling anxious and low. He requested an in-person appointment which he did not attend. On the same date Daniel attended a PELC urgent treatment centre at Harold Wood where he reported suicidal thoughts. He said he had suffered with anxiety and depression since his teenage years. He went on to say that he had been sexually abused "many years ago". On examination it was documented that Daniel did not have harmful thoughts or any intent to harm himself or others. He was discharged.

3.34 On the same date Daniel phoned the Crisis Response Service (CRS) but no details of the call were recorded. It is not known why no details of the call were recorded.

3.35 During the late evening of Monday 27th March 2023 Daniel travelled from Dover to Calais via Eurotunnel and returned during the early hours of Monday 3rd April 2023.

3.36 On Thursday 6th April 2023 Daniel travelled from Dover to Calais by ferry. This is the second of 2 departures from the UK for which there is currently no corresponding return journey recorded.

3.37 At 10.20pm on Tuesday 11th April 2023 (immediately after the Easter weekend) Daniel flew from London Heathrow to Sao Paulo, Brazil. He returned to London Heathrow on a flight from Lisbon which arrived at 12.55pm on Wednesday 13th April 2023. The flying time from London to Sau Paulo is 11 hours 40 minutes and so it seems possible that Daniel did not, or was unable to, gain entry to Brazil.

3.38 On Tuesday 18th April 2023 NRS emailed Daniel to advise him that they would be changing the locks at his decant property as he had not been in contact to arrange for stored items to be moved into the property. NRS had received no replies to attempts to contact Daniel by phone, text or email and when visiting the decant property, there had been no sign that he had moved in.

3.39 At 6.10pm on the same date (Tuesday 18th April 2023) Daniel flew from London Heathrow to Helsinki, returning on the 7.30pm flight from Helsinki to Heathrow on Thursday 20th April 2023.

3.40 The following day (Friday 21st April 2023) Daniel visited Kentish Town Police Station (London Borough of Camden) to report that someone had sent him indecent images. The Met Police decided that there was insufficient evidence to proceed.

3.41 On Sunday 23rd April 2023 Daniel flew to London Heathrow from Helsinki, arriving at 4pm. There is no record of Daniel's outbound journey to Helsinki. As Daniel visited Kentish Town Police Station 2 days prior to this return flight from Helsinki, it is assumed that his stay in Helsinki was brief). Within a short time of his arrival in the UK on Sunday 23rd April 2023, Daniel flew from London Stanstead to Pescara, Italy, departing Stanstead at 8.35pm. (The journey from London Heathrow to Stanstead would have taken over 1 hour and 30 minutes whether by train, shuttle or taxi)

3.42 On 25th April 2023 Daniel phoned Essex Police to disclose details of a local paedophile ring which sent teenage and animal pornography to people and then blackmailed the recipients into selling their homes to meet the paedophile ring's demands. Daniel also stated he had seen the teenage and animal pornography and admitted to downloading it. Attempts were made to contact/visit Daniel but the Police were unable to locate him, and so no further action was taken.

3.43 On 5th May 2023 Daniel returned to London Stanstead from Milan departing at 11.25pm.

3.44 At 6.40pm on 12th May 2023 Daniel flew from Stanstead to Bergen, Norway returning at 11.35am on 14th May 2023. There is no record of Daniel travelling abroad after this return flight to Bergen.

3.45 On 16th May 2023 Daniel made an online claim for Universal Credit (UC). He gave his address as the Gemini Centre in Chelmsford which is a Job Centre Plus. Daniel declared anxiety and depression as health conditions and stated that these health conditions did not restrict his ability to work or look for work. He declared no housing costs. The Department for Work and Pensions (DWP) has advised the SAR that Daniel had made no prior claims for benefits. Between 16th and 26th May 2023 the DWP made several unsuccessful attempts to phone Daniel to ask him to complete his claim and verify his identity.

3.46 On 21st May 2023 Daniel attended Broomfield Hospital ED in Chelmsford[14] and reported double vision, specifically that he was unable to differentiate between blue

[14] The provider of Broomfield Hospital is the Mid and South Essex NHS Foundation Trust.

or black colour and that he had a fall 7 months earlier for which he had not sought medical attention. Daniel was reviewed and was discharged home. There is no indication that Daniel sought prior medical attention for any such fall.

3.47 On 28th May 2023 Daniel visited Ilford Police Station to report that he had stayed at his uncle's home and woke in the morning to find that his bag had been stolen. The Met Police attempted to investigate Daniel's report but were unable to contact him because an incorrect email address had been recorded when he reported the alleged theft.

3.48 On 2nd June 2023 Daniel changed the address on his UC claim to the Welcome Centre in Ilford which is a day centre for rough sleepers and people who are homeless.

3.49 The following day (3rd June 2023) Daniel attended an in-person appointment at the Redbridge Job Centre at which his identity was verified and a New Claim Advance of £368.74 was paid into his bank account. Daniel was documented to be homeless, had not worked 'in a while' and had been living off his savings. Daniel attended a further in-person appointment at the Job Centre on 6th June 2023 when a 'duty to refer'[15] form was completed and sent to the London Borough of Redbridge Housing who were unable to contact Daniel by phone or email. Daniel was also referred to Work Redbridge[16] for employment/CV support. A Claimant Commitment was completed and agreed by Daniel to search for full time work.

3.50 On 9th June 2023 Daniel attended King George Hospital ED in Ilford following a referral from PELC due to him feeling anxious and depressed. Daniel denied any suicidal ideation or intent. He advised that he was on medication for his mental health but could not recall the name of it. (This may have been incorrect information as Daniel had previously been prescribed Citalopram and decided not to take it). Daniel did not wish to wait for assessment and left the ED. Daniel's GP practice was notified of this attendance.

3.51 On 13th June 2023 Daniel attended an in-person Work Search Review appointment and said that he was in contact with 'the council', YMCA and Street Link[17] 'regarding his circumstances' and that the Citizens Advice Bureau had given him a list of shelters. He said that he had been applying for scaffolding roles as he had a licence to work in this field. Daniel agreed to support from a Disability Employment Advisor[18] due to the health conditions he had declared.

[15] The Homelessness Reduction Act 2017 significantly reformed England's homelessness legislation by placing duties on local housing authorities to intervene at earlier stages to prevent homelessness in their areas, and to provide homelessness services to all those who are eligible. Additionally, the Act introduced a duty on specified public authorities to refer service users who they think may be homeless or threatened with homelessness to local authority homelessness/housing options teams.
[16] Work Redbridge is a Council support service for those looking to access employment, training and volunteering.
[17] StreetLink London connects rough sleepers who are over the age of 18 to local services.
[18] Disability Employment Advisors offer support to claimants who have complex employment circumstances involving health and disability issues.

3.52 On 20th June 2023 Daniel attended an in-person Work Search Review appointment. He said that he remained homeless and was sleeping in a graveyard. He said that he had been contacted by the YMCA and was awaiting help from them.

3.53 On Thursday 22nd June 2023 Daniel visited his GP in Brentwood to request an urgent appointment. When seen by a GP he reported concerns in relation to poor memory, paranoid thoughts about wanting to be put on the sex offenders register, and suicidal thoughts. During the consultation Daniel stated that he was not getting on with his sister, aunt and uncle who he said were trying to steal his National Insurance number, birth certificate and passport. He was referred for an urgent psychiatric assessment and an ambulance was called to convey him to the Basildon Mental Health Urgent Care Department.

3.54 The East of England Ambulance Service NHS Trust (EEAST) ambulance crew arrived at the GP surgery during the afternoon of 22nd June 2023 and noted that Daniel was sitting in the GP waiting room, fully alert and coherent. He appeared calm and said that he felt better after speaking to his GP. When the crew spoke to his GP, the GP informed them that Daniel had been suicidal and had come very close to taking his own life 'one day'.

3.55 Daniel was transported to the Mental Health Urgent Care Department (MHUCD)[19] in Basildon where he said he had disclosed to his GP that he had intended to hang himself the previous day. He said that he had "not been feeling great for some time" and had been experiencing suicidal thoughts and had been contemplating hanging himself. He also reported experiencing anxiety and depression but was not taking any medication. No paranoia or delusional beliefs were noted. He was assessed as presenting with low risk of suicide and deliberate self-harm and no acute mental health issues. The assessment was completed during the evening and Daniel agreed to stay overnight at the MHUCD and leave in the morning. He was discharged into the care of his GP the following morning (Friday 23rd June 2023)

3.56 On Sunday 25th June 2023 Daniel arranged to meet his sister in a public house in Romford but changed the location of the meeting to a cemetery. When his sister arrived there, Daniel said that he had had enough of the last few years and spoke of wanting to end his life. He had a rope with him and ran off into the woods, although he stated that he wasn't going to take his own life*. His sister called the Met Police who considered detaining him under Section 136 of the Mental Health Act. After a discussion with the Mental Health Direct team[20] decided not to detain him and took him to the Integrated Crisis Assessment Hub (ICAH)[21] for assessment.

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[19] The Mental Health Urgent Care Department provides care, assessment and support to people with urgent mental health needs and in crisis, providing a calm and therapeutic space with access to mental health specialists. The MHUCD is managed by Essex Partnership University NHS Foundation Trust (EPUT).

[20] The Mental Health Direct Team is a 24 hour crisis line which is available to professionals to obtain advice and for members of the public to be signposted for support or to access an assessment.

[21] The Enhanced Integrated Crisis Assessment Hub offers a safe and welcoming space for NELFT residents over the age of 18 to access support and professional help when they are in mental health crisis. The Hub is a 24/7 therapeutic space where a range of staff support crisis resolution and access to

*Paragraph 3.56 contains contradictory information about Daniel's suicidal ideation. This reflects the content of the EPUT report ("he spoke of wanting to end his life") and the Met Police report ("he stated that he wasn't going to take his own life").

3.57 The Police advised staff at the Integrated Crisis Assessment Hub (ICAH) that Daniel had been 'vague' when spoken to but did mention that he did not want to live anymore, and a rope had been found in his bag. Daniel reported that he had found his parents' deaths stressful. He said he had been sleeping on the street for the past 3 weeks after being moved from his home in Brentwood to a hotel by the council.

3.58 Daniel was assessed by ICAH and denied any paranoid ideations or auditory hallucinations. His sister joined the interview and expressed concern about her brother's current mental health and said he was very paranoid and thought people were after him and that 'social media knows him'. He denied using illicit substances and said that he drank alcohol socially. His appearance was noted to be unkempt. Daniel agreed to an informal admission to a mental health bed due to presenting with low mood, anxiety, paranoid ideation and suicidal thoughts.

3.59 During the late evening of Sunday 25th June 2023 and throughout the following day (Monday 26th June 2023) efforts were made to locate a bed for Daniel. ICAH initially contacted the Essex Partnership University NHS Foundation Trust (EPUT) bed manager to discuss their assessment and to advise that Daniel required a crisis admission to hospital. No beds were available at that time and EPUT advised that they were not admitting informal patients to private sector beds. After the issue was escalated, the EPUT on call manager advised that, should ICAH manage to locate a private bed, they should consult with the EPUT on call manager as there were private providers they did not use.

3.60 During the morning of Monday 26th June 2023 ICAH was advised by EPUT bed management that they were currently in the process of transferring an older patient from a working age bed to an older adult bed, potentially freeing up a working age bed for Daniel. However, this option failed to materialise as the older patient was not transferred. During the afternoon a private bed was found for Daniel but this was not authorised by EPUT and so ICAH escalated the case to the head of the Integrated Care Directorate (ICD). Due to the delay in transfer of Daniel to an appropriate mental health setting a (Datix) Incident Report was completed. During the late evening Daniel's sister contacted ICAH to request an update and was informed that no bed had been identified. She was understandably unhappy about this situation and was advised about the complaints procedure.

3.61 At 1.30am on Tuesday 27th June 2023 Daniel left the hub with his belongings and refused to return. The Police were notified, and they spoke to him by phone when he confirmed that he was not missing and was "fine". His address was

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other pathways for those who need additional support. The core purpose of the Hub is to provide an emergency department diversion for those with urgent mental health needs that do not require acute medical intervention

documented to be the family home in Brentwood which remained uninhabitable whilst fire damage was repaired.

3.62 There is no indication that Daniel's GP practice was notified by ICAH. However, the Met Police created an adult protection investigation which was shared with Essex Police who referred Daniel to his GP.

3.63 On 28th June 2023 Daniel did not attend a DWP Work Search Review appointment and a message was sent to him to provide reasons for not attending this mandatory appointment by 5th July 2023 or risk losing some or all of his UC payment.

3.64 Between 30th June and 14th July 2023 the GP practice made multiple unsuccessful attempts to follow up with Daniel via phone, text message and letter.

3.65 On 11th July 2023 Daniel visited Chingford Police Station and reported having a sexual relationship with a child in 2004 (when Daniel would have been 16 or 17) which continued for 5 years. The case was transferred from Essex Police to the Met Police as the alleged offence occurred in London. On 19th July 2023 Daniel again visited Chingford Police Station and repeated the information he had given on 11th July 2023. The Met Police completed extensive intelligence checks which highlighted previous reports received from Daniel, following which the investigation was closed.

3.66 Daniel did not attend further DWP Work Search Review appointments on 12th and 18th July 2023.

3.67 On 2nd August 2023 Daniel attended Hackney Police Station requesting to sign on with Jigsaw[22]. The following day (3rd August 2023) Daniel attended Bethnal Green Police Station and requested to speak with the Jigsaw team. He told officers he was being harassed by 1,000 people and that he was being followed by people who had been waiting outside his house. He refused to give any names of the people concerned. He also insisted on signing the Sex Offenders Register. He was told that he wasn't a subject on the register therefore could not sign it. He then told officers that he believed people were going to accuse him of a crime and they were trying to put him on the register. Daniel also stated that he had been sent indecent images – an allegation that had previously been recorded by the Police. He then informed officers that he had been to a police station in Essex to report having an underage girlfriend when he was younger. Daniel stated that he did not have a phone with a working sim card and was sleeping rough in Tower Hamlets. The Met Police transferred the case to Essex Police due to the fact that Daniel resided in the Essex Police area. In response, Essex Police documented that Daniel appeared to be struggling with his mental health and referred him to his GP.

3.68 After receiving an email from Essex Police advising that Daniel had presented to them with paranoid ideas and anxious behaviour, his GP made further

[22] MPS Operation Jigsaw is the Police management of Registered Sex Offenders (RSO) and involves the monitoring of notification requirements, risk management, multi-agency working, enforcement of civil orders and proactive Policing

unsuccessful attempts to contact Daniel to arrange a follow up appointment between 11th August and 21st August 2023.

3.69 On 24th August 2023 Daniel attended a DWP Commitment Review appointment after being informed that a sanction had been applied to his UC claim (Daniel's benefits were stopped from 14th to 28th August 2023). The sanction was ended at this point, subject to Daniel accepting the previously agreed commitments to prepare for and look for work.

3.70 By 29th August 2023 the fire damage at Daniel's home had been repaired and was ready to move back into. Newham Residents Services (NRS) had been struggling to make contact with Daniel between April and August 2023.

3.71 On 31st August 2023 the Job Centre contacted Daniel to remind him to accept the commitments discussed on 24th August 2023 and that his UC claim was at risk of closing if this action was not completed.

3.72 On 4th September 2023 NRS returned items from storage into Daniel's home address. After a lengthy period during which they had been unable to contact Daniel, he phoned NRS on 5th September 2023 and arrangements were made for him to collect his house keys from the hub on 8th September 2023. He was advised of the option to move into a smaller property more suited to his needs.

3.73 On 5th September 2023 the DWP issued Daniel with a Recoverable Hardship Payment to reimburse him for the reduction in benefits due to the sanction imposed previously.

3.74 On 6th September 2023 Daniel attended the Integrated Crisis Assessment Hub (ICAH) after initially presenting at the co-located PELC urgent treatment centre. He 'insisted' on speaking to a doctor. He appeared very guarded when asked why he needed to see a doctor and walked away when staff insisted on knowing why he had attended the hub. With encouragement, he returned to the hub and said that he needed to speak to a doctor so that he could sign on the Sex Offender's Register and then he would be left alone by his persecutors.

3.75 Daniel was assessed. He presented with signs of deluded thought processes, with content of a predominantly paranoid nature. He also disclosed being abused 4 years previously in a public space where he was sexually assaulted on 2 occasions. Daniel believed he was being targeted by these people who wanted him to sign the Sex Offenders Register and they were blackmailing victims to keep the abuse secret. Daniel also reported that he was being harassed in the streets and was being tormented and called a "rent boy". The impression from the assessment was that Daniel was experiencing an acute psychotic episode and a recommendation was made to admit Daniel to hospital as an informal patient due to historical and presenting risks.

3.76 A request was made for a bed to EPUT, which was discussed at a Safer Staffing, Demand and Capacity Call held during the afternoon. Minutes from the call

record that a decision was made that Daniel would be transferred to MHUCD in Basildon for face-to-face gatekeeping[23], with a 4 hour maximum wait time.

3.77 Daniel was transported to the Basildon MHUCD by ambulance and ICAH staff where he was admitted around 7pm on the same date. The following morning (Thursday 7th September 2023) Daniel was reassessed and deemed not be experiencing any delusional beliefs or abnormal perceptions and was not considered to present a risk of self-harm or suicide. He was discharged to the care of his GP, who Daniel was advised to see on Monday 11th September 2023 and his GP was to consider referring him to the local Primary Care Mental Health Nurse (PCMHN). A referral was made to HARP (Homeless Action Research Project). Daniel was also provided with advice on how to access mental health support in a crisis (Contact 111 option 2, emergency services via 999, Samaritans). Daniel advised the MHUCD that he had a DWP appointment that day and planned to collect the keys to his home address from the council the following day. He was provided with a bus and a train pass.

3.78 Later that day (7th September 2023) Daniel attended a DWP Work Search Review when he stated that he had been offered a council property in Brentwood and was picking the keys up the following day. He was advised to report a change of circumstances on his UC account once he had moved in and would then need to attend a different Job Centre. Daniel did not report any change and so the DWP was unaware of whether he had moved into the Brentwood property.

3.79 On 8th September 2023 Daniel attended the hub to collect his house keys but was reluctant to take them. He enquired about a move to Southend and was advised that NRS did not have any properties there. He was advised of his options including registering for Home Swap. He said that he would speak to his sister and get back to NRS. He provided a new email address which was found not to work, when tried later.

3.80 On Monday 11th September 2023 Daniel attended an urgent in-person appointment at his GP practice. He appeared distressed with paranoid and fixed ideas about people trying to persuade him to sign the sex offenders register. An ambulance was arranged to take him to Hospital ED for urgent psychiatric review. The GP practice was not aware of the recent ICAH assessment and gatekeeping admission (Paragraphs 3.74 – 3.77). A discharge summary had been prepared but no address was added and there is no indication that it was sent.

3.81 Daniel was conveyed to the Basildon MHUCD by ambulance. The ambulance crew documented that Daniel had informed his GP that he had witnessed unknown individuals being sexually assaulted by a group of people who had also ‘scammed’ individuals out of their properties and finances and he feared he was going to be physically harmed to the point where he would be killed or placed on the Sexual Offenders Register as Daniel said that this is what they (the perpetrators) do if they

[23] EPUT: Face to face gatekeeping is the in-person assessment and screening to ascertain whether to admit a patient into hospital. The purpose is to identify the appropriate level of specialised mental health service required and ensure it is the least restrictive environment to meet the risk and care needs of the patient.

don't get paid. The GP advised the ambulance service that acute psychosis was suggested. The crew documented that Daniel was homeless and had been living on the streets. Daniel informed the crew that his council property was being refurbished and he was supposed to attend a meeting that day to arrange a future date for his house keys to be handed back to him.

3.82 When the ambulance service contacted the MHUCD to check that they would accept Daniel, they were advised that he had attended the unit the previous week for a similar issue. Following his arrival at the MHUCD, Daniel reported that people were sexually abusing him and requested to be placed on the Sexual Offenders Register. He also said that he had nowhere to stay. He was advised that mental health services were unable to convict and put people on registers. Daniel was considered not to be suffering from any acute mental illness that required admission or the use of Mental Health Act. He thanked staff for the advice and left the department.

3.83 On 13th September 2023 Daniel attended Romford Police Station and reported he was being harassed by 'loads of people' telling him he needs to be on the Sex Offenders Register. Daniel was noted to suffer from mental health issues which appeared to be 'declining'. The Met Police transferred the case to Essex Police as Daniel was documented to be an Essex resident. Daniel may also have made a similar visit to Basildon Police Station on the same date. Essex Police took no further action in respect of the information reported by Daniel and referred him to his GP.

3.84 On 17th September 2023 attended the MHUCD and reported feeling anxious whilst 'waiting for his own place to be completed'. He also spoke about feeling unsafe as people were trying to put him on the Sex Offenders Register. He denied thoughts of self-harm or active suicidal ideation. An assessment identified no acute mental illness and concluded that his presentation was due to social circumstances related stressors. Daniel was documented to have mental capacity[24] at that time to make informed choices and fully understood how to seek help in the community. Daniel left the MHUCD.

3.85 During the late evening of 17th September 2023 a member of the public referred Daniel to the Havering Rough Sleepers Team after seeing him at locations in Romford. The Rapid Response Team visited the reported locations but was unable to find Daniel.

3.86 On 21st September 2023 Daniel did not to attend a DWP Work Search Review appointment. He was requested to give reasons for missing this mandatory appointment and advised that missing an appointment without good reason could result in the loss of some or all of the UC payment. Daniel did not respond.

3.87 Between 22nd September and 2nd October 2023 the GP made further unsuccessful attempts to contact Daniel to offer further support in respect of his mental health.

[24] Mental capacity as defined by the Mental Capacity Act 2005; summary by the Social Care Institute for Excellence: https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance/

3.88 On 27th September 2023 Daniel attended Romford Police Station requesting to sign on with the Jigsaw team and be put on the Sex Offender Register. He stated he was concerned for what would happen if he wasn't placed on the Sex Offenders Register. This incident was shared with the Havering MASH due to concerns about Daniel's declining mental health. The case was then transferred to Essex Police who documented that Daniel stated that he was known by 'everyone walking down the street' and they all want him to be on the Sex Offender Register. He also said that he was known by 'half the police force' and that he could not go to his home address.

3.89 The following day (28th September 2023) Daniel self-referred to the Havering Rough Sleepers Team but the Rapid Response Team was unable to locate him.

3.90 During the early hours of 30th September 2023 the Havering Rough Sleepers Rapid Response Team attempted to locate Daniel without success.

3.91 Later that day (30th September 2023) Daniel visited the MHUCD and handed in a list of names.

3.92 The following day (1st October 2023) Daniel attended the MHUCD and reported that people were trying to put him on the Sex Offender's Register. No change in his presentation since his last visit to the MHUCD was noted and no acute mental illness was identified and so he was discharged. His GP was made aware. The GP noted that it was felt that Daniel had mental capacity.

3.93 During the late evening of the same day (1st October 2023) the Havering Rough Sleepers Team attempted to find Daniel but were unable to do. They closed the referral as there was no evidence of rough sleeping.

3.94 On 2nd October 2023 Daniel visited Basildon police station asking to be signed onto the Sex Offender Register and spoke of people working with the police to 'dismantle' his life. No further details were provided by Daniel and the matter was treated as non-crime and no further action was taken.

3.95 On 4th October 2023 Newham Residents Services (NRS) made further unsuccessful attempts to contact Daniel in an effort to ascertain whether he planned to move back into his home and when he wished to collect the keys.

3.96 On 6th October 2023 Daniel attended Romford Police Station requesting to sign on with Jigsaw team and to be put on the Sex Offender Register. He also stated that he was being told to admit to several sexual offences which he said he had not committed. He informed staff that he was the victim of abuse and stated that he had a house in Brentwood but couldn't go back there. He then informed officers that there were photos of him circulating via WhatsApp. The Met Police transferred Daniel's case to Essex Police who referred him to his GP.

3.97 Shortly after midnight on 7th October 2023 a member of the public referred Daniel to the Havering Rough Sleepers team, stating Daniel's location. The Rapid Response Outreach team visited the location but was unable to find him.

3.98 On 13th October 2023 the GP referred Daniel to the community mental health Team (CMHT) requesting that an appointment with a psychiatrist be arranged due to Daniel presenting with symptoms of depression, anxiety, suicidal thoughts, paranoid thoughts and fixed delusions. The GP took this action because they had been unable to contact Daniel to explore the ongoing concerns about hid mental health and it was hoped that Daniel may respond to the offer of a CMHT appointment.

3.99 On 14th October 2023 Daniel did not attend a DWP Commitment Review appointment. He was requested to provide reasons for not attending the mandatory appointment and advised that missing an appointment without good reason could result in losing some or all of his UC payment. Daniel did not respond and the DWP had no further contact with Daniel prior to his death.

3.100 On 15th October 2023 Daniel attended Romford Police Station requesting to sign on with the Jigsaw team and to be put on the Sex Offender Register. He added that this needed to be done otherwise he said that he would be killed in prison. He said that he had been sleeping rough but had an address for which he was to be provided with the keys. When asked why he hadn't been sleeping at this address, Daniel replied that "the ones who are causing trouble lived in Brentwood". He went on to say that he had had £150,000 in savings but had spent it all. He said that he had no thoughts of harming himself but reiterated his fear that he would be killed in prison. He later returned to retract the information he had supplied earlier. He gave no explanation for this retraction. The Met Police transferred the case to Essex Police.

3.101 On 16th October 2023 Daniel visited Romford Police Station to retract the information he had provided during previous visits without giving a reason. No further action was taken other than a GP referral.

3.102 On 16th October 2023 Daniel attended the MHUCD. He presented with suicidal thoughts with no plan or intent. Reported stressors were from people coming up to him and picking up his house keys. He added that there were people in Brentwood who were after him. However, Daniel presented as smiling and joking throughout the assessment which was not felt to be congruent with the distress he was describing. Daniel agreed to stay the night as he felt unsafe and wanted somewhere to rest. He left the MHUCD the following morning (17th October 2023). He was given a rail voucher to attend an appointment with the Council to collect the keys for his new flat.

3.103 There was no appointment arranged with NRS who served a notice on Daniel to quit his secure tenancy in Brentwood on the grounds of abandonment. Service was achieved by sending a copy of the notice to Daniel's sister who had advised NRS that she had also been unable to contact her brother.

3.104 On Wednesday 18th October 2023 the referral from Daniel's GP was passed to Essex Support and Treatment for Early Psychosis Team (ESTEP) who made attempts to call Daniel on the same day but their call went straight to voicemail and a message left. ESTEP planned to phone Daniel again the following day. They also wrote to Daniel at his former family home to offer an assessment on 26th October 2023.

3.105 During a date in mid-October 2023 Daniel visited Romford Police Station stating his uncle had stolen his house keys. He also stated that if he was not put on the Sex Offenders Register he would be killed. The Met Police transferred the case to Essex Police.

3.106 During the afternoon of the same mid-October 2023 date Daniel visited Forest Gate Police Station. He was pacing up and down and appeared distressed and anxious and was wearing inappropriate clothing for the inclement weather (T-shirt and jeans). He stated that Prince Charles and the Met Police were looking for him, adding that someone had planted drugs at his home which he said had later been raided by the Police. The Police had concerns for Daniel's mental health but, as this was Daniel's second visit to a Met Police Station that day (Paragraph 3.105), a further referral to Essex Police was not considered necessary.

3.107 During the early evening of the same day Daniel died on the railway track at a railway station in the London Borough of Havering after laying down under the rear carriage of a stationary train on which he had just travelled to the station. The train subsequently struck Daniel as it departed the station. Daniel's rucksack was later handed into Romford Police Station having been left in a nearby garden.

4.0 Family views

4.1 Daniel's sister decided not to contribute to the Safeguarding Adults Review (SAR) until the Inquest had been concluded. After the inquest was deferred to allow further information to be provided to the Coroner, including the completed SAR, Daniel's sister was approached again and asked if she wished to reconsider her decision not to contribute to the SAR until after the Inquest, as it was now planned to complete the SAR prior to the inquest. Daniel's sister decided to confirm her decision not to contribute to the SAR until after the conclusion of the inquest. Daniel's sister recently decided to contribute to the SAR. It is important to point out that there is no obligation on family members to contribute to a SAR and that family members often find discussing what happened to their loved one very distressing. Family members can also find the range of formal processes which can be triggered by the death of a loved one demanding to engage with and quite confusing.

4.2 Daniel's sister previously shared information about her brother with a report the British Transport Police (BTP) prepared for the Coroner[25]. She described Daniel as a shy introvert who was kind hearted with a good sense of humour. She said that Daniel had been struggling with undiagnosed mental health issues for around 4 years. She was unable to pinpoint a trigger for the deterioration in Daniel's mental

[25] Paragraphs 4.3 and 4.4 may need to be deleted from the SAR report as Daniel's family members shared information with the BTP for the purposes of the Inquest rather than the SAR. However, the material will remain in the version of the SAR which will be shared with the Coroner on the 'Worcestershire basis'. (The decision in Worcestershire County Council and Worcestershire Safeguarding Children Board v HM Coroner for the County of Worcestershire [2013] EWHC 1711 (QB)1, illustrates an important point. The public interest in the pursuit of a full and appropriately detailed inquest may outweigh a public interest claim for non-disclosure of a report into a death, particularly when the disclosure is to the coroner rather than to the public. Coroners should therefore expect greater disclosure to them so that they may properly assess the scope of an inquest and the witnesses to be called).

health. She said that Daniel had set fire to the family home before Christmas 2022 and that his family did not know where he had been living whilst the property was under repair. Daniel's sister said that told her that he had to give away all of his money to "the person who had been trying to take it" and had been under a great deal of stress.

4.3 Daniel's aunt and uncle also shared information with the author of the BTP report. His aunt stated that she last heard from Daniel on 17th October 2023 when he phoned her from the MHUCD (Paragraph 3.102). She also stated that Daniel had a key to her home. Daniel's uncle stated that he last saw his nephew when he visited his (the uncle's) address for food and shelter. On that occasion, his uncle described Daniel as unwell, agitated, moving around and "talking gibberish" about people that were after him. His uncle said that he thought that Daniel was having a mental health episode at that time. Daniel's uncle stated that his nephew had been "going downhill" for the previous 10 months and that prior to that he had been happy, working as a scaffolder with a good social life. He did not know what might have triggered the deterioration in Daniel's mental health.

4.4 When Daniel's sister contributed to the SAR she explained the sequence of events which she believed led to the deterioration in her brother's mental health. She said that a work colleague from the scaffolding company by which Daniel was employed for many years began spreading "nasty" rumours about Daniel after he (Daniel) refused to falsely state that the work colleague's partner and child were living in Daniel's family home. Daniel's sister believes that the work colleague's partner was living with him (the work colleague) and claiming benefits to which she may not have been entitled. Claiming that she was living at Daniel's address would have allowed his work colleague's partner to avoid the consequences of falsely claiming benefits. When Daniel refused to say that his work colleague's partner and child were living with him, Daniel's sister said that the work colleague began harassing Daniel. Daniel showed her some of the messages which the work colleague sent to Daniel. She said that the work colleague said "some terrible things" in the messages and threatened to "come after" Daniel and said that he wanted Daniel's money. His sister encouraged Daniel to report the harassment and threats to the Police but Daniel said that the Police "were in on this". She added that Daniel's belief that the Police "were in on this" was an indication that he was becoming increasingly "paranoid" as the threats and harassment escalated. He also stopped going to the pub to meet friends and became quite isolated. His sister described Daniel "as a bit of a loner" whose main social interaction had been with the friends he socialised with in the pub. Daniel's sister believed that the harassment and threats may have begun around 2020.

4.5 Daniel's sister went on to say that the work colleague became aware that when Daniel was 16 he started "going out" with a younger girl who would have been 13 or 14 when the relationship/friendship began. The younger girl was Daniel's sister's best friend and the relationship between Daniel and the younger girl lasted for several years. Daniel's sister said that the work colleague who had been harassing and threatening Daniel used Daniel's relationship with an underage girl as a means of further hounding him and it was the threats in relation to this issue which led to Daniel's preoccupation with being placed on the Sex Offender's Register.

4.6 Daniel's sister said that their mother's death had also affected Daniel's emotional health and wellbeing. Their father had not lived in the family home for several years although Daniel became involved in caring for his father towards the end of his (father's) life.

4.7 Daniel's sister said that her brother had a strong work ethic and managed to amass significant savings whilst working as a scaffolder because he was living with his mother in the family home for much of that time and so his financial outgoings were comparatively small. She said that Daniel was passionate about travel and would often travel alone to places which were on his "bucket list". She felt that Daniel's period of apparently frenetic travel between 27th March and 14th May 2023 may have been an attempt to complete his "bucket list" and may also have been an attempt to use up the last of his savings to prevent the work colleague who was threatening and harassing him from extorting money from him.

4.8 Daniel's sister felt that her brother's decision to avoid returning to Brentwood and eventually begin rough sleeping was motivated by a desire to prevent the work colleague from knowing his whereabouts and to avoid further contact from him.

4.9 When asked to comment on Daniel's contact with services during the final year of his life, his sister focussed in particular on the events of 25th to 27th June 2023 when the decision was taken to admit Daniel as an informal patient to a mental health bed, although no bed was available (Paragraph 3.56 to 3.61). She felt that her brother should have been detained under Section 136 of the Mental Health Act by the Police on that occasion. She also felt that her brother really needed to be admitted to a mental health bed at that time. She added that Daniel also realised that he needed to be admitted which was reflected in his patience in waiting for 36 hours and sleeping on "waiting room chairs", before finally giving up and leaving the hub.

5.0 Analysis

5.1 In this section of the report each of the terms of reference questions will be addressed in turn.

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.

Mental Health support

5.2 Daniel began seeking support in respect of his mental health in October 2022 when he self-referred to Basildon Mind following thoughts of self-harm (Paragraph 3.5). He also disclosed feeling low in mood since his sister and her children moved out of the family home and said that he was still grieving the loss of his parents who died in 2012 and 2016. He was unable to sustain attendance at in-person appointments and by early December 2022, he had been discharged by Basildon Mind.

5.3 Following the fire at his home address, Daniel's sister informed agencies that her brother had been experiencing severe anxiety and paranoia and she had been trying

to “get him sectioned”. She also made mention of the continuing impact of the death of his parents (Paragraph 3.15). Two days after the housefire, Daniel attended the King George Hospital where he reported a 6 month history of suicidal ideation although he said that he had no plans to end his life. He also reported feeling anxious and unable to look after himself. He said that he needed to be sectioned. He was assessed by the hospital psychiatric liaison team who felt that a GP referral to local psychological services was appropriate.

5.4 Daniel first reported concerns about his mental health to his GP in January 2023 when he presented with symptoms of anxiety and he was referred to Vitaminds (Paragraph 3.22). Daniel’s GP was unaware of his recent assessment by the King George Hospital psychiatric liaison team. No discharge letter was completed by the King George Hospital, which triggered an incident report.

5.5 This was one of several occasions when Daniel’s GP practice was not informed of mental health service assessments of, and contacts with, Daniel. His GP was not informed of:

- ICAH’s assessment of Daniel and the decision to informally admit him to a mental health bed on 25th June 2023 (Paragraph 3.58), although the Met Police’s adult protection investigation in respect of the events which led to the ICAH assessment was shared with the GP (Paragraph 3.62)
- The 2 assessments of Daniel carried out by ICAH on 6th September 2023 (Paragraphs 3.74 to 3.77). A discharge summary was prepared but no address was added and there is no indication that it was sent.

5.6 These omissions were very unfortunate. The GP practice is the repository of the majority of a patient’s contact with health services. This enables the GP to provide appropriate care for their patients including follow up in the event of hospital attendances and also allows them to become aware of any escalation in health risks to a patient. In Daniel’s case, the situation was complicated by the fact that as a resident of Brentwood in Essex he either attended or was sent to King George Hospital in Ilford (provider BHRUT, although the provider of that hospital’s psychiatric liaison team is NELFT), the Mental Health Crisis Assessment Hub at Goodmayes Hospital in Ilford (provider NELFT), the Mental Health Urgent Care Department at Basildon Hospital (provider EPUT) and Broomfield Hospital in Chelmsford (provider MSEFT). However, it is important that each of the Hospital Trusts has a reliable system for ascertaining the details of a patient’s GP practice and sending discharge summaries and assessments to the GP practice. The SAR has been advised that a potential barrier to GP notifications may be related to the different information systems in use including Rio and SystmOne.

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.

5.7 Daniel’s GP practice also advised the SAR that when they are notified of a hospital attendance the information contained within the notification often lacks

sufficient detail to assist the GP to make informed decisions about patient follow-up. In Daniel's case, his GP said that it would have been most helpful for hospital discharge summaries to include up to date contact details and a description of the action the hospital wished the GP to take. As an example, the discharge summary sent to Daniel's GP following his attendance at King George Hospital on 9th June 2023 (Paragraph 3.50) states the following:

- Recorded under 'presenting complaints or issues' is 'mental health condition'.
- No information is recorded under 'clinical narrative/note to GP/medication sent home with'.
- Recorded under 'diagnoses' is 'anxiety disorder (suspected diagnosis)'.

The discharge summary contains no further information about the anxiety and depression with which Daniel presented or any information about his denial of suicidal ideation or intent

5.8 The Royal College of Physicians provides standardised guidance on the content of discharge summaries, given their important role as a handover document to GPs. A 2022 British Medical Journal (BMJ) article (1) described a project in which an MDT was formed on an acute medical ward to address significant variations in the quality and content of discharge summaries. The aim of the project was to increase the compliance of discharge summaries with 10 core criteria from a baseline of 55% to 95%. This aim was achieved ahead of schedule and the improvement was sustained thereafter and was expanded to a second acute medical ward. A standard operating procedure was created to help embed the changes on the wards. BHRUT has advised the SAR that they will shortly be going live with a new electronic patient record (EPR) which they anticipate will significantly improve discharge documentation.

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.

5.9 Daniel's GP also asked why it wasn't possible for the hospitals Daniel attended to refer him directly to the services he was considered to need rather than requesting his GP to make the referral. The hospital trusts represented on the SAR Panel felt that a barrier to doing this was that Daniel often presented at "out of area" hospitals. Another reason the hospital might prefer the GP to make the referral could be that the GP would be expected to know the patient much better than the hospital and would be in a better position to make a referral which was likely to meet the patient's needs.

5.10 When Daniel first reported concerns about his mental health to his GP in January 2023, the GP started Daniel on Citalopram but he decided not to take it, preferring to try therapy first. Daniel's GP also referred him to Vitaminds (Paragraph 3.22). After an initial assessment Daniel felt unable to engage with Vitaminds and was discharged back to the care of his GP (Paragraph 3.25). Vitaminds had referred Daniel to the Crisis Response Service (CRS) as they (Vitaminds) felt that they may be unable to provide the urgent risk support that Daniel appeared to need at that

time. The CRS referred Daniel to Crisis Sanctuary. Daniel was briefly supported by Crisis Sanctuary (23rd January to 7th February 2023) after disclosing anxiety and low mood for the past year, hearing voices, experiencing paranoia and having regular thoughts of overdosing (Paragraph 3.23). The Crisis Sanctuary outreach worker struggled to achieve meaningful engagement with Daniel. However, the period during which he felt unable to engage with both Vitaminds and the Crisis Sanctuary appeared to be a difficult period for Daniel when he may have been temporarily residing in hotel accommodation in Barking following the fire at his home. When Daniel later may have been trying to re-connect with the Crisis Support Service, the details of his call was not recorded (Paragraph 3.34).

5.11 Between 3rd March and 9th June 2023 Daniel sought no support in respect of his mental health. During this period Daniel undertook an intense period of international travel (27th March to 14th May 2023).

5.12 Between 9th June 2023 and his death in October 2023, Daniel (or his sister on his behalf) sought support in respect of his mental health on the following 10 occasions:

- On 9th June 2023 Daniel left the King George Hospital ED before an assessment could be completed after initially reporting feeling anxious and depressed (Paragraph 3.50).

- On 22nd June 2023 his GP referred Daniel for an urgent psychiatric assessment at Basildon Mental Health Urgent Care Department (MHUCD) after reporting paranoid thoughts and said he had come close to hanging himself the previous day. He was assessed as having no acute mental health issues and discharged after staying overnight in the MHUCD (Paragraphs 3.53 to 3.55)

- On 25th June 2023 the Met Police conveyed Daniel to the Integrated Crisis Assessment Hub (ICAH) at Goodmayes Hospital after his sister became concerned that he intended to hang himself. Daniel agreed to an informal admission to a mental health bed due to presenting with low mood, anxiety, paranoid ideation and suicidal thoughts, but efforts to find a bed for Daniel were unsuccessful. Whilst the search for a bed continued Daniel spent around 30 hours with his belongings in the Integrated Crisis Assessment Hub before leaving. This seems likely to have been a very stressful period for Daniel and his sister and it seems probable that the lengthy and ultimately unsuccessful wait for a bed may have exacerbated the issues with which he had been presenting with at the time of his arrival at the Hub (Paragraphs 3.56 to 3.61). Additionally, the response to his departure from the Hub does not appear to have been commensurate with the risks Daniel faced. The Hub reported him missing but after the Police managed to contact him by phone and conclude that he was safe and well, the Met Police created an adult protection investigation which was shared with Essex Police who referred Daniel to his GP. This was a missed opportunity for a multi-agency discussion and consideration of a safeguarding referral.

- On 6th September 2023 Daniel was assessed at the ICAH and he was considered to be experiencing an acute psychotic episode and a recommendation was made to admit Daniel to a mental health bed as an informal patient due to historical and presenting risks. After a bed was requested, it was decided to transfer Daniel to the Basildon MHUCD in Basildon for face-to-face gatekeeping. This decision was informed by the view that the Basildon MHUCD was familiar with the support available to Daniel in his local area. Daniel spent the night in the MHUCD before being reassessed and deemed not be experiencing any delusional beliefs or abnormal perceptions and was discharged. This further assessment in the Basildon MHUCD was unnecessary as Daniel had already been assessed by an ICAH consultant. Furthermore, the further assessment was not informed by the earlier ICAH assessment and so vital information from the first assessment (the acute apparently delusional aspects of Daniel's presentation) was overlooked (Paragraphs 3.74 to 3.77).

- Three days later (11th September 2023) his GP referred Daniel for an urgent psychiatric review on the grounds that acute psychosis was suggested. He was assessed at Basildon MHUCD and was considered not to be suffering from any acute mental illness that required admission or the use of Mental Health Act (Paragraphs 3.80 to 3.82).

- Six days later (17th September 2023) Daniel attended the Basildon MHUCD reporting anxiety and exhibiting signs of paranoia. An assessment identified no acute mental illness and concluded that his presentation was due to social circumstances related stressors (Paragraph 3.84).

- On 30th September 2023 Daniel visited the Basildon MHUCD and handed in a list of names (Paragraph 3.91).

- The following day (1st October 2023) Daniel again attended the MHUCD exhibiting signs of paranoia. No change in his presentation since his last visit to the MHUCD was noted and no acute mental illness was identified and so he was discharged (Paragraph 3.92).

- On 13th October 2023 his GP referred Daniel to the CMHT requesting an appointment with a psychiatrist due to Daniel presenting with symptoms of depression, anxiety, suicidal thoughts (Paragraph 3.98). Essex Support and Treatment for Early Psychosis Team (ESTEP) were unable to contact Daniel by phone and wrote to offer him an assessment (Paragraph 3.104).

- Two days prior to his death (16th October 2023) Daniel attended the MHUCD. He presented with suicidal thoughts with no plan or intent. It would appear that no assessment was carried out but Daniel agreed to stay the night as he felt unsafe and wanted somewhere to rest. He left the MHUCD the following morning (Paragraph 3.102).

5.13 There were 2 occasions when a decision was taken to admit Daniel to a mental health bed. On the first occasion (25th June 2023) efforts to find a bed for Daniel were unsuccessful. A lack of availability of beds appeared to be a barrier as at one

point in the protracted bed search, a prospective bed was identified for Daniel but this was dependent on the older patient occupying a working age bed being transferred to an older adult bed. However, this bed transfer did not take place and so the working age bed did not become available for Daniel (Paragraph 3.60). Another barrier appeared to be EPUT bed management's reluctance to admit an informal patient (Daniel had agreed to an informal admission) to a private bed. EPUT relented and initially agreed that Daniel could be admitted to a private bed with providers they used (Paragraph 3.59) but later refused to authorise a private bed which had been found for Daniel (Paragraph 3.60).

5.14 High demand for mental health beds is a national issue. A 2024 Kings Fund report *Mental Health 360: acute mental health care for adults* (2) found that with the exception of the Covid-19 period, when many beds were closed due to infection control, the current numbers of mental health beds (17,836) were at their lowest level since data collection began in 2010/11. As a consequence, the report found that people who need to be admitted can face considerable delays in A&E whilst they wait for an available bed, or may be cared for in inappropriate environments, such as being admitted to a ward in an acute trust.

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.

5.15 The second decision to admit Daniel to a mental health bed (6th September 2023) was taken by an ICAH consultant at Goodmayes Hospital but then reversed when Daniel was subsequently reassessed at the Basildon MHUCD to which he had been transferred for face-to-face gatekeeping. This reassessment was unnecessary and was not informed by the ICAH consultant's initial assessment. EPUT conducted a review of the care they provide to Daniel which has been shared with the SAR. The EPUT review identified learning arising from the management of Daniel's transfer of care from Goodmayes ICAH to Basildon MHUCD including information sharing between NHS Trusts who have different electronic patient record (EPR) systems.

5.16 The EPUT review also found that not all of Daniel's attendances at the Basildon MHUCD, several of which took place out of hours, were booked in. At the time that Daniel was attending the Basildon MHUCD there was no senior band 7 cover out of hours due to an unfilled vacancy. As a result junior staff making decisions in respect of Daniel's complex presentation did not receive the support they needed. The EPUT review also concluded that a mental health hospital admission would have improved the chances of successful treatment due to Daniel's homelessness. The EPUT review also drew attention to missed opportunities to start Daniel on antipsychotic medication and refer him to ESTEP.

5.17 The EPUT review resulted in a Safety Action Plan which addressed the following learning themes:

Learning Theme 1:
Sharing of information between different Trust/Services which are using different EPR Systems
Actions:

- SMART bed management system[26] was implemented in August 2024 to support the bed management process. SMART provides information for the twice daily bed management calls.
- Clinical documentation is being sent to the MHUCD shared mail box by the EPUT bed management team.

Learning Theme 2:
Improve governance to ensure all patients are placed on the system for all contacts with the service including informal contact out of hours.
Action:

- Clinical leads no longer complete triage or assessments (unless all other clinicians have been exhausted) in order to allow them the capacity to maintain oversight of the department, including time taken to complete triage from time of arrival. It is hoped to develop this as a tracked key performance indicator.

Learning Theme 3:
Staff training regarding psychosis symptoms and developing professional curiosity regarding complex presenting needs, past history and repeat attendances.
Action:

- Both competency and scenario based training are under development.
- Continued professional development to be discussed in 1:1 support. Clinical documentation to be reviewed during 1:1 support.

Learning Theme 4:
Urgent Care Department – awareness of service specification by all staff undertaking on-call role.
Actions:

- MHUCD Operational Policy shared with all staff undertaking on-call role.
- Professionals meetings held for frequent attenders when identified across the pathway to consider service response and escalation where appropriate.

Learning Theme 5:
Care pathways for homeless patients
Action:

- Review Trust homelessness pathway and ensure the pathway is understood.

5.18 Unfortunately NELFT was not invited to contribute to the EPUT review. This was a missed opportunity given that NELFT worked closely with EPUT to try and

[26] SMART is a browser-based system that collects bed capacity and patient flow data across acute, mental health and maternity care settings. It is currently in use by NHS trusts in London and East of England. It was developed in collaboration with healthcare providers and provides a system-wide overview of operational pressures, enabling healthcare system partners to deliver an improved patient journey.

identify a bed for Daniel in June 2023 and NELFT is the provider of the hub at which Daniel was assessed by ICAH before transfer to EPUT in September 2023. NELFT decided to conduct an After Action Review (AAR) which also involved EPUT. The Action After Review made 2 recommendations and developed an action plan to implement the recommendations. The recommendations and actions are summarised below:

NELFT Recommendation 1:
Sharing of crisis and admission pathways between EPUT and NELFT.
Action:
MHUCD Manager has share updated EPUT admission pathway with ICAH Clinical Leads to assist teams from external Trusts to identify who best to refer to and consider information about the patient based on the pathway.

NELFT Recommendation 2:
Follow up of patients who are reported missing to the police to ensure their safety and wellbeing.
Action:
ICAH Clinical Leads to ensure that all missing persons reports are followed up so that any further action can be considered and documented. A process has been outlined to monitor and record follow up.

5.19 The EPUT and NELFT action plans represent a substantial response to the learning derived from their reviews of the care and treatment provided to Daniel. The EPUT action plan appears to be largely complete – with the exception of staff training – whilst the NELFT action plan commenced more recently. The action plans provide a fairly high degree of assurance that the learning EPUT and NELFT have derived from their reviews has, or is, being actioned. It is assumed that the steps taken by EPUT to improve bed management will be covered in their response to Daniel SAR recommendation 2. However, EPUT's staff training programme has not yet progressed from development to delivery and NELFT's action plan commenced only in February 2025.

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.

5.20 Use of the Mental Health Act was considered on 2 occasions (Paragraphs 3.56 and 3.82). On 25th June 2023 the Met Police were initially minded to detain Daniel under Section 136 of the Mental Health Act but decided against this after receiving advice from the Mental Health Direct Team. Daniel was then taken on a voluntary basis to ICAH. On 11th September 2023 the MHUCD assessed Daniel as not to be suffering from any acute mental illness that required admission or the use of Mental Health Act. No 'nearest relative' request for a Mental Health Act assessment[27] was

[27] https://www.gov.uk/government/publications/information-for-nearest-relatives-mental-health-tribunal-t117/information-for-nearest-relatives

made by Daniel's sister. However, when she made a Patient Advice and Liaison Service (PALS)[28] complaint to EPUT about the length of time Daniel waited for an admission to a mental health bed, Daniel's sister sought advice on "where she stood" should she feel that her brother needed a Mental Health Act assessment in the future. In response EPUT provided her with advice which included the contact details of the Approved Mental Health Practitioner (AMHP) Hub should she wish to request a Mental Health Act assessment for her brother.

5.21 There is no indication that Daniel's mental capacity was formally assessed. He was documented to have mental capacity when assessed in the MHUCD on 17th September 2023 (Paragraph 3.84) and felt to have mental capacity when he attended the MHUCD on 1st October 2023 (Paragraph 3.92). When assessed as experiencing an acute psychotic episode in the ICAH on 6th September 2023 (Paragraphs 3.74 and 3.75) Daniel's mental capacity was questioned but does not appear to have been formally assessed.

Professional response to Daniel's apparent 'delusional beliefs'

5.22 Agencies first became aware of Daniel's preoccupation with being placed on the Sex Offender's Register when he contacted Essex Police on 25th April 2023 to report the activities of a local paedophile ring who he said were sending teenage and animal pornography to people who they subsequently blackmailed (Paragraph 3.42). He began requesting to be placed on the Sex Offender's Register again from his GP appointment on 22nd June 2023 (Paragraph 3.53) and this then became a constant element of his presentation at police stations and during mental health assessments until his death 4 months later.

5.23 Varied reasons for being placed on the Sex Offenders Register were given by Daniel. He reported beginning a 5 year sexual relationship with a child in 2004 when Daniel would have been a child himself (aged 16 or 17) (Paragraph 3.65). The child was described by Daniel as an 'underage girlfriend' on a later occasion. At other times he reported accusations and harassment by others who were trying to put him on, or persuade him to sign, the Sex Offenders Register. On other occasions he appeared to believe that being put on the Sex Offenders Register would afford him a degree of protection from his persecutors. He began to express fear of death from his persecutors if he didn't pay them or wasn't placed on the Sex Offenders Register (Paragraphs 3.81, 3.100 and 3.105). This seemed to be an escalation in his apparent delusional beliefs which is apparent in hindsight but may have been challenging for any of the range of professionals he was in contact with to have noticed at the time.

5.24 His preoccupation with being placed on the Sex Offenders Register appeared to be linked to staying away from his home address, saying that "the ones who are causing trouble live in Brentwood" (Paragraph 3.100).

[28] PALS provides help in many ways. For example, it can help patients, their families or their carers with health-related questions**,** help resolve concerns or problems when they're using the NHS, tell them how to get more involved in their own healthcare and can give information about the NHS complaints procedure, including how to get independent help if a patient want to make a complaint.

5.25 Both the Met Police and Essex Police reached the conclusion that Daniel's reasons for wanting to be placed on the Sex Offender Register were not grounded in fact based on Daniel's difficulty in providing tangible evidence to support his concerns, together with investigative effort and intelligence checks which did not substantiate Daniel's concerns. However, Daniel shared a list of names with the MHUCD (Paragraph 3.91). There is no indication that this list of names was shared with the Police.

5.26 The settled view of health professionals he spoke to about these matters was that Daniel was experiencing paranoid thoughts and fixed delusions. It would have been challenging for professionals to fully explore his wish to be placed on the Sex Offenders Register with him given the range of explanations he gave for wanting this to happen. He may also have feared the repercussions of identifying the work colleague his sister believes was the instigator of harassment and threats. Daniel's sister has also explained to the SAR that her brother began to believe that "everyone" was involved in the harassment and threats he was experiencing including agencies and family members. However, as well as disclosing an underage sexual relationship, he also disclosed being the victim or sexual abuse 4 years earlier (Paragraph 3.75) which appeared to correspond with a sexual assault he reported to Essex Police (Paragraph 3.3) and said that he was being called a 'rent boy'. He disclosed downloading teenage and animal related pornography. Daniel is not believed to have been in an intimate relationship during the period in which his mental health was deteriorating. His sexuality does not appear to have been explored nor apparently were his feelings about the underage relationship or being the victim of a sexual assault. Had he been offered treatment for his apparent delusional beliefs it may have been possible to explore his feelings, particularly feelings of shame or guilt (he appeared to be distressed by people spreading rumours that he was a paedophile) which may have helped to put his paranoid and apparent delusional beliefs into context. A Mental Capacity Act assessment may have assisted professionals to form a view about whether what Daniel was reporting was real or imaginary.

5.27 However, the question also arises of whether Daniel may have been in fear of a tangible threat. With the benefit of hindsight there are indications that the fears that he expressed to professionals from a range of disciplines may not have been completely groundless. Daniel's sister's account has shed much light on the origin of the fears Daniel expressed to professionals (Paragraphs 4.4 to 4.9).

5.28 With hindsight, the fire at Daniel's home address on 22nd December 2022 appears to have been a more significant event than may have been apparent at the time, as following the fire Daniel appeared very reluctant to return to Brentwood. Essex FRS concluded that the cause of the fire was accidental, but they reached this conclusion without apparently being aware that Daniel had 'been going through some mental health issues' at the time (Paragraph 3.9) and that his sister had been trying to 'get him sectioned' (Paragraph 3.11). Daniel was not present in his address at the time of FRS attendance, but it seems possible that Daniel's mental state may have been a factor which contributed to the ignition of the fire. In her contribution to the BTP report to the Coroner, Daniel's sister stated that her brother set fire to the family home (Paragraph 4.3). Essex FRS have advised the SAR that all fires are

followed up with an After Incident Response and in the event of an absent occupant, the FRS would hand over to a relevant person such as the landlord in this case. Essex FRS have also advised that they appoint Fire Investigation Officers to investigate fires in domestic properties where the cause of the fire cannot be immediately determined. The FRS have also advised that they were not previously made aware of Daniel's vulnerabilities. They added that if they had been made aware of any vulnerabilities, a Safe and Well visit or a Safeguarding Officer visit could have been actioned and if safeguarding concerns arose they would refer to "social care" if the threshold assessment was met.

5.29 It is clear that after the fire at his home, Daniel appears to have been very reluctant to return to Brentwood in that he did not stay in the decant property provided for him despite apparently having no alternative accommodation and apparently sleeping in cemeteries and on the streets for several months. Nor did Daniel accept the keys to his property after the post-fire repair work had been completed.

5.30 It is not known why Daniel was so reluctant to return to Brentwood. He may have associated his home with the life he spent with his parents, whose deaths appeared to have affected him so deeply. He may have been in fear of people in Brentwood who he believed, with or without justification, could harm him. He stated or implied this during his contact with professionals on at least 2 occasions. Daniel's sister has advised the SAR of the reasons why Daniel may have been reluctant to return to Brentwood and began rough sleeping (Paragraphs 4.4 to 4.9).

5.31 Daniel's pattern of international travel raises further questions, although agencies in contact with Daniel would not have been aware of this issue at the time other than when Essex Police established that Daniel was in Colombia after his sister reported him missing (Paragraph 3.19). From the information provided by the Border Force, it is clear that prior to the deterioration in his mental health Daniel flew regularly to holiday destinations such as Malaga, Lanzarote, Ibiza and several cities including Milan (3 times since 2015), Rome (twice since 2015), Berlin, Budapest, Lisbon, Madrid, Paris, Venice and Katowice. He also flew further afield to the destinations of Cancun and Beirut.

5.32 However, the pattern of Daniel's international travel during the final 12 months of his life raises questions. There were 2 outbound journeys with no corresponding return flights – London Heathrow to Madrid on 19th December 2022 and Dover to Calais on 6th April 2023. There is 1 return journey with no corresponding outbound journey – Helsinki to Heathrow on 23rd April 2023. On 11th April 2023 Daniel flew from London Heathrow to Sau Paulo, Brazil and returned via Lisbon on 13th April 2023 which suggests that Daniel may not have entered Brazil or may have been refused entry.

5.33 As previously stated, during the period under review, Daniel flew to Colombia and Brazil. Whilst he had travelled to South America before (Cancun), these two trips do not fit neatly into his previous international travel history.

5.34 Finally, there is what appears to be a frenetic period of international travel between 27th March and 14th May 2023, a period during which Daniel appears to

have become increasingly mentally unwell. During this 7 week period he travelled to France twice, Sao Paulo, Brazil returning via Lisbon, Helsinki twice, Pescara in Italy and Bergen in Norway. Developing a hypothesis which might explain this pattern of international travel is challenging. It may have been a reflection on his mental state, it might have been a final burst of travel before his money ran out as he did not travel abroad after this period and applied for benefits for the first time shortly after his return to the UK. When he attended Romford Police Station 3 days prior to his death he said he had had £150,000 in savings and had spent it all (Paragraph 3.100). It has not been possible to verify this information. His pattern of international travel may be indicative of some form of exploitation, although no hard evidence of exploitation has been shared with the SAR. However, Daniel's persistently expressed wish to be placed on the Sex Offender Register could be construed as an action, if accomplished, 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. However, his sister has advised the SAR that in her view Daniel's apparently frenetic international travel reflected his wish to complete his "bucket list" and may also have been an attempt to spend all of his savings to prevent the work colleague who had been subjecting him to threats and harassment from financially extorting him (Paragraph 4.7).

5.35 The Border Force was asked for possible explanations of the missing records of outbound and return journeys. The Border Force was also asked whether Daniel was refused entry to Brazil in April 2023, whether the authorities at Heathrow would have been advised of any denial of entry and whether they would have interviewed him on his return to Heathrow. The Border Force was also asked to comment on whether there is anything about the pattern of travel from December 2022 onwards which might suggest that Daniel was being exploited in any way and may therefore have been pressurised into undertaking some of these journeys. The Border Force has advised that Home Office Intelligence (which provides intelligence to the Border Force to identify and prevent potential threats at the UK border) held no intelligence on Daniel. Therefore it can be concluded that the Border Force were unaware of Daniel's mental health issues and his international travel raised no concerns with them. It should be noted that the SAR is not an investigation into Daniel's death and no agency in contact with Daniel was aware of his international travel other than Essex Police's knowledge of his trip to Colombia in January 2023.

5.36 There is no indication that any professional who came into contact with Daniel over the final 12 months of his life 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 (3) sets out signs to look out for. Several of these 'signs' were apparent to an extent in Daniel's case: (Signs to look for in italics; extent to which these signs were apparent in Daniel's case in standard type)

- *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 following the housefire and after leaving the ICAH hub on 27th June 2023. He constantly travelled around Essex and the London Boroughs of 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).

- *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 sister, aunt, uncle 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 on 21st May 2023 (Paragraph 3.46). He provided lists of names of the people he said he was in fear of on 2 occasions).

- *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 family 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 (Paragraph 3.12). A Police deployment to that incident may have clarified whether the threat to Daniel was real or imaginary).

5.37 Safeguarding Adults Boards across England and Wales have been developing policies, processes and training to support professionals to recognise and respond to

indications that a vulnerable adult may be at risk of criminal exploitation including cuckooing.

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.

Safeguarding contacts and referrals

5.38 Two safeguarding contacts were raised in respect of Daniel (Paragraphs 3.4 and 3.15). The first contact was made to Essex Adult Social Care by Daniel's GP practice in July 2022. The GP practice raised a concern for Daniel's mental welfare after receiving a referral from Essex Police who had been notified by the Met Police of concern that Daniel may be suffering from anxiety or paranoia. Adult Social Care closed the contact after they wrote to Daniel to request him to contact them but received no reply (Paragraph 3.4). The second contact was raised with Essex Adult Social Care by Newham Residents Services in December 2022 following the fire at his home. Three working days later Adult Social Care closed the contact as they were unable to assess Daniel's needs as his whereabouts were unknown (Paragraphs 3.15 and 3.18). A safeguarding referral may also have been made by King George Hospital or the hospital psychiatric liaison team on 24th December 2022, although the emphasis of the referral appears to have been on 'ongoing support' rather than a specific safeguarding concern and it not known where this referral was sent to, or what the outcome was (Paragraph 3.16). Essex Adult Social Care has no record of receiving any communication relating to Daniel's attendance at King George Hospital on that occasion.

5.39 There were several missed opportunities to consider safeguarding referrals: Essex Fire and Rescue service could have considered a safeguarding referral following the fire at Daniel's home; ICAH could have considered a safeguarding referral after Daniel left the hub after attempts to admit him to a mental health bed had not succeeded. The Met Police had initially considered detaining Daniel under Section 136 of the Mental Health Act and he then spent around 30 hours in the Integrated Care Assessment Hub and left without any intervention other than an assessment which concluded that he needed an informal admission; Essex Police received at least 4 concerns in relation to Daniel's mental health which they referred to his GP (Paragraphs 3.62, 3.67, 3.83 and 3.96). On receipt of the referrals the GP practice would then struggle to contact Daniel despite persistent attempts. There was no feedback loop from the GP practice to Essex Police[29]. If there had been, Essex Police would have become aware that referring Daniel to his GP was an ineffective response and may have considered a referral to Essex Adult Social Care. Essex Police could also have considered a referral to Essex Adult Social Care on the grounds of repeated referrals which indicated that things were not improving for

[29] Essex Police advised the SAR that a feedback loop would not have been appropriate, as further action in relation to Daniel's mental health would not have been within their legal powers in the absence of consent or safeguarding thresholds being met.

Daniel. The SAR has been advised that there is no multi-agency safeguarding hub (MASH) in Essex.

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.

5.40 No multi-agency MDT meetings were held or apparently considered during the period under review. Daniel's GP practice has advised the SAR they now hold complex patient multi-disciplinary team (MDT) meetings at which adult patients about whom there are safeguarding concerns may be discussed. Complex patient MDTs were not held by Daniel's GP practice during the period when concerns about his mental health and wellbeing began to escalate. The SAR has been advised by Mid and South Essex Integrated Care Board (ICB) that whilst complex patient MDT meetings are considered good practice, they are not standard practice or included in contracts with GP practices in Mid and South Essex. The SAR has been advised that complex patient MDTs are also held by GP practices in Havering although it is not clear whether this is standard practice.

Recommendation 7

That Havering and Essex Safeguarding Adults Boards requests NHS North East London Integrated Care Board (ICB) (Havering) and 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.

Daniel's lived experience

5.41 Daniel's sister described her brother as a shy introvert who was kind hearted with a good sense of humour. She said that Daniel had been struggling with undiagnosed mental health issues for around 4 years. A trigger may have been the deaths of his mother and the subsequent departure of his sister and her children from the family home. His sister appears to have been an important person in his life but she struggled to maintain contact with him over the final year of his life. Daniel was also in intermittent contact with an aunt and uncle.

5.42 As he became increasingly mentally unwell and appeared to decide that rough sleeping was preferable to staying in the decant property in Brentwood, Daniel's help-seeking behaviours appeared to consist of a great deal of travelling within Essex and the London Boroughs of Havering, Ilford and Redbridge. He may have travelled by train. He became a familiar presence at Police Stations, urgent treatment centres, A & E departments and mental health units. A member of the counter staff at Romford Police Station remembered him well because he visited the station so often, sometimes several times in a day. She described Daniel as "polite and intelligent." She said that he looked "typically homeless" but not unkempt. She recalled that he rough slept at the Romford Baptist Church on the opposite side of

the road to the Police Station. He carried a rucksack which he sometimes left with the counter staff. She said that he looked “scared” and that she had a feeling “that something was going on”. She added that Daniel would say that he was wealthy but she never saw him with any money. Daniel also visited the Basildon MHUCD frequently. He usually arrived out of hours and would often leave the unit without being seen after saying “hello” to staff that he knew.

5.43 Basildon Mind noted that Daniel struggled to talk during sessions. There were long silences and he said that he was shy and found it difficult to open up. However, Basildon MHUCD staff often found his presentation incongruent (smiling and joking through one assessment) which may have prevented staff fully appreciating the acuteness of his mental illness.

5.44 It seems likely that Daniel may eventually have become exhausted and frustrated that his frequent attempts to seek help achieved so little.

5.45 Through the contribution of his sister to this review, the SAR has become aware that Daniel had been put in fear from what appears to have been a longstanding campaign of harassment and threats from a former work colleague (Paragraphs 4.4 to 4.9).

Identify learning from this Safeguarding Adults Review to share with Public Health in Essex and the London Boroughs of Havering and Newham, in order to inform their suicide prevention programmes.

5.46 Daniel first disclosed thoughts of self-harm (to Basildon Mind) in October 2023 (Paragraph 3.5) although during the appointments he attended with the service later the same month, he said that he was “feeling better”.

5.47 Daniel first reported a history of suicidal ideation when he attended King George Hospital on 24th December 2022 (Paragraph 3.16). On that occasion he said he had no plans to end his life. Following assessment by the hospital psychiatric liaison team the plan was to discharge him to his GP for referral to local psychological services but the discharge letter was not completed (Paragraph 3.22).

5.48 During January 2023 Daniel disclosed fleeting thoughts about “taking tablets and better off not being there” to Vitaminds, adding that he felt he may be unable to keep himself safe whilst waiting to access their service. Because Vitaminds are not commissioned or resourced to provide urgent risk support, they referred Daniel to the Crisis Response Service, to whom he disclosed that he was having thoughts of overdosing once or twice a week and experiencing paranoia but denied any current suicidal intent (Paragraph 3.23). He was then supported by the Crisis Sanctuary and also referred back to Vitaminds.

5.49 During March 2023 Daniel reported suicidal thoughts at the PELC urgent treatment centre at Harold Wood but the examination documented that Daniel did not have harmful thoughts or any intent to harm himself or others, which seemed to contradict his reported suicidal thoughts (Paragraph 3.33).

5.50 On 22nd June 2023 Daniel reported that he had come close to hanging himself the previous day to his GP and to Basildon MHUCD (Paragraphs 3.53 and 3.55). He said he had been experiencing suicidal thoughts and contemplating hanging himself. Despite these disclosures, Daniel was assessed as presenting with a low risk of suicide and deliberate self-harm. Once again the assessment appeared to downplay the risk of suicide.

5.51 Three days later (25th June 2023) Daniel appeared to be actively contemplating taking his own life by hanging as he was in possession of a rope and his sister feared that he may use the rope to hang himself (Paragraph 3.56). However, Daniel appears to have made contradictory comments about ending his life to the Met Police and ICAH although suicidal thoughts was one of the grounds on which it was decided to informally admit him to a mental health bed (Paragraph 3.58). As previously stated, no bed could be found for Daniel and so he received no support in respect of his suicidal thoughts.

5.52 On 16th October 2023 Daniel attended the MHUCD and reported suicidal thoughts with no plan or intent (Paragraph 3.102). He presented as smiling and joking throughout the assessment which may have masked the distress he was describing.

5.53 The general approach to assessing suicide risk apparent in Daniel's case is challenged by *Staying Safe from Suicide* (4), NHS England's April 2025 best practice guidance for safety assessment, formulation and management. *Staying Safe from Suicide* urges a shift away from the use of static risk stratification (e.g. low, medium or high risk) often based on simplistic questions because suicidal impulses are highly changeable and can shift in minutes. *Staying Safe from Suicide* notes that 17 people die by suicide each day in the UK. Of those 5 are in contact with mental health services and 4 of those 5 (80%) are assessed as low or no risk of suicide at their last contact. Daniel was assessed as low risk of suicide on 1 occasion (Paragraph 3.55) and no risk of suicide on 5 occasions (Paragraphs 3.16, 3.23, 3.25, 3.100 and 3.102).

5.54 Instead, *Staying Safe from Suicide* promotes a more holistic, person centred approach in which practitioners explore risks collaboratively, understand changeable safety factors and co-produce safety plans. Under this approach assessments would have been focussed on Daniel's complex physical, emotional and social needs and strengths and then consideration given to how to support his immediate and long-term psychological and physical safety.

5.55 In Daniel's case a *Staying Safe from Suicide* approach would have focussed on building a trusting relationship with him (although he presented to a range of different services, he became well known to staff at Basildon MHUCD); involve trusted others such as Daniel's sister; adopt an inclusive approach, which is particularly relevant to high risk groups including rough sleepers such as Daniel; and regular review and refinement of safety planning rather than the reactive approach to crises evident in Daniel's case.

5.56 *Staying Safe from Suicide also 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%) (5)

- 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 he 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.

5.57 It is unclear whether the known antecedents of suicide informed professionals responses to his suicidal ideation and attempts to end his life.

5.58 NHS England set out detailed guidance for implementing *Staying Safe from Suicide* covering leadership and strategy, training and practitioner support, systems and tools and monitoring and learning.

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).

5.59 There is no indication that Daniel ever shared thoughts or plans of taking his life on the railway. Suicide accounts for most fatalities on the railways in Great Britain. There were 290 public and passenger fatalities in 2022/23, of which 265 were suicide or suspected suicide fatalities (6). Network Rail works to reduce rail suicide along with the wider rail industry, BTP, national agencies such as Public Health England, and charities such as the Samaritans, Chasing the Stigma and Shout. Train operators are required to each have a suicide prevention plan as a condition of their

franchise contract with the Department for Transport. British Transport Police reported that their officers made 2,242 life-saving interventions (over 40 per week) during the financial year 2023/24 (7).

5.60 A post incident site review was conducted following Daniel's death which considered mid track fencing[30] and undertrack signage[31]as possible prevention measures although there are no current plans to implement these measures. There are no physical barriers to prevent people from gaining access to the track as passengers need to be able to access the train stopping at the station. Additionally, not all stations are staffed and so it is not uncommon for no staff to be present at a station. At many stations the train is dispatched by the train manager on board the stopping train who is responsible for the safe entry and exit of passengers from the service. Dispatch platform staff are usually only seen at major interchange stations.

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.

In Daniel's situation, what would best practice have looked like?

5.61 To address this question the SAR has drawn upon the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) which has collected in-depth information on all suicides in the UK since 1996. NCISH recommendations have improved patient safety in mental health settings and reduced patient suicide rates, contributing to an overall reduction in suicide in the UK (8).

5.62 NCISH has developed the following list of 10 key elements for safer care for patients which have been shown to reduce suicide rates.

- Safer wards
- Early follow up on discharge
- No out-of-area admissions
- 24- hour crisis resolution/home treatment teams
- Family involvement
- Guidance on depression
- Personalised risk management

[30] Mid Platform Fencing limits or block access to the fast lanes.

[31] Undertrack signage is deployed at some stations and is positioned just under the platform edge and can be seen from the opposite platform saying "keep off track".

- Outreach teams
- Low staff turnover
- Reducing alcohol and drug misuse

5.63 Of the 10 elements, the following are relevant to the care of Daniel:

- **24-hour crisis resolution/home treatment teams:** CRHTs provide intensive support in the community to patients who are experiencing crisis as an alternative to in-patient care. (As the search for a mental health bed to which to admit Daniel was proving unsuccessful in June 2023, EPUT West Essex Home Treatment Team advised they would be unable to support Daniel in the community due to him being homeless).

- **Family involvement.** NCISH recommends that staff should make it easier for families to pass on concerns about suicide risk and be prepared to share their own concerns to ensure that there is a better understanding of the patient's history and what is important to them in terms of their recovery and may support better compliance with treatment. (The EPUT review noted that Daniel informed staff during assessments that there was no family involvement and that the MHUCD team's first knowledge of Daniel having family involvement was when they attended the MHUCD following Daniel's death to ask about his contact with services). The importance of family involvement to ensure there is a better understanding of family history is further emphasised by the account that Daniel's sister has shared with this SAR.

- **Personalised risk management**. NCISH recommends that all patient's management plans should be based on the assessment of individual risk and not on the completion of a checklist. Patients should have the opportunity to discuss specific stresses in their life and anniversaries and dates that are important to them. Families and carers should have as much involvement as possible in the assessment process, including the opportunity to express their views on potential risk. Consulting with the patient's GP may also be helpful (Daniel's family played no part in the assessment of risk to Daniel. There is no indication that his mental capacity was formally assessed. There is no indication that Daniel's GP was consulted when mental health services assessments and, as stated, his GP was often not advised of involvement with mental health services or assessments shared).

- **Outreach teams:** Community mental health teams should include an outreach service that provides intensive support to patients who are difficult to engage or who may lose contact with traditional services (Daniel was not referred to a community mental health team until 5 days prior to his death (Paragraph 3.98).

5.64 The shift away from static risk stratification towards the holistic, person centred approach promoted by *Stating Safe from Suicide* (Paragraphs 5.52 – 5.54).

Good Practice

- Given the frequency with which Daniel presented at Partnership of East London Co-operatives (PELC) walk-in centres, he appeared to value the availability of this service and was often referred onwards for more specialised help.

- Vitaminds promptly referred Daniel to the Crisis Response Service when they assessed his needs as more urgent and higher risk than their service was commissioned or resourced to provide.

- The Newham Residents Service housing officer worked hard to maintain contact with Daniel during a period when this was quite a challenging task

List of recommendations:

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*
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- *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.

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(2) Retrieved from https://www.kingsfund.org.uk/insight-and-analysis/long-reads/mental-health-360-acute-mental-health-care-adults

(3) Retrieved from https://www.gov.uk/government/publications/criminal-exploitation-of-children-and-vulnerable-adults-county-lines/criminal-exploitation-of-children-and-vulnerable-adults-county-lines#signs-to-look-out-for

(4) Retrieved from https://www.england.nhs.uk/long-read/staying-safe-from-suicide/

(5) Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2021registrations

(6) House of Commons Library Suicide Prevention: Transport Research Briefing report completed in August 2024.

(7) ibid

(8) Retrieved from https://sites.manchester.ac.uk/ncish/ https://sites.manchester.ac.uk/ncish/

Appendix A

Process by which the SAR was completed

Initial information request templates and chronologies were completed by the following agencies:

- Basildon, Havering and Redbridge University Hospitals Trust (BHRUT)
- Department for Work and Pensions
- East of England Ambulance Service NHS Trust
- Essex County Council Adult Social Care
- Essex Partnership University NHS Foundation Trust (EPUT)
- Essex Police
- Metropolitan Police
- Mid and South Essex NHS Foundation Trust
- Newham Residents Service
- North East London NHS Foundation Trust (NELFT)
- Tile House Surgery, Brentwood, Essex

A report was also provided by the Border Force. EPUT shared their Learning Response report and NELFT shared their Action After Review report with the SAR.

The individual chronologies were brought together into a collated chronology.

A virtual learning event was arranged to allow practitioners who had contact with Daniel to share their views.

The independent reviewer prepared successive drafts of the SAR report for consideration by the Panel of managers from the range of agencies in Havering, Essex and Newham which were in contact with Daniel.

The final SAR report will be presented to the Safeguarding Adults Boards in Havering and Essex in due course.

Glossary of Abbreviations

ASC – Adult Social Care
BHRUT – Barking, Havering and Redbridge University Hospitals Trust
CMHT – Community Mental Health Team
EPUT – Essex Partnership University Foundation Trust
ESAB – Essex Safeguarding Adults Board
DWP – Department for Work and Pensions
HSAB – Havering Safeguarding Adults Board
IAPT – Improving Access to Psychological Therapies
ICAH – Integrated Crisis Assessment Hub
ICS – Integrated Care System
MASH – Multi Agency Safeguarding Hub
MDT – Multi-Disciplinary Team
MHUCD – Mental Health Urgent Care Department

NCISH – National Confidential Inquiry into Suicide and Safety in Mental Health
NELFT – North East London Foundation Trust
NEL ICB – North East London Integrated Care Board
NRS – Newham Residents Services
PALS – Patient Advice and Liaison Service
PELC – Partnership of East London Co-operatives