Isle of Wight Safeguarding Adults Board
Safeguarding Adults Review – Howard (8th July 1963 – 21st March 2017)

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1. Introduction

1.1. Howard died aged 53 on 21st March 2017. He had no fixed abode at the time of his death. He was found deceased in a bus shelter on the seafront by a member of the public who contacted the police and ambulance service. The cause of death was found to be cardiac arrest, ischaemic heart disease and coronary heart atheroma, and alcoholic liver disease.

1.2. Howard had a long history of alcohol abuse. He was considered to be at risk of financial and physical abuse from people he associated with. He had a heart condition for which he took prescribed medication. Following hospital discharge in late December 2016 he had sometimes stayed on the night bus but had also sofa-surfed and slept on the streets.

1.3. The Isle of Wight Safeguarding Adults Board received a referral from Adult Social Care for consideration for a Safeguarding Adults Review on 12th May 2017.

1.4. The referral form records that, when homeless, Howard could not manage his personal hygiene needs and that he did not have access to facilities to manage his incontinence. When in hospital he was not assessed as having social care needs. It had been judged that he was able to attend to his own care and support needs. The referral identifies concerns about how agencies worked together to safeguarding and support him.

1.5. It is the wish of Howard's relatives that his first name is used throughout this review.

2. Safeguarding Adults Reviews

2.1. The Isle of Wight Safeguarding Adults Board (SAB) has a statutory duty[1] to arrange a Safeguarding Adults Review (SAR) where:

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

2.2. The SAB has discretion to commission reviews in circumstances where there is learning to be derived from how agencies worked together but where it is inconclusive as to whether an individual's death was the result of abuse or neglect, including self-neglect.

2.3. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future[2]. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

2.4. Initial scoping chronologies were requested on receipt of the referral for the period 1st January 2016 to the date of Howard's death (21st March 2017). The information received from agencies[3] was merged into a combined chronology, which was discussed by the Isle of

[1] Sections 44(1)-(3), Care Act 2014
[2] Section 44(5), Care Act 2014
[3] The following agencies responded with information; Hampshire Constabulary, IOW Community Safety Partnership, Southern Housing Group, IOW Ambulance, 111 Service, IRIS, Emergency Department at St Mary's

Wight SAR Sub-group on 1st September 2017. The scoping chronologies identified significant multi-agency involvement and raised concerns regarding how agencies had worked individually and together to safeguard Howard. Having considered the case in accordance with the statutory guidance[4] for implementation of the Care Act 2014, the recommendation of the SAB SAR Sub-group was for the SAB to commission a discretionary Safeguarding Adult Review.

2.5. The Independent Chair of Isle of Wight Safeguarding Adults Board accepted this recommendation. I was confirmed as the lead reviewer on 3rd October 2017.

2.6. The membership of the SAR Panel comprised the members of the Board's SAR sub-group, with the addition of co-opted members representing at senior level the agencies which had commissioned or provided services to Howard.

- Independent lead reviewer and overview report writer:
  - Michael Preston-Shoot
- Isle of Wight SAB Business Manager
- Isle of Wight SAB SAR Sub-group Chairperson
- Isle of Wight Council:
  - Adult Social Care
  - Safeguarding Adults team
- Isle of Wight Clinical Commissioning Group
- Isle of Wight NHS Trust
- Isle of Wight Community Safety Partnership
- Hampshire Constabulary
- Southern Housing Group
- Sussex Community NHS Foundation Trust

The SAR Panel received administrative support from the Isle of Wight Safeguarding Adults Board Senior Administrative Officers.

2.7. Information was also obtained from West Sussex County Council, Sussex Police and Surrey and Sussex NHS Trust.

2.8. A section 42 (Care Act 2014) enquiry was completed by the Isle of Wight NHS Trust in August 2017 in consultation with the Isle of Wight Council, following a letter of complaint from Howard's Half-Sister, his next of kin.

Hospital, Housing Services IOW Council, IOW Adult Social Care, Aspire Ryde, Salvation Army Outreach Service & Homeless Hostel, IOW NHS Trust.

[4] Department of Health (2017) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office.

3. Review Process

3.1. Terms of reference were itemised, as follows, to explore housing, health and care and support arrangements in respect of Howard:

3.1.1. To investigate how agencies worked together with respect to Howard's:

a) Housing needs;
b) Care and treatment with respect to alcohol abuse;
c) Admission to and discharge from hospitals;
d) Transition between services, settings and local authority areas;

3.1.2. To explore how safeguarding procedures were used;

3.1.3. To inquire into the degree to which mental capacity and risk assessments were timely and appropriate;

3.1.4. To investigate how Howard's history was taken into account and the professionals' understanding of this;

3.1.5. To explore the degree to which making safeguarding personal was evident in this case;

3.1.6. To investigate how the interplay between Howard's different health and care needs was understood and managed;

3.1.7. To inquire into whether the Mental Capacity Act 2005, the Housing Act 1996 and the Care Act 2014 were applied appropriately and effectively.

3.2. Methodology

3.2.1. The SAR panel and independent reviewer agreed that the timeframe for the review would cover the period from 10th April 2015 to his death. This was decided in order to include a safeguarding strategy meeting held later in April 2015. Within that timeframe, it was agreed that specific issues would be considered by means of agency submissions of their chronologies detailing their involvement with Howard, their responses to reflective questions about their involvement, and a learning event attended by practitioners and managers.

3.2.2. The reflective questions addressed to agencies were derived from reading the combined chronology of agencies' involvement with Howard. The questions were agreed by the SAR panel and independent reviewer, and are included as Appendix One in this report. Responses to the questions were requested based on reflective conversations within individual agencies.

3.2.3. The learning event explored key episodes and events within the timeframe being reviewed based on issues and concerns emerging from the combined chronology and responses to the reflective questions.

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

3.3. Family involvement

3.3.1. Family members met with the independent reviewer to share their observations about how agencies worked together to safeguard and support Howard.

3.3.2. Family members shared information pertaining to Howard's life journey, contact with medical, housing, social care and health care professionals, hospital discharges and the final months leading up to his death. They also made available documentation relating to concerns they had expressed to agencies when Howard was alive about the support being offered, and complaints that they had submitted following Howard's death.

3.3.3. Family members provided the pen portrait of Howard which is included in the SAR. It is their wish that his given first name be used for this review.

3.3.4. Family members have been clear that they hope that agencies will identify and implement lessons to be learned in order to improve practice for homeless adults with complex health needs on and beyond the Isle of Wight.

4.Pen Picture

4.1. This pen picture has been adapted from information provided by Howard's Half-Sister, in liaison with Howard's Aunt.

4.2. Howard was born on the Isle of Wight, where the family can be traced back over 300 years. He grew up with his mother, grandmother, grandfather and half-sister. His father had moved abroad. Howard was happy and flourished academically. He started playing cricket that became one of his life's passions. He was very upset when his grandfather died and when subsequently he had to move house with his mother. Relationships within the family were also difficult, especially with his step-father. This was when family members first noticed obsessional behaviour and expression of paranoid ideas.

4.3. Howard went to university to study law. He graduated and began to study to become a barrister. However, he dropped out. He obtained a position in a legal/investigative department. Relationships at work did not go well and he left. He also lost his flat when he could not afford the mortgage repayments.

4.4. He then set up his own business, initially dealing with taxation affairs and PAYE. With the success of his business he started flying small planes, was an avid walker, and enjoyed

canoeing. He obtained his Day Skipper license and sailed in Greece, The Canaries and the Lofoten Islands where another of his great passions lay. He had developed a love of Norway and returned several times.

4.5. When his mother died in 2009 Howard was devastated. This was when things started to unravel at work. He began to drink heavily and to neglect his business. His business was investigated and he was eventually charged with fraud and sentenced to six months in prison of which he served three.

4.6. After his release he had fresh ideas for a new venture and formed another company. Unfortunately at its inception, just when he was moderating his drinking and starting to advertise this business, a cuckooing gang moved in on him and from this point forward there was a downhill spiral from which he never escaped and he was soon permanently homeless.

5. Case Summary

5.1. The detail in this section is all derived from the combined chronology and the additional information supplied by the agencies involved.

5.2. In April 2015 Howard was seen by the GP with whom he was a registered patient on the Isle of Wight. At that point he was living in a tent in woods. He continued to be registered to GP practices on the Isle of Wight even though shortly afterwards he moved to West Sussex, a location with which he had no local connection. GP practices on the Isle of Wight continued to receive some notifications about treatment received elsewhere[5] and to offer him appointments for heart checks.

5.3. Police records highlight on-going concerns about Howard throughout April and May 2015. There were ten recorded episodes, involving variously concerns for his safety, street sleeping, drinking and urinating in public, and inability to access homeless shelters because of his drinking. A detox placement was recorded as having ceased due to his continued drinking. It was noted also that he had been evicted because of anti-social behaviour and had been sofa-surfing. Sometimes he was moved on, sometimes alcohol was confiscated. On only two of these occasions were notifications of concern sent to Adult Safeguarding. The records have noted the absence of a wet hostel on the Isle of Wight and the advice from Housing to the Police that Howard had been given ample opportunities to address his situation, made more difficult by his failure to moderate his use of alcohol. After one incident the Police did contact the Isle of Wight Drug and Alcohol Service (IRIS – Island Recovery Integrated Service), as suggested by Housing, who agreed to engage with Howard.

5.4. The Safeguarding Adults Team arranged a safeguarding adults meeting for 30th April 2015, having received a referral from a GP on 10th March[6]. Neither the GP nor the Homeless

[5] This appears to have been erratic and sometimes only after specific requests were made. This is picked up again in analysis later in this review report.

[6] Earlier Adult Safeguarding records contain a referral from the Police on 17th January 2015 which was assessed as an alert. No further action was taken as the Police had given Howard advice and completed a welfare check.

Prevention Officer attended this meeting[7]. The same day a letter was sent to Howard, who had been invited to but had not attended the meeting, detailing the outcome[8]. Various options were outlined in that letter – social housing via the Home Finder scheme, accommodation in the private rental sector, or supported hostels. The letter noted that both Fellowship House and Butler Gardens were dry hostels so, for admission there, Howard would have to work with IRIS. The alternative presented was Crawley Open House in West Sussex, which was not a dry house. Exploring options on the mainland may have arisen because Howard told Housing staff that he would be prepared to go in order to secure help. This was presented as a short-term solution to solve a crisis, with the aim of long-term accommodation on the Isle of Wight. The letter concluded with a statement that Adult Safeguarding would keep his case open pending further review. His case was closed to Adult Safeguarding on 29th July 2015.

5.5. IRIS received a referral from Adult Safeguarding on 21st April within which it was noted that Howard had no fixed abode. Howard was assessed on 7th May 2015. The records have noted undiagnosed mild depression, anxiety and heart problems. He was assessed as having decision-making capacity. An appointment was arranged for 3rd June which Howard did not attend. A further appointment was sent by text message by IRIS for 13th July and the Adult Safeguarding team notified that he would be discharged if the appointment was not kept. He did not attend, clearly because he was by then in West Sussex. He was discharged by IRIS on 4th September following unsuccessful efforts to contact Howard on his mobile phone.

5.6. Agencies on the Isle of Wight had established in early June that Crawley Open House had a vacancy but that Howard would need to make contact himself and the space would be offered on a "first come" basis. Howard did make contact but by the time he arrived the vacancy had gone and he had to sleep outdoors. In the middle of June 2015 he approached Housing in West Sussex but he was referred back to the Isle of Wight as he had no local connection.

5.7. On 2nd September 2015 West Sussex County Council, Adult Social Care, received a police report to the effect that Howard was sleeping rough, street drinking and a victim of financial exploitation and violence. The information had come from Crawley Open House where a staff member was concerned about his alcohol use and its impact on his physical health, and his erratic and chaotic use of medication for his heart condition. The record contains reference to a para-suicidal tendency, and a self-admitted "self-destruct" course, namely Howard placing himself in dangerous situations whilst appearing not to care too much about himself.

According to the Police he did not appear then at immediate risk but did not appear to appreciate the risks surrounding his circumstances. On 27th February 2015, having been in hospital, Adult Safeguarding received a referral from the Hospital Social Work team, noting financial abuse and refusal of help. A social care assessment had been completed and he had been discharged to Butler Gardens with support from IRIS. He left Butler Gardens to stay with a friend the following day.

[7] Police, IRIS, Housing, Health, Social Care Solicitor and Adult Safeguarding were represented at the meeting.

[8] Howard had in fact telephoned Housing to indicate that he could not get to the meeting without assistance. Although Housing staff discussed this request for assistance to attend the meeting with IRIS personnel, no help was forthcoming, representing a missed opportunity to involve Howard in case management plans.

5.8. On 8th September Crawley Open House notified West Sussex County Council that Howard had been admitted to hospital and was advised that a notice to assess should be submitted by ward staff to trigger an assessment of needs. West Sussex County Council was only notified on 3rd October that Howard had been discharged on 8th September. An unsuccessful attempt was made to speak to Crawley Open House staff on 17th October. A discussion did take place on 28th October with a request that Howard be advised to contact West Sussex County Council if he required support. No actual assessment of his care and support needs was undertaken by West Sussex County Council.

5.9. West Sussex NHS records have recorded that Howard attended an Urgent Treatment Centre on 2nd October and 23rd October for repeat prescriptions. On the first occasion he left before being seen. He was recorded as staying at Crawley Open House. Sussex Police records have noted that on 2nd September 2015 Crawley Open House reported welfare concerns. A vulnerable adult at risk form was sent to West Sussex County Council Adult Social Care but assessed as requiring no further action. Sussex Police have recorded an admission to hospital on 17th February 2016 following an incidence of financial abuse and threats. A possible assault and the risk of financial exploitation were recorded for 1st April, with Howard apparently declining legal action. On 29th June he was threatened for money but a vulnerable adult at risk notification was not sent. On 21st July following an assault he was relocated by Sussex Police for his own safety. Howard's relatives have stated that the Police paid for his return to the Isle of Wight and for two nights in a hotel on arrival.

5.10. In February, March, April and May 2016 Howard was treated in East Surrey Hospital[9]. The first short admission was precipitated by palpitations following a robbery in which his medication was stolen from him. He was advised not to stop drinking abruptly when discharged because he had not completed a full detox in hospital. He was advised to stop taking anticoagulation medication due to a high bleeding risk in view of his drinking. He is reported as saying that he wanted to stop drinking but had been unable to find a suitable support group. Primary diagnosis was described as atrial fibrillation[10] and alcohol withdrawal. Secondary diagnosis was listed as alcohol misuse and withdrawal seizures.

5.11. The March admission via the Emergency Department saw him referred to Psychiatric Liaison but he was discharged the same day back to the Crawley Open House. The April admission was for two weeks when he was treated for a urinary tract infection, urinary incontinence, nausea and chest pains. Angiograms showed unobstructed coronaries. He was advised to stop drinking. Primary diagnosis was described as sepsis, angina and rhabdomyolias[11]. Secondary diagnosis was given as alcohol misuse and withdrawal seizures. He was discharged to Crawley Open House.

[9] East Surrey Hospital is part of Surrey and Sussex NHS Trust and is located in Surrey and not West Sussex.
[10] Abnormal heart rhythm.
[11] This is a breakdown of damaged skeletal muscle, releasing myoglobin into the blood stream, which in excess can cause kidney damage.

5.12. The May 2016 hospital attendance was at an Emergency Department where he presented with chest pain, suicidal thoughts and alcohol abuse. His chest pains were relieved with medication. He was assessed by psychiatric liaison for low mood and judged to be low risk, with no on-going suicidal thoughts at the time of assessment. He was judged as safe to return to the Bed and Breakfast hostel at which he was staying. He is recorded as expressing feelings of hopelessness and wanting nature to take its course. He spoke about his recent contact with the Isle of Wight Council and that he had returned some forms relating to housing in the hope of returning there if offered accommodation. He stated that he had been encouraged to engage with alcohol services and that his previous placement at an open house had made arrangements for him to go for detox at a unit in Bognor Regis but he felt it was too far and did not see the logic of doing it. Howard said he would only go into a rehabilitation unit if it was in Crawley where he had made friends. He also stated that he had not yet registered with any local GP due to him moving around and feeling that he needed to be registered in the Isle of Wight as he might return there. He was given information leaflets about available services and discharged. The assessment concluded that risk of self-harm was currently low but significant due to impulsivity, alcohol misuse and on-going social stressors. He was regarded as vulnerable but no adult safeguarding referral was made.

5.13. On 29th and 30th May 2016, and again on 5th and 18th June, Howard presented at the Urgent Treatment Centre in Crawley, West Sussex. The presentations are similar, namely for lost scripts or claiming that his medication had been stolen. Howard is recorded as having access to a GP through the Open House. Prescriptions were given. The 18th June attendance appears to be the last in West Sussex. From the available records it appears that Howard remained in West Sussex between June 2015 and 21st July 2016.

5.14. Between 5th May, whilst resident in bed and breakfast accommodation in West Sussex, and 22nd July 2016, by which time it appears that Howard had returned to the Isle of Wight, his case as a homeless person was assessed by Housing staff in West Sussex and the Isle of Wight. Initially he was referred by West Sussex to the Isle of Wight (section 213, Housing Act 1996) and his case closed by the Isle of Wight when there was no further contact from Howard. It was reopened and a paperwork medical assessment completed in early June (section 184, Housing Act 1996), drawing on information supplied by the GP on the Isle of Wight with whom Howard was registered. On 28th June a decision was reached that Howard was not in priority need. This decision was restated on 11th July 2016 following receipt of a letter from a neurologist advising seizures caused by excessive alcohol but a heart condition managed by medication. On 19th July Howard's medical information was referred to an Independent Medical Advisor and the response received made no recommendation to house him as a priority need. On 22nd July during a telephone conversation between Housing staff in West Sussex and the Isle of Wight it emerged that West Sussex did not regard Howard as in priority need and that he had not kept an appointment or left details regarding how to contact him for further appointments.

5.15. By 21st July 2016 Howard was back on the Isle of Wight. He did not attend an appointment at the GP clinic on 22nd July. A letter was sent advising an appointment for a

blood pressure check. Howard was seen by a GP on 5th September, who noted that he was homeless, drinking and declining detox. Contact was made with the hospital in West Sussex where Howard had been treated previously for his medical records. He was treated by the same GP for a urinary tract infection on 29th September.

5.16. On 18th October Howard was conveyed by Ambulance to an Emergency Department, having been found by a passer-by leaning against a wall with chest pains. He appeared intoxicated, admitted to having vomited earlier, and refused pain relief. He was admitted overnight, discharged the following day with a diagnosis of atrial fibrillation, acute gastritis and alcohol excess. The discharge notes advise on-going monitoring, review of medication for his atrial fibrillation and cessation of drinking.

5.17. On 29th October Howard was a witness to an assault with intent to steal medication at a house in Ryde. The Police attended but the victim declined to press charges. The Police completed a threat to life with respect to Howard on 3rd November and assessed risk as minimal. He was provided with safeguarding advice and two panic alarms but he declined the offer of one-night's accommodation and to make formal complaints against people he alleged had threatened him. The Police referred Howard to Adult Social Care for support due to his vulnerability but his case was closed on 4th November despite his homelessness, alcohol abuse and vulnerability because of the people he associated with.

5.18. On 7th November he attended an Emergency Department with chest pains. This episode was repeated on 17th November when he was recorded as also being doubly incontinent. On both occasions Howard was recorded as stating that he had a muscle wasting disease and rhabdomyolisis was factored into assessments. There is some uncertainty as to whether Howard was taking medication for atrial fibrillation but on both occasions he reported weakness and chest pains. Primary care and hospital discharge notes suggest that alcohol detox and withdrawal were being attempted. The GP practice sent a letter after the 7th November episode recommending a follow-up appointment. A gastroscopy report was received by the GP practice on 24th November, with normal results, an upper gastrointestinal bleed having been investigated.

5.19. The pattern is repeated. On 1st December Howard was unable to stay at the Salvation Army hostel, which was full. Later the Ambulance was called to the hostel where Howard had symptoms of a possible upper gastrointestinal bleed, atrial fibrillation for which currently he did not appear to be taking medication, decreased mobility, alcohol withdrawal, and haematemesis[12]. He reported that his cardiac medication had been stolen. He was wearing hospital clothing from two weeks previously, his personal hygiene was noted as poor and he stated that he has been sofa-surfing. He was later assessed at an Emergency Department.

5.20. On 3rd December he presented at the Fellowship House hostel just after midnight. As a result of staff observations that gave rise to concern, the Ambulance was called and he

[12] Vomiting of blood, usually from the upper gastrointestinal tract. Potentially indicative of serious problems.

was taken to an Emergency Department. Howard once again reported that his medication had been stolen. The diagnosis was arrhythmia and it is possible that he had had stroke symptoms in the previous twenty-four hours. The combined chronology records that without the intervention by Hostel and Ambulance staff, Howard would probably have died on the streets. However, the chronology has also recorded that there were no safeguarding concerns at this point.

5.21. On 7th December Howard did not attend a GP appointment. The following day he did approach Housing as homeless and advised that he was willing to consider going to Fellowship House, which had in the past been suggested/offered as an option and declined by him. An appointment was made for 13th December to complete a Supporting People referral and to sign consent forms to make medical enquiries as he had stated that his health had deteriorated since the last homeless assessment. Howard did not keep that appointment because by then he was in hospital. On 9th December he is reported to be living at the homeless bus shelter.

5.22. Events from 9th December to Christmas Eve represent a key episode. On 9th December an Ambulance attended Howard who had fallen and sustained a facial injury on his way from the homeless bus to a supermarket to buy alcohol. Following assessment and treatment at the scene, he was taken to an Emergency Department. He was wearing the hospital clothes in which he had been discharged the previous week. He was unkempt, with evidence of self-neglect. He was later discharged after treatment. These events were repeated the following day, again with evidence of intoxication but also chest pain. He requested that the Ambulance take him to hospital, where he was admitted to a stroke ward.

5.23. On 15th December he was referred to the Hospital Social Work team and seen the following day, on account of his low mood, by a Mental Health, Self-Harm Liaison Worker. There are extensive notes of this interview. He is reported as saying that this was the first time he had been seen by a mental health worker because he had continued to drink. He thought that he was “mildly depressed” due to his situation. A social history was obtained. He is recorded as being a law graduate who had run his own tax firm and as stating that he had become greedy as a result of which he was arrested in March 2011 and subsequently convicted of fraud and sentenced to a prison term. At the same time his long-term relationship had broken down after he had had an affair. After his release from prison in March 2013 he had been homeless, sofa-surfing or sleeping rough. He had been told by the council that he was not a priority and now felt not worthy of help. He disclosed mixing with people who were alcohol dependent and/or used illicit drugs. They stole from him and he felt vulnerable in their presence but he mixed with them to avoid feeling isolated and lonely. The Police had taken him to the homeless bus shelter to get away from them. He noted his heart condition, which he thought was deteriorating, and his muscle wasting disease, rhabdomyolitis.

5.24. The interview concluded with an assessment and plan. Howard’s mental state was significantly impaired from being homeless and his depression was likely to worsen if there

were no changes to his social situation. There was evidence of self-neglect (dirty clothes, long dirty fingernails and unkempt appearance) but no evidence of suicidal ideation or self-harm. He was vulnerable because of the above, coupled with his physical health and association with peers. The plan was a letter of support to access accommodation. He had spoken of wishing to go for respite at Gouldings on discharge and this could be aligned with support from reablement to access housing thereafter. Liaison with IRIS was planned about the longer-term plan. IRIS received a referral on 19th December.

5.25. On 20th December Hospital Social Work practitioners liaised with Housing staff. Howard was described as incontinent and with care needs but Adult Social Care are recorded as being unable to assist because his case was categorised as a housing issue. Bed and breakfast accommodation is recorded as being unsuitable if Howard has care needs. Housing practitioners advised referral back to Adult Social Care with subsequent re-referral to Housing (section 213, Housing Act 1996) if necessary. On the same day the Mental Health Self-Harm Liaison Worker reviewed her plan with Howard who was now on a rehabilitation ward. No response had been received from Gouldings. Howard agreed to make contact if a supporting letter for housing was needed. Nursing staff were requested to contact the liaison team if discharge plans were being arranged. The Liaison Worker was clear in her contacts with other professionals that Howard's mental state would deteriorate if his housing issues were not resolved. On the same day it is noted by Adult Social Care that Housing are unable to accommodate him.

5.26. On 21st December Howard was told that he might be discharged later in the week. The Mental Health Self-Harm Liaison Worker spoke with staff in the Hospital Social Work team. Gouldings are reported as stating that they could manage Howard's needs but that they were unable to accommodate him at the present time because of the residents already there with complex needs. It was agreed that Howard would not be discharged until he had accommodation in place. Subsequently a member of the Hospital Social Work team met with Howard. Despite Howard saying that he was in poor health, with mobility problems, aggravated by his homelessness, he was advised that he was able to self-care and be fully independent. Consequently he might be declined for a placement as he did not meet the criteria for social care support. He was told that Gouldings did not have a vacancy.

5.27. On 22nd December Adult Social Care determined not to provide residential care as Howard's social care needs "appeared to have disappeared[13]" when this means of providing accommodation had been suggested. The bus shelter was suggested as one option, as he did not have any care needs, or further referral to Fellowship and/or Carisbrooke Road hostels, with support from the Mental Health Self-Harm Liaison Worker, for which Supporting People referral forms would be necessary.

[13] The entry on the combined chronology from hospital social work records states that when it was suggested residential care may be provided his care needs 'appear to have disappeared' and ASC would therefore not be providing accommodation.

5.28. On 23rd December, owing to annual leave, another Mental Health Self-Harm Liaison Worker responded to a telephone call from Howard who was distressed at having been told he was about to be discharged. As a result of his potential homelessness he expressed feelings of hopelessness and concern about the impact on his physical health of living on the streets. Having read the records, the Liaison Worker spoke with a member of the Hospital Social Work team. A bed at Butler Gardens was mooted but required an open referral to IRIS who might be able to access this accommodation. He also spoke with a Deputy Ward Sister who confirmed that discharge that morning had been prevented by the Hospital Social Work team as Howard was vulnerable and in need of temporary housing. Adult Social care liaised with IRIS and with the Community Mental Health Service in an attempt to access a bed at Butler Gardens about which Howard was said to feel positive. It emerged that the homeless bus could take Howard and that Housing were unable to assist. Howard was discharged with sufficient incontinence pads for the Christmas period. GPs were requested to review his medication.

5.29. On 29th December a GP letter was sent to Howard care of the bus shelter at ASPIRE in Ryde. However, the Hospital Pharmacist, having medicines for Howard, had a different address, in Newport, for the homeless bus shelter at which Howard was assumed to be staying. The Pharmacist had been unable to contact Howard via his mobile phone. The GP chronology notes his multiple risks and vulnerabilities. Howard appears to have visited the surgery for support in relation to his homelessness.

5.30. On 30th December Howard visited the surgery. He reported that his medicines had been stolen. He requested a supply of incontinence pads and a letter regarding his welfare benefits. Medicines were prescribed and a referral sent for District Nurse support. On 1st January Howard presented at an Emergency Department with incontinence of urine. Tests found evidence of a urine infection but the health care records note that he was able to pass urine without incontinence and on request to provide a sample.. Discharge comments suggest that contact was going to be made with Adult Social Care and IRIS regarding re-housing.

5.31. The following day Howard presented again, stating that he could not stay on the homeless bus because of his double incontinence. He was concerned about his mental health and about the risk of stroke. He presented as unkempt with a strong odour but appeared disinterested in using the shower facility at IRIS. He was interviewed by a member of the Community Mental Health Team. No acute mental health problem was discerned. He was advised to see his GP and Adult Social Care regarding re-housing, and IRIS with respect to his alcohol addiction. He was advised to be resourceful in respect of his homelessness, with local hotels suggested. He rang his Half-Sister to arrange for her to pay for this overnight accommodation. He was deemed to have mental capacity. Some of his benefits had been stopped because he had not attended a review. In this interview Howard reported that his bank card had been lost.

5.32. On 3rd January he attended the GP practice. The GP completed necessary forms for welfare benefits, giving a diagnosis of ischaemic heart disease, depression and alcoholism.

The GP noted Howard's new mobile phone number. It appears that Howard did not attend IRIS or Housing as he had intended. On 16th January IRIS discharged Howard as he had not attended appointments. The same day he was seen in an Emergency Department, having been taken by Ambulance. He felt weak and dizzy, with palpitations. He was unkempt. He stated that his medications had been stolen. He was admitted. Having been discharged the GP surgery attempted to contact Howard to arrange review appointments for his various medical conditions, and to advise that a housing report that had been prepared was available to see.

5.33. In parallel with these contacts with health care practitioners, Howard had several contacts with the Police. On 31st December Police took Howard to a homeless shelter in Newport after a resident, with whom he may have lodged previously, complained of his anti-social behaviour – being drunk and shouting outside the house. No referral to Adult Social Care or Adult Safeguarding was made. A similar situation arose on 4th January when he was found drunk in a stairwell, waiting for a friend with whom he intended to stay. No further action was taken on this occasion. On 28th January Howard alleged that prior to his readmission to hospital on 16th January he had been threatened with a rifle. The Police investigated but found no evidence and took no further action. On 31st January Howard stated that he had been assaulted. This too was investigated, no evidence found and no further action taken.

5.34. Similarly, Housing personnel were also involved with his case. Fellowship House allowed him to stay in a room because of the cold weather on 3rd and 5th January, advising him to go to the Housing Department. A follow-up appointment was offered for 11th January which Howard did not attend. On 12th January he presented at Fellowship House but was not accommodated because he had arrived too late. A staff member did contact the Police to advise that he was homeless and intoxicated. The following day Howard was seen at the outreach surgery offered by the Salvation Army. He stated that he was staying with friends and therefore declined the offer of food and a shower. He was advised of a parcel for collection at Fellowship House. On 25th January a Homeless Outreach Intervention Worker tried to see Howard in hospital and advised Housing staff that she would begin the process for renewing his application for re-housing as a person in priority need. However, the Homeless Outreach Intervention Worker was not advised when Howard was discharged from hospital and his whereabouts were then difficult to establish.

5.35. On 6th January Adult Social Care staff began attempts to contact Howard but neither they nor Housing nor the homeless bus had a telephone contact number that appeared to connect. An email appointment was sent for 10th January which Howard did not attend. Housing and Adult Social Care shared information about possible ways of contacting Howard, following which an Adult Social Care practitioner left his contact number with the homeless bus shelter, IRIS and the Rough Sleeper Officer in the hope of being able to arrange an assessment. Renewed attempts were made to arrange an assessment on 2nd February, including contacting agencies for information, obtaining a mobile telephone contact number and leaving a letter for Howard at a public house that he was known to frequent.

5.36. Having received the letter left for him at the public house, Howard telephoned Adult Social Care on 3rd February. He is recorded as stating that he needed support and housing and as welcoming assessment of his care and support needs. He was advised that an assessment would be arranged and meanwhile to contact the Homeless Housing team, which he declined to do, saying that he was currently sofa-surfing. Immediate attempts thereafter by the allocated worker to speak to Howard failed as the telephone number appeared unavailable.

5.37. A safeguarding adults meeting was held on 8th February, agreeing that Adult Social Care would continue to attempt to complete an assessment. Contact was attempted on 8th and 11th February, including visiting several public houses and leaving letters for him. Contact was made by telephone on 13th, with Howard agreeing to meet on 15th February for an assessment, an appointment that he did not keep. Following telephone contact with Howard, another assessment appointment was arranged for 17th February, which he also did not keep. He did not keep an appointment with his GP on 14th February either.

5.38. Howard self-referred to IRIS on 13th February and was advised that he would be discharged if he failed to keep appointments. An appointment was offered for 21st February that he did not attend. Attempts to contact him failed over subsequent days.

5.39. The focus of agency involvement then shifted to the Police. Contact with Housing on 25th February established that Howard would not be rehoused as in priority need and that he was on the waiting list for the Salvation Army but unable to stay at the homeless bus shelter because of his incontinence. The Police unsuccessfully attempted to find accommodation for Howard on 25th February following complaints from residents about his rough sleeping in Newport. The same occurred on 28th February. Evidence of self-neglect, including double incontinence, is recorded. Hotel accommodation was arranged for that night. The Salvation Army Homeless Outreach Worker was unable to find him. Adult Social Care received a Police report of this involvement on 2nd March.

5.40. Separately Housing advised Howard through the Citizens Advice Bureau on 8th February that they were not under a duty to rehouse him.

5.41. On 4th March the Police reported their concerns about Howard's vulnerability to Adult Social Care, having investigated but taken no further action when he, with the same friend who had been present on 25th and 28th February, was found rough sleeping in a bus shelter in Shanklin. An Ambulance crew had also attended. On 6th March Ambulance crew attended a bus shelter, prompted by a telephone call from his Half-Sister. Following examination and contact with Social Housing Support for assistance, he was left in the care of a friend and a Mental Health Support Worker who had arrived on scene having heard where Howard had been found. He did not see a Primary Care Service within an hour which had been advised. No safeguarding concern or social care referral were sent. He was seen the same day by a Community Police Support Officer who recommended that he go to a new crisis centre in Ryde. He was assessed as having mental capacity by the Mental Health

Support Worker but as struggling with incontinence and soiled clothing. Howard felt that Housing were leaving him vulnerable and acknowledged that he was eating little but drinking. He is recorded as stating that having detox and a place to stay might help him regain his independence.

5.42. Howard failed to keep an appointment with IRIS on 7th March. An unscheduled meeting the following day took place. A Supporting People referral was completed and sent off. Howard appeared to be in withdrawal. A scheduled appointment was given for 16th March that Howard did not attend. The following day the Adult Social Care Worker suggested to IRIS that an off-island detox placement be jointly funded, followed by privately rented accommodation with the Council acting as guarantor. The following day the Police submitted their concerns to Adult Social Care regarding Howard being at risk from drug related violence from others in Ryde.

5.43. A safeguarding adults meeting was held on 14th March. IRIS and Housing staff did not attend. Concerns focused on his lack of housing and vulnerability. Gouldings was mooted as a possible placement but there were concerns about risks to other residents. The joint funded proposal was discussed. The same day Housing informed Adult Social Care that no accommodation would be forthcoming until Howard addressed his alcoholism. The following day the Salvation Army Homeless Outreach Worker submitted a Supporting People referral, to be told that there was no duty to house Howard as he was not in priority need.

5.44. On 16th March whilst investigating robberies the Police visited a house where Howard was present. He disclosed having been forced to hand over a small amount of money but did not wish to make a statement. Safety planning was discussed with him. On 19th March the Police reported their concerns about Howard to Adult Social Care, including his double incontinence, ill-health and vulnerability. On 20th March the allocated worker in Adult Social Care again suggested to IRIS a joint funded placement.

5.45. He reported to a Community Police Support Officer on 21st March that he had been assaulted by a woman at this same house. Accordingly on 21st March he was on the streets. Initially he was seen by an ASPIRE volunteer and later a Community Police Support Officer walked with Howard to ASPIRE to get him food and support for a place to stay. He was noted to be shaking. He was taken to a local church for a shower and was supported during the day. He spoke with the allocated worker in Adult Social Care and was positive about the proposal for a joint funded placement followed by private rented accommodation. He declined an emergency night shelter placement, preferring hospital admission because of his medical problems. At his request he was escorted to a bus shelter in Ryde as his mobility was very poor.

5.46. Later that evening an Ambulance was called by a passer-by. Howard had died at the scene following a cardiac arrest. No suspicious circumstances were found by the Police who attended.

6. Themed Analysis

6.1. The themes are derived from reading the combined chronology and from the additional information supplied by the agencies involved at the request of the independent reviewer.

6.2. Working Together

6.2.1. There were just three adult safeguarding multi-agency meetings during the period being reviewed. There were no formal multi-agency meetings between May 2015 and February 2017 despite the challenges in engaging Howard, his on-going homelessness, concerns about his health and wellbeing, and evidence of risks of physical and financial abuse. At none of the three formal meetings were all the agencies involved with Howard present. For example, there were no representatives from the Police or from Housing at the meetings in February and March 2017, or from IRIS at the March meeting, although invitations had been sent. This is a major and significant omission. Any professional with concerns about how agencies were working together to address Howard's needs should have felt able to convene a multi-agency meeting and all agencies with contributions to make should have attended with the purpose of agreeing a risk management plan and nominating a keyworker and lead agency.

6.2.2. At the April 2015 meeting his housing and support needs, and the evidence of vulnerability and risks are recorded and a plan agreed, as outlined in a letter to Howard sent immediately after the meeting. However, the plan focuses on finding accommodation that could address his misuse of alcohol as well as resolve his housing needs. There is no plan to address the evidence of financial abuse, sometimes accompanied with physical abuse and threats of harm. Moreover, it does not appear that any agency was appointed as the lead agency, or any practitioner as the lead or key worker, responsible for co-ordinating information-sharing and monitoring implementation of the plan. This too is a significant omission as participants at the learning event observed.

6.2.3. At the February 2017 meeting the appointment of a Care Act 2014 advocate was raised but not pursued. Referral to the Vulnerable Adults Panel was mooted because of the difficulties in engaging Howard but this is not reflected in the agreed actions and was not pursued. At this meeting and the one held in March 2017 plans are outlined for trying to engage with Howard and for pursuing placement options, with lead practitioners clearly allocated.

6.2.4. There is evidence that agencies closed down their involvement with Howard, often because of his non-engagement, without multi-agency discussions to consider the impact of such decisions on case management. For example IRIS closed his case in September 2015 and again on 16th January 2017. Practice within IRIS is reported to have changed to ensure now that other involved agencies are informed when case closure is being considered. Adult Social Care closed Howard's case almost immediately after a

referral from the Police in early November 2016 without an assessment having been attempted.

6.2.5. Observations from the agencies involved, prompted by the questions from the independent reviewer, refer to the absence of collaborative working and the distinct lack of communication and follow-up, especially between Adult Social Care, Housing, GP and Hospital staff, and between clinicians and hostel staff. Those personnel who have reviewed their own agency's practice and the context in which it took place, and/or attended the learning event have referred to the need for multi-agency meetings and response in the form of a service-wide care plan, the absence of case conferences and failure to appoint a lead agency. In place of working holistically, assessments were disconnected and no opportunities were taken to bring the expertise of different agencies together, for example around the time when Howard was discharged from hospital on 23rd December 2016. As commentary from Adult Social Care recognised, a strategic joint working strategy between Adult Social Care and IRIS was missing, within which Howard's case could have been managed more effectively. A greater degree of co-ordinated action was needed between Adult Social Care, Housing, IRIS and the Police. There was limited liaison between the Housing staff in West Sussex and the Isle of Wight who were managing his applications for housing as a homeless person. In short, services did not talk to each other sufficiently and there was no co-ordination of the effort to meet Howard's needs. This is a significant omission.

6.2.6. The review of GP records undertaken as background for this report has commented that, despite Howard being known to have multiple risks and vulnerabilities, each encounter with him was seen in isolation rather than as prompts for raised concern and managed assessments and intervention. No multi-disciplinary meetings were considered. It has also emerged that the GP practice with which Howard was registered has not been formally notified of his death. His death was only discovered because the GP, in trying to contact Howard, contacted Housing staff for his contact details, to be told that he had passed away.

6.2.7. Some reference was made in the information supplied by the agencies involved, and also at the learning event, to the limited use made of capacity in the voluntary sector for complex cases. The Police have suggested that information-sharing and recognition of Howard's vulnerabilities could have been improved, for example by using the procedures available in West Sussex for vulnerable adult at risk referrals and on the Isle of Wight for referral to the Vulnerable Adult Panel[14]. For this to happen, staff must be familiar with the referral pathway which, in this instance, has been questioned.

6.2.8. The Police in their submission referred to Safetynet, a neighbourhood management system to aid the co-ordination of partnership activity. This enables '*sharing of information in a wide variety of business areas to co-ordinate a partnership response, the sharing of information on partnership activity to safeguard repeat victims, vulnerable*

[14] This is now the Multi-Agency Risk Management Panel (MARM).

people and tackle repeat perpetrators'. This system is used on the Isle of Wight by Police, Environmental Health and the Community Safety team. There is only limited use by other partners. The Police submission concludes that the system does not work as effectively as it could due to a lack of partnership use of the system. In addition there is no current guidance available for Police personnel that provides clarity on how Safetynet is to be utilised to manage vulnerability and track risk. This is an area for development that has been recognised by the Hampshire Constabulary.

6.2.9. As observed by Housing, working together may have been made more challenging because of Howard's "transience and reluctance to engage." However, the absence of multi-agency meetings meant that there was no inter-professional strategy and no opportunity to develop a better understanding of each agency's services and thresholds.

6.2.10. Concluding this theme, agencies have recognised that there was limited partnership working to recognise, prevent and address Howard's on-going issues. It has been suggested that this is a systemic issue, a challenge present in similar cases to the one reviewed here. Indeed, at the learning event those practitioners and panel members who attended agreed that difficulties remain accessing Housing and Adult Social Care services and co-ordinating assessments across these two sectors. The absence of agreeing a lead agency and a key worker in this case was also commented upon. A key worker would have assisted with the co-ordination of efforts to assist Howard.

6.3. Information-Sharing

6.3.1. At the February 2017 adult safeguarding meeting, concern was expressed that not all incidents to which the Police had responded were notified to Adult Social Care or Adult Safeguarding as concerns. Indeed, it is evident from the combined chronology that practice in response to similar incidents varied in terms of whether notifications were sent by the Police regarding the risks being experienced by Howard. Practice appears to have been inconsistent and is, therefore, a matter of concern.

6.3.2. Again, reading through the combined chronology, the Police sometimes judged Howard to be at risk and at other times not. Given the repeating and recurring incidents to which they were responding, it is unclear on what basis different judgements were being reached. Hampshire Constabulary's commentary provided for this review comments that Howard's circumstances were well known to all the agencies involved and the incidents with which they were involved were repetitive and demonstrated no change. That may have influenced decision-making about whether to submit notifications of concern. There was, as highlighted above, no multi-agency opportunity to explore these judgements. It is also unclear whether the Police, Adult Social Care and Adult Safeguarding have different or similar perceptions of risk that would influence their thresholds for action.

6.3.3. In the Police submission to the review there is frank acknowledgement of the varied practice in relation to notifications of concerns. This submission further observes that

minutes and agreed actions from the February 2015 adult safeguarding meeting were not received, and concludes that incomplete recording meant that a holistic oversight of Howard's needs and vulnerabilities, and of any multi-agency planning would have been difficult to discern. It also critiques information-sharing arrangements on the Isle of Wight. There is now a Multi-Agency Adult Safeguarding Triage meeting, involving Police and Adult Social Care but not NHS personnel. It observes that other Safeguarding Adult Reviews on the Isle of Wight[15] have found that information-sharing is not robust and recommends that a MASH be developed.

6.3.4. The review of GP involvement with Howard has also commented on information-sharing. It has already been observed that the GP surgery was not immediately informed of Howard's death. It has observed too, especially at the learning event, that different IT systems used on the mainland and on the Isle of Wight meant that at crucial points GPs on the island had to request rather than being able to access immediately information about treatment given through Urgent Treatment Centres and hospitals in West Sussex. This meant that information given to Housing with respect to Howard's applications to be considered in priority need were incomplete and incorrect.

6.3.5. There were delays in GPs being able to share information with Housing about his physical ill-health because Howard could not be contacted to give his consent. Of concern is that Isle of Wight Housing Services, in its submissions to the review, stated that it was not aware that Howard was at risk from others and therefore did not refer his case to adult safeguarding. This raises further questions about how agencies were working together as well as about information-sharing. The contribution from Housing Services comments on the need for specific multi-agency meetings to share information about individuals with complex needs in order to promote timely and responsive interventions.

6.3.6. Concluding this theme, it would appear that information-sharing is a systemic issue, a challenge present in similar cases to the one reviewed here. Participants at the learning event were clear that there remains uncertainty about information-sharing besides lack of access to the information systems used by different agencies and practitioners, which inhibits working together. They identified a need to improve the recording of consent to share information.

6.4. Housing

6.4.1. From at least September 2013 onwards the position of the Housing Department was that no duty to provide accommodation was owed to Howard as a homeless person. A record dating from 2013 states that Howard was not in priority need and was not vulnerable at that time because his condition was being managed. Even if one accepts for the moment that his health needs were being managed in September 2013, it is clear from the combined chronology that practitioners found it increasingly difficult to

[15] It refers specifically to the Miss T SAR – see section 7 below.

manage and meet his physical and mental health needs because of Howard's intermittent or erratic engagement. It is equally clear that the GP and others flagged up the risks to his physical health and mental wellbeing as a result of his homelessness. As observed more than once when agencies submitted their reflections on this case, people will not recover from mental health or substance misuse problems without secure housing.

6.4.2. It is clear from available medical evidence that Howard was a disabled person as originally defined by the Disability Discrimination Act 1995 and subsequently the Equality Act 2010. Increasingly over the time period reviewed, his day-to-day activities were restricted by problems associated with mobility, continence, physical co-ordination and perception of risk. It is likely that his memory or ability to concentrate were increasingly affected. There is evidence too of anxiety and depression. It is arguable that specific duties in this legislation owed to disabled persons were not considered.

6.4.3. A key question is whether Howard had a priority need. Throughout the period being reviewed, the judgement of Housing staff, including on review, was that he was not. The Housing Act 1996 and subsequent case law have established that a person would be in priority need if vulnerable as a result of mental illness, learning disability or physical disability. Medical assessments have been questioned in decided cases. Howard would be vulnerable if less able to fend for himself than an ordinary homeless person so that injury or detriment would result when a less vulnerable individual would be able to cope without harmful effects[16].

6.4.4. To some extent GPs were hampered in the information they could supply because of Howard's erratic engagement as well as the challenge noted above of keeping track across NHS settings of assessment and treatment decisions, and of obtaining and recording consent to share information. At one point a GP could provide little information as Howard had not been seen for a year. Nonetheless, medical assessment regarding whether he had a priority need relied on the information provided at this time. In their reflective commentary for this review Housing staff have observed that they believed that his heart condition was being managed but they have also stated that they did not have confirmation of his muscle wasting disease and so this was not considered. Overall, when Howard was known to have a serious heart condition and to have had seizures caused by excessive alcohol use, alongside increasing incontinence, it is hard to reconcile the decision that Howard was not vulnerable and in priority need with the physical and mental health problems with which he presented. Moreover, GPs and other professionals were clearly indicating how his homelessness was negatively impacting on his health and wellbeing.

6.4.5. The assessment by Housing also appears to have been profoundly influenced by two perspectives. The first is that there were no irreversible medical complications as a result of Howard's alcohol use. Given what was known at the time, it is nonetheless

[16] Cowan, D. (2011) *Housing Law and Policy*. Cambridge University Press.

surprising that Howard was judged as not significantly more vulnerable than an ordinary person faced with homelessness. The second perspective was that Howard's alcohol use was "behaviour of choice." The section on mental capacity below will return to a critique of "lifestyle choice" perspectives.

6.4.6. With respect to a person who is not intentionally homeless but who is also not in priority need, the Housing Act 1996 provides a power to provide accommodation (section 192(3)). There is no reference in the combined chronology as to whether Howard was regarded as intentionally homeless. If he was not, there is equally no reference to whether any consideration was given to exercising a power (as opposed to a duty) to house him. If he were judged to be both intentionally homeless and not in priority need, there is a duty to provide advice and assistance to enable him to secure accommodation. It is difficult to see from the combined chronology and information supplied subsequently, what meaningful attempts were made to provide him with assistance. Housing staff provided advice about options within the third sector and hostels, and information about registering for social housing. It is questionable, though, whether he would have been able to act on this advice and information without substantial support.

6.4.7. Housing in a commentary provided for the independent reviewer clarified that the power to provide accommodation was not considered as there was accommodation for him to use (the Bus Shelter) and as the demand for temporary accommodation was so great from those to whom a duty was owed that there was no room to be flexible and employ statutory powers. Thus, decision-making regarding whether or not to exercise a statutory power was driven by resources as much if not more than by an assessment of need. Indeed, the same commentary has observed that there are no wet hostels on the Isle of Wight and that there is insufficient general and specialist accommodation. It is important to acknowledge here the challenging financial envelope within which public sector organisations have to work and the national shortage of available and affordable housing.

6.4.8. It is clear from the combined chronology that Howard was assumed and expected to be resourceful in accessing accommodation when all the indications were that he could not find a stable solution to his homelessness without assistance. Whilst Housing staff did provide advice, missing appears to have been any consideration as to whether, without support, he could act on the information that had been provided. A question to be answered, therefore, concerns the organisational culture regarding homeless people misusing alcohol in terms of perceptions of tenant-ability, risks and eligibility. Arguably a more robust, humane and flexible approach to housing with integrated support was needed to help Howard stabilise and recover. The absence of a "wet hostel" on the Isle of Wight did not help. That said, there were occasions when the Salvation Army provided Howard with hostel accommodation, even though he was not abstaining from alcohol, because of his circumstances and the risk of death. What was needed but missing was a proactive cohesive and collaborative multi-agency risk management plan rather than a single agency responding to an immediate crisis.

6.4.9. Some participants at the learning event thought that Housing should be relocated, either into Public Health or Adult Social Care. With reference back to working together, it was suggested that there had been other occasions when Housing had a duty towards homeless people but had been unable to find appropriate accommodation and that Adult Social Care had refused to assess because of believing the issue to be one solely related to homelessness. There was a general view that there was insufficient provision to respond effectively to the island's small homeless population. However, as panel members have observed, colocation does not automatically mean integration and what is required is a better understanding of each other's services, referral pathways and thresholds, and effective mechanisms for working together.

6.5. Responses to Alcohol Abuse

6.5.1. When Howard was discharged from prison he spent a couple of nights in Butler Gardens before staying with an acquaintance and sofa-surfing. In September 2013 he spent a brief period in Fellowship House. The minutes of the April 2015 adult safeguarding meeting recorded Howard's poor engagement with IRIS and the difficulty that hostels had experienced in trying to support him. Limited options were available on the Isle of Wight, not least because of the absence of a "wet hostel".

6.5.2. Minutes of the February 2017 adult safeguarding meeting document that, following the meeting in April 2015 staff in Adult Safeguarding spoke to Crawley Open House and established that a place was available for Howard. Howard himself was then expected to ring, which apparently he did. It appears, however, that he was given no assistance to travel to West Sussex since his Half-Sister has stated that she paid for his fare to Crawley. In the event, his Half-Sister believes that his arrival there was unexpected, such that he was given a sleeping bag in order to sleep outside because a place was not by then available. Moreover, the close liaison that should have been evident to facilitate his transfer back to the Isle of Wight and into rented accommodation, as outlined in the letter he received immediately after the April 2015 meeting, did not materialise. This conveys a sense that there was no effective follow-up. Neither Adult Safeguarding nor IRIS kept his case open or provided continuity of relationship with him.

6.5.3. The Police submission to the review reports that a Designated Public Places Order was in place in Ryde during part of the time period being considered here. The Police found no evidence of persistent or unreasonable anti-social behaviour by Howard at this time and therefore no orders available under the Anti-Social Behaviour, Crime and Policing Act 2014 were used in respect of him.

6.5.4. As already noted, the commentary from Housing on the case has noted that Howard was "reluctant" to abstain from alcohol use and that this limited the options available. His alcohol use was seen as "behaviour of choice." On what basis, including access to specialist advice, this judgement was reached remains unclear. Participants at the

learning event were also concerned about the lack of understanding regarding referral to IRIS.

6.6. Repeating Patterns

6.6.1. It is possible to discern from the combined chronology several repeating patterns, none of which appear to have been addressed even if they were recognised at the time. There were missed appointments with his GP, with IRIS and with those staff in Adult Social Care and the Salvation Army who were offering assessments and support with his application for housing from late 2016 onwards. He presented with accounts of his medication having been stolen, of financial abuse and of being threatened or assaulted from September 2015 onwards if not earlier. There are similarities in his presentations at Hospitals and at Urgent Treatment Centres.

6.6.2. These patterns, if recognised, would have been an opportunity to explore his chaotic lifestyle and his self-neglect. When he gave reassurances that he was okay, when he stated that he did not want to press charges against those who had assaulted or threatened him, and when he missed appointments, there is no evidence other than that these decisions were accepted at face value. Howard himself was recorded as having said in September 2015 that he was on a "self-destruct" course but this does not seem to have prompted persistent attempts to assess his care and support needs, or prompted re-evaluation of the need for a full mental health assessment in primary care[17]. There is no sense from the combined chronology and other available information of questioning and sustained exploration based on concerned curiosity. Indeed, one entry as a comment on the combined chronology notes that other agencies, such as the Ambulance Service, were not submitting social care alerts and that his deteriorating health and increasing need and vulnerability were not triggering a different assessment and intervention response. It is concluded, therefore, that contacts with different agencies were seen as episodes in isolation rather than repetitive patterns.

6.6.3. Indeed, a number of agency submissions to this review have commented that each encounter with Howard was seen in isolation. No different approach was taken when Howard failed to attend yet another appointment. There were no multi-disciplinary team meetings or case conferences that would have been an optimal way to explore what the Police described as continuing low level anti-social behaviour and vulnerability relating to alcohol misuse, homelessness and exposure to financial and physical abuse from criminal associates.

6.6.4. Between 28th February 2017 and Howard's death on 23rd March three notifications of concern were submitted by the Police. These documented increasing risks, including that he was incontinent and not looking after himself, his bedding was soaked in urine and he was walking with difficulty, not eating regularly and being cared for by another homeless

[17] At the learning event one participant who had worked with Howard thought that what he really wanted was to be cared for and supported to resolve the issues and barriers facing him. When given the opportunity he really wanted to remain in hospital whilst away forward was found.

man with his own needs. One of these notifications also stated that Howard himself had said that he would not survive much longer. None of this information appears to have prompted urgent reconsideration of the approach being taken by agencies.

6.6.5. Family relatives believe that some of these repeating patterns can be explained as rooted in fear of reprisals from those he was associating with, something acknowledged in some Police notifications of concerns to Adult Social Care, and as a determination to end his life since he could see no other way out. There is no evidence that anyone talked with Howard about whether he did indeed see any future for himself. For much of the time period under review, there is no evidence of a sustained plan, supported by continuing relationships with and assertive outreach from key professionals, to address the evidence of physical and financial abuse from known and named individuals. Indeed, at least one name of someone who might well have been financially and physically threatening Howard occurs throughout the time period under review and was known to the Police.

6.7. Health

6.7.1. There were attempts by his GP to follow-up the advice given by Hospital clinicians in order to manage his heart condition and the risks associated with his high alcohol intake. There were some proactive attempts to follow-up missed appointments. Follow-up, including medication review, was difficult because Howard was of no fixed abode and used his mobile telephone numbers intermittently. It was not clear where the letters for Howard were actually sent and there was no multi-agency plan to co-ordinate attempts to keep in touch with him[18]. No attempts by GPs to see Howard other than at the surgery appear to have been attempted.

6.7.2. Evidence about his chaotic or erratic use of medication for his various physical health needs does not appear to have prompted a multi-professional review that could have included discussion of whether he might have been confused, because of his deteriorating condition, over exactly what medications he should have been taking. Howard's relatives believe that he may have been confused and are concerned that his statements were accepted without challenge about keeping appointments and taking medication when the number of admissions would indicate otherwise. A multi-professional review of the medical response to his situation might also have been indicated because Howard presented with multiple physical health needs, aggravated by his significant use of alcohol, including decreased mobility and haematemesis.

6.7.3. It has been suggested that a full healthcare risk assessment would have been appropriate at various points including Howard's tissue viability, nutritional intake, mental test score, mental capacity and mobility, especially in the run-up to discharge on

[18] Had there been one or more multi-agency meetings, which could have been convened by any agency with concerns about multi-agency working, and had there been an agreed risk management plan, roles and responsibilities could have been specified, including nominating a lead agency and key worker to co-ordinate inter-agency efforts to address Howard's needs.

23rd December 2016 and again subsequently when evidence indicates that his health was deteriorating. Reflections submitted on GP involvement in this case have observed that there is no evidence of a formal medication review and that Howard's multiple risks and vulnerabilities do not appear to have raised concern or been explored for assessment and managed intervention. Equally, it has been observed that there is no recall system for vulnerable patients, which means that reviews and reassessments happen opportunistically if at all. In Howard's case, although he was recognised as "vulnerable" and at risk, there was little concerned curiosity as to why and GPs were unsighted on much of his history.

6.7.4. There were assessments of his mental health, for example on 2nd January 2017 by the Community Mental Health Team when he was deemed not to have an acute mental health problem, and again on 3rd January 2017 by his GP when depression was diagnosed. It is unclear whether Howard was assessed with respect to Impulse Control Disorder when this is associated with significant alcohol misuse. Input by healthcare professionals to this review has commented that there is no evidence of a full mental health assessment in primary care. Howard's relatives continue to question how rigorous were the assessment of his mental health and suicidal ideation.

6.8. Mental Capacity

6.8.1. There is little reference to formal assessment of his mental capacity in the combined chronology. He was assessed as having mental capacity when not intoxicated and in contact with West Sussex Police and the Hampshire Constabulary, when in hospital during December 2016, when in contact with Urgent Treatment Centres and when in contact with Ambulance crews.

6.8.2. His failure to keep appointments with IRIS and with Housing, for example, despite his stated intentions did not trigger review of his mental capacity. The Police submission to the review has observed that there is nothing in the records to confirm that Police Officers considered four specific questions that should be answered when considering a person's mental capacity. Submissions regarding GP practice have observed that there was no detailed primary care assessment of Howard's mental capacity. This should have been indicated because of the evidence of fluctuating capacity, combined with known health needs and chaotic lifestyle, and at times coherent presentation but appearance of self-neglect and inability to follow-through on decisions.

6.8.3. There is nothing to indicate that his executive capacity was assessed at any point in the period under review. Howard's relatives have commented that he could present coherently. When he reassured practitioners that he was taking and would take medication, but subsequently did not appear to act in line with his statements, questions were not asked about his executive capacity. Family relatives believe that professionals should have demonstrated more concerned curiosity and questioned Howard more closely. There is a direct link here to what the submission from Housing has stated explicitly – the influence of Howard being seen to be living out a lifestyle

choice. Lifestyle choice was assumed; no-one appears to have asked Howard whether he was really choosing to self-neglect in this way, a finding that other SCRs and SARs have also pointed to[19]. Equally there is nothing to suggest, for example when he was spoken to by Police and did not wish to proceed with action against those who were financially abusing and/or threatening him, that it was considered whether he was acting under duress and the victim of coercive and controlling behaviour.

6.8.4. His capacity was recorded as fluctuating in the minutes of the April 2015 adult safeguarding meeting and subsequently, for example when in hospital, but it is unclear how it was proposed to act in his best interests when Howard did not have decisional capacity. The Community Mental Health submission to the review has concluded that his fluctuating mental capacity was not well managed. The Salvation Army submission has concluded that mental capacity assessments do not appear to have taken into account the complex nature of capacity, both decisional and executive, and that responses to fluctuating capacity need to be improved. Participants at the learning event noted that the appointment of an Independent Mental Capacity Advocate was never considered, which might have assisted those involved to respond effectively to Howard's fluctuating capacity.

6.9. Adult Social Care and Adult Safeguarding

6.9.1. No assessment of Howards care and support needs was conducted by West Sussex County Council whilst Howard was in Crawley. No safeguarding referrals were made by the Urgent Treatment Centre in Crawley because staff there did not perceive there to be safeguarding concerns. The East Surrey Hospital where he was treated on four occasions in the first half of 2016 did not, it would appear, refer Howard for an assessment of his care and support needs.

6.9.2. No assessment of his care and support needs was completed whilst Howard was on the Isle of Wight during the period under review, although attempts were made from December 2016 onwards but frustrated in part by the difficulty of maintaining contact with him. His case was closed without an assessment on 4th November 2016. When he was in hospital for much of December 2016, there was no meaningful involvement of social work staff until discharge approached, his situation being primarily defined as a housing problem. One referral from the Hospital in January 2017 to Adult Social Care was declined on the grounds that Howard did not have care needs. Assessment under section 9, Care Act 2014, for assessment should be done when it appears that a person may have care and support needs. The threshold is low for such an assessment and the failure to conduct and complete an assessment of his care and support needs is a significant omission and missed opportunity.

[19] Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews.' *Journal of Adult Protection* (2015) 17 (1), 3-18. Preston-Shoot, M. (2016) 'Towards explanations for the findings of serious case reviews: understanding what happens in self-neglect work.' *Journal of Adult Protection* (2016) 18 (3), 131-148. Preston-Shoot, M, (2017) 'On self-neglect and safeguarding adult reviews: diminishing returns or adding value?' *Journal of Adult Protection* (2017) 19 (2), 53-66.

6.9.3. The Ambulance Service, in their reflective submission to the review, has commented that it does not have a direct referral pathway to Adult Social Care and that there is no guarantee that Adult Safeguarding will pass on a referral to Adult Social Care when a section 42 enquiry (Care Act 2014) is not indicated. This apparently has already been highlighted as a concern. Similarly, participants at the learning event suggested that there was a need to improve access to Adult Social Care and to improve communication to referrers about the outcome of received notifications of concern and referrals for section 42 (care Act 2014) enquiries.

6.9.4. Notifications of an adult at risk of harm, primarily from the Police but also from the Salvation Army, GP surgery and Ambulance Service, were not sent routinely or were only passed on occasionally and do not appear to have prompted a review of Howard's case. No effective action was taken with respect to the evidence of physical and financial abuse, the latter according to Howard's relatives running into many thousands of pounds. The Police submission to the review has commented that no obvious action was taken by partner agencies when safeguarding concerns and care and support needs were notified, and that Police Officers do not understand what happens after risk assessments have been submitted. There is an absence of feedback from Adult Social Care/Adult Safeguarding. It was suggested at the learning event that other professionals and agencies might have assumed that responsibility had been handed after a notification of concern and/or were deterred from making repeat referrals because of an absence of positive response.

6.9.5. Both the Police and Ambulance Service submissions to the review have noted that Howard's case was well documented and that this may have deterred staff from raising concerns again, especially when earlier notifications of similar risks had not resulted in preventive or protective action being taken. Workload pressures have also been observed to impact on whether or not concerns are notified. A multi-agency response was needed but in its absence there appeared to agencies like the Police to be limited options. One possible response, given that no notification of safeguarding concerns prompted a section 42 enquiry, would have been for an agency to have activated what is now the Multi-Agency Risk Management (MARM) procedure but this did not happen, raising doubt about the degree to which it is known and embedded in practice.

6.9.6. The commentary from Housing for this review has stated that it was inappropriate for Housing to refer Howard to Adult Safeguarding because no information was held about the risks from others. Information was available to the agencies involved, not least from the Police, of risks from others regarding financial and/or physical abuse from the beginning of the period under review. However, importantly, this aspect of the commentary represents a misunderstanding of section 42, Care Act 2014. Abuse and neglect includes self-neglect, both for the purposes of section 42 and indeed all aspects of adult safeguarding under the legislation.

6.9.7. The threshold for a section 42 (Care Act 2014) enquiry is outlined in three sub-sections, namely that a person has care and support needs, is experiencing or at risk of abuse and neglect, including self-neglect, and as a result of those care and support needs is unable to protect themselves from that abuse and neglect. As the statutory guidance[20] states, the response under safeguarding will depend on the individual's ability to protect themselves by controlling their own behaviour. There will be times when people are no longer able to do this without external support. In the judgement of the independent reviewer, the threshold was met in this case. There is substantial doubt about the awareness within and across agencies of the threshold criteria for a section 42 enquiry. Equally, where self-neglect, physical threats and/or financial abuse impact on someone's wellbeing, that individual has care and support needs and a duty to assess also arises under section 9 (Care Act 2014). The focus then should be on promoting a person's wellbeing through assessment with a view to meeting an individual's practical, financial and emotional needs, including the need for accommodation. Assessment should cover social networks, physical health, historical issues impacting on the individual, mental health and responses to trauma and vulnerability.

6.9.8. Under the Care Act 2014 local authorities and partner agencies have a duty to prevent deterioration of an individual's wellbeing, for which early intervention is indicated. There are clear links here to the positive obligation on public authorities to promote a person's right to life (Human Rights Act 1998). Wellbeing includes personal dignity, physical and mental health, emotional wellbeing, and suitability of living accommodation. It is impossible to promote a person's wellbeing if they are not safe, with their care and support secure. That process begins with an assessment of care and support needs, including accommodation, for which the threshold is low – namely the appearance of need for care and support. Assessment should be integrated and co-ordinated, namely including in this case health and housing needs and their impact on Howard's day-to-day life. That there was no completed assessment in Howard's case is a major and significant omission. As for any subsequent eligibility for services, it seems sufficient clear from the available information at the time that Howard's needs arose from or were related to physical and/or mental ill-health and that without support he was unable to achieve at least the following important outcomes – personal hygiene and toilet needs (incontinence), appropriate clothing (he was often seen in hospital clothing) and ability to sustain occupancy of accommodation.

6.10. Hospital Discharges

6.10.1. Howard's relatives have expressed both concern and distress that, on 23rd December 2016, Howard was discharged in his pyjamas with a supply of incontinence pads, to the homeless bus when it was uncertain whether he could be accommodated there because of his on-going incontinence. Howard's Half-Sister had to post clothes to Howard. The minutes of the adult safeguarding meeting held in March 2017 have also recorded

[20] Department of Health (2017) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office.

concern about this hospital discharge. Submissions to this review have recorded concern that no multi-agency discharge planning meeting was held prior to the December discharge when this would have been appropriate. The support requested from Adult Social Care and Housing should have been formalised into a plan.

6.10.2. The minutes of the February 2017 adult safeguarding meeting have recorded that the Hospital had established that the homeless bus would take him in. However, family relatives believe that staff at that shelter had expressed reticence and reluctance to take him because of his incontinence. Howard told a Community Mental Health Worker on 2nd January that he could not stay there due to his incontinence. He was also not supported in the journey from the Hospital to the homeless bus and there is evidence that the Hospital Pharmacist did not know how to contact Howard with respect to his medications and Hospital staff did not know where reliably to send further supplies of incontinence pads.

6.10.3. There is also evidence of delayed notifications of hospital discharges – to West Sussex County Council with respect to a discharge in September 2015 and to the Salvation Army Homeless Outreach Intervention Worker regarding the discharge on 30th January 2017. Submissions by the agencies involved to this review have commented on the absence of co-ordination and care planning following each of the hospital discharges which, given the repeating patterns and evident needs in this case, is a major omission. Indeed, the notes obtained for a May 2016 admission note that multiple risks and vulnerabilities had not been shared. The involvement of Adult Social Care and Social Workers located in hospital teams should have been considered before Howard was discharged.

6.10.4. Participants at the learning event expressed concern regarding Howard's discharges from hospital. None seem to have prompted detailed social work assessments or to have addressed the complexities of comorbidities, including his homelessness. There was an absence of a cohesive, co-ordinated and collaborative approach at these points of significant transition.

6.10.5. The independent reviewer has concluded that there was a lack of co-ordination around at least some of Howard's hospital discharges and missed opportunities, especially in December 2016 to agree a plan to address his housing, health and social care needs. For example, if a referral was made to the continence team on or around 23rd December 2016, as requested by the Homeless Bus, this does not appear to have been followed up. The requests that he was not discharged before accommodation was found and that Mental Health Liaison staff be notified prior to discharge did not translate into effective multi-agency working. Medical clinicians had deemed him fit to be discharged and some form of accommodation was available, albeit unable to meet his longer-term needs. As observed in feedback to the independent reviewer, the 23rd December discharge, and arguably others, did not adhere to guidance on alcohol-related disorders[21], namely that

[21] NICE (2011) Alcohol-use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence. London: National Institute for Health and Care Excellence.

stable accommodation should be found before people are discharged. However, as also observed by panel members, there are considerable pressures on health and social care systems as a result of the available financial and resource envelope.

6.11. Carer Involvement and Complaint Management

6.11.1. There are occasional references in the combined chronology to contact being made with Howard's Half-Sister with respect to appointments and support being offered to him, for example by IRIS in February and March 2017.

6.11.2. Both Howard's Aunt and Half-Sister expressed concern about Howard's situation and how agencies were responding to it, from 2015 onwards if not earlier. They are clear that they expressed their concerns to Adult Safeguarding in 2015 but no record has been found of this and Howard's relatives are adamant that Adult Social Care/Adult Safeguarding staff did not engage with them at that time. They expressed their concerns to and questioned Housing in later January 2017 about why more was not being done to resolve Howard's homelessness. They had done so earlier also but were told that information could not be shared without Howard's consent. They have expressed disappointment to the independent reviewer about the attitudes of some practitioners towards them, describing responses as sometimes obstructive and rude.

6.11.3. Frustrated by what they believed to be the lack of sustained action to address Howard's homelessness and associated problems, Howard's Half-Sister engaged the then local MP to write to the Council. There is evidence that the MP's letter was seen by the Council's Chief Executive Officer and Director of Adult Social Care. The minutes of the adult safeguarding meeting in February 2017 have recorded the latter's considerable concern about the contents within the MP's letter and a determination to agree a plan to meet Howard's needs. A response was sent to the MP. Howard's relatives have expressed disappointment with the content of this response.

6.11.4. Subsequent to Howard's death, Howard's Half-Sister has pursued complaints with the Isle of Wight Council and with the NHS. Family relatives have been frustrated and annoyed by the delayed responses and the tone within them. They believe that unwarranted assumptions have been made about Howard. A section 42 enquiry was also completed as a response to complaints from Howard's Half-Sister. The focus of their complaints has been on the treatment offered for Howard's incontinence, kidney functioning and mental health needs at different times; the December 2016 hospital discharge; the failure to assess and meet his housing and his care and support needs; the failure to protect him from physical and financial abuse. They have also expressed to the independent reviewer questions about Police involvement when Howard was being threatened and their assessment of whether there was evidence of an assault when he was found deceased. Hampshire Constabulary has no record of having received a formal complaint about this aspect of the case.

6.11.5. Responses to some complaints have been sent within statutory timescales; others have been less timely. The responses have also tended to list chronologically the attempts to engage with Howard, to record his mental capacity and his erratic engagement with staff, to note the advice he was given and the plans that were formulated. The responses might be factual, for example with respect to the occasions when he was assisted into supported accommodation, but there is limited reflection on and hitherto limited acknowledgement of what might be learned from what took place.

7. Windows on Systemic Issues – Isle of Wight SARs

7.1. Previously completed and published Isle of Wight Safeguarding Adult Reviews have highlighted themes similar to those uncovered by this review and explored in section 6. The repetitive themes are highlighted here in italics.

7.2. Of perhaps most relevance is the review on Mrs P (2017)[22], who had a *long history of alcohol abuse and connected health problems*, with a history on *non-engagement* and dis-engagement. It questioned how IRIS, Accident and Emergency, Ambulance and Community Mental Health *worked together* despite all being part of one Isle of Wight NHS Trust. It concluded that agencies *worked in silos* and failed to identify the case as requiring an *adult safeguarding* section 42 enquiry. Services were *unclear how to make referrals* to each other and there was *no programme of work for hard to engage people*. Some of these findings had already been reported in an earlier review[23], namely the absence of a joined-up multi-agency response to the management of a person's health and social care needs, with both commissioners and providers struggling to provide a person-centred response.

7.3. Another review of a self-neglect case[24] criticised *discharge planning* and the lack of clarity about the basis on which the person was deemed to have *mental capacity*. A further review[25] found a shortage of specialist placements and *limited housing/accommodation options*, and *delayed multi-agency strategy meetings*. The local authority was unclear about what kind of *adult social care* involvement was needed, resulting in limited engagement and assessment. *No lead agency* was identified and *case closures* were not discussed with other agencies involved. Not all *safeguarding concerns* were referred to the Council.

7.4. These findings that suggest the presence of systemic challenges on the Isle of Wight are echoed in a final review[26] that focused on the lack of *multi-agency working together*, the absence of *mental capacity* assessments, the *failure to work with the individual* on risks and their choices, understanding of *self-neglect*, inconsistent *referral of concerns to adult safeguarding*, missed opportunities to risk assess *patterns*, and the lack of any overall ownership of the case that might be shown by the appointment of a *lead agency* and key worker.

[22] Isle of Wight Safeguarding Adult Review – Mrs P (2017)
[23] Isle of Wight Safeguarding Adult review – Mrs X (2015)
[24] Isle of Wight Safeguarding Adult review – Mr V (2015)
[25] Isle of Wight Safeguarding Adult Review – Miss T (2016)
[26] Isle of Wight Safeguarding Adult Review – Mr W (2015)

8. Learning from Published Safeguarding Adult Reviews

8.1. There are other published SARs that offer learning in respect of cases involving self-neglect reflected in alcohol dependence, health concerns and housing issues. Variously, these reviews[27] highlight the following:

- Links between homeless and mental distress;
- Alcohol use as a coping mechanism to manage emotional distress;
- Practitioners working in silos rather than cohesively together;
- Absence of professionals' and multi-disciplinary meetings to agree and implement a co-ordinated plan;
- Chronic alcohol misuse not seen as a safeguarding issue or form of self-neglect;
- Absence of services commissioned and equipped to manage such cases;
- The challenges involved in adequately assessing mental capacity;
- Failure to explore with the individual their apparent "choices" such as reluctant to engage;
- Absence of holistic assessment, including of complex psychological needs, as a basis for joint planning;
- Alcohol dependence not addressed;
- Failure to appoint a lead agency;
- Lack of Care Act 2014 care and support assessments and of risk assessments;
- Limited or no engagement with family and friends;
- No liaison with Banks and other financial institutions regarding financial abuse.

8.2. Once again it is possible to see these issues being reproduced in Howard's case.

9. Concluding Discussion

9.1. It is important to highlight evidence of good practice in this case. There were determined efforts latterly to make contact with Howard and to support him to resolve his homelessness and alcohol misuse by the Salvation Army Homeless Outreach Intervention Worker and by the allocated Adult Social Care Worker who sought to assess Howard in locations amenable to him and to find an appropriate placement for from late December 2016 onwards. West Sussex Police paid for his return to the Isle of Wight and an initial hotel stay in mid-2016 in order to protect him from physical violence and financial abuse. Individual Police Officers, Homeless Bus and Hostel staff showed their humanity, for example by letting Howard in on very cold nights or seeking to find him somewhere safe to be and by responding as best as they felt able to his housing and care and support needs. Howard's primary GP was proactive in trying to engage him.

[27] Rochdale SAB (2017) Safeguarding Adult Review – Tom; Waltham Forest SAB (2017) Safeguarding Adult Review – Andrew; Worcestershire SAB (2017) Safeguarding Adult Review – RN; Brighton and Hove (2017) Safeguarding Adult Review – X; Waltham Forest SAB (2017) Safeguarding Adult Review – John.

9.2. Risk assessments by Police and Ambulance crews were thorough, with some attempts to link Howard with accommodation providers. The Self-Harm Liaison Team had brief involvement with Howard during the December 2016 admission and attempted to support him, especially with efforts to find stable accommodation. On the day he died staff from ASPIRE ensured that he had meals and a shower, and cared for him. Some of the notifications of concern from the Police and the records within the Ambulance Service clearly detail Howard's needs.

9.3. Nonetheless, the evidence has led the independent reviewer to conclude that there was a lack of effective and co-ordinated multi-agency work to manage his complex needs. This is most evident with respect to responding to his homelessness when Howard clearly had evolving and increasing physical health needs, the hospital discharge on 23rd December 2016 and the manner of his arrival at the Crawley Open House and the failure to implement the plan agreed at the April 2015 adult safeguarding meeting. Howard was invited to the adult safeguarding meeting held in late April 2015 but then not assisted to attend when he requested help to do so. Whether his attendance at the two subsequent adult safeguarding meetings was considered has not been recorded.

9.4. There were occasions when notifications of concerns should have been sent to Adult Safeguarding and there were missed opportunities to escalate concerns when it was clear that there was an absence of multi-agency assessment and care planning. The Vulnerable Adults Panel (now MARM) was not utilised as an alternative to pursuing a section 42 (Care Act 2014) enquiry. It was suggested at the learning event and in material submitted by some agencies that Howard's self-neglect had become "normalised" in the sense that the circumstances in which Howard was found were repetitive and unchanging, with options appearing to those involved to be fairly limited. He was certainly expected at times, in the view of panel members and the independent reviewer unrealistically, to carry out actions to improve his situation without support.

9.5. Howard's case was approached essentially in crisis management mode rather than through a co-ordinated response focusing on prevention and protection. There were missed opportunities to involve voluntary sector agencies more in meeting Howard's care and support needs. There were occasions when the Police, for instance, fulfilled roles that were more appropriate for other, health and social care, agencies. When a proposition emerged in February 2017 for meeting Howard's needs, initially in a facility off-island before supported accommodation on island, decisions from commissioners were not forthcoming in a timely manner. When hostels and the bus shelter were responding to Howard's crisis presentation, this was not combined with attempts to generate a multi-agency plan to meet his needs.

9.6. This case highlights gaps in service provision on the Isle of Wight, namely:

9.6.1. There is no wet hostel and no direct access hostel. However, access can be arranged to resources on the mainland and indeed a facility was found on one occasion in West Sussex that would accommodate Howard.

9.6.2. Outreach capacity is limited for engaging with people whose engagement is erratic and/or inconsistent as are emergency accommodation, rehabilitation and detox facilities, and pathways to prevent potential homelessness for frequent users of Emergency Departments and Hospitals.

9.6.3. There are no flexible emergency funds to meet immediate housing needs when other services cannot assist.

9.6.4. Lack of temporary and emergency housing options for individuals who have substance misuse and continence needs.

9.6.5. Agencies do not work as "one system" in response to people with complex needs, with clear pathways for accessing assessments and service provision, and with clarity about which organisation is leading on risk, need and capacity assessments and case management planning.

9.7. Material provided by agencies for the review and comments made at the learning event include observations that thresholds for section 42 enquiries and for activation of MARM may not be well understood and therefore not embedded in practice or providing an effective framework for addressing risks through timely information-sharing, and co-ordinated assessment and planning. Indeed, the Housing submission commented that a multi-agency approach was required to meet people's complex needs and that thresholds for accessing Adult Social Care and Mental Health services were high. There appears to be limited access to or use of practitioners who specialise in working with people with alcohol problems, complex mental capacity assessments, and homelessness and/or adult safeguarding. Referral pathways into Adult Social Care may be unclear or experienced as unavailable to some other agencies, as advised by the Ambulance Service, and limited feedback from Adult Safeguarding about the outcome of notifications of concern was reported to be a concern. This is indeed a national issue.

9.8. Understanding of self-neglect and how best to intervene may not be well understood across the agencies involved, with further guidance and training perhaps indicated, for example with respect to assessing mental capacity and balancing a person's autonomy and self-determination with a duty of care. The independent reviewer is aware that a programme of training on working with adults who self-neglect has been provided on the Isle of Wight to staff. It might be timely to review the reach of this training but equally workforce development will be more effective if there is a parallel focus on workplace development. This is needed to ensure that messages from research and SARs, and knowledge and skill development, delivered through training can be implemented subsequently in practice because organisational cultures, structures, policies and procedures are aligned with the focus of the training.

9.9. In so far as this review has highlighted systemic issues to be addressed by the Safeguarding Adults Board and its partner agencies, workplace development should be part of any ensuing action planning. The Hampshire Constabulary submission to the review, in the form of a thorough, reflective and critically analytical learning review, has suggested that there are similar on-going cases involving homelessness, significant health concerns, and an absence of care planning following notification of concerns. In the context of diminishing

public sector resources, which the Police submission also highlights, a multi-agency strategic response to the learning from this review is needed to ensure that subsequent operational responses are more effective.

9.10. Referring back to the terms of reference for this review, in summary the evidence leads to the following conclusions:

9.10.1. Agencies did not work together effectively in this case;
9.10.2. Safeguarding procedures were not utilised in a sustained attempt to prevent and protect Howard from abuse and neglect, including self-neglect;
9.10.3. Assessments of mental capacity and risk were either insufficiently thorough and/or failed to culminate in a sustained plan;
9.10.4. The history of the case, as reflected for instance in repetitive patterns, did not lead to a questioning of the approach being adopted;
9.10.5. Making Safeguarding Personal practice is not evident in this case in that there is no meaningful record of how Howard's wishes, views, hopes and desired outcomes contributed to a sensitive, co-ordinated and appropriately assertive care, support and safeguarding plan;
9.10.6. In terms of parity of esteem, there is no evidence that his mental health and physical health needs were considered together as part of a holistic healthcare approach;
9.10.7. There were missed opportunities to use powers and duties within the Care Act 2014 (use of section 42 enquiries to share information and promote a multi-agency response), Housing Act 1996 (discretionary power to house) and Mental Capacity Act 2005 (assessment of decisional and executive capacity).

9.11. Participants at the learning event were conscious of the stretched resource context in which all agencies were operating. For example, they noted system pressures on hospital discharge, especially during winter, and the funding issues affecting commissioners and providers.

10. Recommendations

10.1. It has been suggested that changes to improve practice have been implemented as a result of this case and findings from other reviews. It has been suggested that the Multi Agency Risk Management (MARM) procedure is better embedded and that there have been improvements in how agencies work together. However, at the learning event it was suggested that awareness and understanding of the MARM process might be variable, leading to doubts about whether it is securely embedded in practice.

10.2. It has been suggested that pathways into and thresholds for section 42 enquiries are more robust and that the provision of self-neglect training and guidance on Making Safeguarding Personal has enhanced staff understanding. It has been suggested that hospital discharges now involve greater co-ordination between NHS personnel and Adult Social Care. Participants at the learning event believed that safeguarding support for primary care personnel, including General Practitioners and District Nurses, had been strengthened, and

that the multi-agency safeguarding system was now characterised with individual practitioners taking greater professional responsibility and also challenging other agencies. There had been injection of specialist resources in Accident and Emergency, specifically alcohol misuse specialist nurses and mental health and support workers. However, concerns have also been expressed that the hospital discharge process remains at times unco-ordinated and that multi-agency approaches to dual diagnosis remain unresolved.

10.3. It would be appropriate for the Isle of Wight Safeguarding Adults Board to audit current practice to evaluate whether such improvements to co-ordinate multi-agency pathways and involvement have indeed been achieved. This forms the first of the recommendations below.

10.4. Review of the findings and conclusions at the learning event and panel meetings resulted in the shared view that Howard's case was not unique. Interlocking systemic factors are recognisable that could, if unchecked, reappear in other cases. The recommendations that follow are designed to strengthen how agencies work together in similar cases in the future.

10.5. Arising from the analysis undertaken within this review, the SAR Panel recommends that the Isle of Wight Safeguarding Adults Board:

Working Together

10.5.1. Recommendation One: Isle of Wight SAB to conduct a multi-agency audit to answer the question of how embedded in practice are MARM and Integrated Locality Meetings, with particular focus on the use of lead agencies and key working, and the follow-through of risk management plans, with proposals brought forward to address the findings.

Adult Safeguarding

10.5.2. Recommendation Two: Isle of Wight SAB to conduct a case file audit of section 42 enquiry threshold decisions and to agree proposals for service development based on the findings.

Housing

10.5.3. Recommendation Three: Isle of Wight SAB to receive from Housing a review of practice and decision-making regarding priority need for housing applications.

10.5.4. Recommendation Four: Isle of Wight SAB to receive from the local authority proposals for implementation of the Homelessness Reduction Act 2017 and to consider whether these proposals address the learning from the housing findings in this case.

Hospital Discharge

10.5.5. Recommendation Five: Isle of Wight SAB to receive from Adult Social Care, Isle of Wight CCG and Isle of Wight NHS Trust a review of co-operation regarding hospital discharges and proposals to improve communication, assessment and service provision at this key

transition point between social care, primary care and secondary health care, with particular emphasis on joint assessments for homeless people.

Working Together – Adult Social Care and Housing

10.5.6. Recommendation Six: Isle of Wight SAB to receive from Adult Social Care and Housing a joint multi-agency protocol on assessment and service provision with respect to homeless people with care and support needs.

Training

10.5.7. Recommendation Seven: Isle of Wight SAB to lead on a multi-agency training needs analysis to explore levels of confidence and knowledge with respect to self-neglect, referrals and thresholds for Section 42 Care Act 2014 enquiries, Mental Health Act 1983 assessments, Mental Capacity Act 2005 assessments, and to commission a multi-agency training programme where this is indicated.

Management of Complaints

10.5.8. Recommendation Eight: Isle of Wight SAB to receive from Isle of Wight Council, Isle of Wight CCG and Isle of Wight NHS Trust reviews and proposals to strengthen their management of complaints.

Service response to Alcohol Abuse and Homelessness

10.5.9. Recommendation Nine: Isle of Wight SAB to receive from joint commissioning proposals to improve resources for individuals who are homeless and who misuse alcohol, including consideration of commissioning a wet hostel, extra care accommodation and street-based outreach, and strengthening of the contribution of existing hostels and third sector organisations.

Dual Diagnosis

10.5.10. Recommendation Ten: Isle of Wight SAB to receive a review from Adult Social Care and IRIS of multi-agency working together in cases of dual diagnosis, with proposals to strengthen strategic and operational collaboration.

Information-Sharing

10.5.11. Recommendation Eleven: Isle of Wight SAB to disseminate the report to West Sussex Safeguarding Adult Board and Surrey Safeguarding Adults Board and request an action plan relating to the findings on hospital discharge, assessment and support for homeless people in particular.

10.5.12. Recommendation Twelve; Isle of Wight Sab should co-ordinate a review of the use of different IT systems with a view to reinforcing a system whereby different professionals can access important information to assist their efforts to meet a person's health, care and support needs.

Embedding Learning to Address Systemic Issues

10.5.13. Recommendation Thirteen: Isle of Wight SAB to hold learning and service development seminars after one year to review progress in implementing the lessons and recommendations from all SARs that have been completed by the Isle of Wight SAB since the Care Act 2014 was introduced.

Appendix One

Reflective Questions for Agencies

Questions for Housing Services in IoW and in West Sussex

1. What assessments did you conduct when under the Housing Act 1996 in respect of Howard?
2. What needs and risks did you consider in these assessments?
3. What was your rationale for determining that he was not in priority need?
4. Did you consider exercising your power to provide housing to Howard as a homeless person even though you had decided that you did not have a statutory duty to provide him with accommodation? If not, why not?
5. What are your thresholds for determining priority need (recalling that Howard had been homeless since March 2013, had a heart condition and a muscle wasting disease, and was abusing alcohol)?
6. How effective do you consider the liaison between Housing Services in West Sussex and IoW?
7. How did you work with other agencies and services in gathering information to determine whether or not Howard was in priority need as a homeless person, and subsequently when you had determined that he was not in priority need? How effective were these working relationships?
8. At any stage did you refer Howard to adult safeguarding? If not, why not? If you did, what was the outcome?
9. What advice and guidance did you give to Howard when your assessments concluded that that he was not in priority need and therefore not eligible for housing?
10. What observations do you have about services on the IoW for people with complex needs relating to physical and mental wellbeing, and alcohol issues, who are homeless or at risk of homelessness?

Questions for the Police Service

1. When Howard was the victim of crimes and did not wish to proceed with Police involvement, what mental capacity assessments were undertaken and with what outcome? What consideration was given to whether he was acting under duress and/or subject to coercion?
2. On how many occasions when the Police had contact with Howard were referrals made to other services, such as Adult Social Care?
3. Were any of these referrals specifically recommending a section 42 enquiry under the Care Act 2014?

4. What were the outcomes of any referrals and what observations do you have about multi-agency working in Howard's case?
5. On those occasions when the Police had contact with Howard but did not make referrals or pass concerns to other services, why was this?
6. Was consideration given to the use of anti-social behaviour legislation either in respect of Howard or those with whom he associated? What was the thinking behind whether or not to use such a legal option?

Questions to Adult Social Care

1. What need, risk and safeguarding assessments were undertaken between 10th April 2015 and his return to the IoW around June/July 2016? What was the outcome of these assessments?
2. What need, risk and safeguarding assessments were conducted between June 2016 and his death in March 2017, with what decisions and outcomes?
3. What mental capacity assessments were undertaken, when, and with what outcome?
4. How effective was hospital discharge planning in December 2016?
5. How effective was liaison with Housing Services regarding his homelessness?
6. How effective was inter-agency working with NHS Trusts, third sector agencies providing services to homeless people, and services for people abusing alcohol?
7. There was a safeguarding meeting on 8/2/2017. Why do you think such a meeting was not held earlier in this case? What needs and risks were considered at this meeting? What options were considered and what was decided?
8. There was another safeguarding meeting on 14/3/2017. What needs and risks were considered at this meeting? What options were considered and what was decided?

Questions to NHS Trusts in West Sussex and IoW regarding hospital admissions/discharges, ED and Urgent Treatment Centre contacts

1. What referrals were made to adult safeguarding? If referrals were not made, what was the rationale behind this decision?
2. What referrals were made to Adult Social Care, with what outcomes? If referrals were not made, what was the rationale behind this decision?
3. What mental capacity assessments were conducted, with what outcomes?
4. What risk assessments were conducted, with what outcomes?
5. How effective was liaison with Howard's GP, Adult Social Care and Housing Services, considering that Howard did not have a fixed abode?
6. What was the rationale behind his discharge arrangements on 23/12/2016?
7. Various patterns emerge from the case chronology – homelessness, lost or stolen medication, alcohol abuse, recurring physical health problems, self-neglect (unkempt), confusion. Was any consideration given to convening a case conference to co-ordinate a risk management plan? If not, why not?

Questions to GPs

1. What referrals were made to adult safeguarding? If referrals were not made, what was the rationale behind this decision?
2. What referrals were made to Adult Social Care, with what outcomes? If referrals were not made, what was the rationale behind this decision?
3. What mental capacity assessments were conducted, with what outcomes?
4. What risk assessments were conducted, with what outcomes?
5. How effective was liaison with secondary healthcare settings, Adult Social Care and Housing Services, considering that Howard did not have a fixed abode?
6. Various patterns emerge from the case chronology – homelessness, lost or stolen medication, alcohol abuse, recurring physical health problems, self-neglect (unkempt), confusion. Was any consideration given to convening a case conference or multi-disciplinary meeting to co-ordinate a risk management plan? If not, why not?
7. How effective was information-sharing between different GPs? What are the barriers here, if any, and what impact did they have in Howard's case?
8. How do you respond when someone does not attend appointments, especially when their mental capacity might fluctuate, they are homeless and/or misusing alcohol?

<u>Questions to Ambulance Service</u>

1. What referrals were made to adult safeguarding? If referrals were not made, what was the rationale behind this decision?
2. What referrals were made to Adult Social Care, with what outcomes? If referrals were not made, what was the rationale behind this decision?
3. What mental capacity assessments were conducted, with what outcomes?
4. What risk assessments were conducted, with what outcomes?

<u>Questions to IRIS</u>

1. What referrals were made to adult safeguarding? If referrals were not made, what was the rationale behind this decision?
2. What referrals were made to Adult Social Care, with what outcomes? If referrals were not made, what was the rationale behind this decision?
3. What mental capacity assessments were conducted, with what outcomes?
4. What risk assessments were conducted, with what outcomes?
5. How effective was liaison with secondary healthcare settings, GPs, Adult Social Care and Housing Services, considering that Howard did not have a fixed abode?
6. Various patterns emerge from the case chronology – homelessness, lost or stolen medication, alcohol abuse, recurring physical health problems, self-neglect (unkempt), confusion. Was any consideration given to convening a case conference or multi-disciplinary meeting to co-ordinate a risk management plan? If not, why not?
7. How do you respond when someone does not attend appointments, especially when their mental capacity might fluctuate, they are homeless and/or misusing alcohol?

<u>Questions to Salvation Army</u>

1. What referrals were made to adult safeguarding? If referrals were not made, what was the rationale behind this decision?
2. What referrals were made to Adult Social Care, with what outcomes? If referrals were not made, what was the rationale behind this decision?
3. What mental capacity assessments were conducted, with what outcomes?
4. What risk assessments were conducted, with what outcomes?
5. How effective was liaison with secondary healthcare settings, GPs, Adult Social Care and Housing Services, considering that Howard did not have a fixed abode?
6. Various patterns emerge from the case chronology – homelessness, lost or stolen medication, alcohol abuse, recurring physical health problems, self-neglect (unkempt), confusion. Was any consideration given to convening a case conference or multi-disciplinary meeting to co-ordinate a risk management plan? If not, why not?

<u>Questions for all agencies and services involved with HD</u>

1. What worked effectively regarding how services and agencies worked together?
2. What could be improved in terms of how services and agencies worked together?
3. How well in your view do services understand and work with people who self-neglect?
4. How well in your view do agencies work with people whose mental capacity fluctuates?
5. What gaps in services exist for people with a complex and challenging configuration of problems, risks and needs like Howard?
6. What examples of good practice were there in this case?
7. There are two dry hostels on the IoW. Were referrals made to these services? If yes, with what outcome? If not, why not?
8. What in your view are the key lessons to be learned that emerge from Howard's case?
9. What recommendations would you like to see in the final SAR report?