Lewisham Safeguarding Adults Board

Safeguarding Adult Review

Mia

Independent Author – David Byford

Contents

Chapter 1

1 Introduction

1.1 This Safeguarding Adult Review (SAR) was commissioned by Lewisham Safeguarding Adults Board (LSAB) for Mia (pseudonym). Mia was a 41-year-old woman and a European Union (EU) National who was homeless and sleeping rough in Lewisham. Information from her mother in her country of origin confirmed she came to the UK with a boyfriend in 2012, although this relationship subsequently came to an end and does not form part of the analysis in this review. It is not known when she became street homeless and under what circumstances; however, she died in hospital on the 3 July 2019.

1.2 This SAR recognises homelessness and rough sleeping as a contributing factor to her death, together with being subjected to coercive and manipulative control as a victim of domestic abuse (DA) at the hands of her male partner, Adam (pseudonym) a 35-year-old, EU National. Mia was also drug dependent which contributed to wider issues she endured in relation to self-neglect. These concerns and complexities impacted her health and well-being and are subject to the analysis and learning within this report.

1.3 Mia lived in various squats and temporary accommodation, as well as presenting as homeless, predominantly in the London Borough of Lewisham. Mia first came to the attention of Lewisham Adult Social Care (ASC) in 2017, from a Metropolitan Police Service, Merlin Adult Come to Notice (ACN) referral submitted to Adult Social Care (ASC), Social Care Advice and Information Team (SCAIT). Her case was discussed at a Multi-Agency Risk Assessment Conference (MARAC) meeting that was held. The Police Safer Neighbourhood Team (SNT) identified Mia as an adult at risk, and concerns at the time were linked to her relationship with her partner Adam, who was also known to Police.

1.4 Mia self-reported that she was a dependent intravenous (groin) crack cocaine and heroin user, who also abused other illegal substances. She financed her addiction through street begging and theft (shop lifting). Police had very regular contact with her, sometimes several times a day, as she was known for Anti-Social Behaviour (ASB) by members of the public, Metropolitan Police Service (MPS) Dedicated Ward Officers (DWO) and Police Community Support Officers (PCSO) within the Lewisham area.

1.5 She had unresolved health issues including hematemesis, deep vein thrombosis and a history of abscesses believed to be linked to her poor injecting practice, which she reported to substance misuse health professionals. There were concerns that she had suffered an assault in the month prior to her death (discussed in Chapter 3), and she also had an infected leg with the source thought to be a rat bite; however, the infection is believed by professionals more likely to be as a result of her injecting herself.

1.6 Her overall lifestyle concerns were never resolved before her death, despite the advice and support she received from the many professionals she encountered. Mia occasionally spoke to her GP to seek treatment and was advised to seek further assistance at the local hospital Emergency Department (ED). Appointments were booked. Mia did not attend all appointments made for her. Other professionals were aware of her urgent medical needs who encouraged and offered support for her to obtain treatment. Her Thames Reach London Street Rescue (LSR) key outreach workers also accompanied her to hospital appointments to receive treatment but on one occasion Mia would not wait for the treatment and left the hospital.

1.7 A few months prior to her death MPS Merlin ACN's highlighted concerns for her health and well-being which were raised at a Lewisham MARAC that was held in March 2019, but concerns remained. The referrals and the action taken by professionals are subject to analysis of the services provided in the narrative of Chapter 3, and in the findings in Chapter 5.

1.8 On the 3 July 2019 Mia became unwell. After contacting emergency services, she was conveyed to hospital by the London Ambulance Service (LAS). She had an ischaemic bowel which caused sepsis and organ failure whilst in the hospital and died shortly after of 'Septic Shock'.

1.9 Her death was commiserated by members of a local church and by members of the public and professionals who knew her. The local Reverend showed empathy, who, with the assistance of an interpreter located Mia's family, communicated with her mother and assisted in having Mia's body repatriated back to her country of origin.

1.10 Agency records were initially unclear as to the exact cause and circumstances of her death. One report indicates that she died whilst having a stomach operation; another of an infected rat bite as mentioned above; that she died whilst having surgery on her knee, and another suggestion was that Adam had injected her to cause an overdose. This latter allegation was appropriately investigated by the MPS and found to be groundless, and her death was subsequently recorded by police as non-suspicious. A report by Change Grow Live (CGL) a National Health and Social Care Charity who were attempting to work with Mia shortly before her death, was written for the London Borough of Lewisham Drug and Alcohol Related Deaths Panel advised Mia died of '*Septic Shock,'* this was a provisional cause of death that has not been confirmed.

1.11 Commissioning of the SAR. It was agreed at a Lewisham SAB Case Review Sub-Group that the mandatory criteria were not met for this case to be a SAR, but it was felt that there was sufficient concern on how agencies worked together and that a discretionary review will be conducted under Section 44 (4) of the Care Act 2014.

1.12 Purpose of the Safeguarding Adult Review. The purpose of the Safeguarding Adult Review is not to re-investigate or to apportion blame. SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again.

1.13 Lewisham Safeguarding Adults Board. Research of guidance identifies that Lewisham has a wide range of safeguarding materials to support the LSAB and its partners in the function of their duties (See footnotes and Bibliography in Appendix 1).

Comment: ***Pan London and local guidance translates the legislative requirements and expectations for individual services to safeguard and promote the well-being of adults at risk. They relate to adults with needs for care and support, and for carers, providing a framework for LSAB to monitor the effective implementation of policies and procedures.***

1.14 Definition of Rough Sleepers. Under the Ministry of Housing, Communities and Local Government (MHCLG) guidance, rough sleepers are defined as:

- People sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments).
- People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or 'bashes').[1]

1.15 This definition does not include people in hostels or shelters, people in campsites or other sites used for recreational purposes or organised protest, squatters or travellers. Bedded down is taken to mean either

[1] Ministry of Housing, Communities and Local Government, Rough Sleeping Statistics, Housing Statistical Release, February 16th, 2018, pg. 10

lying down or sleeping. About to bed down, includes those who are sitting in/on or near a sleeping bag or other bedding.[2] Including the above definition, Mia and Adam were rough sleepers, squatters and also sofa surfed when the occasion arose.

1.16 Voice of Mia. The voice of Mia was captured as reported in her interaction with professionals. It is evident throughout the narrative in this report that they were listening to her and giving clear safeguarding and health advice as she was recognised as an adult at risk. Up until the time of her death her deteriorating physical appearance was consistently being reported by local police officers, who were worried for her health and well-being. Two police officers in particular were persistent in their submission of Merlin ACN's in order to inform safeguarding partners of their concerns for her, and who also supported attempts to find her accommodation. Mia continued not to engage in offers of support, which is a common form of self-neglect, but the reasons for this were never fully assessed.

[2] Ministry of Housing, Communities and Local Government, Rough Sleeping Statistics, Housing Statistical Release, February 16th, 2018, pg. 10

Chapter 2

2 Terms of Reference (Summarised)

2.1 Overarching aim and principles of the Safeguarding Adult Review for Mia. The purpose and underpinning principles of this SAR are set out in section 2.10 of the London Multi-Agency Safeguarding Adults Policy and Procedures. All Lewisham Safeguarding Adults Board (SAB) members and organisations involved in this SAR, and all SAR panel members, have agreed to work to these aims and underpinning principles. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

2.2 Legislation. Section 44, Care Act 2014 places a statutory requirement on the Lewisham Safeguarding Adults Board (LSAB) to commission and learn from SARs in specific circumstances, as laid out below, and confers on LSAB the power to commission a SAR. A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if: -

- *there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and*
- *the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect, or*
- *the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.*

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

- *identifying the lessons to be learnt from the adult's case, and*
- *applying those lessons to future cases.*

2.4 Governance and accountability. This SAR will be conducted in accordance with requirements set out in:

- Care Act 2014 and statutory guidance (DH 2014).
- Safeguarding Adults Reviews under the Care Act: implementation support (SCIE 2015).
- London Multi-Agency Safeguarding Adults Policy and Procedures.
- Lewisham SAB SAR Framework (2016).

2.5 As the accountable body responsible for its commissioning, Lewisham SAB has received updates on progress of this SAR at Board meetings and through written briefings as required during the process.

2.6 Agencies Involved in the SAR and who provided Individual Management Reviews and chronologies.

- Change Grow Live (CGL)
- Thames Reach - London Street Rescue
- London Borough of Lewisham - Single Homeless Intervention Project
- Lewisham & Greenwich NHS Trust – University Hospital Lewisham
- Athena – Refuge
- London Borough of Lewisham - Crime Enforcement Team (DA & ASB MARAC)
- London Community Rehabilitation Company
- Metropolitan Police Service
- GP practice x 2

2.7 SAR methodology. This SAR has undertaken a hybrid methodology including an analysis of Individual Management Reviews (which include critical reflection); an analysis of the combined chronology of events; and a practitioner learning event where the views of the attendees have been incorporated within the narrative of this report. This has ensured that all of the available information has been captured from the professionals involved in this case, whilst also providing an opportunity for reflection and development. This approach was also selected as it would allow for the best opportunity to identify lessons to be learned across the partnership.

2.8 General guidance. The review process was conducted with the following underpinning principles and guidance in mind:

- Evidence of Making Safeguarding Personal.
- Evidence of, or consideration of Mental Health Act & Mental Capacity Act Assessments.
- Whether this case highlights any general difficulties and concerns in relation to policies and processes around information sharing and communication between different professionals and agencies.

2.9 SAR specific questions. Agencies were asked to address where relevant the following specific areas of enquiry in their submissions to the SAR process:

- Determine and provide a factual record of the circumstances and cause of death.
- Mental Capacity.
- Risk Assessment.
- Challenges of Engagement.
- Professional Curiosity.
- Communication & Information Sharing.
- Legal Literacy.
- Safeguarding Literacy.

2.10 Additionally, IMR authors were asked to answer key questions within their reports, and this is detailed in the analysis in Chapter 4.

2.11 Scoping period. The SAR will cover the time period of Friday 1 January 2016 until Wednesday 3 July 2019 when Mia died.

2.12 Mr David Byford was appointed as the Independent SAR Reviewer and Author of this SAR report.

2.13 Involving and supporting the adult and family. Mia's family were contacted and invited to take part in the review. This was through an initial virtual meeting with an interpreter and through a translated email which posed questions from the SAR Author, and the LSAB Business Manager in relation to the family's involvement and contribution to the review. Repeated contact was made with the family, but they did not respond to these questions, although they had initially agreed to do so.

2.14 Involving and supporting key staff and volunteers. The perspectives of all key staff and volunteers that attended the Practitioner Learning Event were nominated by an individual from each agency, who was responsible for identifying and notifying relevant staff and volunteers of this SAR, and for giving them the opportunity to share their views on the case. The nominated individual from each agency was also responsible for ensuring relevant staff and volunteers were provided with a safe environment to discuss their feelings, and offered emotional support where needed, including counselling or other therapeutic support.

2.15 Liaison with the police, criminal justice system and coroner. There were no reported police or coroner's investigations, or on-going statutory reviews linked to or impacted on the completion of the review. A date whether there will be a coroner's inquest is to be confirmed.

Chapter 3

3 Period 1 - Background

3.1 Mia's mother was contacted for the purpose of participating in this review for her daughter. She confirmed that Mia left her country in 2012, to go to London to be with her then boyfriend. This was the reason given for leaving her home. Mia had two children, a boy (now 21 years old) and a girl (now 18 years old) but there was no detail offered as to why Mia left them behind. Her mother remembered Mia as being a happy person who always "brought the sunshine with her." As a child she would take long walks on the beach singing and dancing.

3.2 The last time Mia's mother saw her daughter was when she came to London to see her in July 2018. It was only after her return to her homeland that she lost contact with Mia. Apparently, Mia's mobile phone number stopped working and thereon had no further contact during the next twelve months before she died. Thames Reach, London Street Rescue (LSR an outreach service), were made aware that she had a previous boyfriend in 2015, but it is not known if it was the same boyfriend she had travel to the UK to live with previously.

3.3 Mia was arrested on eight occasions including two postal charges from her time in the UK up to January 2018. The offences included five cases for begging, four of cases breaching her Community Protection Notice (CPN) for begging, one occasion for resisting arrest and two cases of breaching a conditional discharge at a local Magistrates Court. Mia had twenty contacts with police, the majority being linked to theft, drug use, begging and allegations of assault (not of a domestic nature). The first time Mia and Adam were stopped together was on the 10 August 2016.

3.4 Period 2 - Analysis of events within the scoping period of the SAR (1 January 2016 to 3 July 2019)

3.5 A LSAB integrated chronology was completed which records agency interaction with Mia. There is a high proportion recorded from the MPS chronology due to their regular contact with Mia that resulted in Merlin ACNs being submitted as detailed below.

3.6 **2016** - **Adam assaulted Mia (1).** The first significant incident recorded in this period was on the 4 September when police were called by members of the public. They had seen Mia being assaulted by her partner Adam outside a local railway station. They were arguing and Adam grabbed her by the neck, pushed her up against a wall and slapped her. Police attended but Mia was reluctant to engage with the officers and was very vague as regards to the incident. She displayed signs of physical injuries to her face and admitted Adam assaulted her, and he was arrested. In interview he said they had been drinking and alleged they argued over buying drugs at the location they were seen at. He was bailed pending attempts to contact Mia. She later attended Lewisham Police Station on the 6 September, stating she would not support a prosecution and that she had assaulted Adam during the incident. No further action (NFA) was taken by police. There was also a missed opportunity to refer Mia to a specialist domestic abuse support service.

3.7 The MPS IMR comments that both police officers who arrested Adam were aware of the full range of options available to them at the time, which included an evidence based (victimless) prosecution and an application for a Domestic Violence Protection Order (DVPO). Both officers felt that without any Closed-Circuit Television (CCTV), body worn video (BWV) of her injuries, no cooperation from Mia who had not wanted medical assistance, coupled with the counter allegations made by Adam, the professional opinion was the threshold for prosecution would not be met. A Community Safety Unit (CSU) staff member was spoken to for the purposes of this review by the MPS IMR author, who stated that a DVPO would be considered in the highest risk cases, and during the four months the officer was in the Community Safety Unit (CSU) could not recall any being issued due to a lack of knowledge and training for officers at that time.

Comment: ***The safeguarding structure within the MPS has changed considerably with the introduction of the Borough Command Unit (BCU) model in late 2018 and early 2019. This includes a safeguarding wing incorporating investigation and support functions such as the partnership and prevention hub.***

3.8 Thames Reach first came into contact with Mia in September 2016, when she was found rough sleeping in the borough. There was only one other interaction with Mia in 2016.

3.9 Mia and Adam were stopped by police and searched in the street on the 30 September after members of the public made complaints about them begging and being known drug users. Nothing was found during a search of their person and no action was taken by police. It was this interaction which was the first recorded between Mia and a Police Community Support Officer (PCSO). The PCSO was passionate about her attempts to assist Mia to try and break her away from the cycle of her drug use, begging and homelessness. She stated that the recorded events did not accurately mirror the sheer volume of interaction she had with her. She stated that two or three times a day she would speak to Mia regarding begging. The PCSO appropriately referred her on multiple occasions to "Streetlink", which enables members of the public to connect rough sleepers with local services, and the "999 Club" a small charity providing advice and health checks for homeless people in Lewisham and South London, regarding having a place to sleep and to obtain some hot food. The officer showed compassion and personally purchased food for her when she saw she needed it. She stated that working with Mia was frustrating as she sometimes wanted to engage and seemed to want help, only to not go through with it leading back to begging on the streets. It was the officer's opinion that Adam had a coercive hold on her. Throughout her interactions with Mia, the officer only completed one Merlin ACN on the 22 March 2019. Due to Mia's worsening physical state, others should have been completed which is addressed in the MPS IMR.

3.10 The MPS IMR reports that within the new BCU model introduced in 2018, service wide awareness campaigns were delivered to improve the consistent completion of Merlin ACN's, but this is still a concern, although previously considered by the South East Borough Command Unit (SE BCU). The IMR Author recognises that, given the number of interactions by PCSO's and the low amount of Merlin's recorded in their interaction with Mia, submission of Merlin's still needs to be addressed. Therefore, additional MPS recommendations have been made regarding completing and dip sampling Merlin ACN's for adults at risk; to review the current MPS Begging Standard Operating Procedures (SOPs) and the new application of the AIRSPACE computer system, which is the primary tasking tool for tackling Anti-Social Behaviour (ASB) on Safer Neighbourhood Teams (SNT). The use of CRIMINT (an intelligence report) is widespread in this case, which records anti-social behaviour or begging, although this been replaced by the Early Intervention Scheme (EIS) which is also recorded on the AIRSPACE system.

3.11 **2017 - Adam assaulted Mia (2).** On the 7 July, police were called by a member of the public who said Mia had been assaulted. Police attended and spoke to Mia who alleged that she had argued with her (referred to as) ex-partner Adam in a squat over money. He had chased her out of the address where he punched and kicked her. She returned to the address, but the argument continued, where she alleged, he punched her again, threw her to the floor and kicked her in the back. She managed to run out of the premises again where she was seen by the member of the public who reported the assault to police. Police officers noted minor marks and bruising to her arm, back and a small cut to her upper lip. She initially refused medical assistance but was persuaded by police to let them take her to the University Hospital Lewisham (UHL) Emergency Department (ED) for a check-up. Officers then dropped her off at a friend's address. She would not make a statement and did not want Adam arrested. However, in line with the MPS positive action Standard Operating Procedures (SOPS) for DA Investigations, he was arrested the same day. In interview, he claimed Mia was the aggressor and he had only pushed her away after she pushed him into a radiator (he had two deep cuts to his face and arm which he alleged were caused as a result of her assault). A charging decision request was placed before the Crown Prosecution Service (CPS) as an evidence-based prosecution given that the injuries were recorded on a BWV, but the CPS decided and advised that the matter should be NFA.

Comment: ***CPS victimless prosecutions together with DVPNs and DVPOs at the time were useful and effective tools to support practitioners dealing with victims and adults at risk. They ensure a perpetrator can be dealt with regardless of the victim's involvement and allow time and space for practitioners to provide support, protection and assistance to a victim willing to accept help. This is a finding within this SAR (see Chapter 5).***

3.12 **Merlin ACN (1).** The following day a detailed and comprehensive Merlin was recorded (shared with ASC) in relation to a recent Dedicated Ward Officer (DWO) meeting held, where Mia was identified as an adult at risk due to her begging, homelessness, risk of domestic violence and refusal to engage with a number of support agencies (self-neglect). A request was made for her name to be added to the agenda for the next ASB MARAC meeting due on the 19 July. The information presented at this meeting showed that Mia did not have any obvious social care needs. There appears no consideration of Mia's care and support needs in the regulations issued within the Care Act 2014. As a follow up, ASC made contact with the Crime Enforcement and Regulations Service and requested that the police be informed that all attempts by ASC to make contact with Mia had been unsuccessful; and to inform the police that ASC would be happy to link in with Mia if they see her as it was understood the SNT had a good relationship with her. No records of the minutes of the ASB MARAC on the 19 July 2017 can be found and supporting documentation is unavailable. There was not another MARAC held for Mia until March 2019 when her case was referred to a DV MARAC regarding the domestic abuse and controlling behaviour of Adam.

3.13 The SNT police officer who attended the Practitioner Event held for the SAR was unaware the use of the Merlin was not the correct way to place a case for inclusion at a MARAC meeting, as it requires a separate Local Authority MARAC referral form to be submitted. Whilst the Merlin was forwarded to ASC this would not automatically trigger the anticipated referral and the discussion that the officer wished to bring to the attention of other agencies of his concerns for Mia. However, ASC SCAIT reviewed the Merlin and assumed the officer was requesting a MARAC and acted accordingly to call the meeting. MPS have a dedicated MARAC police officer who can assist in the completion and submission of MARAC referral forms, but as the MPS IMR states, it would not be a regular occurrence for frontline officers to know the correct process and as such an appropriate MPS recommendation has been made to address this issue.

3.14 **Merlin ACN (2 and 3).** On the 25 July 2017 Mia was moved on by police for begging on three separate occasions. She was becoming more aggressive in her behaviour. On the third occasion she was told if she was seen again, she would be arrested which does show a conciliatory attitude by police. Mia said she wanted to beg in Sydenham, but her boyfriend Adam would not let her, a comment which may reflect a form of control by Adam not identified by the PCSO interacting with her. Two days later, Mia was issued with a Community Protection Warning Letter (CPWL) due to her persistent begging. Having received the CPWL she continued begging, was not arrested but police signposted her to the Single Homeless Intervention Project (SHIP) to address her street homelessness. She continued to breach her CPWL. She was described as looking in a very poor state, displayed weight loss, her hands were turning blue, and she had a loss of teeth. There were two further detailed Merlin ACNs completed by the SNT PC in November and December, which both highlighted her poor physical appearance. On the first occasion in November, police decided due to potential language difficulties she should be issued with a map to show where she was prohibited from begging. On the second occasion she was referred to Street Link.

Comment: ***The PCSO should have considered referring the identified concerns and the potential coercive behaviour, and this issue has been addressed within the MPS report.***

3.15 During December Thames Reach LSR state there was a general assessment in their notes and a first suggestion that Mia was being controlled by her partner as she said she found it difficult to get away from him. There was a referral made to the Local Authority emergency SWEP (Severe Weather Emergency Protocol) accommodation on the 8 December. There was also an offer of support to reconnect with her

family, but she declined. This was a suitable offer considering Mia's situation at the time. LSR made a referral to the Thames Reach's, Supporting Women (I) Toward Change (SWITCH) with a first meeting recorded on the 10 January 2018 as Mia was generally known to be squatting and not a regular rough sleeper on the street at that time.

3.16 **2018 -** On the 6 February as SCAIT could not get a response from their attempts to speak with Mia the police (if they saw her) were requested to ask her to contact SCAIT so they could discuss the referrals received for her. This it is suspected relates to the third Merlin submitted in December 2017, which had taken some time as ASC SCAIT were having difficulty seeing Mia. However, this Merlin is one of two that ASC have not recorded in their IMR.

3.17 **Merlin ACN (4).** On the 10 February, Mia was arrested for begging and breaching her Community Protection Notice (CPN). She was charged with both offences and remanded in custody to attend court. The begging charge was withdrawn at court two days later when she attended. For the breach of her CPN she was fined £150 with a £30 victim surcharge. A Merlin report was completed and described Mia's physical condition as infirm and weak. The completing SNT officer highlighted previous Merlin reports regarding Mia. This showed good practice on behalf of the officer who was drawing the attention of partner agencies to Mia's circumstances and his increasing concerns for her.

3.18 On the same day both Thames Reach LSR and SWITCH workers recorded Mia had indicated concerns of physical and emotional abuse from Adam and her local drug dealer. This corresponded with a referral made by Thames Reach to The Green Room (Refuge) to resolve her rough sleeping and to help manage her other risks. Throughout January to March 2018 there were multiple interactions and persistent offers to encourage Mia to access The Green Room made by her Thames Reach key workers to accept the help being offered, which she did not readily engage with or accept.

Comment: ***Thames Reach highlighted the support they were providing during this period, although there is no evidence of any discussion to address this or signposting her to support services, which was a missed opportunity which has been acknowledged.***

3.19 On the 12 February, Change Grow Live (CGL) as a drug and alcohol recovery service in Lewisham offering support to anyone over 18 across the borough, say Mia attended a required assessment following her arrest for begging. She provided a positive Cozart drug test[3] for heroin and crack cocaine at Lewisham Police Station following her arrest. As a result, she was required to attend an assessment with a CGL custody-based worker in the City of Westminster who had contact with her. She presented to CGL, and an appointment was made to attend Turning Point on the 21 February, but she fell asleep in a station toilet, so her Thames Reach workers rearranged her appointment to the 28 February.

3.20 Mia was informing Thames Reach that she was finding it difficult to leave Adam due to his emotional blackmail. Prior to the rearranged appointment on the 26 February Mia was placed in The Green Room who were advised that Mia had been found on the street by her outreach workers and brought to the refuge after fleeing domestic violence and that she would be at risk if she returned to Lewisham, but she left the refuge the following day and returned to be with Adam.

3.21 On the 5 March, Mia was supported to access The Green Room by her Thames Reach workers, but again left the following day after her key workers went with her to attend a GP appointment. As she was over an hour late, the GP could no longer see her, but she attended a rescheduled appointment on the 9 March where her GP prescribed antibiotics and she was given a medical certificate. Mia was advised that she needed to return the following week to see the practice nurse for a full examination and to also see her

[3] All police forces in England and Wales can introduce self-funded drug testing on arrest as an approach to reducing drug-related offending. Home Office 2012.

GP. On the 13 March her GP prescribed another course of antibiotics for sore hands that she had. Her blood pressure was very low, and she was informed that she needed to eat and drink more. It was noted by her key workers and shared with her GP that she had not always taken her prescribed methadone regularly and had not been accessing The Green Room.

3.22 Thames Reach confirm in contact with her on the 15 March that Mia felt desperate to address substance misuse and "*does not want to die.*" She agreed to arrange a joint visit with her partner Adam as he was putting her under emotional blackmail that no-one was helping him with his own health problems. Mia was reminded and made aware she was meeting a key worker the following day for Immigration and Turning Point (who deliverer integrated care in the community) appointments. She was worried about seeing the Immigration Service but was reassured and attended on the 16 March as arranged. At the meeting she was informed by Immigration Service that she has to report every month to them.

3.23 Through April and June Mia's health continued to be a concern as recorded in police CRIMINT intelligence reports and by her Thames Reach worker who were continuing to support her. She was again placed in The Green Room on several occasions during this period but as she had done before, Mia left the next day. In April a PCSO noticed Mia did not look well, her skin was yellow with blisters and sores on her face. A Merlin should have been completed and a MPS recommendation addresses this contact. In June, Mia was seen begging, she tried to run away and struggled violently with police. She was charged with begging and resisting arrest and detained for court. It was noted on the custody record that Mia had pains in her arms and legs, a deep venous thrombosis (DVT) abscess and swollen infected hands. The arresting officer could not recall Mia's physical state and was a new probationer at the time and did not consider a Merlin ACN. Mia, however, was taken to UHL's Emergency Department (ED) for treatment complaining of a left groin and leg swelling pain due to intravenous drug use the day before. She was accompanied by two police officers, and after treatment, she was discharged back into police custody. Mia appeared at the Magistrate's Court the following morning and was given a twelve-month conditional discharge.

3.24 CGL reported in their risk and recovery plan, along with a medical assessment completed for the Coroner subsequently after her death, that during this time she had a history of abscesses in her arm, DVT in her left leg and swelling. She also reported hematemesis and that she was Hepatitis C negative but with positive antibodies. They record she had a history of mental and behavioural disorder due to opiate dependence, injecting both crack and heroin into her groin. She started medication assisted treatment but she only remained on this treatment for one week. The only medical assessment she attended was on the 6 August 2018, but she had been seen by her GP who had further referred her to a Gastroenterologist at UHL, regarding her health and medical concerns. There was no apparent contact between the CGL and her GP, but Mia's Thames Reach outreach workers were communicating with other services such as Turning Point, The Green Room and her GP practice and within the arranged Probation meetings as outlined below.

3.25 During June, Thames Reach were helping Mia (who had lost her identity card) to receive a replacement by contacting the relevant Consulate and also writing a letter to the Department for Work and Pensions (DWP) regarding her benefits as she had no *'recourse to public funds'* which was not assessed fully (see Chapter 5, SAR recommendation 2). There was also liaison on several occasions with her GP for her medication when they attended the appointments with her. Appointments were also made with the local Jobcentre and assistance regarding obtaining a bank account for her. Mia was also made aware that she could still access The Green Room during this period. On the 11 June Mia was seen by her Thames Reach workers where they offered to take her to hospital, but she refused.

3.26 **Adam possibly assaulted Mia (3).** On 13 September, a SWITCH member of staff saw Mia whilst sitting on the bus. It was observed that a male slapped Mia in the face as she tried to walk away. From the description it was believed to be Adam, and SWITCH passed the information on to her Thames Reach key worker, who in turn did not refer this DA incident. This is identified learning within this review. Furthermore, Probation confirmed that Mia appeared in a local Magistrates Court in October for offences of begging in a

public place and failing to comply with a community protection notice that occurred previously. Upon conviction, she was sentenced to a 12-month Community Order with a 10-day Rehabilitation Activity Requirement, and she was allocated to the London Community Rehabilitation Company (CRC), a private sector supplier for Probation and Prison based rehabilitative service for offenders on 26 October 2018 and Mia's case was allocated to a Probation Officer (PO). Mia was required to report to Probation and had sixteen planned office visits and attended eleven in total. On two occasions she did not attend without a reasonable excuse and on three occasions she did not attend, but had a reasonable excuse, namely on medical grounds. Often Thames Reach and their Advance Minerva[4] keyworkers would attend the sessions to collaboratively offer support to her.

3.27 Mia's recourse to public funding**.** In October Thames Reach informed her she was not eligible for any benefit due to her EU status. This was apparently due to Brexit, there was a one-to-five-year break in her residence that needed to be accounted for if she was to meet the five-year residence rule for settled status. Then in November Probation conducted an OASys (Offender Assessment System), Initial Assessment and Sentence Plan, and considered the risk posed to herself was due to her chronic heroin misuse (£100 a day believed for both her and Adam) whilst not engaging in any form of substance misuse intervention. The initial sentence plan assessed that if she engaged, she could gain employment and could work on her drug related issues independently and disassociate herself from her abusive partner. The risk of harm was identified as imminent as she was not seen to be engaging with services, which she was to a certain extent, and that she was in a domestically violent relationship with a partner. Probation suggested in their assessment that Mia and Adam were co-dependent on each other. During one of the planned office visits, the PO states Mia reported a pain in her leg which Mia believed was caused due to injecting into her groin area and her hands were swollen. She was encouraged to attend hospital and the PO wanted to call an ambulance for her, but she declined the offer. She said that she would attend herself on the bus and was supplied with a bus ticket. Probation's case file on Mia was still open up to the date of her death.

3.28 **Merlin ACN (5).** Mia was spoken to by police officers in the street on the 22 November and a Merlin was completed. She had a number of scabs over her face, her hands were cold and swollen and her complexion was sallow. Her appearance gave them cause for concern, especially in light of the inclement and cold weather at the time. She said that when she couldn't afford to pay her friend rent and slept in the local supermarket car park several times a week. She admitted that she had a heroin and crack addiction that cost her £50 a day, had previously been referred to ASC and Street Link, but did not engage with them, and failed to meet the threshold for a placement into suitable accommodation with SHIP. Police again included a full report which contained salient points regarding Mia's vulnerabilities. She was referred to the Athena service via email on this day by the PO following a disclosure by Mia that about a year previously she experienced domestic abuse from her partner and continued to be frightened of him. Unsuccessful attempts were made by the Independent Gender Violence Advocate IGVA) to engage with Mia including requests to other professionals such as Lewisham CRC, Thames Reach and Advance Minerva key workers to help make contact, as Mia was not answering her phone calls. Between November 2018 and March 2019 staff at the Athena service made ten calls to Mia in an attempt to offer support. The service received one call back from Lewisham CRC and one from Thames Reach workers who at the time of this call were with Mia, but it was unsuitable for her to communicate with them as she was on the street.

3.29 Between the initial referral dates in February until the end of November, ASC made four telephone calls to Mia without success. They say that after receipt of every Merlin they persisted in trying to make contact with her via her mobile number including contact with her outreach worker to facilitate access. This eventually paid off, and on the 28 November 2018 ASC made contact with Mia on her mobile, but she is

[4] **Minerva Wrap Around**, is a new service, designed and delivered by Advance Charity and funded by MOPAC. The service will provide enhanced, specialist support to women and girls over 15, with **complex multiple needs** who have **committed crime** and are at risk of re-offending.

reported to have requested for a call back as she was 'going to probation'. The following day a call was made to Mia but there was no answer. A voice message was left on her mobile for a return call. She did return the call, and, on the 30 November ASC SCAIT managed to see and obtain Mia's history regarding her drug use and homelessness. It is not known if they were aware of the IGVA attempts to contact her. SCAIT confirmed she had a key worker from Thames Reach which is connected with "Street Link" and had received support for the past year, who knew she did not have any income and could not be housed. It was noticed by SCAIT that her hands were quite red and swollen when she was seen, and advice was given to see her GP. They passed Mia's details onto SHIP for further housing advice and support, and for her drug use she was signposted to CGL. SCAIT closed Mia's case due to the ongoing work and the referrals that had been made. There was no consideration to conduct a Section 9 care and support assessment, or a Section 42 Safeguarding Enquiry, which would have been appropriate, and as such was also a missed opportunity to assess her recourse to public funds.

Comment: ***There needed to be supervision oversight to ensure that a safeguarding plan was implemented to address her many complex health and lifestyle concerns, and to identify what agencies were working with her. A Multi-Disciplinary Team or Agency meeting should have been called in an attempt to capture and understand the wider aspect of Mia's case. ASC having received an adult safeguarding referral, should have ensured that every step was taken to try to engage with Mia and the outreach workers to assess the coercive control that Adam had over her, which was never fully investigated or understood by agencies linked to this SAR. Safeguarding Adult Managers (SAMs) should ensure these adult safeguarding concerns are identified and that appropriate action is taken, but this did not happen in Mia's case.***

3.30 CGL state that Mia was last seen on the 18 December when she dropped into the service, and was seen by a nurse and subsequently advised to attend her GP or hospital due to a sore on her leg.

3.31 **2019.** On the 2 January Mia called police alleging she was being assaulted. Police attended but she had no injuries. It later transpired that the matter was a civil dispute over rent owed by her. It is reported that the '999' phone operator could not understand her and had to employ an interpreter to get the full details of the initial allegation. The officer who dealt with Mia at the scene said she could speak enough English to make herself understood. On this occasion she did not confirm her allegation of assault. (See the following contradictory entry).

3.32 Three days later Mia was seen begging. As officers moved her on, they asked her how she was. She mentioned that she had been assaulted a few days earlier and her head was in pain. She gave more details about the incident that she was waiting for a drug dealer to arrive to supply her and another male acquaintance. After waiting for 40 minutes, they had an argument as Mia did not want to wait any longer and started to walk away. This other male went after her demanding the money for the drugs. She refused and he grabbed her by the throat, punched the back of her head and slapped her. Mia managed to get away but came across him a short while later. He began following her and got on the same bus as her, so she called the police. Police attended but the matter was treated as a civil dispute.

Comment: ***A full statement was taken from Mia on the 6 January. The following day the male perpetrator was arrested for assault. He admitted grabbing Mia and using force to try and prise open her hands to get the money. He received an adult caution for the assault on the same day. Mia was informed of the result by phone. It is unclear why she felt able to furnish the second officer with enough details to investigate a crime in comparison to the first account.***

3.33 **Merlin ACN (6).** On the 15 January an Adult at Risk Merlin was created for Mia as a result of her approaching officers in the street for help and assistance. She was now sleeping rough in the car park of a local supermarket and was trying to come off drugs; however, sleeping rough exposed her to other drug dealers and users. She was trying to secure permanent accommodation having previously been referred by police to Street Link. The officers contacted SHIP to see how she could receive assistance from them. It was

planned that the following day officers would make contact with her to advise her that she needed to present herself to her local office where staff from SHIP would try to assist her.

Comment: ***Again, this was excellent support provided by the local police who were aware of her vulnerabilities and that she was an adult clearly at risk. ASC SCAIT acknowledged the Merlin and notified SHIP for their information and Mia's case went to the March 2019 DV MARAC meeting (see below).***

3.34 Police spoke to Mia again on the 23 January, where she confirmed she was still homeless and was looking to be placed somewhere in the Dartford area. She told police (information from CGL and her Thames Reach key worker) that she was currently on a methadone programme and disclosed she still used crack cocaine three times a day. There was no mention of her physical condition on the CRIMINT intelligence report completed.

3.35 **DV MARAC.** A meeting was held on the 6 March for Mia with agencies expressing concerns about Mia's long-standing history of DA at the hands of her partner Adam. He was taking advantage of Mia financially, and by their occasional landlord. Actions were for the IGVA to liaise with the Rough Sleeper's Service and to engage with Mia, and CRC on behalf of Probation, to contact Mia.

On the 21 March the IGVA called her Thames Reach worker to ask if she could facilitate contact with Mia. The Thames Reach worker explained that the client was booked to attend a meeting with her and ASC on Monday 25 March. The IGVA and Thames Reach worker agreed for the Thames Reach worker to support Mia, and for her to call the IGVA (who could not make the meeting) before or after her appointment with ASC so that the IGVA could introduce herself and meet up with her.

3.36 **Merlin ACN (7).** A further Merlin by a PCSO was completed on the 22 March as a result of a number of previous incidents of begging and drug offences. It was noted she had by now been previously referred to various agencies, including ASC, SHIP, Street Link and MARAC due to her vulnerabilities, but there was a stated difficulty by agencies to engage with Mia. It records she was a heavy drug user, and her appearance and health had deteriorated over the previous years. It further recorded concerns from her outreach worker that Mia was currently staying in a crack den and would be found dead in the near future due to her dramatically deteriorating health (This comment was prophetic). The report recorded that it was still believed she was in a relationship with Adam, despite previous DA incidents involving him.

3.37 On the 26 March, Mia called her new GP practice (GP2) as she had moved a month previously and was using another address (a squat/temporary accommodation known to Thames Reach) stating that she had been bitten by a rat three days before in her groin area. She had a weeping wound and a high temperature and was advised to go to hospital, but she did not attend. Thames Reach had concerns about the address she was in and believed she had been financially exploited by the landlord which they discussed with the Crime Enforcement and Regulations Team. This information does not appear to have been further explored or developed by sharing the information with other agencies.

3.38 **Adam (believed) assaulted Mia (4**). On the 14 April Mia called '999" alleging that she had been punched in the face by her boyfriend. She then abandoned the call. When she was called back, she was reluctant to talk, but gave her home address. Officers attended but were unable to locate her whereabouts. As the boyfriend was unnamed, and despite prompting from a supervisor, no further action was taken. The MPS IMR identified this report did not conform to the minimum expected standard for a DA investigation, considering the known history of Mia. There was no professional curiosity displayed, no attempt to reconnect with Mia given that a suspect may be present and no Domestic Abuse, Stalking, Harassment and Honour (DASH) risk assessment tool, closing report or rationale completed. This would have been expected and is therefore addressed by a MPS recommendation.

3.39 On the 9 April CGL called Mia on the phone who advised them she had an infection in the wound site in her groin where she was injecting, and her leg (it was not recorded which leg) was swollen and discoloured.

She was advised to attend her GP or A&E and she stated her GP had given her a letter to take to the hospital. She was further advised that if she attended for opiate motivation treatment on the 11 April 2019, CGL would ask a nurse to look at her injection sites and support her to go to hospital, if necessary. Mia did not take up this CGL offer. She did, however, attend UHL ED for trauma and muscular pain to her hip, leg/knee and ankle/foot. She attended with a Thames Reach LSR outreach worker, was treated and referred back to GP2.

3.40 There were four appointments arranged in May and June 2019 for the IGVA to meet with Mia, but she did not attend, and a fifth appointment was made for July which was after the notification of her death. The IGVA sent twenty-one emails to CGL, Thames Reach and Advance Minerva to see if they could facilitate contact and as stated previously they were working with Mia, not all of which were responded to. The IGVA called Mia on seven occasions without success and never managed to speak to her. Improvements to the service to assist contact in the future have been addressed by a Refuge recommendation in the review.

3.41 **Adam assaulted Mia (5 and 6 not reported)**. On the 21 May and 20 June Mia made Thames Reach outreach workers aware she had been physically assaulted (believed by Adam). On both occasions she was offered support to report this to police, but she was reluctant to do so. It would have been an opportunity on both occasions to make a formal safeguarding referral, (there was also no referral for a possible DA against Mia (3) above in September 2018). Staff did however refer Mia to other support agencies and services such as Advance Minerva for support. There was a missed opportunity to re-refer Mia to the DV MARAC as a Repeat Case.

3.42 During this period Probation, along with Thames Reach and other agencies partners, held two multi agency client case review meetings. On the 17 May she did not attend, but on the 26 June she attended the case review with a friend from a Church, also present were Thames Reach, Probation and Advance (Minerva) although the IGVA could not attend. There was a discussion about how Mia could engage with the IGVA, and it was reported that an accommodation offer for The Green Room was declined, as Mia wanted accommodation in Lewisham, and so she returned to the streets.

Comment: C*onsideration should always be given to reporting allegations of domestic abuse to the police, and it would also be relevant to report the Safeguarding Concern to ASC if the professional believed that the safeguarding duty/criteria under the Care Act 2014 had been met.*

3.43 Also in June, Mia's Consulate were approached by Mia's Thames Reach key worker for a passport for her, but declined to help her as there was an outstanding arrest warrant for her in her native country. Mia suggested she had not completed what is believed are the terms of a probation order (actual details are not known to this review).

3.44 The last recorded police information for Mia was a CRIMINT intelligence report on the 13 June. It relates to information received that Mia and her boyfriend Adam had been sleeping rough in an area where lots of used needles had been found. Mia had been approached by a local resident and was asked to stop leaving the needles lying around. She responded by swearing and threatened to stab the resident with a dirty needle. This information was noted for officer safety linked to her increasingly aggressive behaviour and the fact she might be carrying around used syringes.

3.45 Period 3 - The death of Mia.

3.46 On the 3 July 2019, Mia was brought to UHL by ambulance after complaining of generalised weakness and chest pain stating that she had used crack cocaine. Mia appeared to be in a critical condition when she arrived in hospital. She was given appropriate treatment. Her partner Adam was involved at the hospital and was given information about her care and condition. Despite full active treatment, with multi-organ support, she failed to improve and died at 7.07pm. The cause of death was given as septic shock. Her case was referred to the Coroner and the SAR is unaware if there will be a formal Coroner's Court inquest.

3.47 Police were informed of Mia's death the next day on the 4 July 2019 by a member of the public, who also stated that Adam had injected her with the dose that led to her death. This information was recorded on the CRIMINT, assessed by the Local Intelligence Team (LIT) and is marked as being passed to the safeguarding team for review. Police enquiries concluded that the allegations were baseless. Mia's death was concluded as a non-suspicious sudden death, but their enquiries did not comply with MPS Standard Operating Procedures (SOP) that were updated in December 2020, as a sudden death Merlin and a third party CRIS investigation report should have been created.

Chapter 4

4 Analysis of Key Questions of Professional Practice from the Terms of Reference and the Practitioners Event.

4.1 This chapter analyses and assesses the responses from the agencies IMR's and professionals' views from the practitioners' event, and from the SAR Panel meetings that were held in order to evaluate professional practice in their interaction with Mia. All of these views are encompassed within the narrative of this report and within each of the specified key questions outlined within the Terms of Reference. Agency IMR authors responses to the questions asked are:-

4.2 Key Question 1. Were practitioners sensitive to the needs of the adults at risk in their work, knowledgeable about the potential indicators of abuse or neglect, and about what to do if they had a Safeguarding Concern about an adult with care and support needs in these circumstances? Agencies were sensitive to Mia's care needs and recognised her as an adult at risk. There were numerous agencies who were aware of Mia's lifestyle, but no agency or practitioner was aware of the wider impact of the risk that was posed to her, or considered other initiatives and methods, which a pool of professional knowledge may have identified. It was established that Thames Reach, although sensitive of Mia's needs, did not raise formal Safeguarding Concerns on three occasions for DA. Missed Merlin ACN's were identified by MPS, and other agencies who were interacting with her on a regular basis, as outlined below, could also have made a referral to ASC.

4.3 There was, however, excellent support provided by the Thames Reach outreach key worker and by other professionals, most notably the SNT and PSCO officers who supported Mia, who only arrested her as a last resort and submitted detailed Merlin ACN's for Mia as an adult at risk.

4.4 ASC SCAIT staff undertook the necessary actions on receiving the initial referral and ensured Mia had been referred into the next MARAC meeting in 2017. SCAIT subsequently closed the case as she was being dealt with by outreach workers and her case was referred to SHIP regarding possible accommodation. After several further Merlin ACN's were submitted, Mia was discussed in her final MARAC meeting in March 2019. This review has noted that two Merlin's are not referred to in the ASC IMR, which is also addressed within the findings in Chapter 5. More professional curiosity should have been considered to ensure Care Act assessments were carried out for Mia.

4.5 Probation readily identified Mia as an adult at risk early in their contact with her. Throughout the duration of Mia's Community Order her PO appeared to be sensitive to the potential indicators of risk evidenced through their OASys initial assessment, and through the sentence plan they completed. The PO further identified potential indicators of abuse from Adam, and appropriately supported a referral to Athena and participated at the final DV MARAC panel meeting. The IMR Author confirmed a referral should have been completed to ensure that Lewisham ASC were aware of these concerns.

4.6 Both Mia's previous GP1 and current GP2 practices were very familiar with the needs of adults at risk and of Mia. GP2 was fully aware of Mia's issues with substance misuse (heroin and crack) and also that she was registered with the practice address as "care of" to assist contact with, and for her.

4.7 SHIP were clear that on the brief presentation of Mia, that her file did not indicate that officers went far enough in their initial assessment in terms of the eligibility for assistance. This suggests a referral would have been expected to have been made to ASC, or a Safeguarding Concern raised given the information recorded. There was communication between the service and SCAIT, however any result of this contact was not recorded. There was a plethora of support given to Mia regarding her individual needs and concerns raised with multiple agencies according to SHIP.

4.8 Mia was referred to the Athena service in November 2018 and her case remained opened until after her death. During this time duty workers spoke to Mia on two separate occasions. The first time the duty worker spoke to her she was under the influence of illicit drugs. The IGVA recognised that it was not safe or appropriate to continue with the assessment and rescheduled the call for a more convenient time. Apart from the disclosure that Mia was under the influence of illicit drugs, there were no safeguarding concerns flagged. On the second occasion when a duty worker spoke to Mia, it was not safe for her to continue the conversation at that point (she was on the street). Following that the IGVA could not make contact with Mia even when requesting assistance from other agencies.

4.9 Key Question 2. Did the agency have in place policies and procedures for safeguarding adults at risk and acting on Safeguarding Concerns about abuse or neglect? All agencies in the review confirm there were up to date policies and procedures in place, which are subject to comment where relevant and addressed within the agency and the SAR recommendations in the following chapter.

4.10 Key Question 3. What were the key relevant points/opportunities for assessment and decision making in the case in relation to these adults? Do assessments and decisions appear to have been reached in an informed and professional manner? ASC state it was difficult to conduct assessments as there were many unsuccessful attempts made to make contact with Mia on her mobile number. ASC was contacted by an assigned police officer who had been in contact with Mia and gave ASC her new mobile number, but there was still no reply from Mia. In a further effort ASC made contact with Mia's Thames Reach outreach worker, but this again proved unsuccessful. In view of not having any contact with Mia, ASC missed the opportunity to undertake any form of assessment. The PCSO's seemed to have an intimate knowledge of where Mia was, and as ASC have a duty to engage with Mia, should have arranged to go with police or an outreach worker to a likely location where she may have been in order to attempt to locate her, which the IGVA should also have considered as discussed below.

4.11 Thames Reach attended two recorded multi-agency case review meetings with Probation in May and June 2019. Mia was invited to both meetings and attended the second one on the 26 June 2019, one week prior to her death. This meeting was attended by Advance Minerva who provide specialised support for women in the criminal justice system. Notes of the first meeting record that Mia failed to attend and confirmed there was a lack of engagement with the IGVA. Advance Minerva were tasked to discuss Mia with her Probation Officer and Crime Enforcement and Regulation Service to assert stricter requirements to engage with support. At the June meeting Mia attended with a friend from a Church along with Thames Reach, Probation and Advance Minerva representatives who generated a further action for Mia to engage with the IGVA. As stated previously she was offered accommodation at The Green Room, which was declined at the meeting, as she wanted accommodation in Lewisham (the first indication of the reason why she was not accepting this accommodation offer). Action was made to continue monitoring her welfare as she had returned to rough sleeping.

Comment: ***At the second meeting, Mia was told she still had to report to the Home Office every two weeks but was now refusing to go. She was not a habitual resident and was not exercising her treaty rights (she was not working, had no accommodation and was not studying) and was unable to access benefits but could have support registering at the Job Centre. She was again reminded she needed to report to the Home Office, or she could be served with a 151A detention order, and thereafter possible deportation. It was observed Mia did not look well and everyone expressed concerns regarding her health. As she had no recourse to public funds, ASC should have completed care and support assessments in order to ensure that her ECHR human rights were not breached by establishing what support was necessary, including her possible repatriation.***

4.12 The CRC IMR felt that the Probation assessment was comprehensive, but Probation focused solely on 'safeguarding' children (the CRC IMR author's view) and did not identify Mia as presenting as a potential

safeguarding adult case due to her vulnerabilities. The OASys initial assessment and sentence plan conducted in November 2018 did correctly identify that Mia presented as a risk in relation to self-neglect due to her failure to seek help or access services to meet her physical health needs. It is considered that a referral to ASC should have been made under the category of self-neglect because of these indications which suggests that Probation were considering her vulnerabilities in their case management meeting with Thames Reach and Advance Minerva workers.

4.13 GP1 recorded Mia's registration with the surgery until 2018, where she attended the GP Practice on six occasions and was consulted by a senior clinician on five of those occasions. The GP record the treatment was appropriate to her problems and onward signposting to other services was appropriate for her needs. GP2 state her case appeared to relate to her acute medical issues and problems. Mia was seen, assessed and examined. A safe management plan was constructed, and she was informed of the risk and given clear advice about the need to be assessed urgently in ED. Letters were given to her on two occasions to encourage her to attend hospital. She was also seen with her Thames Reach outreach worker in a consultation in relation to her medical conditions for extra support. When Mia's results were available, the doctor proactively contacted her.

Comment: ***The GP surgery was used as a forwarding address, which was the first time they had considered such action. At the practitioners' event, the other attendees were unaware of this fact and as such this information and the contact details should have been more widely shared.***

4.14 CGL as a voluntary sector organisation offer one-to-one key work sessions, group work (psychological and social interventions), opioid substitution therapy, alcohol detoxification and opportunities for peer support. CGL did not manage to effect any assessment of Mia due to difficulties in contacting her, and there was no engagement from Mia in return as she may not have been aware of their intended involvement with her.

4.15 At her presentation at UHL as a victim of assault in July 2017 no Safeguarding Concern was reported to the adult safeguarding team and as such this may be classed as an unsafe discharge. The IMR author believes this was due to lack of professional curiosity or unconscious bias. At the time of the assessment there was no set question in triage to highlight if the patient had been a victim of DA, therefore no Safeguarding Concern and subsequent referral to victim support was submitted. At the three further presentations Mia was accompanied by other agencies and the safeguarding risks she was facing were being addressed at the time. The last occasion was when she passed away.

4.16 SHIP's only relevant opportunity for assessment was the initial interview they had with her in October 2017. They state (as recorded above) that due to her residence and working status that Mia would not have been eligible for housing assistance, however the initial assessment focused on whether immediate interim accommodation could be given, which was an incorrect way of making the assessment and is learning for the agency. It is unclear whether this was followed up properly from the information on agency files. Support was offered, contact maintained, and an assessment made by the Rough Sleeping Coordinator, which was a new post from October 2018. This officer worked with all rough sleepers in Lewisham to coordinate support for them. It is clear from the external rough sleeper database CHAIN (Combined Homelessness and Information Network) that support services and others were working with Mia in a previous capacity as an identified rough sleeper but were "thwarted" by the challenges they encountered with Mia.

4.17 The Athena Refuge and DV service had two direct contacts with Mia. These were in December 2018 and February 2019 but there were no opportunities to complete an assessment during these brief interactions. There were missed opportunities to contact Mia due to the inbuilt disadvantages of the system at the time as there were no allocated workers, and as a result staff were not familiar with the clients' circumstances and therefore unable to appropriately prioritise calls. Between November 2018 and March

2019 there were five further attempts to contact Mia. These calls included a request from the PO on the 28 November 2018, a call from Thames Reach worker (duty worker unavailable) on the 9 January, and two cases when the Athena duty worker agreed to call on 15 January, the 19 and 25 February 2019, although these were not made. A new procedure has now been developed which requires all new clients referred to the service to be assigned an allocated worker straight away who will be familiar with, and be able to prioritise calls to clients accordingly.

4.18 Key Question 4. Did action accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made in the light of assessments? (This is also addressed in Question 3 above). In December 2017 Thames Reach were aware Mia was being controlled by her partner and she was finding it difficult to get away from him. A referral to Local Authority Emergency SWEP (Severe Weather Emergency Protocol) accommodation was made and an offer of support to reconnect to her homeland was declined. They referred Mia to other services such as the SWITCH service as Mia was generally known to be squatting and not a regular rough sleeper on the street, to The Green Room for accommodation (that was declined as discussed above), and for the MARAC held in March 2019. There was no referral for specialist support to the Athena service, this was a missed opportunity. Thames Reach highlighted an awareness of Mia's substance misuse but there was no evidence of discussion to address this or of signposting the risk to other support services. This was a missed opportunity, but the priority and focus was getting Mia out of the DA situation and placing her in secure accommodation away from an abusive partner. What is concerning as referred to in Chapter 3, was the fact that there were three potential occasions when outreach workers did not report the additional domestic abuse she allegedly sustained at the hands of Adam, which is addressed within the findings and subject to a SAR recommendation in Chapter 5.

4.19 Probation confirm their initial assessment and sentence plan correctly identified presenting risk factors, which is outlined within the narrative in Chapter 3. Police appropriately submitted Merlin ACN's for Mia as her situation indicated that she was an adult at risk.

4.20 GP2 determined that when Mia's condition warranted more acute therapy, she was advised multiple times to attend ED and was given letters to help her when attending. The CGL service mainly focused on trying to engage Mia in treatment. Information was sought from GP2 to support treatment and for outreach support to try to engage her in obtaining treatment. UHL referred her to other professionals, but she did not attend the appointments to have a 'Doppler assessment' (an ultrasound and non-invasive test that can be used to estimate the blood flow through blood vessels) for her left leg and Gastroenterology.

4.21 SHIP's assessment as stated previously was not carried out in the correct manner. It is accepted that Mia would not have been eligible for housing assistance given her status in the UK as an EU national. SHIP's IMR Author states that as the process was not rigorous, this cannot be completely confirmed from their records, but they suggest that the actions carried out by the Rough Sleeping Coordinator and other services were appropriate and correct. They do not elaborate any further, and as they state, the assessment was not up to standard and as such is identified agency learning.

4.22 Key Question 5. Where relevant, were appropriate care plans in place, reviewing processes complied with, and how did they involve relevant risk assessment in protecting the adult at risk? This question is addressed above. There was no ASC safeguarding plan completed for Mia. Thames Reach however, had action plans recorded in relation to resolving Mia's immediate risk of abuse from her partner and to help resolve her homelessness. Thames Reach confirm from their attempts to support Mia that she was not eligible for benefits and the offer of supported reconnection to her home country was declined by Mia as discussed above, where it was thought she would more likely be entitled to statutory support and connected support services. Key workers were persistent with their offer for accommodation throughout January to March 2019 at The Green Room for her. Although, there was a lack of consideration by the local

authority as a person in need with no recourse to public funds, for a Sec 9 assessment or Sec 42 Enquiry, which was another missed opportunity.

4.23 Probation had a sentence plan including a risk assessment plan to mitigate risk. CGL suggest if Mia had engaged more consistently, there would have been an opportunity for her to be more involved in her care plan and risk planning, but this was because of the difficulty in the Recovery Worker making contact with her. In response to this view, there should have been more proactive steps taken to consider engaging with Mia by attending the area with other professionals who knew her usual location, which would have assisted in the mitigation of risk to fully understand the reason why she did not engage with CGL.

4.24 Key Question 6. Were more senior managers or other agencies and professionals involved at points they should have been? Thames Reach conclude there was no clear evidence that Mia's case was routinely raised and discussed in staff supervision sessions. The missed appointments affected Mia in getting the support when she needed it and should have been addressed with and by senior management. The Athena Refuge IGVA worked with the Lewisham CRC PO, the Thames Reach worker, and Advance Minerva's worker to establish contact with Mia and discussed Mia during supervision with a line manager. Probation Managers were involved at the point of allocation, and at the point of death, with evidence of professional involvement and collaborative working from the PO who at a number of points, could have discussed concerns about Mia and sought management oversight.

4.25 GP1 confirm Mia was mainly seen for consultation with the senior partner and clinicians in the Practice. GP 2 had contact with the SCAIT team to find out if the patient had attended A&E. This appears to be an appropriate contact. CGL's designated safeguarding lead and staff from the management team were involved in discussing safeguarding concerns in regard to her relationship, and ASC were approached for further guidance and support.

4.26 In 2017 ASC flagged the police Merlin report to both the MARAC lead and safeguarding manager. The safeguarding manager attended the MARAC where Mia's case was discussed, and an action plan was agreed to facilitate contact with Mia via the SNT. There were further Merlin ACN's, and a final Merlin resulted in the March 2019 DV MARAC. There appears to have been no effective supervision during the intervening period (MPS record 7 submitted but ASC only refer to 5). There was an opportunity for a Safeguarding Adult Manager (SAM) within ASC to have called a multi-agency meeting to agree a safeguarding plan and bring together all the agencies involved with Mia's case. This could have captured the overall picture of her needs and the risks posed, but there is no record supplied to the review that a SAM or other manager was involved in Mia's case and had oversight of this.

4.27 Key Question 7. Was the work in this case consistent with agency policy and procedures for safeguarding adults at risk of abuse and neglect, and wider professional standards? Generally, agencies and professionals record in their submission to the review that they followed relevant policies and procedures. Where there was a deviation, such as missed opportunities by some professionals to submit a statutory safeguarding concern and or a Merlin ACN, this is referred to within the narrative of this report in individual agency IMR recommendations, and also referred to within the findings and SAR recommendations in the following chapter.

4.28 Key Question 8. Was mental capacity considered and/or any formal Mental Capacity Assessment conducted and recorded? In reviewing this case there was no MCA completed or consideration given to obtaining advice from a relevant professional or an IMCA considering the worrying and high-risk lifestyle that Mia had. Professionals at the practitioners' event believed that due to her complexities an IMCA should have been considered, even though most suggested in their interaction with her, that she 'appeared' to have the capacity to make her own relevant decisions.

Probation considered Mia's mental health (15 November 2018) and completed a 'Kessler 6' mental health assessment, which required no further action. Although this was not directly linked to her mental capacity, Mia advised during this assessment that she had no mental health issues other than stress due to her personal circumstances, and denied any thoughts of suicide or self-harm. The PO still had concerns about her general health and the impact of Mia's long-term substance misuse, domestic abuse and coercive relationship with Adam should have triggered a mental capacity assessment.

4.29 Key Question 9. Were practices sensitive to the racial, cultural, linguistic and religious identity of the adult? If this was a relevant factor, was it cited and explored appropriately? There is no evidence to suggest from agencies that there was any significant concern regarding this question for Mia. Her spoken English was recorded as 'high' as she was able to converse in English with multiple key workers and professionals. MPS officers supplied her with relevant interpreted documents to explain the compliance required for the CPN.

4.30 Probation completed an equalities questionnaire at the point of induction. When in supervision Mia declined the assistance of an interpreter as she felt that she could understand the English language. During her final Probation Office appointment an interpreter's assistance was utilised when going through her complex situation particularly regarding her requirement for Home Office contact due to her immigration status. Furthermore, when the Athena service duty worker spoke to Mia, she was not sure if she understood everything, and on each occasion the duty worker spoke to Mia, an interpreter was used. Other professionals such as her Thames Reach workers and SNT police officers who knew Mia had no concerns with her understanding in their communication with her. Mia had a connection with a local church, and this could have been explored further by agencies in order to help co-ordinate, understand her and to improve engagement with services. This SAR cannot answer whether her lack of acceptance of professional help and support that was offered was as a result of cultural issues.

4.31 Key Question 10. Were relevant, appropriate safeguarding or care plans in place, and if so, were these reviewed and complied with? There were no safeguarding or care plans made for Mia as discussed above. Thames Reach have reported there have been changes made to the CHAIN system, which is a multi-agency system used to record contacts with the homeless population wherever they are in London to maintain consistency of contact with this transient community. Thames Reach did not believe it had been the most effective system to monitor when care plans needed to be reviewed. SHIP state that although there were no such plans formally in place from a housing perspective, it is clear that relevant care and support was provided for her, although the findings of this review would disagree with this statement from SHIP as outlined in the narrative and findings of this review.

4.32 Key Question 11. Are there are any particular features of this case, or issues surrounding the death or injury of the adult(s), that you consider require further comment in respect of your agency's involvement? This question is discussed within the narrative and analysis of the key events (Chapter 3) and within the findings and SAR recommendations (Chapter 5).

4.33 Learning. Additional questions regarding learning were asked of IMR Agency Authors, which are discussed within the narrative of this report, and where relevant are captured within Agency IMR's, SAR recommendations and within the key questions above. The additional questions in the Terms of Reference are, **1)** Is there good practice to highlight, as well as ways in which practice can be improved? **2)** Are there lessons from this case for the way in which this agency works to safeguard adults? **3)** Are there implications for ways of working? **4)** Are there implications for management and/or supervision? and **5)** Are there implications for training (single or multi-agency). These are also captured within Chapter 5, the findings and SAR recommendations.

Chapter 5

5 Findings and suggested SAR Recommendations for the consideration of LSAB

5.1 This chapter outlines the findings identified from the analysis of professional practice in Chapter 3 and 4. They are produced for consideration by the LSAB to reflect and implement any learning from this SAR.

5.2 This review recognises that since the commissioning of this SAR significant changes have been made to National legislation, local policy and guidance. The findings identified for this SAR have been reinforced in some circumstances for lessons to be learnt in relation to the new Domestic Abuse Act 2021, the Lewisham Adult Safeguarding Pathway 2021 and Self-Neglect and Hoarding Multi-Agency Policy, Practice Guidance and Hoarding Toolkit, which are summarised within the narrative of this report for reference purposes.

5.3 Homelessness and Rough Sleeping. The Single Homeless Intervention Project (SHIP) have subsequently made changes to their assessment and other processes since this SAR commenced. Lewisham Council now have a specific rough sleeper team which casework each rough sleeper in Lewisham in partnership with a homeless charity providing outreach and other resources. In 2020, due to the Covid-19 pandemic, a suspension of the derogation has been in place meaning that councils had more flexibility in working with non-eligible EU nationals, and the 'Everyone In Scheme'[5] during the initial lockdown, which means that a repeat of this case would have been unlikely in relation to finding accommodation in Mia's circumstances. This is notwithstanding the homeless person's willingness to engage. This has involved maximising opportunities from Central Government funding, which is being pursued, working with key partners, Lewisham PITHC, Housing Options and Community Agencies.

5.4 The new Lewisham Rough Sleeper's substance misuse outreach service made a successful bid in securing £450k for the borough from the Rough Sleeping Drug and Alcohol Treatment Grant. CGL are in the process of recruiting key staff to improve services within Lewisham to build an enhanced nursing and outreach capacity. Having extra dedicated posts for people who are street homeless will help, with the hope that all individuals can be tracked and offered interventions. CGL have also secured an extra £50k for detoxification and rehabilitation services.

5.5 The SAR Report recommendations below overarch, encompass and support Individual Agency IMR recommendations which have not been repeated, as they will form part of an LSAB Action Plan that will follow the completion of this review. The findings and LSAB SAR report recommendations identified are:-

FINDING 1 - Review of Safeguarding Referrals

5.6 **What are the issues and what should be considered?** The most important aspect for safeguarding partners, agencies and practitioners is to ensure that adult safeguarding concern referrals are always completed, risk assessed and submitted for necessary action to protect and support an individual. This should include where appropriate, factors such as in this SAR, namely homelessness, rough sleeping, domestic abuse together with coercive and manipulative control, drug misuse and potential mental health concerns. There is a need for agencies to remind their staff of their obligations for compliance, as this is the method which stimulates action for effective safeguarding processes to begin.

5.7 In Mia's case there were missed opportunities from some agencies and organisations to submit referrals for her, but there were also several excellent Merlin ACN's submitted that did meet the criteria for a Section 42, Care Act 2014 Safeguarding Enquiry.

[5] "Everyone In", pioneered in London, was world leading, and resulted in very low Covid infection rates amongst homeless people.

5.8 This review has also determined that there is a requirement to review agency referral compliance and the launch of the new Lewisham Adult Safeguarding Pathway (31 March 2021) has helped to reframe and publicise this. The MPS Merlin ACN system is being used to inform the Local Authority about general 'vulnerability,' which means that a large number of reports are potentially sent to ASC that do not meet the criteria for the Care Act. As such this creates pressures and delays to the delivery of safeguarding activity.

5.9 This SAR, however, acknowledges that all professionals, including police staff, must continue to be supported and encouraged to complete and submit safeguarding concern referrals. In respect of the MPS, the fact there are now a large amount of Merlin's for adults at risk being completed, shows that learning from previous statutory reviews has stimulated better compliance. The issue for supervisors in agencies and within the MPS local Public Protection Desk (PPD) therefore is to ensure that adult at risk cases, that are high risk, are actioned whilst being mindful that a medium or low-risk grading should there be a repeat referral, will always result in a referral to ASC for safeguarding consideration. The MPS Merlin system is being revamped for a possible re-launch next year, with anticipated new policies and procedures produced. The revision it is respectfully suggested, should reflect and show consistency with the Pan London Multi-Agency Adult Safeguarding Policy and Procedures, which is the policy document that all statutory partners have signed up to use. This review also suggests that the Care Act terminology Adults at Risk should be used instead of 'vulnerable adults', and should also be adopted more widely by all safeguarding professionals.

5.10 Adult Multi-Agency Safeguarding Hub (MASH). This SAR believes that to support the safeguarding concern referral process there is a need for an Adult MASH; a team of professionals from a range of agencies able to work together to protect adults who may be at risk of abuse, harm and neglect, to lead to a better outcome. It is understood that Lewisham have received confirmation that there will now be a Lewisham Adult MASH established which this review fully supports.

5.11 The LSAB and the MPS along with other adult safeguarding partners and voluntary sector agencies, should therefore review local processes to ensure that cases that meet the Care Act criteria for a Safeguarding Concern are submitted appropriately to ASC if, **1)** there is reasonable cause to suspect that the adult has needs for care and support; and **2**) there is reasonable cause to suspect that the adult is at risk or experiencing abuse or neglect. The following recommendation is made:-

SAR Recommendation (1) for LSAB, Safeguarding Partners and Voluntary Sector Organisations linked to the SAR

It is recommended that the agencies linked to this SAR, including the Metropolitan Police SE BCU Public Protection Desk, review their current referral processes to ensure all adult Safeguarding Concerns that meet the Section 42 Care Act criteria of 1) there is reasonable cause to suspect that the adult has needs for care and support; 2) there is reasonable cause to suspect that the adult is at risk or experiencing abuse or neglect, are referred to Adult Social Care for safeguarding action to be considered.

It is also recommended that the Adult MASH establish a system to be able to recognise and act upon repeated Safeguarding Concerns, which have not previously met the criteria, or the adult has not consented to/ engaged with safeguarding enquiries.

FINDING 2 - Compliance with the London Multi-Agency Adult Safeguarding Policies and Procedures, Lewisham Adult Safeguarding Pathway Guidance and the Domestic Abuse Act 2021

5.12 **What are the issues and what should be considered?** There were missed opportunities from some professionals to refer concerns, and these have generally been addressed within Agency IMR's submitted as part of this review. There was no reference in any report submitted to this SAR that showed that a Safeguarding Adult Manager or Local Authority member of staff who should manage, make decisions, provide guidance or have oversight of safeguarding concerns that are referred to the Local Authority was involved throughout Mia's case. A Lewisham Adult Safeguarding Pathway 2021 has now been developed and

together with the London Multi-Agency Adult Safeguarding Policies and Procedures 2016 (updated in April 2019) expects that all four stages of a Safeguarding Enquiry are conducted: Concerns; Enquiry; Safeguarding Plan and Review; and Closing the enquiry, but this did not happen in relation to Mia. In fact, there was no Section 42 Safeguarding Enquiry conducted for Mia, despite the repeated MPS Merlin ACN referrals that were made.

5.13 Multi-Agency Meetings. Mia's health and welfare, possible self-neglect, homelessness and rough sleeping lifestyle, domestic abuse, including coercive and controlling behaviour from her partner and drug misuse remained a serious risk to her. This should have been managed using multi-agency safeguarding procedures, allowing for all of the professionals involved in her life to meet together. Agencies and professionals who were working with her were not fully aware of the overall situation so they could not make a thorough risk assessment, or understand the ongoing actions being taken by each agency which would have allowed them to work more effectively together. This would have enabled a more joined up approach to understand the full circumstances of Mia's case, to share information, identify action to be taken in order to protect and support Mia, and address the concerns that were impacting on her health and wellbeing.

5.14 Physical, Emotional Coercive or Controlling, Manipulative Behaviour. This review has identified that in Mia's abusive relationship she was subject to coercive and manipulative control at the hands of her partner who also repeatedly physically abused her. It is clear, according to key professionals interacting with her, that they were aware of and understood this worrying concern and her submissive behaviour towards her partner's decisions. The new Domestic Abuse Act became law on the 29 April 2021.[6] It will provide further protection for people who experience domestic abuse and strengthen measures to tackle perpetrators. It now has a wide-ranging legal definition of domestic abuse which incorporates physical violence, including emotional coercive or controlling behaviour, and economic abuse which should help to focus professionals' attention when assessing DA cases in the future.

5.15 Engagement. Professionals did raise Mia's lack of engagement in the practitioners' event, but there was more that agencies and professionals could have done to ensure engagement with her in return. Outreach agencies and the police could have arranged for the IGVA and ASC to come to public locations she was known to frequent, who were aware on a daily basis where Mia would be. This proactive option was not considered. The control that Adam posed over her was never fully explored and there was no information provided to the SAR that he was spoken to regarding his behaviour and the influence he had over her. This SAR cannot answer whether more persistent and respectful challenge of her apparent reluctance to engage with professionals or not, would have effected change, without first removing her from the control of Adam. This statement assumes that Mia was able to access services, however women who are in abusive relationships are often controlled and prevented by their partners to access support services. A local protocol should be developed for SAMs or other managers to improve compliance with relevant adult safeguarding policies, procedures and guidance. Their responsibilities should be made more widely known for the support and information of other safeguarding practitioners dealing with similar DA cases.

5.16 Recourse to public funds. There were also missed opportunities to conduct a Section 9, Care Act 2014 needs assessment and a Human Rights Act 2000 assessment (a process to determine whether care and support can be provided to a person with no recourse to public funds). The following recommendation is made:-

SAR Recommendation (2) for LSAB and Adult Social Care

It is recommended that Lewisham Safeguarding Adults Board develop a local domestic abuse and adult at risk protocol ensuring:-

[6] Home Office, Ministry of Justice, Gov UK

- **Adult Social Care, Safeguarding Adult Managers and other agency leads comply with the London Multi-Agency Adult Safeguarding Policy and Procedures, legislation and relevant guidance to appropriately manage, make informed decisions and have oversight of domestic abuse cases in accordance with the Domestic Abuse Act 2021.**
- **Professionals should be able to recognise and act upon the signs and symptoms of emotional coercive or controlling behaviour, and economic abuse in order to support adults at risk.**
- **To support the above two objectives multi-agency training on the Domestic Abuse Act 2021 should be arranged with a particular focus on recognising coercive and controlling behaviour, and economic abuse, and the impact of those behaviours on an adult's decision making. This training should include LGBTQ relationships and coercive control outside of intimate relationships.**
- **Where concerns persist in a domestic abuse or adult at risk case, a multi-agency safeguarding planning meeting should be convened to consider the wider impact on the health and well-being of the person.**
- **Assessments are conducted to access a person's recourse to public funds and where relevant a Human Rights Act 1998 assessment is conducted.**

FINDING 3 - Magistrate Court Community Orders, Domestic Abuse Protection Orders and Domestic Abuse Victimless Prosecutions

5.17 What are the issues and what should be considered? Statutory agencies need to consider legal literacy and their powers in exercising their multi-agency safeguarding duties. Professionals must understand the full range of options that are available to them in finding a positive outcome for an adult at risk. This should include effective communication with the Courts in a safeguarding adult case, such as Mia, who was repeatedly appearing before the Magistrates Court for breaching her ASBO and CPN's and other minor allegations of crime. There could be better use of community orders to achieve more constructive outcomes, including the use of Mental Health Treatment Requirements (MHTR), Drug Rehabilitation Requirement (DRR) and Alcohol Treatment Requirement (ATR) (the adult must agree to accept such course of action) which should always be considered. Police, in consultation with the CPS, should always consider requesting a Court to consider their powers to ensure a thorough assessment. In relation to Mia's case the CRC state an oral pre-sentence report was used to seemingly place an emphasis on supporting Mia "to gain stability in her personal circumstances," and suggests it is possible a DRR was not recommended as it was deemed too onerous for the matters for which Mia was being sentenced. However, if a person is persistently appearing before the court and there are treatment options available through the delivery of community orders, these should be considered as a way to support an adult at risk, if they are willing to accept the assistance of this treatment and help.

5.18 Where an adult is subject to domestic abuse and does not wish to support any criminal proceedings, a request to the CPS to conduct a victimless prosecution should be considered. (There is research in Appendix 1 which suggests a willingness by the CPS to increase victimless prosecutions). Furthermore, Domestic Violence Protection Notices (DVPN's) could have been placed on an alleged perpetrator of DA who was not in police custody and charged with an offence. It gives the police 48 hours to apply to a Court for a DVPO that gives professionals 28 days to support the adult at risk in breaking away from an abusive relationship. A DVPO could have prevented the perpetrator from returning to a residence and from having any contact with the victim and would allow a degree of breathing space to consider available options with the help of supporting agencies. Both currently, DVPNs and DVPOs (see new DA Act 2021 changes below) relevant to this review, contain a condition prohibiting the perpetrator from molesting the victim, but these tools were not always used effectively, or in Mia's case not at all.

5.19 The new Domestic Abuse Act 2021 became law on the 29 April 2021.[7] The act gives police new powers including a Domestic Abuse Protection Notice (DAPN) that provides immediate protection following a domestic abuse incident and a new civil Domestic Abuse Protection Order (DAPO). These replace the DVPO and DVPN's in existence during the period of this SAR and consolidate existing protection orders. A DAPN would be issued by the police and can require a perpetrator to leave the victim's home for up to 48 hours as before for immediate protection. As with the current DVPO, police can make an application for a DAPO to a Magistrates' Court. A DAPO can also be applied for by a third party in family court proceedings, such as a social worker, as the DAPO will help prevent offending by forcing perpetrators to take steps to change their behaviour, including seeking mental health support or drug and alcohol rehabilitation. A breach of a DAPO is now a criminal offence.

5.20 The new act will provide further protection for people who experience domestic abuse and strengthen measures to tackle perpetrators. It now has a wide-ranging legal definition of domestic abuse which incorporates physical violence, including emotional coercive or controlling behaviour, and economic abuse. The measures include important new protections and support for victims ensuring that abusers will no longer be allowed to directly cross-examine their victims in the family and civil courts, and gives victims better access to special measures in the courtroom to help prevent intimidation.

5.21 DAPNs will provide victims with immediate protection from abusers, while courts will be able to hand out new DAPOs to help prevent offending by forcing perpetrators to take steps to change their behaviour, including seeking mental health support or drug and alcohol rehabilitation. Other measures include: extending the controlling or coercive behaviour offence; establishes in law the office of Domestic Abuse Commissioner; places a duty on local authorities in England to provide support to victims of domestic abuse and their children in refuges and other safe accommodation; provides that all eligible homeless victims of domestic abuse automatically have 'priority need' for homelessness assistance; places the guidance supporting the Domestic Violence Disclosure Scheme ("Clare's law") on a statutory footing, and the expectation that the law will fundamentally transform professional response to tackling domestic abuse by providing much greater protections from all forms of abuse. The following recommendation has therefore been made:-

SAR Recommendation (3) - Magistrate Court Community Orders, Domestic Abuse Protection Orders and Victimless Prosecutions

It is recommended that the LSAB seek assurance from statutory partners that they are implementing their responsibilities under the Domestic Abuse Act 2021, and are utilising the available safeguarding action that can be taken including:-

- **The MPS and Crown Prosecution Service working together to submit a request to the Magistrate Courts for them to consider Community Orders that will offer treatment options for an adult at risk who is persistently appearing before the court with possible mental health, drug and alcohol concerns, notwithstanding the person must agree for the help to be provided.**
- **That Police make a request to the Crown Prosecution Service to conduct a victimless prosecution when the victim does not support this.**
- **Police and other agencies to effectively utilise Domestic Abuse Protection Notices and Orders (DAPN and DAPO) that consolidates existing protection orders and non-molestation orders under the Domestic Abuse Act 2021.**

[7] Home Office, Ministry of Justice, Gov UK

FINDING 4 – Governance, Supervision, Displaying Professional Curiosity and Risk Assessments

5.22 What are the issues and what should be considered? There was a persistent concern for Mia's health and welfare in relation to her lifestyle choices and homelessness. This together with the added complexities linked to Mia being controlled by an abusive partner were not explored further through supervision. There were concerns from her key workers which were not always shared, with three unreported physical abuse cases missed and not referred by her Thames Reach workers. Police submitted seven detailed Merlin ACN's outlining clear safeguarding concerns as to her physical appearance and the deterioration of her health. A Safeguarding Adult Manager (SAM) should have identified whether there were adequate responses to these safeguarding referrals, and if a Care Act 2014 assessment or MCA were needed or warranted in compliance with the London Multi-Agency Adult Safeguarding Policy and Procedures 2016, which were in place at the time and updated in April 2019.

5.23 Supervision (or audit) should have picked up and directed safeguarding action at the very least on receipt of the second received Merlin, especially as Mia's health and well-being was still a serious concern. Even more so, as concerns were compounded by the additional police Merlin's submitted to ASC. One of the key police officers who knew Mia and saw her regularly on the streets was so concerned he completed several Merlin's for her and emphasised his worry and highlighted the previous Merlin's that had been submitted. There should also have been more management oversight as not all safeguarding action was fully considered, as the findings and recommendations in this chapter have found. Of the seven MPS Merlin ACN's referred (the first in 2017 and the last in March 2019), the ASC IMR only records five of these which may be an oversight.

5.24 SAMs and other managers must review adult at risk referrals to ensure that all high-risk assessments are conducted effectively, that all available actions and initiatives are considered, and that staff are demonstrating effective professional curiosity. No high-risk case should be closed without management oversight, ensuring that staff try to understand the meaning of a person's behaviour, are able to recognise key features in their lifestyle, and work with partners to reduce risk and initiate appropriate safeguarding plans. Supervision should guarantee action complies with local and national multi-agency safeguarding policies and procedures. There was a lack of attention in relation to risk management and assessment, as these were not always comprehensive or considered in Mia's case, as highlighted in the narrative of Chapter 3 and 4. The following recommendation is made for ASC supervision:-

SAR Recommendation (4) for the Senior Management of Lewisham Adult Social Care

It is recommended that Lewisham Adult Social Care reassure the LSAB that Safeguarding Adult Managers and Operational Leads have been reminded to reinforce the supervision of Safeguarding Enquiry decision making processes, whilst emphasising the need for effective professional curiosity. ASC staff should thoroughly explore the circumstances of homelessness and accompanying health and social complexities, ensuring that all available actions and initiatives including Care Act needs assessments and safeguarding enquiries are conducted in compliance with local and national Safeguarding Adult Policy and Procedures, including the new Domestic Abuse Act 2021, with no high-risk case closed without managerial oversight.

FINDING 5 - LSAB Multi-Agency training for safeguarding professionals

5.25 What are the issues and what should be considered? LSAB should promote and supply up to date and relevant safeguarding multi-agency training for safeguarding professionals. This review recommends that agencies must ensure key professionals attend this training, which will improve personal knowledge and awareness of safeguarding, highlight the learning from national and local statutory reviews, and help improve professional practice.

SAR Recommendation (5) for LSAB Safeguarding Partners and

Voluntary Sector Organisations to the SAR

It is recommended that safeguarding partners and voluntary sector agencies should also support LSAB safeguarding training (outlined in Recommendation 2) to improve the knowledge of agency staff and professional practice. Safeguarding training should be prioritised for key workers, health professionals and MPS DWO and PCSO's who come into contact with homeless people and other adults at risk. This should include the MPS PPD and agency staff who risk assess and submit safeguarding referrals to ASC in order to support working together.

FINDING 6 - Appropriate Hospital Discharges

5.26 What are the issues and what should be considered? An additional question was asked of the review to consider if there was any unsafe discharge when Mia presented at hospital. In Mia's case there were four presentations within the scoping period. In the first presentation in 2017 she attended the ED having been a victim of abuse. There was no professional curiosity displayed and no referral was made to ASC or to DA support services. Mia was discharged with no safeguarding action being considered or further consideration given to the fact that she was returning to the streets. This was a failure recognised by the UHL IMR author who confirmed that in three subsequent attendances she was with police or outreach workers where policy was followed, including the last occasion when she unfortunately died.

FINDING 7 – Communication, Record Keeping and Sharing Information

5.27 What are the issues and what should be considered? Agencies need to adopt robust and efficient record keeping systems and share appropriate safeguarding information in line with the Pan London Information Sharing Agreement. There were occasions when agencies did not share information or have effective record keeping, such as the minutes of the 2017 ASB MARAC meeting which could not be found. Also, the rationale for some agency action was not always recorded or cannot be traced, as outlined in Chapter 3 and 4 above. There was communication between agencies, but this was not always comprehensive as agencies with knowledge of Mia and her needs were not invited to the limited meetings held and not everybody knew who was working with Mia. There is a need to ensure the right people are invited to participate at multi-agency meetings to ensure effective communication, so that all relevant information is considered.

5.28 University Hospital Lewisham Hospital did not notify police of the death of Mia, a homeless adult at risk which the police assume was because the death was in a hospital setting. This SAR is of the view that the death of a homeless person should always be reported to police until there is evidence to the contrary that there were no suspicious circumstances that required an investigation. In fact, in Mia's case, there were several scenarios and discussions after she died as to the cause of her death, including the baseless allegation that Adam injected Mia with a drugs overdose. By not informing police, potential evidence could be compromised in a case. Lewisham and Greenwich NHS Trust, UHL should ensure in similar sudden death cases of street homeless and rough sleepers, that police are informed of the death as a matter of course. The following recommendations are to address communication, record keeping and for Lewisham and Greenwich NHS Trust, UHL as follows:-

SAR Recommendation (6) for LSAB Safeguarding Partners and Voluntary Sector Organisations to the SAR

It is recommended that all Lewisham Safeguarding partner agencies, including voluntary sector organisations involved in this SAR, assure the LSAB that agencies have robust record keeping systems in place with supervision oversight, to ensure that all relevant safeguarding information, records of actions taken, and minutes of meetings are recorded appropriately in line with relevant local and Pan London guidance.

SAR Recommendation (7) - for Lewisham and Greenwich NHS Trust, University Hospital Lewisham notification of the death of a homeless person

It is recommended that Lewisham and Greenwich NHS Trust, University Hospital Lewisham, ensure that they inform police of the death of a homeless person in a hospital setting. This is to ensure there are no known outstanding safeguarding concerns for an adult at risk, prior to and at the point of death, thereby preserving the integrity of any evidence if required in any subsequent criminal or coronial proceedings.

FINDING 8 - Metropolitan Police Service Review of Adult at Risk Policies and Procedures

5.29 What are the issues and what should be considered? The MPS IMR and the police officer who attended the practitioner's event held for Mia identified that the MPS Adults at Risk Policy and Procedures and guidance on domestic abuse was not widely known about. In particular the officer thought that if a Merlin ACN was completed it would automatically go before a MARAC meeting. The IMR and documents reviewed for this SAR show that some policy documents still refer to vulnerable adults and not adults at risk. This may be a good opportunity considering the MPS are reviewing their Merlin policy to also review and update their domestic abuse and adults at risk policy and procedures, which will need revision in light of the introduction of the Domestic Abuse Act 2021 which has very clear implications for police; the Pan London Multi-Agency Adult Safeguarding Policy and Procedures 2019, the Lewisham Adult Safeguarding Pathway 2021, and the Lewisham Self-Neglect and Hoarding Multi-Agency Policy, Practice Guidance and Hoarding Toolkit, 2021. To assist police personnel dealing with homelessness, domestic abuse and adults at risk cases, it is suggested that a briefing sheet or flowchart to support them in carrying out their role and duties could be developed. The following recommendation is made:-

SAR Recommendation (8) for the Metropolitan Police Service to review Adult at Risk Policies and Procedures

It is recommended that the Metropolitan Police Service review their current domestic abuse and adults at risk policy to incorporate national and local adult safeguarding legislation, policy and procedures; and to consider developing a briefing sheet or flowchart for the information and support of police personnel concerned in domestic abuse, homelessness and adult at risk cases.

Appendix 1

Bibliography

The following legislation, documentation and guidance was consulted for the process of completing this SAR (see also legislation and guidance within the report and inserted footnotes for additional review and research material considered):-

- *Care Quality Commission (2010) Guidance about compliance: Essential standards of quality and safety. What providers should do to comply with the section 20 regulations of the Health and Social Care Act 2008, London: CQC*
- *Care Act 2004, 2014.*
- *Domestic Abuse Act 2021*
- *Implementation of Community Orders, Ministry of Justice Analytical Series 2014.*
- *Equality Act 2010.*
- *European Convention on Human Rights (ECHR).*
- *Human Rights Act 1998.*
- *Lewisham Adult Safeguarding Pathway (1 April 2021).*
- *Lewisham Self-Neglect and Hoarding Multi-Agency Policy, Practice Guidance and Hoarding Toolkit 2021.*
- *LGA guidance, Homelessness Reduction Act 2017. London: Local Government Association.*
- *LGA, March 2020, Adult safeguarding and homelessness - A briefing on positive practice. Author Michael Preston-Shoot (on behalf LG/ADASS).*
- *London news articles regarding homelessness.*
- *Mayor of London - Life Off the Streets task force minutes 2016 to 2019.*
- *MPS DVPN and DVPO guidance (April 2017).*
- *MPS London MASH Toolkit, Risk assessment 2013.*
- *Mental Capacity Act 2005.*
- *Mental Health Act 1983. Supporting Community Order Treatment Requirements February 2014.*
- *NHS England Safeguarding Adults pocket guide.*
- *Rough Sleeping Support Service (RSSS) in support of vulnerable and at-risk individuals, Home Office 2020.*
- *Thames Reach - Risk Policy.*

Appendix 2

Glossary of terms

Definition	Abbreviation
Adult Come to Notice (Merlin)	ACN
Adult Social Care	ASC
Alcohol Treatment Requirement	ATR
Anti-Social Behaviour	ASB
Anti-Social Behaviour Order	ASBO
Approved Mental Health Professional	AMHP
Body Warn Video	BWV
Borough Command Unit	BCU
Change Grow Live	CGL
Closed Circuit Television	CCTV
Combined Homelessness and Information Network	CHAIN
Community Protection Notice	CPN
Community Protection Warning Letter	CPWL
London Community Rehabilitation Company	CRC
Crown Prosecution Service	CPS
An intelligence report used by Police	CRIMINT
Community Safety Unit	CSU
Dedicated Ward Officers	DWO
Deep Venous Thrombosis	DVT
Department for Work and Pensions	DWP
Department of Health & Social Care	DH
Domestic Abuse	DA
Domestic Abuse Protection Order (Notice)	DAPO and DAPN
Domestic Abuse, Stalking, Harassment and Honour risk assessment tool	DASH
Domestic Violence Protection Order (Notice)	DVPO and DVPN
Drug Rehabilitation Requirement	DRR
Early Intervention Scheme	EIS
Emergency Department	ED
European Convention on Human Rights	ECHR
European Union	EU
General Practitioner	GP
Independent Gender Violence Advocate	IGVA
Individual Management Reviews	IMR
Independent Mental Capacity Advocate	IMCA
Lewisham Safeguarding Adults Board	LSAB
Local Authority	LA
Local Intelligence Team	LIT
London Ambulance Service	LAS
London Street Rescue (Thames Reach)	LSR
Mental Capacity Assessment	MCA
Mental Health	MH
Mental Health Act	MHA
Mental Health Treatment Requirement	MHTR
Metropolitan Police Service	MPS
Ministry of Housing, Communities and Local Government	MHCLG

Definition	Abbreviation
Multi-Agency Risk Assessment Conference	MARAC
Multi-Agency Safeguarding Hub	MASH
No Further Action	NFA
Offender Assessment System	OASys
Police Community Support Officer	PCSO
Police Constable	PC
Probation Officer	PO
Public Protection Desk	PPD
Safeguarding Adults Board	SAB
Safeguarding Adults Managers	SAMs
Safeguarding Adult Review	SAR
Severe Weather Emergency Protocol	SWEP
South East Borough Command Unit	SEBCU
Social Care Advice and Information Team	SCAIT
Social Care Institute for Excellence	SCIE
Safer Neighbourhood Team	SNT
Single Homeless Intervention Project	SHIP
Single Point of Contact	SPOC
Standard Operating Procedure's	SOP's
Supporting Women (I) Toward Change (Thames Reach)	SWITCH
Terms of Reference	TOR
University Hospital Lewisham	UHL