Northamptonshire Safeguarding Adults Board

Northamptonshire Safeguarding Adults Board

Safeguarding Adults Review

Jonathan
2020

Overview Report

Independent Overview Report Author: Bruno Ornelas

Date agreed by NSAB: 2nd March 2021

TABLE OF CONTENTS

1. Introduction to Review and Author

1.1 Northamptonshire Safeguarding Adults Board commissioned this Safeguarding Adults Review in relation to Jonathan who was living in a hotel following hospital discharge at the time of his death and there were concerns about how agencies worked together. Jonathan died aged 46 on 31st December 2019 and was found deceased in the hotel room by a social worker carrying out a welfare check. The cause of Jonathan's death was found to be coronary artery thrombosis and coronary atherosclerosis. Jonathan was considered to have multiple vulnerabilities and risks which were confounded by homelessness, in particular, rough sleeping. He had spent many nights sleeping on the streets, including during the cold winter months, often at freezing temperatures. He had frequent visits to emergency departments and a history of offending. Despite regularly coming to the attention of a number of statutory services as an adult experiencing street homelessness with significant physical and mental health conditions, his housing, health and care and support needs, including risks, were not readily acknowledged.

1.2 The combined chronology shows over 700 entries recorded by several agencies within a 12-month period. Jonathan had over 40 attendances at emergency departments often resulting in treatment and admission as an inpatient. He also had a high level of contact with both statutory and community-based services, including police officers, probation workers, housing and homelessness professionals, and social workers. This represents a high level of involvement from agencies and the records show an elevated degree of concern for Jonathan's wellbeing, including risk to life. There were many examples of determined efforts to engage with Jonathan and relieve him of his homelessness, including ample examples of human kindness and compassion from agencies and members of the public alike.

1.3 Nonetheless, it is clear from the information provided as part of this review that there was a lack of purposeful and effective multi-disciplinary working to address Jonathan's complex issues which were not merely confined to a housing issue. There was a clear failure to implement a meaningful and personalised plan of action, poor hospital discharges and a failure to assess his care and support needs.

1.4 Opportunities to protect Jonathan were regularly missed, often as a result of professional preconceptions of care and support needs and risk, including a narrow interpretation of policy and the relevant legislative provisions and principles. In their reflective discussions with the Independent Reviewer, several agencies commented on the lack of planning, communication, care planning and co-ordination between agencies, whereby Jonathan's repeating pattern of crises were rarely acknowledged.

About the author

1.5 Bruno Ornelas is an experienced safeguarding lead and academic researcher with interests in multiple exclusion homelessness. Bruno has considerable experience in managing services for homeless adults and brings relevant social-legal knowledge to projects, facilitation and chairperson experience. Bruno has developed practitioner toolkits based on learning reviews and quality assurance frameworks to ensure greater emphasis on multi-agency practice and legally literate decision-making. Bruno has a postgraduate qualification in Safeguarding Adults Law and Policy and is a doctoral researcher in social work looking at how complex needs panels and safeguarding work for people experiencing multiple exclusion homelessness. Bruno has held independent advisory roles, delivers training and participates in high level strategic work to devise guidance on safeguarding and homelessness with the LGA/ADASS.

2. Safeguarding Adults Review

2.1 The purpose of conducting a SAR is to:

2.1.1 Establish whether there are lessons to be learnt from the circumstances of the case, for example, the way in which local professionals and agencies work together to safeguard adults at risk.
2.1.2 Review the effectiveness of procedures and their application (both multi-agency and those of individual organisations).
2.1.3 Inform and improve local inter-agency practice by acting on learning (developing best practice) in order to reduce the likelihood of similar harm occurring again.
2.1.4 Prepare or commission an Overview Report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.
2.1.5 Acknowledge that all agencies will have their own internal and/or statutory review procedures to investigate serious incidents. This protocol is not intended to duplicate or replace these, but it does remain a statutory requirement in its own right and will be complemented by other such processes.
2.1.6 Understand where there are possible grounds for other review processes to be activated (e.g. Domestic Homicide Review, Child Serious Case Review, Health Serious Incident) a decision should be made at the outset, by the lead decision makers of the respective review processes, about which process will lead and who will Chair, with a final joint report being taken to all the relevant review commissioning bodies. However, it must be remembered a SAR is a statutory requirement and will be required to be undertaken as much as other processes.

2.2 Section 44 of the Care Act 2014 states:

"A SAB[1] must arrange for there to be 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,

a. 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
b. condition 1 or 2 is met.

Condition 1 is met if:

a. the adult has died, and
b. the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if:

a. the adult is still alive, and
b. the SAB knows or suspects that the adult has experienced serious abuse or neglect.

3. Review Process

a. A panel was established to oversee the process of the review. The Chair of the Safeguarding Review Sub Group, Georgette Fitzgerald (Designated Nurse Adult Safeguarding) chaired the panel and Bruno Ornelas attended as the Overview Report Author. See Appendix Two for a list of the agencies represented on panel.

b. The panel members had no direct involvement in the case. The business of the panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for people at risk of harm and abuse in these circumstances are more likely to occur as a result of this review having been undertaken.

[1] SAB – Safeguarding Adults Board

3.1 Understanding Multiple Exclusion Homelessness

3.1.1 The focus of this Safeguarding Adults Review is to learn lessons and improve multi-agency support for individuals who have an appearance of need for care and support and who experience multiple exclusion homelessness. It is also an opportunity to tell the human story of Jonathan the person, known to friends and relatives as 'Jon boy'.

3.1.2 The idea of Multiple Exclusion Homelessness (MEH)[2] is a concept used to illustrate the intersections between multi-faceted and overlapping causes and consequences of homelessness. The complexity of needs which underpin experiences of homelessness are becoming progressively more known with a more expansive view being adopted so that homelessness is not confined to st a 'housing' issue or merely 'rooflessness'. As such, MEH is characterised as:

"People who have been 'homeless' (including experience of temporary/unsuitable accommodation as well as sleeping rough) and have also experienced one or more of the following additional domains of deep social exclusion – 'institutional care' (prison, local authority care, psychiatric hospitals or wards); 'substance misuse' (drug problems, alcohol problems, abuse of solvents, glue or gas); or participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work)." Fitzpatrick, et al (2011)[3]

3.1.3 Most adults experiencing MEH face significant increased risk of serious abuse, exploitation and neglect as well as an escalation of their health and care needs and a reduction to their life expectancy. Safeguarding Adult Reviews (SARs) undertaken in relation to people at risk of harm who were homeless[4] recognised opportunities to improve multi-agency practice. Research found that this required a shift in culture to protect against professional preconceptions often applied to people with MEH backgrounds and / or, conversely, to avoid the normalisation of a high level of risk. Both were found to negatively impact on safeguarding decision making and related assessment processes.

3.1.4 To this end, this review seeks to gain an understanding of Jonathan's experiences and challenges. These experiences and challenges can be seen as a deep form of social exclusion, further compounded by a combination of risks factors. It is the aim of the review to provide learning to agencies through a shared understanding of risk, including those associated with care and support needs for people experiencing MEH.

3.2 Methodology

3.2.1 Research into the effectiveness of review methodologies in relation to SARs remain unexplored terrain. Recommendations from recent national SAR research[5] has included requirements for reviews to offer an account and reflective analysis of the methodology used when carrying out a SAR. To this end, the independent overview author and the SAR panel selected a hybrid approach[6] through a combination of detailed chronologies from partner agencies, a practitioners' event and individual agency reflective questions as to support a fully inclusive, focused and balanced review. Drawing on the author's previous experience of SAR analysis where homelessness was a factor[7] and given the similarities in this case with the case of Howard (Isle of Wight SAR, 2017), it was agreed that a similar methodology would be suited for the purposes of this review.

---

[2] Multiple Exclusion Homelessness was introduced as a concept in a presentation delivered to scoping panel members by the Independent Overview Author, titled: '*Safeguarding and Homelessness: learning from 14 safeguarding reviews'* – 23rd June 2020. Slides were then shared with panel members.
[3] Fitzpatrick, S., Johnsen, S. and White, M. (2011) 'Multiple exclusion homelessness in the UK: Key patterns and intersections', Social Policy and Society, 10(4), pp. 501–12.
[4] Martineau, S. J., Cornes, M., Manthorpe, J., Ornelas, B., & Fuller, J. (2019). Safeguarding, homelessness and rough sleeping: An analysis of Safeguarding Adults Reviews. London: NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London.
[5] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement. London: LGA/ADASS
[6] Recognising the importance of drawing on tested methodologies from other related SARs. The Author and SAR panel selected this approach as adopted by Professor Michael Preston-Shoot in the SAR involving Howard (Isle of Wight, 2017).
[7] Martineau, S. J., Cornes, M., Manthorpe, J., Ornelas, B., & Fuller, J. (2019). Safeguarding, homelessness and rough sleeping: An analysis of Safeguarding Adults Reviews. London: NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London.

3.2.2 The SAR panel and independent overview author agreed that the review would cover a 12-month period from January 2019 to his death in December 2019. The timeframe presented a significant period of involvement and contact between agencies and Jonathan, including a professionals meeting held in September 2019. Submissions to the combined chronology included comments from December 2018 and some historical information dating back to 1996. This was taken into account in section 5 of this report.

3.2.3 Agencies submitted their chronologies describing their individual involvement with Jonathan within the 12-month timeframe. These were combined to form a single chronology and individual reflective questions were derived from specific issues from the chronology and sent to agencies. Written responses to the questions were requested alongside individual agency reflective conversations with the independent overview author.

3.2.4 The reflective questions are included as Appendix One.

3.2.5 Agencies responding to the questions and taking part in reflective conversations were agreed by the SAR panel – see Appendix Two in the report.

3.2.6 Based on the collated chronology and answers to individual agency reflective questions, a virtual practitioner's event was held in October 2020, to consider key areas of learning within the agreed period of review.

3.3 Family involvement and significant others

3.3.1 A close relative of Jonathan spoke with the independent author to share information about Jonathan's life course, his interests, hopes and wishes. Their observations about how agencies worked together to safeguard Jonathan were also shared, including his pattern of contact with services and interactions with the family. Family members did not wish to use a pseudonym for the purpose of this review and opted that his first name was used instead. Jonathan was known to his friends and family as 'Jon boy'.

3.3.2 The relative was clear of the positive support given to them by Jonathan's social worker during the last stages of his life and the interest shown to understand Jonathan the person whilst he was alive and the emotional support they provided to the family following his tragic death. It was the application of the social worker's concerned curiosity about Jonathan's circumstances that led the relative to consider whether agencies could have worked better together and much sooner had the social worker (and/or their approach) been adopted earlier.

3.3.3 It is the family's wish that practice improvements are made so that agencies work better together to safeguard adults in Northamptonshire and beyond with similar experiences and challenges to those of Jonathan's. The family have made it clear that 'seeing the person and not just the problems' is key to securing better wellbeing outcomes for homeless adults with complex needs, or, at the very least, it would provide adults like Jonathan with an opportunity to be 'seen and heard', so that their presenting needs, risks and behaviours were better understood.

3.3.4 A local resident who attended church and who also volunteered as a Street Pastor had befriended Jonathan. Through this relationship, the Street Pastor concentrated their efforts on 'getting to know Jonathan' the person. The Pastor was closely involved with Jonathan towards the latter stages of his life and up until he was found deceased at a local hotel. Their approach was one of showing human kindness, having conversations about interests, sharing humorous stories, diffusing situations when Jonathan became upset and provided practical help with clothing, transportation and food, including providing him with a traditional dinner on Christmas day.

3.3.5 The Street Pastor regularly provided citizens based advocacy on Jonathan's behalf to help him access services and to have his voice heard. This followed a growing sense of concern that agencies were not working effectively to safeguard Jonathan. As one of three referrers for this SAR[8], the Street Pastor spoke with the independent author to share their observations about how agencies worked together to safeguard and support Jonathan, including their views for practice improvements. Such views have been considered within the report.

Due to restrictions posed by Covid-19 it was not possible to carry out meetings in person. As such, all contact with agencies, relatives and others relevant to the review were carried out over the phone, through conference calls or via Microsoft Teams.

4. A short case history

4.1 Born in 1973 and raised in Northamptonshire, Jonathan was a white British male whose upbringing is described as 'normal' by his relatives and he was popular amongst his peers. He was known to his friends and family as 'Jon Boy'. Jonathan's hopes and aspirations centred on starting a family of his own, securing work and buying a house. He was well liked and known for his loyalty and willingness to help others. It was not until early adulthood where his relatives noticed changes to his behaviour. Jonathan had a job at an engineering factory, he started to go out more and it is believed that it was during this period when he started drinking to excess and experimenting with drugs.

4.2 Jonathan was living in a hotel at the time of his death. He died aged 46 on 31st December 2019. Jonathan was found unresponsive in the hotel room by a social worker carrying out a welfare check who then contacted the police and ambulance service. The cause of death was found to be coronary artery thrombosis and coronary atherosclerosis. The degree of coronary disease was advanced for his age for which prolonged substance misuse could have been a contributing factor.[9] The toxicology evaluation showed no evidence of recent drug use prior to Jonathan's death.

4.3 The referral to Northamptonshire Safeguarding Adults Board identifies concerns about how agencies worked together to safeguard and support Jonathan.

4.4 Jonathan was considered to have multiple vulnerabilities and risks which were confounded by homelessness, in particular, rough sleeping. He had spent many nights sleeping on the streets, including during the cold winters months, often at freezing temperatures. He had frequent visits to Emergency Departments (EDs) and had a history of offending, including imprisonment. Despite regularly coming to the attention of a number of statutory services as an adult experiencing street homelessness with significant physical and mental health conditions, his priority need for housing together with his care and support needs were not readily acknowledged.

4.5 There were a number of concerns raised by agencies that indicated a high level of concern and risk factors for Jonathan, including self-neglect, that did not trigger safeguarding enquiries nor did they instigate risk management planning. When in hospital, it was decided that he could independently manage his own care and support needs. Jonathan was expected to attended appointments that had been arranged for him which he often failed to do as a result of his conditions.

4.6 Despite the numerous safeguarding concerns raised, it is not clear from the chronology what types of abuse or neglect Jonathan was thought to have been experiencing[10]. One record notes self-neglect as the primary reason for safeguarding, however, practitioners faced a clear challenge conceptualising how Jonathan's situation had come about. Likewise, there were variations in deciding what is dangerous and what is safe, including a normalisation of the risks that Jonathan was clearly experiencing.

[8] The other two SAR referrers were Northamptonshire Police and the Short Term Assessment and Reablement Team (STEPS).
[9] See Postmortem for the Northamptonshire Coroner, page 6.
[10] National SAR Analysis by Professor Michael Preston-Shoot et al (2020) recommends under 'improvement priority eight' that safeguarding adult reviews identify the types of abuse and neglect within cases being reviewed.

4.7 It is possible to discern from the combined chronology and from reflective discussions with individual agencies that Jonathan was experiencing combinations of abuse and neglect, often but not always, linked to self-neglect, psychological and emotional abuse including neglect and acts of omission. These are explored in the themed analysis.

4.8 The combined chronology notes only one professional's meeting that occurred in September 2019, with discussions amongst professionals centred on Jonathan's ability to make competent and cognisant choices, albeit damaging ones. Not all relevant partner agencies contributed to purposeful and meaningful interventions and there was a distinct lack of concerned curiosity to understand his lived experience and life course.

5. Agency contact

5.1 A summary of agency contact drawn from the combined chronology illustrates Jonathan's struggle to manage his life and the impact this had on him and those with whom he came into contact, including the level of demand on the range of agencies involved. There were over 700 individual records within the combined chronology, which shows the substantial involvement that existed with agencies. The detail in this section is derived from the combined chronology and the additional information supplied by the agencies involved. This section does not provide an analysis of events as this is explored in section 6 of this report.

Background - 1996 to December 2018

5.2 Jonathan had been known to the police since early adulthood with regular reports linked to domestic incidents and assaults; the first of these dating back to 1996 when he was 23 years old. From 2015, there were incidents reported by a relative who was concerned about his substance misuse. During this period, Jonathan had also become involved in drug offences. There were two missing person reports filed in December 2018 due to concerns for his safety.

5.3 At the age of 25, Jonathan was diagnosed with hypermanic disorder. His medical record notes that he was diagnosed with bipolar disorder in 2003 and type II diabetes in 2005. Following a road traffic incident in 2010, Jonathan was diagnosed with cervical spinal stenosis. The records also show that he had a prosthetic knee and a diagnosis of personality disorder in 2013 and 2014 respectively. Jonathan suffered a stroke in 2017 and was diagnosed as having high cholesterol. In 2018, he was diagnosed with carotid artery stenosis, a condition which reduces blood flow to the brain.

5.4 In December 2018, there were multiple contacts between Jonathan and agencies, with Jonathan regularly coming to the attention of statutory services as an adult experiencing street homelessness and significant physical and mental health conditions.

5.5 Six Public Protection Notices (PPNs)[11] were submitted in December 2018 by Northamptonshire Police which were subsequently referred to adult social care; although there is no specific mention for safeguarding support, or to invoke safeguarding procedures to facilitate multi-agency risk and safety planning. Four of the PPNs went through a process of safeguarding screening by Northamptonshire County Council's Customer Service Centre (NCC's CSC) and contact was made by the centre with agencies, including Jonathan's temporary GP. The case was subsequently closed as "*Social Care needs had not been identified. As Jonathan was in receipt of support from health services for his mental health needs the case was marked as No Further Action for CSC as per process"* [date 19.12.18]. There were other occasions in December 2018 where the case was closed as no care and support needs had been identified.

[11] Northamptonshire's Police Safeguarding Adults procedure provides guidance for Police workers when to raise PPNs. This can be an adult risk PPN or mental health PPN, for example.

5.6 In December 2018, agencies had arranged for Jonathan to attend appointments with his temporary GP and Northampton Borough Council's Housing Department. Jonathan did not always attend what had been arranged for him[12]; when he did attend he would often present with no paperwork making it difficult for agencies to support him to access services and accommodation. On one occasion, Jonathan presented a collection of old magazines which he believed to be his 'paperwork'. This resulted in Jonathan arguing with agencies when he was subsequently told that this was not the paperwork required of him.

5.7 Throughout December 2018, there were repeat concerns about Jonathan's safety and multiple calls were made between services to find out his whereabouts. Once his location had been established these concerns would subside resulting in no further action.

5.8 From the information in the combined chronology, it is noted that Jonathan attended hospital (Emergency Department) on at least three occasions in the month of December 2018, often assisted escorted by police officers due to their concerns about his physical and mental health.

5.9 Jonathan accessed a community night shelter on different occasions in December 2018, and the chronology shows a pattern of eviction as a result of his behaviours which were found to be in breach of the accommodation rules.

January 2019 to March 2019[13]

5.10 In **January 2019,** two PPNs were submitted by the police and Jonathan presented six times at emergency departments across two different hospitals[14] resulting in two admissions. The first admission was on **4th January 2019** following reports by Jonathan of thoracic pain[15]. Jonathan was subsequently diagnosed with a lower respiratory tract infection and leg cellulitis. In addition, investigations into a pulmonary embolism and a urinary tract infection were conducted but ruled out. Jonathan was also treated for a diabetic foot ulcer; however post-operative treatment was not completed as Jonathan self-discharged on **7th January 2019**.

5.11 On **7th January 2019,** Jonathan arrived in a taxi at the night shelter and is denied entry due to previous 'disruptive behaviours'. In the early hours of the following day (**8th January 2019**), he returns to hospital[16] in the company of police officers. Jonathan had been arrested but was deemed not to be medically fit to remain in custody[17]. According to the chronology, the custody health care professional was having difficulties establishing the types of medication needed to treat Jonathan's physical and mental health conditions. The chronology notes that, whilst in the ED, Jonathan was referred to the hospital mental health team[18] for an assessment. It is not clear whether the mental health assessment actually occurred, although a professional judgement was made by the mental health team in that there was 'no acute mental health need' and that Jonathan could be seen by the crisis team in custody instead. Jonathan was subsequently discharged from hospital and given a discharge letter alongside his medication (analgesia and antibiotics) which he had left at the ward where he had been treated the previous day.

[12] The chronology notes that Jonathan's missed appointments in community settings were often as result of: attendance or admission to hospital, difficulties planning and organising, memory issues, or he struggled to get to the location of the appointment on time i.e. lack of funds for transportation and mobility issues.

[13] Housing department play a key role throughout the combined chronology, however, their involvement with Jonathan does not represent a continuous period. Housing worked with Jonathan throughout Dec 18 to Jan 19 and the resumed contact with him from June 19. From Feb 19 to May 19 Jonathan spent a period in prison and was out-of-area in Nottingham.

[14] Kettering General Hospital on three occasions and Northampton General Hospital on three occasions.

[15] Admission to Kettering General Hospital

[16] Kettering General Hospital

[17] Notes show from the chronology that Jonathan was using a mobility aid (crutches) and unable to mobilise in custody safely. It is also not clear for what offence led to Jonathan's arrest.

[18] The Mental health team service by Northamptonshire Healthcare Foundation Trust(NHFT)

5.12 In the early hours of **9th January 2019**, Jonathan self-presented at the ED of another hospital[19] (16 miles away from the previous hospital). Notes from the chronology show that Jonathan had reported 'post op problems'. He was subsequently examined and became abusive towards hospital staff. Jonathan was discharged[20] on the same day with further analgesia[21].

5.13 In the early hours of **10th January 2019**, Jonathan called the emergency services (999) from a phone box complaining of hypothermia, problems with his feet, pneumonia and open sores on his legs. Jonathan was subsequently transferred to Kettering General Hospital ED. Initial observations were carried out by hospital staff and Jonathan was deemed to be clinically well. In the evening of the same day, Jonathan returns back to Kettering General Hospital requesting to be seen by the mental health team. Jonathan reports to be feeling suicidal due to an upcoming court case, however he left hospital before the referral and assessment had been completed.

5.14 It is not clear from the chronology, but somewhere in between his two presentations at the emergency department at Kettering General Hospital on **10th January 2019** (approx. 2am and 7pm), Jonathan was suspected of committing criminal damage to a local council building. Although there were no witnesses, Jonathan admitted to committing this offence when questioned by the police[22]. Jonathan was also charged for other criminal damage offences within a short period of time. As well as damage to a council building, Jonathan damaged a police building on **14th January 2019** and a police vehicle on **18th January 2019**. **NB** *these last two offences are highlighted later in the chronology.*

5.15 Jonathan returned to Kettering General Hospital (ED) in the early morning of **11th January 2019** complaining of back pain. He also divulged to hospital staff that he was homeless and was seeking to stay in hospital as he wanted to avoid another episode of rough sleeping. Jonathan was seen by a nurse and a doctor in the ED, however no clinical reasons to admit Jonathan were found[23].

5.16 On the evening of the same day, **11th January 2019**, Jonathan returned to the night shelter but was again denied entry. He then presented at Northampton General Hospital and explained that he had collapsed and had arrived at hospital assisted by a member of the public. He also stated that he had been homeless since December [2018]. Jonathan was assessed at ED and his blood tests showed elevated troponin[24] and he was subsequently admitted for treatment. There were also concerns over signs of cellulitis and leg ulcers. Jonathan self-discharged on **14th January 2019.**

5.17 Following his self-discharge on the **14th January 2019,** Jonathan was arrested for smashing a window at a local police station. The entry in the chronology describes this as *"*[Jonathan] *was acting very strange and came to* [police station] *saying that he was wanted. He was arrested a few days ago and was not showing as wanted so was told he could leave.* [Jonathan] *then started smashing window of police station in order to be arrested and stated that he did it so that he could get help.* [Jonathan] *has been in hospital today but states that he needs help.* [Jonathan] *has done this numerous times and has tried to hand himself in when he is not wanted.* [Jonathan] *is homeless so unknown whether he just wants somewhere to stay…"*[25] The chronology shows that an 'Adult Safeguarding PPN' was submitted by Northamptonshire Police, however, the outcome of this is not clear.

5.18 Jonathan was referred to hospital by the police custody nurse due to concerns over an infection on his leg. He was supported by police to the ED at Northampton General Hospital in the late evening of **14th January 2019.** The chronology notes that Jonathan's ability to comply with oral antibiotics was poor, so he was administered intravenous antibiotics instead. The chronology also notes that, Jonathan *'became abusive and started banging his head'* in the waiting area of the ED.

[19] Northampton General Hospital. Throughout the period of review Jonathan regular attends these two hospitals i.e. Kettering General Hospital and Northampton General Hospital.
[20] It is unclear from the chronology whether Jonathan was deemed medically fit for discharge.
[21] Jonathan had also received analgesia medication upon discharge from Kettering General Hospital the day before.
[22] As seen later in the chronology, Jonathan's criminal damage to property was to get himself arrested as he was in desperate need of help.
[23] Although not mentioned in the combined chronology, Kettering General Hospital would often provide Jonathan with clothing and food – information provided to Independent Reviewer following reflective discussion
[24] Chemical released from damaged heart muscle – chronology entry dated 11.01.19
[25] Extracted from combined chronology – entry by Northants Police dated 14.01.19

5.19 Jonathan was discharged with antibiotics and a wound care dressing, a copy of his notes was provided for the custody nurse. He then left the department accompanied by the police.

5.20 On **16th January 2019**, Jonathan was at Northampton General Hospital (ambulatory care) where he received wound care. For this admission, there are no further notes that described his presentational state or discussions as to his homelessness or circumstances given his pattern of attendances at hospital.

5.21 On **17th January 2019,** Jonathan was brought to Northampton General Hospital ED by ambulance. He was seen by a consultant, however, it is not clear as to why he was taken to ED. The chronology states that Jonathan *'wanted his leg dressing changed as* [he] *has not got a GP'.* Jonathan also presented with bruising above his left eye which he claimed to have sustained in police custody. Jonathan's non-infected leg was also in a plaster cast, although it is not clear from the chronology how this occurred. He was discharged by the hospital and a taxi was arranged for him to go to Oasis House.[26] The chronology shows that Jonathan arrived at ED in the morning of 17th January 2019 and was discharged later in the evening at approximately 9-10pm.

5.22 During usual office hours of **17th January 2019**, NCC CSC attempt to contact Jonathan using the phone number provided on the PPN. They were unsuccessful as the number was showing as invalid. Further attempts were made to retrieve other contact details for Jonathan by accessing other recording systems however, contact with Jonathan was not made. The chronology shows that it was common practice for NCC CSC to write to individuals when contact has not been made, however it is noted in the chronology that, as Jonathan did not have a fixed address, staff were unsure as to what to do. This was subsequently raised as a concern to more senior staff at the NCC CSC, although it is not clear what the outcome of the escalation led to.

5.23 On **18th January 2019,** Jonathan is arrested and charged for damaging a police vehicle[27]. Immediately prior to arrest, Jonathan had threatened to cause damage as he wanted to *'get arrested as he was cold and homeless'*.[28] Jonathan was subsequently remanded in custody for this offence and two previous other offences, both related to criminal damages. All of which followed a similar pattern, in that, all three occurrences arose as a direct result of his circumstances. Jonathan was subsequently released by the court.

5.24 Jonathan had an appointment[29] with the housing department at East Northamptonshire Council (henceforth 'housing') for the **18th January 2019,** however he did not attend[30]. Based on the chronology, it is clear that agencies attempted to find out if Jonathan had attended the housing appointment and what the outcome was. This included a follow up call from the NCC CSC to housing on the **21st January 2019** to which NCC CSC were informed that Jonathan had not attended the council's housing office.

5.25 It was also confirmed by NCC CSC that Jonathan did not have an allocated social worker as *'at present there have been no social care needs identified'.* Housing advised NCC CSC that Jonathan would be required to present at their office between 9am to 5pm, Monday to Friday. Housing also suggest to contact the out-of-hours Homeless Team should the police come into contact with Jonathan outside of office hours[31].

[26] Oasis House is a service operated by Midland Heart that offers accommodation & support to homeless people in Northampton.
[27] Jonathan damages the rear light of a police car with a walking aid.
[28] Chronological entry dated 18.01.19
[29] The chronology notes that this was not an arranged appointment, rather it was advice given to Jonathan by East Northamptonshire Council that he attend their offices for the purposes of completing a homelessness application.
[30] It would not have been possible for Jonathan to attend East Northants Housing office as he had been arrested for damaging a police vehicle. It's can't be established whether Jonathan would have attended had he not been arrested. Although, there are repeat occurrences throughout the chronology of Jonathan attending East Northamptonshire Council housing offices, usually in an unplanned manner.
[31] There are two entries in the chronology recording the conversation between CSC and Housing. These records are similar, in terms of their discussion, although there is no record in CSC's entry that notes Housing's advice to contact the out-of-hours homeless team, or which area and agency operates the out-of-hours service.

Nottingham

5.26 The entries within the combined chronology indicate that Jonathan was in the Nottingham area between **22nd January 2019** to **24th April 2019**[32] with periodic and short term stays in Northampton. There is limited information about his interactions with services in Nottingham, which makes it difficult to reach any substantial conclusions for the purposes of this review. However, it can be derived from his time in Nottingham that a repeating pattern of crisis episodes resulted in further interactions with emergency services. This included an admission to hospital on the **7th March 2019** after Jonathan had collapsed in a court holding room. A clinical note records Jonathan as 'obviously *malnourished and dishevelled, poor personal hygiene, multiple wounds on his body, multiple skin site infections and widespread crackles in his chest.'* He remained as an inpatient at Nottingham University Hospital for a three-week period until he was discharged on the **25th March 2019**. Not long after, Jonathan returned to Northamptonshire.

5.27 It's important to note that during his inpatient stay at Nottingham University Hospital referrals for services were made, including to Nottingham City Care Integrated Discharge Team[33]. The notes show evidence of joint working to manage clinical risk and to support Jonathan into appropriate housing with care, this included a referral to Edwin House[34].

5.28 It's possible to understand from the combined chronology that Jonathan resided in a hostel following his discharge from hospital with plans in place to move to Edwin House. A move which did not materialise, possibly due to his eventual arrest between **25th April 2019** and **2nd May 2019** for missing a court appearance at Northampton magistrates.

NB: ***There are no recorded entries in the chronology for the month of February 2019. Jonathan's location is unknown.***

5.29 The entries within the combined chronology indicate that Jonathan was in the Nottingham area between **22nd January 2019** to **28th March 2019**[35]. There is limited information about his interactions with services in Nottingham, which makes it difficult to reach any substantial conclusions for the purposes of this review. However, it can be derived from his time in Nottingham that a repeating pattern of crisis episodes resulted in further interactions with emergency services. This included an admission to hospital on **7th March 2019** after Jonathan had collapsed in a court holding room. A clinical note records Jonathan as '*obviously malnourished and dishevelled, poor personal hygiene, multiple wounds on his body, multiple skin site infections and widespread crackles in his chest.'* He remained as an inpatient at Nottingham University Hospital for a three-week period until he was discharged on **25th March 2019**. Not long after, Jonathan returned to Northamptonshire.

April 2019 to June 2019

5.30 On **5th April 2019**, Jonathan presented at Northampton General Hospital ED complaining of pain following an alleged attack. From the chronology it is not clear whether Jonathan was assessed and reviewed. He was subsequently found smoking in the toilets and asked to leave the hospital.

5.31 Jonathan attended Kettering General Hospital ED on three further separate occasions and on three consecutive days - **6th, 7th and 8th April 2019**. On each occasion, Jonathan complained of different problems related to his mental health, feeling unwell and pneumonia. An alert was created on the hospital's electronic records instructing that Jonathan was not to be seen by the mental health team

[32] There are no recorded entries in the chronology for the month of February 2019. Jonathan's location is unknown.
[33] Records not that the service is "to support discharge arrangements and to prevent risk of unnecessary readmission to hospital". The service is comprised of an integrated health and social care team that provides intensive multi-disciplinary reablement assessment and intervention".
[34] Edwin House is recorded as *"a care and enablement centre in Nottingham, which provides nursing and recovery orientated treatment and support for people living with chronic physical and mental health issues related to substance misuse".*
[35] There are no recorded entries in the chronology for the month of February 2019. Jonathan's location is unknown.

unless there had been a 'significant [mental health] change'[36] [37]. As a result, Jonathan was not referred to the mental health team for an assessment. He refused to leave the hospital but removed himself once hospital security was called.

5.32 On **8th April 2019**, Jonathan is arrested for breach of bail conditions which prohibited his entry to Northamptonshire. He had previously been reported missing by Nottinghamshire Police and was located at Kettering General Hospital and subsequently arrested by Northamptonshire Police. Due to the bail conditions 'not to enter Northamptonshire' Jonathan was conveyed back to Nottinghamshire.

5.33 On **24th April 2019**, Jonathan is supported by Framework[38] to register at Derby Road Health Centre in Nottingham. A new patient health check is arranged for **1st May 2019**.

5.34 Following a court warrant for his arrest [39], Jonathan is held in custody . On **2nd May 2019**, he is subsequently transferred to HMP Woodhill in Milton Keynes. The chronology shows that Jonathan remained imprisoned until **24th June 2019**.

5.35 The chronology shows that on the day of Jonathan's release from HMP Woodhill, the prison's resettlement service[40] made a referral to Wellingborough Council Housing service. The chronology shows that Jonathan was also allocated to BeNCH CRC [41]on the day of his release from prison. An appointment was arranged for Jonathan to attend probation on **25th June 2019**, however, Jonathan did not attend and another appointment was made for the following day (**26th June 2019**) at Jonathan's request.

5.36 On **25th June 2019**, Jonathan presented at Northampton Borough Council Housing department and explained that he had been released from prison and that his probation appointment was in Wellingborough. Housing staff note that Jonathan does not have any form of identification or prison release papers. Housing staff fund transportation so that he can get to his probation appointment.[42]

5.37 On **26th June 2019**, Jonathan arrives at his probation appointment supported by a relative who became visibly upset throughout the appointment and left. A new appointment was arranged for **2nd July 2019**.

5.38 Also on **26th June 2019**, Jonathan made his way to Rushden Night Shelter but was denied entry due to historic disruptive behaviours. The night shelter provided Jonathan with a sleeping bag.

5.39 There are seven different records within the collated chronology linked to **27th June 2019**. These detail records of discussions between Housing, Rushden Night Shelter and BeNCH CRC. The records show inter-agency dialogue around priority need status for the purposes of housing, his health conditions and information exchange around his recent imprisonment. Jonathan had also attended Northampton Borough Council Housing office on the 27th June 2019.

5.40 Drawing on clinical information supplied by two GP's with whom Jonathan was registered; on the **27th June 2019** it was found that Jonathan did not appear to be in priority need for housing [43]. The Housing Officer noticed that Jonathan had lost weight and he was walking with a mobility aid. As such, a new appointment was arranged for the following Monday (1st July).

[36] Chronology entry dated 06.04.20

[37] Kettering General Hospital have noted this as outdated alert which had not been reviewed since its inception in 2010. The alert was placed at the request of the Mental Health team.

[38] Framework is a Housing Association based in Nottingham.

[39] Warrant without bail - failing to attend at Northampton Magistrates Court

[40] Resettlement at HMP Woodhill is provided by NACRO

[41] Formally known as Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Rehabilitation Company or BeNCH CRC

[42] Individuals leaving prison should have a prison release plan, which can include support with retrieving essential documents like ID. This usually details the activities the individual is required to do on the day of release. It is common for people who are of no fixed address to present at a local housing office for the purposes of securing accommodation. No prison release plan was supplied for the purposes of this review, it is therefore unclear as to why Jonathan presented at NBC Housing and not elsewhere, or indeed, what support he was given to retrieve key documents.

[43] Decision made by the Housing department, not GP's.

5.41 On **29th June 2019**, Jonathan was taken to Kettering General Hospital by ambulance. He had been found on the floor outside a church in Rushden. The ambulance report notes open leg wounds without bandages and chest sepsis was queried. He was treated for community acquired pneumonia and received oral antibiotics. Further assessments at Kettering General Hospital (ED) noted Jonathan to be incontinent and to having abrasions, burns and cuts to his legs. Jonathan was admitted onto a ward where he remained until **2nd July 2019.** The chronology shows that Jonathan's behaviours on the ward were often disruptive and challenging. He would make repeat requests to go outside for cigarettes whilst often being verbally abusive and threatening towards staff.

29th June to September 2019

5.42 On the day of discharge, **2nd July 2019,** transportation was arranged by the hospital to take Jonathan to Kettering Borough Council Housing office at 4pm.

5.43 This most recent period of hospitalisation (circa 4 days), it was recorded than Jonathan 'did not attend' two appointments that had been arranged for him prior to being hospitalised. This relates to appointments with probation (BeNCH CRC) and housing (Northampton Borough Council) on **2nd July 2019**.

5.44 Upon leaving Kettering General Hospital, Jonathan attended his housing appointment, this time at Kettering Borough Council. The chronology notes that *'He* [Jonathan] *didn't complete an application with us* [Kettering Borough Council, Housing] *as he wanted to be in Rushden but then ended up walking out and leaving his medication behind'.* Subsequently, Jonathan presented at Rushden Night Shelter and was again denied entry due to historical disruptive behaviours. The chronology records his presentation at the night shelter as '[Jonathan] *presented and said he had just been discharged from hospital but had no clothes with him. Staff found him clothes. His eyesight was poor, legs full of scabbed wounds and he agreed to let us register him with a* [Doctor]'.

5.45 Jonathan was found rough sleeping at Rushden Night Shelter car park on **3rd July 2019**. An ambulance was called as he reported to a shelter volunteer to feeling unwell. The ambulance report did not identify any physical issues on assessment, but the report notes that Jonathan expressed feeling suicidal. Jonathan did not go to hospital and continued to sleep rough that night. The chronology notes several entries of communication between agencies. These discussions occurred during periods of crisis or around episodes of hospitalisation. The chronology notes information exchange in relation to Jonathan's appointments, concerns about his welfare and requests for information and advice-giving between agencies. Jonathan did not have a mobile phone making it difficult to contact him. An approach was devised to reach out to Jonathan indirectly, in that one agency would contact the other if he presented at their office. It is not clear whether such a strategy was documented in a risk management plan and shared more widely.

5.46 On the **4th July 2019,** Housing were unable to determine if Jonathan was in priority need, on the basis that he had stated that he could manage to walk up *'5-6 flights of stairs'.* However, Housing did not reach a full conclusion until further medical evidence and information about his offending history became available"

5.47 On **5th July 2019** it is logged that Housing completed a referral to adult social care.

5.48 Jonathan attended Kettering General Hospital ED on **8th July 2019** stating that his GP[44] had sent him. Jonathan is reviewed in hospital and given antibiotics for cellulitis. His blood results and chest X-ray were normal. Jonathan was discharged.

[44] Jonathan's involvement with GPs were few. There were difficulties in the information that GPs could supply because of Jonathan's erratic engagement. It is not clear from the records if the GP had advised Jonathan to go to Kettering General Hospital. Nor is it clear if Jonathan was referring to a GP in Nottinghamshire (where he was registered at the time of his death) or to a temporary GP based in Northamptonshire.

5.49 On **9th July 2019,** Jonathan was taken to Kettering General Hospital by a member of the public. However, Jonathan left before observations could be completed.

5.50 On **10th July 2019** and **11th July 2019** Jonathan returned to Kettering General Hospital requesting help with accommodation, food and clothing. On both occasions Jonathan left the department before any observations or discharge planning could be completed.

5.51 On **11th July 2019,** a decision is made to relieve Jonathan's homelessness (relief duty) following an assessment of need by Housing[45]. The chronology shows that there was no means of making contact with Jonathan to give him the outcome. A letter was sent to Jonathan at his Mother's home address.

5.52 On **12th July 2019** Jonathan arrived at Housing and collected his letter and personal housing plan. He explained to the Housing Officer that he had been to the Job Centre and collected £80 which he claimed to have spent in a single day. The Housing worker helped Jonathan to book an appointment with probation for the **16th July 2019**.

5.53 An entry in the homelessness log notes that no bids for properties had been made whilst Jonathan was at the Housing office on **12th July 2019**. The professional view was that Jonathan would not be able to sustain a tenancy.

5.54 During the early hours of 15th **July 2019,** Jonathan presented at Rushden Night Shelter requesting an ambulance to be called as he was 'cold'. It is not clear from the chronology whether an ambulance was sought. Not long after, Jonathan removed parts of his clothing and threw them away. There is no indication in the records whether this was as a result of distress, frustration or some other reason. Later that morning, Jonathan presented at the shelter once more who arranged for him to attend his prearranged probation appointment. Subsequently, Jonathan was seen by his probation worker at their office. It is not clear what the outcome of the meeting with probation was. Probation note a follow up email with the Job Centre and additional conditions being added to his license for drug and alcohol treatment.

5.55 On **18th July 2019,** Housing log a duty to refer notification sent to them from the Job Centre. Housing informed the Job Centre that Jonathan is an active homelessness case and he is known to them. Jonathan presented at the Housing office and was encouraged to remain there whilst the Housing worker secured him a night shelter. Jonathan was advised to go to a housing project in Bedford[46]. He was advised to arrive there early as the project allocated beds based on a queuing system. Jonathan became agitated and swore at the Housing worker, stating that he could not afford to get to Bedford. Jonathan was then seen walking in the direction of Rushden Night Shelter.

5.56 Between **18th July 2019** and **24th July 2019**, there are further exchanges between Housing, the GP, probation, adult social services and NCC CSC where information is gathered in relation to Jonathan's health and offending history. There is evidence in the records that information was exchanged, however it is not always clear how it was used to inform decision-making, assessments or risk management plans. The exception to this is from Housing who upon retrieving Jonathan's health records, sought a second opinion regarding priority need status. Housing had also made referrals to several supported Housing providers and services, including to specialist accommodation[47]. The chronology shows the Housing worker following up on all referrals made, including a referral to adult social care sent on **5th July 2019[48].**

[45] s.189B (1) Housing Act 1996 as inserted by s.5(2) Homelessness Reduction Act 2017.

[46] The proposed accommodation in Bedford was approximately 20 miles from the Housing department where Jonathan was located at the time. It is not clear from the chronology how Jonathan was expected to get to Bedford. In terms of assessing suitability of location, Housing authorities need to consider the 'proximity and accessibility of medical facilities and other support which are currently being provided and are essential to well-being' as referred to in Location of accommodation for homeless applicants report. There is no clear rationale provided within the chronology that indicates why Jonathan was asked to go to Bedford, nor was consideration given to how he would cope out-of-area given his multiple conditions and vulnerabilities.

[47] Referrals made by Housing to other housing related services: (i) Mayday Trust; (ii) Amicus; (iii) Turning Point and; (iiii) Lifeways. Housing had also made a referral to adult social services on 05.07.20 with Housing chasing the status of the referral on several occasions since it was made.

[48] Adult Social Services did not initially communicate the outcome of the referral to Housing, but to probation. Housing prevailed upon social services as to find out the outcome of the referral they had made.

5.57 On **24th July 2019**, NCC CSC confirm to Housing that there would be no further action following Housing's referral to adult social care, but no clear rationale is given. The Housing worker challenged this and provided further information about Jonathan's circumstances. The combined chronology would suggest that this was not new information being provided by Housing to social services, but a reiteration of previous conditions and situations relating to Jonathan's circumstances and needs. Subsequently, the decision was reconsidered by a Principal Care Manager at NCC CSC who assigned the case to the 'Pro Support safeguarding work queue'.

5.58 On **25th July 2019,** Housing established that Jonathan did not have a bank account in which his benefits could be paid into. An appointment at the Job Centre was arranged for **1st August 2019.** Jonathan was required to take a form of identification and provide bank account details to this appointment. He had a universal credit payment due on **4th August 2019.**

5.59 On **25th July 2019,** a decision to provide interim accommodation was made and Jonathan was placed at High View Hotel in Wellingborough. Housing contact Rushden Night Shelter and fund a taxi for him to get to the hotel and staff at the shelter give him a food parcel.

5.60 On the evening of **25th July 2019** Jonathan attended Northampton General Hospital ED complaining of 'dizziness'. Following an assessment, he was admitted to a ward and treated for pneumonia. Jonathan was identified as a missing person whist in hospital but was located as he was in the hospital and the treatment was completed. He was discharged from hospital on **27th July 2019** and returned to High View Hotel.

5.61 The combined chronology shows that NCC CSC reviewed the case and processed the referral through adult safeguarding on **26th July 2019.** The combined chronology notes that it was not clear what could be offered to Jonathan by adult social services or what his care and support needs were. A decision is made to establish his care and support needs and to gather further information. Housing sent Jonathan's medical history to NCC CSC and raised concerns about his deteriorating physical health, including incontinence, and mental health. The safeguarding concerns were reconsidered by NCC CSC as reportable under self-neglect.

5.62 On **27th July 2019** a member of the public called for an ambulance having found Jonathan walking in the rain with no coat. Jonathan told the ambulance crew that he was trying to get his mental health medication but *'can't remember how to get there'.* He also complained of chest pain. Jonathan was transferred to Northampton General Hospital but self-discharges prior to being seen. On the same day, Jonathan returns to Northampton General Hospital after another ambulance call by a police officer who had found him *'wandering in the rain'* and was concerned that he could have pneumonia. It is not clear whether Jonathan was treated in hospital. The combined chronology shows that the hospital contacted the out-of-hours duty team in relation to Jonathan's accommodation.

5.63 On **30th July 2019** NCC CSC informed Housing that Jonathan would be required to give consent for a social care needs assessment.

5.64 Northamptonshire Police took Jonathan to the Housing office on **30th July 2019** as he could not remember the name of the hotel where he was staying.

5.65 Further reports of concern were raised by Housing with NCC CSC about Jonathan's physical and mental health deterioration. NCC CSC make a referral under safeguarding to the Short Term Enablement and Prevention Team (STEPS)[49].

[49] The chronology show that this is a service which 'undertakes short term support and assessment for up to six weeks and makes plans for longer term support if it needed'. They should be able to provide help with food parcels in the immediate and work with Jonathon to help him access other services he needs' [Dated 30.07.20]

5.66 On **31st July 2019** a decision was made by STEPS to revoke the safeguarding notification. The full reason for rescinding the safeguarding enquiry is not given. According to the combined chronology it was concluded that probation could support Jonathan with mental health and self-neglect. The STEPS duty worker confirmed to probation that Jonathan would be placed on the waiting list for an adult social care needs assessment instead.

5.67 It is unclear how many nights Jonathan stayed at High View hotel since **25th July 2019**. The chronology shows that Jonathan had stayed at his parents' address for at least two nights (possibly 29th and 30th July 2019). The chronology also shows that Jonathan's father took him back to the hotel on 31st July 2019 following an incident in the family home where Jonathan became threatening and abusive towards his mother and father resulting in the police being called.

5.68 Jonathan spent **1st August 2019** at the hotel but was found rough sleeping in a car park near Rushden Night Shelter on **4th August 2019.**

5.69 In the early hours of **5th August 2019** Jonathan was taken to Kettering General Hospital ED by Northamptonshire Police. Jonathan presented with pain to his shoulder following an alleged assault. It is not clear from the combined chronology what the police outcome of Jonathan's allegation was and whether he was treated in hospital and the outcome of any discharge plan.

5.70 On **7th August 2019** a social worker from the Short Term Enablement and Prevention Team (STEPS)is allocated who makes contact with Housing and probation.

5.71 Following a 999 call on **11th August 2019** Jonathan was taken to Northampton General Hospital ED. There are several records in the combined chronology from two different teams within the Hospital[50]. Jonathan arrived at hospital complaining of a persistent cough, breathlessness and mental ill health. A referral to mental health for assessment was made by ED. The mental health team did not carry out the assessment because there were no concerns about Jonathan inflicting harm on himself or others and that he appeared orientated to time and place. Jonathan was discharged in a taxi to High View hotel.

5.72 Probation and NCC's adult social services arrange a joint visit to Jonathan at the hotel on **15th August 2019.** Jonathan informs the assessor that he is incontinent, has a history of addiction and speaks about his previous offending. He also describes that he is 'tapping' (street begging) for money and 'getting others to skip dive' for food. The initial needs assessment revealed that Jonathan's 'main concern' is to secure benefits and a bank account. The assessor makes plans to see Jonathan again to complete the assessment, although it is not clear if a date was arranged. Probation noted a *'strong smell of urine in the room and bedding wet'*. It was noted by probation in the chronology that social services would organise a support worker to help Jonathan with his benefits and to open a bank account. Probation would organise a food parcel.

5.73 Between **15th August 2019** and **20th August 2019** Housing requested feedback from adult social services in relation to Jonathan's needs assessment. No reply was given to Housing. Housing escalate to a social work team manager on **22nd August 2019**.

5.74 Jonathan arrives at the Daylight Centre Fellowship (henceforth 'the Centre') on **22nd August 2019.** He registers as a new client and informed the centre that he had been evicted from High View hotel due to 'wetting the bed'. Housing checked this with the hotel proprietor who stated that Jonathan had not been evicted but had been given a warning for not cleaning his room and for wetting the bed. The centre provided Jonathan incontinent pads and the hotel proprietor intended to arrange a 'plastic sheet' to protect the mattress. The hotel proprietor informed Housing that 'they are not a care facility'.

[50] Adult Mental Health Liaison and the Emergency Department.

5.75 On **22nd August 2019**, Housing informed NCC's adult social services of Jonathan's incontinence and potential eviction from the hotel. The combined chronology notes a professional discord between Housing and NCC's adult social services in relation to Jonathan's care and support needs. Housing advised NCC's adult social services that Jonathan's homeless application could be closed as they do not believe he has mental capacity to make a homelessness application.

5.76 On **27th August 2019** Jonathan allowed another male to stay in his room at High View hotel. He also threatened the hotel proprietor who subsequently contacted the police. The police treated the incident as a non-emergency. Jonathan's actions were against accommodation rules. Housing informed the hotel that they would immediately evict him the next day. Housing informed probation and NCC's adult social services of this.

5.77 On **28th August 2019,** a decision is made by Housing to end the interim accommodation duty on the grounds of unreasonable behaviour. Jonathan is notified and is required to leave the hotel.

5.78 Jonathan refuses to leave the hotel and stayed a further two nights between **28th August 2019** and **30th August 2019.** The police are called to remove Jonathan. It is reported throughout the chronology that Jonathan did not appear to be at risk, nor was his behaviour abusive or threating. The police were unable to force entry and the hotel proprietor would have been required to seek possession via the courts.

5.79 **On 29th August 2019,** Housing raised their concerns that Jonathan's mental health was deteriorating and sought support from a GP who, in turn contacted the mental health team. Based on Jonathan's history, the Approved Mental Health Professional did not note acute mental illness or suicidal ideation that would warrant detention under mental health legislation. Throughout this period, the combined chronology notes repeat concerns being exchanged across agencies. In particular, from Housing who raised concerns with NCC adult social services and probation. During this time, Housing raised a safeguarding notification and a decision was also made by them that Jonathan did not have mental capacity to make a homeless application. Social services and probation were notified.

5.80 Jonathan voluntarily left the hotel on the morning of **30th August 2019**.

5.81 On **30th August 2019,** the Housing department sent a 'minded to make'[51] intentionally homeless decision letter to probation for them to consult with Jonathan.

September 2019 to December 2019

5.82 On **2nd September 2019** Jonathan attended a planned probation appointment accompanied by a female who is not believed to be linked to services. Probation consulted with Jonathan on the 'minded to letter' which Jonathan disagreed with. Jonathan did not agree that he had intentionally left his former settled address when he lived with his parents in Northants. The 'minded to' letter shows the reasons[52] which had led Housing to decide that Jonathan may be intentionally homeless as a consequence of his actions and they provided Jonathan with an opportunity to comment before the final 'intentionality' decision was reached.

5.83 On the same day, Northamptonshire Police raised an 'adult safeguarding PPN'. The combined chronology shows police concerns for Jonathan's wellbeing, which were documented as '[he] *has a tendency to go wandering around Wellingborough and is unsteady on his feet and occasionally is seen talking to himself'.* A further transfer to the ED at Kettering General Hospital followed and Jonathan

[51] Commonly referred to as a 'minded to' letter, which is a letter for informing a homeless applicant that a local authority is minded to decide the applicant: (a) has a priority need; but (b) became homeless intentionally. The letter gives the applicant a date by which they should make representations and provide any supporting information. The applicant's 'right to be heard' provides the applicant: (a) information that is (or could be) averse to their application and; (b) provide the applicant an opportunity to comment on it.

[52] Letter 'Minded to make' intentionally homeless decision, dated 30.08.19, provides five reasons as to why Jonathan may be intentionally homeless. Jonathan disagrees with all five reasons. There is a hand written note in the letter (by probation) which states that Jonathan 'does not have mental comprehension or mental capacity to fully cooperate with this'. It is not clear what Jonathan was perceived as being unable to understand.

was assessed as requiring a mental health assessment as he had expressed suicidal ideation. Jonathan self-discharged before the assessment could take place and the hospital filed a missing person's report with the police.

5.84 On the evening of **3rd September 2019,** Jonathan returned to Kettering General Hospital and complains of leg pain but refused blood tests and physical examination. Jonathan stated that he had bipolar disorder which he was not taking medication for and that he needed help. He was assessed by the mental health team who determined that Jonathan does not have an acute mental illness and that his presentation is linked to social circumstances. Following a check of their records, it is also determined that Jonathan's presentation is as result of a '*disorder of personality'* and confirmed a historical diagnosis of Emotionally Unstable Personality Disorder. He was discharged the following morning.

5.85 On **5th September 2019** Jonathan went to St Mary's Hospital[53] requesting help for his mental health, homelessness and benefits. He was subsequently signposted to the ED and the police were called as he had refused to leave. However, there is no record of Jonathan attending either Kettering General hospital or Northampton General Hospital on the 5th September, or indeed, any recorded contact with the police.

5.86 On **6th September 2019,** Jonathan was transferred to Kettering General Hospital ED following a fall outside a medical centre. He reported to have sustained a knee and head injuries. Jonathan became verbally abusive towards hospital staff as the initial assessment was performed. Staff reported that Jonathan was *'jumping from one topic to the other'*. Jonathan was assessed by the mental health team who determined that his needs were *'social'* and not due to mental illness. Jonathan was discharged the following day**, 7th September 2019.**

5.87 On **10th September 2019** a police intelligence report noted that Jonathan was sleeping rough outside a bank in Wellingborough**.** The Centre raises a safeguarding concern *'due to Jonathan being at risk on the streets'.*

5.88 On **11th September 2019**, Housing raised concerns with NCC adult social services management team over Jonathan's care and support needs, self-neglect and mental incapacity to make a homeless application. Consequently, NCC adult social services management requested a professional's meeting be arranged by Jonathan's social worker and for a team manager to review the case.

5.89 On **11th September 2019**, BeNCH CRC sent a safeguarding referral to NCC.

5.90 Jonathan went to the Centre for a pre-arranged shower appointment on **11th September 2019** and asked for assistance to wash. Staff at the centre explained that they were unable to assist with personal care. Jonathan was provided with a hot meal but was observed as not being able to utilise his right hand to cut his food.

5.91 On **11th September 2019** STEPS corresponded with Housing and probation to inform that a professionals meeting is to be arranged[54]. The combined chronology reflects that mental capacity may fluctuate, in particular if the person is using drugs and alcohol. Housing responded to suggest that mental capacity could also fluctuate as a result of untreated illnesses and conditions.

5.92 On **12th September 2019,** NCC CSC triage a safeguarding referral sent by 'anonymous'[55]. An open notification was being worked on by the STEPS team.

5.93 On **12th September 2019,** Jonathan returned to the Centre and was assisted to have a shower with support from another service user.

[53] St Mary's Hospital is a multi-functional mental health hospital site in Kettering which has services for both inpatients and outpatients.
[54] No meeting date had been arranged at this stage.
[55] The combined chronology would locate this to BeNCH CRC as the referrer

5.94 On **12th September 2019,** Housing formally determined that Jonathan lacked mental capacity to be dealt with and considered under homelessness legislation, therefore any duties owed to him, in housing terms, no longer apply. A letter was sent to the Centre who confirmed that they would hand it to Jonathan.

5.95 Jonathan was assessed by a social worker at the centre on **13th September 2019**. Throughout the assessment Jonathan became verbally aggressive towards the social worker. The assessment continued once Jonathan had calmed. Based on the combined chronology, it is not clear what the outcome of the assessment was or what needs were identified. Additional information supplied by the Daylight Centre indicates that Jonathan was reliant on informal care and support, in terms of attending appointments and for help with washing and dressing, including laundry tasks. Jonathan indicated that he often struggled to remember things and that he required information to be given to him in 'plain English'. Jonathan informed the assessor that he had difficulties with the right side of his body following a major stroke.

5.96 A police report on **14th September 2019,** indicates that Jonathan had been sprayed with an unknown liquid whilst sleeping in a doorway next to a bank. A PPN was completed and given to Jonathan's social worker.

5.97 On **15th September 2019,** a member of the public calls the Emergency Duty Team explaining that Jonathan is *'a stroke victim, uses a Zimmer frame and is incontinent'* and was concerned that '*he would be on the streets tonight*'. The duty team offered to accommodate Jonathan in a bed and breakfast but he refused. It is not clear why Jonathan had refused accommodation on this occasion.

5.98 On **18th September 2019,** Jonathan returns to Kettering General Hospital ED by ambulance reporting to be a victim of an assault. It was noted that Jonathan had chronic obstructive airway disease (COPD). He was admitted to a ward and was awaiting contact from his social worker. Jonathan was discharged in the afternoon of 18th September 2019 and advised to go to the 'council office'.

5.99 Also on **17th/18th September 2019**, Social Services invite the following agencies to a professionals meeting which was held on **19th September 2019**[56]: Housing, probation, police vulnerable adults team, GP[57], acute mental health liaison service (AMHLS) and the Centre. Housing requested for the meeting to be arranged for the following week given the short notice and to allow for key contributors to return from leave and attend the meeting. Housing were unable to attend and their contributions to the meeting were provided electronically. Housing maintained that Jonathan did not have mental capacity to make a homeless application and that he was an adult with care and support needs and at risk.

5.100 **Professionals meeting on 19th September 2019** - Additional information was considered alongside the combined chronology. The actions agreed at the meeting are listed below:

(a) **Adult Social Services** to: refer Jonathan back to Housing, support to open a bank account, register with a GP, seek information with regards to his health history and consider a referral for occupational therapy.
(b) **Northamptonshire Police** to: decide on charging Jonathan for any future criminal offences.
(c) **BeNCH CRC [58]** to: monitor the level of support they are currently providing.
(d) **All agencies** to: inform social services if/when they come into contact with Jonathan so a visit can be arranged.

[56] There is no record in the chronology from social services of when the invitation to the professionals meeting was sent out. It is a case note from Housing which indicates that professionals were not notified of the meeting until the day before. Supplementary information in the form of reflective questions indicate that social services has sent invitations to the meeting on the 17th September 2019.
[57] The combined chronology notes that the GP declined the invitation as they did not feel that they knew Jonathan well enough, nor could they contribute with further information as he was a temporary patient.
[58] Formally known as Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Rehabilitation Company or BeNCH CRC

5.101 There were no recorded minutes for this meeting and therefore the professional rationale when deciding on actions is not clear. The combined chronology notes that the Mental Health team[59] had reiterated their stance that Jonathan did not present with mental health needs when he had been assessed by them. There is also no evidence within the combined chronology of Kettering General Hospital or Rushden Night Shelter[60] being invited to the professionals meeting, nor were their contributions sought to inform discussions.

5.102 Jonathan attended Kettering General Hospital once on **21st September 2019** and twice on **22nd September 2019.** He complains of different issues such as shortness of breath, abdominal pain and mental ill health. On the first two attendances, Jonathan was discharged and advised to follow up with his GP. On the last of these attendances, the hospital contacted the emergency duty team who advise them to contact Rushden Night Shelter. The hospital arranged a taxi and Jonathan presented at Rushden Night Shelter the same evening. He was subsequently refused entry due to historic disruptive behaviours and was given hot food and bedding.

5.103 Between **23rd September** and **30th September 2019,** there were several exchanges between agencies in relation to Housing's decision that Jonathan lacked mental capacity for the purposes of housing. The combined chronology indicates that both Social Services and mental health were of the view that Jonathan did have mental capacity for the purposes of making decision relating to housing matters. The chronology shows that Jonathan was supported by probation and the Centre to compose a written appeal, on the grounds that he could manage a tenancy with support from social services.

5.104 On **26th September 2019** Jonathan is excluded from entering the Homes Direct office following another incident of abusive behaviour towards Housing staff. The police are notified and a PPN was raised.

5.105 On **1st October 2019,** a new social worker[61] is assigned who made contact with agencies. The social worker shares direct contact details with the Centre and requested they make contact should Jonathan present there.

5.106 Jonathan attended a planned appointment with probation on **1st October 2019.** It is not clear what the outcome of this meeting was.

5.107 On **2nd October 2019** Jonathan is assisted by the police and is taken to Kettering General Hospital ED due to concerns about his mental health. Jonathan was assessed by the mental health team and it was decided that he does not have acute mental health needs. Jonathan is discharged in a taxi to Rushden Night Shelter, however it is not clear from the notes if the hospital was aware of Jonathan's exclusion from the shelter. The chronology notes that the mental health team contacted social services to inform them about Jonathan's attendance and their assessment of his presentation. Jonathan arrived at Rushden Night Shelter following his discharge from hospital. Staff at the shelter were concerned that he appeared confused and disorientated and completed a safeguarding referral. Jonathan left before an appointment with his GP could be booked.

5.108 The chronology notes further correspondence between agencies between **2nd October 2019** and **14th October 2019**. Social Services attempt to visit Jonathan but this was not successful as he had not presented at the Centre as he normally would. Concerns [62]were also raised by Housing to the NSAB Business Manager, who asked whether an Adult Risk Management (ARM) meeting had been arranged. The chronology does not indicate that agencies acted on the advice of the NSAB Business Manager and no ARM meeting was arranged. Subsequently, the NSAB Business Manager raised concerns directly with the STEPS' Social Worker.

[59] Northamptonshire Healthcare NHS Foundation Trust

[60] Northampton General Hospital confirmed they were not invited to the professionals meeting on 19th September 2019.

[61] Change to Social Worker due to previous worker being on long term absence

[62] It is not clear when concerns were brought to the attention on the NSAB Business Manager, although a response was provided on 11th October 2019.

5.109 On **14th October 2019,** Jonathan met with his social worker at Rushden Night Shelter to continue his needs assessment[63]. The combined chronology indicates that Jonathan was engaging well with the questions asked of him and that he had expressed himself clearly. The assessor's meeting notes indicate a sudden and dramatic change to Jonathan's demeanour, resulting in Jonathan becoming verbally abusive and incoherent. Jonathan was struggling to balance and unable to converse with staff present at the assessment (this included two support workers accompanying the Social Worker). The social worker observed that the change to Jonathan's presentation did not seem to be linked to drugs or alcohol, but thought it could be of "organic origin". The assessment ended and Jonathan remained at the shelter.

5.110 Soon after the assessment had ended, a staff member from the night shelter called an ambulance and Jonathan was taken to Northampton General Hospital. He was subsequently transferred to the Intensive Treatment Unit (ITU) for investigation where he was subsequently intubated and ventilated. A CT scan showed evidence of traumatic brain injury. He was treated for suspected meningitis and encephalitis[64]. A lumbar puncture could not be performed due to spinal deformities. Once Jonathan's condition had stabilised he was transferred to a ward.

5.111 The chronology notes that a referral by Northampton General Hospital for medical rehabilitation was not accepted as there was no discharge destination due to Jonathan being homeless. Jonathan was discharged from hospital on **18th December 2019** (approx. 10 weeks after admission[65]).

5.112 The combined chronology shows agencies corresponding with Northampton General Hospital and requesting updates with regards to Jonathan's condition during his inpatient stay. The hospital reported that Jonathan was making 'good progress'. On **1st November 2019** Jonathan was discharged from the Acute Mental Health Liaison Service who had been asked by the ITU to review him due to his extensive agitation. On **7th November 2019** his case was closed to the STEPS team as *"Jonathan is making good progress in hospital therefore now closed to the Steps North Team".*[66]

5.113 The chronology notes correspondence between social services and the Northampton General Hospital's complex discharge team. It was decided to refer Jonathan to the Hospital Health Assessment Team (HAT) and to the hospital's in-house Housing team. The combined chronology indicates there was consensus between STEPS, the Complex Discharge Team and the Hospital's Housing Team that a discharge plan would be required (including destination) so that medical rehabilitation was made possible.

5.114 On **11th November 2019** the STEPS social worker carrying out Jonathan's assessment informed HAT management that the case is closed to STEPS and it is not clear why this occurred from the chronology.[67] Information was provided to HAT regarding Jonathan's complexities and that he lacked capacity to manage a tenancy. Housing, probation, Rushden Night Shelter and Jonathan's family were notified that STEPS would end their involvement and that HAT would complete the needs assessment.

5.115 On **26th November 2019** there was uncertainty as to who made, or would make, the referral to HAT.

5.116 On **28th November 2019,** the ward completed a referral to HAT. The assessment started and a HAT worker was assigned.

5.117 On **4th December 2019,** HAT decided to end their involvement with Jonathan as *'all his needs relate to housing'. It is not clear if the assessment had been finished and concluded.* Observations on the ward indicated that Jonathan was able to manage independently despite being *'forgetful and can be easily distracted when completing tasks'.* No care and support needs were identified by either staff on the ward or by HAT.

[63] The combined chronology notes that this was to carry on from the previous assessment on 13.09.19.
[64] Inflammation of the brain
[65] The full length of stay at hospital was not entirely due to clinical need. Jonathan had been medically cleared a few weeks prior to discharge but agency disagreements with regards to discharge destination caused a delay.
[66] NASS observation recorded on CareFirst
[67] The combined chronology shows that STEPS closed the case on 7th November 2019 and informed HATS of this on 11th November 2019.

5.118 Up until the date of discharge from hospital on **18th December 2019**, there were several exchanges between agencies. Following HAT's observations that Jonathan did have mental capacity, could manage independently and had no care and support needs, Housing reviewed the decision with regards to Jonathan's incapacity and accepted that he was in priority need for the purposes of interim accommodation. Temporary accommodation was arranged at the Euro Hotel in Wellingborough. Jonathan was discharged with his medication, but he did not have any money, bank account, phone or ID.

5.119 Jonathan did not attend an appointment at the Job Centre on **19th December 2019**.

5.120 On **19th December 2019,** STEPS reopen the case and agencies are notified that a worker would be assigned after the Christmas period. Housing make several referrals to different support agencies.

5.121 On **20th December 2019** Housing send a safeguarding referral to NCC on the grounds of an unsafe hospital discharge, including neglect and acts of omission. Social Services decide that the concerns raised by Housing would not be appropriate for safeguarding as an appropriate discharge was arranged. Housing are notified of the outcome.

5.122 On the **21st December 2019,** Jonathan suffers a fall at the Euro Hotel and sustains a head and rib injury. He was able to call for assistance (999) and was taken to Northampton General Hospital ED. Jonathan informs the hospital that he has poor eyesight and is unable to take his medication as he cannot read the instructions. Subsequently, Jonathan was referred to the Intensive Care Team (ICT) who declined the referral as they *"could not help with medication issues".* Recognising the risks that Jonathan would face post discharge prompted a further referral to the Crisis Response Team (CRT). Similarly, this was declined, and CRT said they *"cannot help with medication only".* A record within the chronology notes that Jonathan had stated he *"already* [has] *got a care worker, social worker among other multi-disciplinary team members and the fact that he had got enough money to afford private carer and that they want to be discharged home".*

5.123 Jonathan also stated that he did not feel safe at the hotel. Jonathan was assessed and reviewed and deemed medically fit for discharge. Jonathan requested to go back to the hotel. A taxi was arranged but it is not clear if Jonathan made it back to the Euro Hotel. The combined chronology notes that this was the last time Jonathan was seen by professionals prior to his death[68].

5.124 Entries within the combined chronology indicate multiple concerns amongst agencies that Jonathan's whereabouts were unknown. Jonathan had not been seen by professionals for several days. However, it is not clear from the combined chronology if a formal missing person's report was raised or if any action was taken as a result of these concerns. Social services carried out an unplanned visit on the **23rd December 2019** but were unable to gain entry to the hotel.

5.125 On **27th December 2019,** Jonathan missed an appointment with probation.

5.126 On **27th December 2019,** Jonathan's friend calls social services reporting concerns that she was unable to access the Euro Hotel to see Jonathan and that she was concerned about Jonathan's frailty and poor mobility. Social Services advise the friend to call the police given the immediate welfare issues. The friend calls the police but the police do not attend. The chronology shows that the police considered they did not have grounds to exercise powers of entry as there was no immediate threat to life[69].

5.127 A police record notes that a hotel cleaner was the last person to see Jonathan alive on the **27th December 2019.**

[68] Jonathan was seen by a friend on several occasions before Christmas. On Christmas day the friend went to the Euro Hotel to give Jonathan a Christmas dinner and washed the dishes. The friend returned on Boxing Day to give Jonathan tobacco and food.

[69] It is not clear from the chronology what information had been shared with the police or how this decision was reached.

5.128 On **31st December 2019** social services attend the Euro hotel. The door to Jonathan's room was unlocked and the workers were able to enter. Jonathan was found lying on the floor and there was no response from him. His death was confirmed at 10:18am when an ambulance crew arrived. Arrangements were made between social services and the police to notify the family.

6. Analysis

Jonathan's presenting issues and risks are categorised as themes. These were derived from reading the combined chronology and from the additional information supplied by the agencies involved in the review.

6.1 Housing and Homelessness

6.1.1 Records from December 2018 until June 2019 show that the position of the Housing was that Jonathan was not in priority need and was not vulnerable because he could manage to walk several flights of stairs. Housing were increasingly reliant on retrieving his medical records and the list of medications, and seeking a professional opinion from social services to confirm that Jonathan was, in fact, vulnerable. Even though Housing were willing to review their decision pending further information, it is clear from the combined chronology that Jonathan's physical and mental state was deteriorating, as observed on several occasions by his repeat attendances at hospital and through the safeguarding concerns raised by agencies, including from Housing themselves.

6.1.2 The Housing Act 1996 and subsequent case law have established that a person would be in priority need if vulnerable as a result of mental illness, learning disability or physical disability. Consideration should have been given to whether or not Jonathan would suffer or be at risk of suffering more harm or detriment than an 'ordinary person' as a result of homelessness.

6.1.3 It is not clear whether social services provided a professional opinion to Housing with regards to Jonathan's vulnerability for the purposes of determining priority need. However, it is important to note the variations between social workers and Housing practitioners when assembling notions of vulnerability when considering need. Invariably, there are different sets of considerations under the respective legal framework followed by Housing practitioners and social workers to think through. Standing in contrast to vulnerability definitions found in housing terms, are notions of adults at risk within health and social care contexts. Arguably, Jonathan was both vulnerable and at risk. Regardless of the legal framework being followed (whether it is Housing Act 1996 or the Care Act 2014), Jonathan was entitled to a service and would have been classed as needing assistance.

6.1.4 It is positive practice to make housing decisions regarding priority need, vulnerability and intentionality of homelessness with the involvement of health and other relevant services. It is clear from the commentaries in the combined chronology that Housing applied positive standards in this respect. It is also clear from the chronology that Jonathan's problems were increasingly restricting his mobility, he had issues with continence and his ability to concentrate and remember appointments were increasingly affected. Given what was known at the time, it is surprising that Jonathan was not judged as significantly more vulnerable than an ordinary person faced with homelessness and that a change in view about this did not occur at a much earlier stage. It is considered that this represents a missed opportunity to intervene in a managed and purposeful way.

6.1.5 In the end, Housing decided to provide Jonathan with interim accommodation because he was deemed to meet the criteria for priority need. There was an additional perspective occurring alongside this as a result of Jonathan being assessed to lack mental capacity to make a homeless application and his ability to manage a tenancy was questionable given the nature of his disabilities and conditions.

6.1.6 The assessment by Housing appears to have been influenced by three factors which proved difficult to reconcile. The first factor, given what was known about Jonathan at the time, involved understanding his ability to follow through with actions in his Personal Housing Plan. It is clear that Housing staff provided Jonathan with advice about housing options and information about rental properties. Additionally, several referrals were made to different Housing organisations and appointments were arranged including with a specialist accommodation provider. It is clear to see that, in this respect, Housing staff went 'above and beyond' to secure a more appropriate placement for Jonathan following the assessment. Although it is questionable whether he would have been able to act on this advice and information without substantial support, given his disabilities and erratic engagement with services at that point.

6.1.7 The second factor appears to be related to the decision on whether to grant the main housing duty before the end of the 56-days relief period. The homelessness code of guidance[70] advises that once the local authority has gathered all the information it is required to make a decision in relation to the individual's priority need and intentionality, in or around day 57.

6.1.8 The third and last factor relates to Jonathan's mental capacity to make a homeless application. Both the Mental Capacity Act 2005 and its code of practice (2007) make it clear that an individual should be assessed on whether they have the ability to make a particular decision at a particular time. When Housing first considered Jonathan as lacking capacity to make a homeless application, they found themselves in a position where no other statutory agencies appeared to be offering any assistance or making a determination with regards to his care and support needs. Housing were rightfully concerned that Jonathan would not be able to hold down a tenancy given his physical and mental health conditions without substantial support.

6.1.9 The questions asked about Jonathan's ability to care for himself and to maintain a tenancy, was the main premise which led Housing to conclude that Jonathan did not have capacity to make a homelessness application. It appeared to Housing that Jonathan could not retain information nor understand the consequences that not meeting the conditions of a tenancy would have on his wellbeing, including to keep a potential home. However, having the ability to live independently and having capacity to make a homelessness application are arguably different issues and therefore decisions.

6.1.10 It is clear that Housing did consult with agencies[71] with regards to Jonathan's mental capacity, however it is not clear whether agencies understood what was being asked of them or what a finding of lack of capacity in a specific area would mean in a housing sense, and whether there was any confusion between Jonathan's difficulties to live independently and his mental capacity to decide on making a homelessness application. For instance, Jonathan clearly asked for help and wanted assistance, however, he would also make claims to be wholly independent without the need for support which at times was taken at face value. Reconciling the variances between Jonathan's stated aims, his need for assistance and his actual actions presented a challenge for Housing.

6.1.11 Additional information supplied by Housing at the request of the independent reviewer shows that Jonathan had missed appointments with several accommodation providers, and had a missed appointment at the Job Centre. In addition, concerns about his ability to understand and retain information linked to the Personal Housing Plan were key factors in determining that he lacked capacity to make a homelessness application. However, these matters are not entirely evidential of a lack of capacity to make a homelessness decision. Jonathan's behaviours, erratic engagement with services and difficulties remembering appointments could result from his physical disabilities and/or communication difficulties. Alternatively, they could be seen as an indication of Jonathan's frustration and distress, given that he would not be able to achieve certain tasks without substantial support.

[70] para 14.16 Homelessness Code of Guidance, MHCLG, Feb 2018.
[71] GP and probation.

6.1.12 Whether or not this was the case, the assessment was not carried out in the way required by the Mental Capacity Act code of practice nor did Housing appear to, or ask others to, make adjustments given that Jonathan was physically disabled as required by the Equality Act 2010. It would not be reasonable to expect Jonathan to physically attend all appointments given his health issues, financial troubles and having no means of contact without substantial support.

6.1.13 Supporting a person's decision is not about making the decision for them but ensuring that they grasp that there are consequences that will follow on. This requires practitioners to engage their professional curiosity in order to understand the person's individual circumstances and ascertain what elements of decision-making the person may need help with and why. There are a variety of ways in which practitioners can support people to make decisions. This consists of helping people who may be struggling with their memory or who have communication difficulties, for example checking they know, or going over, the features of the decision needed, and then letting them have appropriate time to weigh up those features relevant to a decision.

6.1.14 Jonathan explained to a social worker at his initial assessment that he prefers information to be given to him in 'plain English', however it is not clear what adjustments were provided to afford Jonathan the opportunity to process information and in a manner that was more suited to him[72] which in turn may have impacted upon his ability to weigh up information.

6.1.15 It is well documented, although seldom understood, that people who are rough sleeping are frequently in risky and distressing situations but may be more fearful of alternatives. As such, practitioners should take a tailored approach to understanding each person's unique circumstances and the wide range of factors that can have an impact on a person's ability to make a decision, in particular, how they may interpret information in the context of their lived experience, understanding of risk and present circumstances. It is important to distinguish between unwise decisions made by adults with capacity and decisions made as a result of a lack of capacity.

6.1.16 Equally, situations where individuals who lack capacity to make a homelessness application[73] under the Housing Act 1996, may still be entitled to accommodation-based support where there is a need to be 'looked after'[74]. Case law[75] has established that looking after means considering whether the person would still need intervention irrespective of their financial circumstances. Local authorities are also permitted to exercise its power to meet care and support needs, including for accommodation, under section 19 (3) of the Care Act 2014, prior to completion of an assessment if there appears to be an urgent need.

6.1.17 Opportunities to review previous exclusions were not carried out by the night shelter and there was a sense of Jonathan being permanently excluded. Whilst this may not have been an appropriate setting for Jonathan, an exclusionary review could have afforded him an opportunity to understand accommodation rules and the consequences that would follow should he continue not to adhere to the requirements.

6.1.18 Further information supplied by Housing indicates that the local night shelter is staffed by volunteers at night. A critical time in the case of Jonathan as he would often present at the shelter late in the evening or early hours of the morning. Additional information supplied to the Overview Author revealed that volunteers at the night shelter are not registered professionals or have had relevant training, or indeed the resources, to manage the complex sets of challenges that Jonathan often presented with. It is also clear that volunteers at the shelter could not manage Jonathan's needs and

[72] Ornelas, B., Schwehr, B., Davies, G. (2020). Unwise choices or uniformed decisions regarding housing options? The duty to make enquiries and the implied duty to support decision making. Stoke-on-Trent: VOICES.
[73] *R v LB Tower Hamlets, ex p Begum* (1993)
[74] "Looking after means doing something for the person being cared for which he cannot or should not be expected to do for himself: it might be household tasks which an old person can no longer perform or can only perform with great difficulty; it might be protection from risks which a mentally disabled person cannot perceive; it might be personal care, such as feeding, washing or toileting. This is not an exhaustive list. The provision of medical care is expressly excluded… if there is a present need for some sort of care, then obviously the authorities must be empowered to intervene before it becomes a great deal worse." Lady Hale in *R (M) v Slough* [2008]
[75] *R (M) v Slough* [2008]

behaviours without substantial support from other agencies. It was nonetheless an opportunity for the night shelter to review its processes and training offer to volunteers, so that they feel better equipped to work with people experiencing multiple exclusion homelessness, like Jonathan.

6.1.19 Specific guidance on Psychologically Informed Environments (PIE) for homelessness services was developed by the Department for Communities and Local Government in 2012[76] and a PIE assessment model developed by No One Left Out in 2015[77]. At the centre of a PIE approach are 5 key elements: (1) Relationships (2) Staff support and training (3) The physical environment and social spaces. (4) A psychological framework; and (5) Evidence generating practice. PIE developers, like Claire Ritchie et al (2015) reminds us that " These elements help staff work more effectively with people who have complex and multiple needs, changing the way we understand and tackle the behaviour that leads to homelessness, in a measurable way. The approach focuses strongly on relationship building to promote recovery and can be used by outreach and day centre staff as well as hostel and shelter workers". A core aspect of a PIE approach is to aide reflective practice as a process of continuous learning from professional experiences. Used regularly it encourages problem solving and critical thinking skills.

6.1.20 It was clear that Jonathan was presenting with a complex set of configurations that were challenging to manage, nonetheless, services working across homelessness that rely on volunteers to deliver key services play a critical role in local homelessness strategies. The challenge remains for system leaders and practitioners to effect changes in practice and address the risks of those experiencing multiple exclusion homelessness.

6.2 Hospital Discharges

6.2.1 Various challenges were identified in terms of how well services worked together related to the hospital discharge process. Most of the issues identified related to the perceived lack of planning, communication and co-ordination between services. Whilst there is evidence of information being shared between agencies, it is not always clear how this was utilised to support assessments and inform decision-making. For some services, in particular Housing, this resulted in them chasing up what they felt should have been completed in hospital or that could have been planned for better with earlier communication.

6.2.2 One clear example of this was in relation to medication and the difficulties Jonathan encountered self-administering them upon discharge. There was a sense that Jonathan would be able to follow up with his GP (registered in Nottingham) even in the knowledge of his difficulties accessing primary care and the fact that he was homeless. This was never followed up by the Hospitals. There was a distinct lack of professional curiosity in relation to how Jonathan, who had nowhere safe to stay, had multiple risks and vulnerabilities, could be expected to end a cycle of crisis without substantial support backed by purposeful multi-agency planning/intervention. Indeed, without support and a safe place to stay, it could be considered as inevitable, if not foreseeable, that Jonathan would be at high risk of readmission to hospital.

6.2.3 In total, Jonathan attended two hospitals on at least 40 occasions in 2019. Not taking into account the time he spent in prison (approx. 12 weeks) or as an inpatient (up to 16 weeks) this would average approximately 1.5 to 2 attendances at an emergency department each week within a 5-month period.

6.2.4 A number of agency submissions to this review have remarked that each encounter with Jonathan was seen in isolation. There were several occasions when Jonathan would self-discharge prior to assessment or treatment commencing, but the majority of his presentations resulted in treatment or in admission. His stays in hospital ranged from 1 or 2 nights up to 12 weeks within the review period.

[76] Keats, Helen, Maguire, Nick, Johnson, Robin and Cockersell, Peter (2012) Psychologically informed services for homeless people. Southampton, GB, Communities and Local Government (Good Practice Guide)

[77] No One Left Out: Solutions Ltd for Westminster City Council (2015) Psychologically Informed Environments: Implementation and Assessment.

6.2.5 Jonathan's attendance at hospital was often chaotic and intermittent. From the combined chronology it is clear these occurred frequently with each presentation posing its own set of challenges. It is possible to discern a pattern of crisis episodes, none of which appear to have been addressed holistically even though his frequent attendance had been recognised at the time. There were a mixture of presentations ranging from Jonathan attending on his own, emergency call outs and ambulatory care or police taking him. On at least two occasions he was taken to hospital by a 'passer-by' who had found him collapsed on the streets. On another occasion Jonathan arrived as he was 'too unwell' to remain in custody following an arrest. Jonathan would often have multiple attendances on the same day and across two different emergency departments located around sixteen miles apart.

6.2.6 Jonathan would often receive clinical assistance for low level and treatable illnesses like leg wound care for diabetic related leg ulcers or chest infections, to more complicated interventions resulting in inpatient stays. On his lengthiest stay in hospital (October to December 2019), Jonathan was in a critical condition and admitted to intensive care where he was treated for meningitis and encephalitis. CT scans showed that Jonathan had suffered historic strokes and traumatic brain injuries, but there is no evidence that his cognition was ever tested, nor that this was raised as part of any discharge planning, risk or needs assessment. It is surprising, therefore, that his ability to execute plans or to be organised was never questioned.

6.2.7 Jonathan regularly stated that he was suffering with poor mental health and feeling suicidal. It is possible to recognise a repeating pattern where Jonathan would be referred to the mental health team for assessment, often resulting in 'no further action' as he did not present with acute mental illness. Towards the latter part of the review period, he was no longer referred to the mental health team for assessment as an alert on Kettering General Hospital's records indicated that he was not to be referred unless there had been a significant change to his presentation. A commentary in the chronology, in addition to a reflective discussion with hospital workers, showed that this was an outdated alert dating back to 2010 that should have been removed. Several commentaries within the combined chronology indicate that Jonathan was seeking help for 'social' problems or because he was cold and homeless, not always for medical reasons.

6.2.8 It is clear that Jonathan presented with both care and support and housing needs. This would trigger the issuing of both 'Assessment' and 'Duty to Refer' Notices to adult social care and the local Housing authority respectively. It is also clear that such duties were not always followed and his care and support needs appear to be insufficiently acknowledged, particularly in relation to hospital discharge planning. Indeed, it is important to be mindful that the definition of care and support is much broader under the Care Act 2014 and not solely linked to personal care tasks. For example, encompassing accommodation related outcomes and, as a result, many people who are homeless with complex needs could be eligible for support from either the Local Authority or another agency. It is, therefore, questionable whether staff working in hospitals had the necessary legal knowledge around social care and housing law to plan purposeful and effective discharges for people with a complex set of configurations and risks, like Jonathan.

6.2.9 The duty to refer under the Homelessness Reduction Act 2017 should help to ensure that services are working together effectively to prevent homelessness by ensuring that peoples' housing needs are considered when they come into contact with public authorities. It is also anticipated that it will encourage local housing authorities and other public authorities to build strong partnerships which enable them to work together to intervene earlier to prevent homelessness through increasingly integrated services. Hospitals and other staff must seek the permission of the person before a referral is made to the local housing authority. However, consent may not be required in order to safeguard vulnerable adults or children. It is, nonetheless, important that practitioners' use professional curiosity and be mindful of how they ask questions as adults who are homeless may feel stigmatised by their circumstances.

6.2.10 In the case of Jonathan, he often stated that he had been assaulted and was fearful of rough sleeping, but when he gave assurances that he was okay or if he left abruptly, this would often be accepted at face value with no further lines of enquiry being explored based on professional curiosity which may have helped guard against placing undue confidence on Jonathan's ability to care for himself.

6.2.11 Fiona Bateman (2020)[78] reminds us that the key safeguarding principle of accountability derives from the public law obligations. This means practitioners, especially those working in relevant partner agencies, must be able to satisfy they have met their professional clinical and care governance duties. This will include careful consideration and recording of mental capacity, taking into account the person's ability to make capacitated and cognisant choices as to understand, retain, weigh up foreseeable consequences and, crucially, communicate the decision made. Mental capacity law requires the assumption of capacity until it is proven otherwise, but this alone will not itself absolve practitioners of their duty of care.

6.2.12 One entry as a comment in the combined chronology notes that a referral to medical rehabilitation could not proceed because there was no destination pathway. It can be concluded that Jonathan's homelessness or lack of housing was a barrier to him reaching his full recovery potential. As no accommodation was sourced for Jonathan the default pathway was to 'signpost' Jonathan back to the local housing authority without arrangements in place for meeting his wider care and support needs. It is important to highlight that excluding those with nowhere suitable to live could mean an agency breaches its duties under the Equality Act 2010.

6.2.13 There were no multi-disciplinary team meetings involving community-based services or case conferences between October 2019 and December 2019 when Jonathan was a hospital patient, which arguably would have been an optimal way to explore his needs, risk mitigation strategies and housing options.

6.2.14 In a commentary, it is noted that daily ward rounds involve professionals from different disciplines, however, it is not clear how these meetings link with community-based services, or indeed what purposeful planning occurred for Jonathan. It was also accepted that Jonathan's apparent independence to manage his personal care and mobilise safely on the ward were determining factors that concluded he had no care and support needs and that these could be sustained in the community. Arguably Jonathan's needs should have been explored and assessed in more detail to ensure there was an accurate picture to enable appropriate care and support planning to occur. This is explored further under section 6.3 'care assessments and safeguarding'.

6.2.15 Housing authorities and homeless services have a vital role to play in out-of-hospital care but should not be expected to work reactively with homeless patients, as it was the case for Jonathan on multiple occasions. The involvement of these agencies should be well planned and integrated with health and social care. Multi-agency responsibilities for adult safeguarding and the extreme risk of death among this cohort of patients mean that it is no longer acceptable to overlook instances of neglect and acts of omission where patients are discharged to the street. It should be acknowledged that the hospitals would often fund transportation for Jonathan to present at Housing or a night shelter. It remains difficult, however, to reconcile Jonathan's stated claims that he had money to pay for his own care and could manage independently, when set against repetitive patterns of hospital attendances, and the clear and obvious risks he would face as a street homeless person. His failure to act on stated intentions did not prompt a review of his capacity, for example, despite the multiple mental health assessments he had.

[78] Fiona Bateman is an Independent Chair to Safeguarding Adults Boards and founding trustee director at CASCAIDr. Reference to webinar delivered by Bateman, F and Ornelas, B (2020) 'Homelessness and multiple disadvantage: Understanding factors that affect decision making during the Covid-19 crisis', Homelesslink. London.

6.2.16 Several submissions have commented on the lack of planning, communication and co-ordination between agencies and care planning following each of the hospital discharges which, given Jonathan's repeating pattern of hospital attendance and his evident needs, is a significant oversight. The handover between the social workers located in the hospitals and community social work team, including the multiple risks and vulnerabilities identified, does not appear to have been considered in the hospital assessment which is a significant omission in the assessment and subsequent discharge process.

6.2.17 It must be emphasised that housing is unlikely to have been the primary or only need at the point of discharge for Jonathan. Standard practice in many hospitals is to 'signpost' patients who are homeless to Housing authorities. This is often before a housing assessment has taken place and before arrangements are confirmed for meeting wider care and support needs. After an acute illness with treatment in hospital, patients are usually expected to recover at home. Housed patients with certain treatable diseases have relatively low readmission rates, reflecting recovery or ability to manage the condition in the community. This is not the case for Jonathan who did not have a good place to recover and consequently he had a high level of readmission rates irrespective of the cause of hospitalisation.

6.2.18 It should be recognised that adults experiencing multiple exclusions and homelessness, like Jonathan, provide particular challenges for agencies and their commissioners, especially in times of significant financial constraints and when much of the landscape is being re-configured, often at a rapid pace, to meet competing priorities. However, both research and SARs in relation to homeless hospital discharges remind us of how new approaches to practice are improving discharge outcomes for homeless patients. For example, adopting a 'trusted assessor' approach so that patients do not have to repeat their story and restart assessments entirely from scratch following each admission. Such an approach would avoid duplication and provide more timely responses for people with multiple needs who are homeless. This would require a commitment to more collegiate ways of working across disciplines as to overcome organisational barriers and provide cost effective ways of securing purposeful and planned interventions in accordance with the relevant statutory functions.

6.2.19 Insecurity of tenure and not knowing what will happen after discharge is a highly traumatising experience which can confound further psychological distress. The risks associated with rough sleeping for example, is exacerbated by having nowhere to store medication or advice on how to take it. It is clear that Jonathan had an acute need in this respect. A lengthy hospital admission, as it was in Jonathan's case from October 2019 to December 2019, provides an opportunity for rest and recovery, or indeed respite from a life away from the streets. Within the safeguarding literature, discharges from settings like hospitals and prisons are often referred to as 'transitions'. More recently, research into homelessness and safeguarding[79] shows that transitions should be seen as opportunities for comprehensive risk assessments, mitigation planning and to coordinate purposeful and meaningful support. This is also an opportunity for people to feel hopeful and optimistic about the future as their health becomes restored. Even though such feelings should be encouraged it may present a 'false dawn' and should not be mistaken for truly informed expressions of intent that can be followed through by the patient upon discharge and without substantial support.

6.2.20 Safeguarding Adult Reviews (SARs) have increasingly drawn attention to instances where poor discharge arrangements have contributed to the deaths of people who are homeless. In particular, they have highlighted the poor practice associated with seeing each hospital admission in isolation, the failure to provide appropriate multi-disciplinary responses and to initiate safeguarding where unsafe discharge occurs. It is clear that learning from these reviews ought to apply to Jonathan.

6.2.21 There was a significant window of opportunity to maximise the health benefits following an admission, however, there was a missed opportunity for purposeful multi-agency working and a failure to work cohesively before Jonathan was discharged on 18th December 2019. For primary care and other staff working in the community, having to deal with patients presenting in crises due to an

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

unplanned discharge is frustrating and highly disruptive to their day-to-day practices. When people fall through the cracks or have no choice and control in the discharge planning process, they will usually return to hospital quite quickly, which is what happened on 21st December 2019 when Jonathan returned to hospital having suffered a fall in the hotel room.

6.2.22 At the point of hospital discharge, in particular on 21st December 2019, there was a distinct lack of understanding the risks Jonathan would face, including exploration of the likelihood and severity of harm he could incur. There was no consideration of the available options to protect Jonathan, or exploration with him about the impact that his choices could have on his wellbeing. Undue confidence was placed on his ability to care effectively for himself and there was a failure at working collaboratively to understand risk, with little to no value given to levels of safety following discharge(s) from hospital.

6.2.23 No single practitioner can be expected to know all the details about a person's life or have all the knowledge required to navigate complex processes and systems, however, this does not absolve practitioners of their duty of care. As much is already known about homelessness and safeguarding, it can no longer be regarded a defensible position to omit professional curiosity from day-to-day practice. Equally, placing undue confidence on what the individual may express and without appropriate levels of professional skepticism being applied is likely to present as a missed opportunity to understand concerns. Instead, practitioners are expected to act on what they are reasonably expected to know through careful exploration of the available options (including legal ones) and applying both professional judgment and challenge where necessary.

6.2.24 On 21st December 2019, the notes reveal entries where Jonathan was declined assistance with the administration of medicines at the point of discharge because *"they cannot help with medication only"*[80]. Although, medication management is not a prescribed outcome as defined in the eligibility regulations under the Care Act 2014, an adult's ability to manage medication may well be necessary to achieve one or more of the prescribed outcomes.

6.2.25 In cases where an adult may have difficulties managing medication without assistance, health and adult social care services may encounter challenges in terms of the division of responsibilities for such support. It is clear from the chronology that Jonathan required medication to manage his health conditions which had been prescribed to him; however managing medication was an aspect of his care and support needs which he would not be able to achieve without assistance given his poor eyesight. There is an obligation on the NHS to ensure that required medications are correctly administered (e.g. quantity, frequency etc.), including careful recording if the person requires assistance to take medication. Although, it cannot be expected for a single NHS employee to undertake all tasks associated with the administration of medication, it does remain the responsibility of the health body to best decide how to discharge its functions under the NHS Act 2006. There was a clear lack of joined up working across health and adult social care services in this respect which represents a missed opportunity to safeguard Jonathan.

6.2.26 In summary, where hospital patients like Jonathan who have care and support needs are discharged without appropriate support being offered and available it is likely that this would be a safeguarding issue.

6.3 Care assessments and safeguarding

6.3.1 The family commented to the Overview Report Author that Jonathan was well known to services and questioned whether the risks he faced had been normalised which may have deterred agencies from taking action or raising concerns again. Indeed, it can be established that the notifications being raised by partner agencies indicate a similar pattern of concern in that Jonathan was vulnerable, had multiple physical and mental health conditions which were impacting on his wellbeing in a significant way.

[80] 'They' refers to Crisis Response Team and Community Intense Care Team

6.3.2 Multiple notifications of concern were submitted by agencies throughout the review period to adult social care and adult safeguarding. These highlighted the risks Jonathan faced and areas where he required support, in addition to the safety issues made worse by homelessness.

6.3.3 Fifteen Public Protections Notifications (PPNs)[81] were made by the Police during the review period. From the additional information provided at the request of the Overview Report Author, it shows that twelve of these PPNs are recorded as referrals to adult social care. Whereas others are recorded as Adult Safeguarding PPNs within the collated chronology. Likewise, Housing and probation raised notifications for both safeguarding and adult social care assessment.

6.3.4 No safeguarding referrals were made by the hospitals despite Jonathan's high attendance at emergency departments. It is also clear that staff in the hospitals did not perceive there to be safeguarding concerns and therefore it was never raised as such.

6.3.5 Notifications sent by the police and Housing to the NCC CSC were not routinely passed on to adult social care or adult safeguarding. The police, in their reflective discussion with the Overview Report Author commented that it is not widely understood by police officers what happens after PPNs have been submitted. There is an absence of feedback from adult social care or adult safeguarding with regards to the outcome of notifications raised by the police and/or other agencies. Equally, there is an expectation from agencies submitting notifications or raising concerns through the NCC CSC that cases will be assessed and allocated to Safeguarding, or indeed a social worker, meaning that there is a lack of checking whether referrals or notifications have been received, including understanding the status of concerns raised.

6.3.6 In a reflective submission to the Overview Report Author, it was highlighted that agencies making referrals to adult social services, including safeguarding, should make specific requests (for adult social care or safeguarding) within their referrals. However, given the concerns that failures to act in the case for Jonathan could lead to further suffering of abuse and neglect, it would have been critical that agencies were notified immediately of concerns irrespective of which route was followed. In the event that there is no duty to make enquiries, guidance provide by ADASS (2019:8)[82] states that *"practitioner(s) must still consider and record how any identified risk will be mitigated (including through communication with partner agencies) and how that will be communicated to the adult concerned…"*.

6.3.7 It is possible to discern a pattern which indicates that Jonathan's care and support needs were not being sufficiently acknowledged, with each referral or notification being seen in isolation. On several occasions it was judged that Jonathan did not have any care and support needs to trigger a safeguarding adult enquiry under section 42 of the Care Act 2014. On one occasion it was noted that 'eligibility' for a social care assessment had not been satisfied which denied Jonathan of his right to an assessment. There is an assessment duty under section 9 of the Care Act 2014 which means that if there is an appearance that a person may have care and support needs that an assessment should be undertaken. This represents a low threshold for the purposes of carrying out a needs assessment. With respect to Jonathan it appears that there was a significant oversight and missed opportunity to conduct and complete an assessment of his care and support needs, much earlier on.

6.3.8 Equally, there is a statutory criteria for a section 42 enquiry under the Care Act, 2014 which is that where a local authority has 'reasonable cause to suspect' that an adult in its area who has care and support needs (these are not eligible needs), is experiencing or at risk of abuse or neglect and as a result of those needs is unable to protect themselves against the abuse or neglect or risk of the same[83].

[81] Northamptonshire's Police Safeguarding Adults procedure provides guidance for Police workers when to raise PPNs. This can be an adult risk PPN or mental health PPN, for example.

[82] 'Making decisions on the duty to carry out safeguarding adult enquiries' (2019:8)[82].

[83] Section 41(1) Care Act 2014.

6.3.9 Furthermore, if the criteria for a section 42 enquiry is reached, the local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom[84].

6.3.10 With regard to Jonathan, there were substantial opportunities to bring together information contained with the PPNs in addition to concerns raised by partner agencies through other methods creating an overall picture. However, such opportunities were routinely missed with each notification being considered in isolation. It is concerning and questionable as to the degree to which agencies understand the statutory criteria for a section 42 enquiry, particularly when set against challenging circumstances linked to MEH and repeating patterns, which Jonathan experienced.

6.3.11 Jonathan had expressed a need for information to be given to him in 'plain English' which was indicative of a communication requirement he had. Such a request does not appear to have been considered. The care and support statutory guidance[85] which accompanies the Care Act 2014 requires local authorities to give the person being assessed advance notice so that they can prepare for the assessment. This should include a list of questions to be covered to support the person to think through the needs they have and the outcomes they want to achieve. Given what was known about Jonathan at the time, such an approach could have been helpful preparation for him and helped to ensure that he was supported and better involved in the assessment process. Indeed, in a reflective submission from adult social services it was thought that an independent advocate should have been considered

6.3.12 There are rights under section 67 of the Care Act 2014 to independent advocacy for representation and support with assessment to facilitate the person's involvement in the assessment process, including care planning and reviews. An independent advocate must be arranged if the local authority considers that a person would have 'substantial difficulty' in doing one or more of the following:

a) understanding relevant information;
b) retaining that information;
c) using or weighing that information as part of the process of being involved; and
d) communicating the individual's views, wishes or feelings (whether by talking, using sign language or any other means)[86].

6.3.13 It was the persistence and professional challenge from Housing that led to Jonathan being considered for a social care assessment with an initial assessment occurring in August 2019. Although attempts were made to further assess Jonathan's needs, these were in part frustrated due to the difficulties maintaining contact with Jonathan. Housing and Homelessness agencies were well acquainted with the risks Jonathan faced, however, their views as to how he could be helped were routinely ignored.

6.3.14 At the practitioner's event, it was felt that views from Housing and Homelessness practitioners were not given the same parity in decision making, often being left out for the purposes of deeper case analysis as to support an overall picture of Jonathan's circumstances. This is a significant omission given the extent to which both Housing and Homelessness services came into contact with Jonathan and were well placed to inform initial assessments and risk planning strategies.

6.3.15 The care and support statutory guidance require assessors to be prompt at recognising where there are shortfalls in knowledge of a particular condition or circumstance and seek to consult with someone who has relevant expertise[87]. This is to ensure that the assessor can ask the right questions relating to the condition and interpret these appropriately to identify underlying needs. A person with relevant knowledge can be considered as somebody who, either through training or experience, has attained knowledge or expertise of the particular condition or circumstance. Such a person may be a doctor or health professional, or an expert from the voluntary sector. Involving voluntary services in this regard could have supported the assessment and its conclusion much sooner.

[84] Section 42(2) Care Act 2014.
[85] Care and Support statutory guidance
[86] Section 67(4) Care Act 2014.
[87] Para 6.86, Care and Support statutory guidance.

6.3.16 This represents a failure to work with partner agencies for the purposes of collating and gathering relevant information and placing undue reliance on Jonathan's stated claims, often without further questioning or enquiry through professional curiosity. It is also a significant omission that could be seen as to violate his dignity.

6.3.17 There is no evidence that there was any consideration as to whether Jonathan would have qualified for an independent advocate under sections 67 and68 of the Care Act 2014. Given his difficulties around attending appointments, acting on advice being given to him including understanding information and seeing through assessments without interruptions because of his conditions. Itis reasonable to question whether his difficulties being involved in the assessment process were substantial enough as to trigger the appointment of an Independent Advocate. In a reflective submission by social services it was recognised that Advocacy support should have been considered.

6.3.18 Given the evidence that Jonathan was at an increased level of risk of physical assault and neglect, it is surprising that no safeguarding enquiries occurred nor, as a minimum, were multi-agency risk and/or needs assessments being undertaken and much sooner. This is a significant omission and given the risks faced by people experiencing MEH, like Jonathan, it would have required a proactive investigative response as to consider the positive obligations under the Human Rights Act 1998.

6.4 Inter-agency collaboration, leadership and coordination

6.4.1 At the practitioners' event the concept of 'intersectionality thinking'[88] was introduced as a means to encourage multidisciplinary teams to think ethically and critically when working across sector boundaries, including with individuals who are experiencing multiple disadvantages, like Jonathan. If applied to Jonathan's case, intersectionality would support agencies to acknowledge the intertwined nature of multiple domains of need and risk rather than examining them in silo or functioning as independent categories. Additionally, findings and learning from the first national analysis of Safeguarding Adult Reviews[89] have highlighted the importance of counteracting discriminatory practices and unconscious bias towards gender, race, ethnicity, sexuality and disability so that individuals are not prejudiced by their circumstances or characteristics.

6.4.2 To this end, intersectionality thinking can be used to expand understandings of the interconnecting factors that shape and determine health and social inequity across multiple exclusion homelessness populations. This will, perhaps inevitably, require practitioners to grapple with tensions linked to notions of homelessness as a voluntary choice, challenges in legal knowledge, including poor safeguarding literacy and understanding how narrow interpretations the law can, if left unchallenged, constrain multi-disciplinary working and exacerbate exclusionary processes and practices.

6.4.3 The combined chronology indicates that practitioners found it difficult to negotiate the initial screening process for accessing adult social care assessments, including safeguarding. Challenges also arose understanding how Jonathan's situation had come about. Likewise, there were variations in judging what is dangerous and what is safe, including a normalisation of the risks that Jonathan was clearly experiencing whilst often failing to consider the mundane and obvious. Such divergences of professional views often resulted in high conflict situations across the workforce, indeed, much of the housing department's time was spent 'arguing the case' for access to adult social services. On the other hand, hasty determinations were reached that 'thresholds' for assessments had not been met, including a failure to acknowledge Jonathan's care and support needs or, in some cases, there was a complete sense of inaction from agencies.

[88] Intersectionality thinking invites practitioners and services to expand their understanding of the intersecting factors that shape and determine health and social inequalities. Intersectionality acknowledges the intertwined nature of multiple domains of needs and risk rather than examining each area in isolation.

[89] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement. London: LGA/ADASS.

6.4.4 A poll[90] carried out at the practitioners' event showed that most practitioners either 'disagreed' or 'somewhat agreed' when asked to describe individual confidence levels working with people experiencing MEH. It was also explored how a shared understanding of key terms, like MEH and intersectionality, can be used to shape practice responses to risk, needs assessment and planning, with some suggesting a specific policy and procedure that incorporates adult safeguarding and MEH should be developed. Policies and procedures for adults who self-neglect might provide a strategic focus.

6.4.5 At the learning event practitioners acknowledged how adults experiencing MEH are often placed in the "too difficult" box. It was also clear that practitioners felt overwhelmed by the thought of how legislative powers and duties could have been applied in the case of Jonathan. Understanding the risks that adults like Jonathan may face, including a significant increased risk of serious abuse, exploitation and neglect as well as an escalation of their health and care needs and a reduction to their life expectancy will help practitioners to objectively define risks and needs.

6.4.6 A poll[91] at the practitioners learning event asked the following "From your perspective, what are the most common barriers to effective practice?". Practitioners identified poor communication and information sharing, silo working and normalisation of risk as the top three categories that hinder effective practice. Interestingly, there was only a single selection for 'poor safeguarding literacy' and no selection for 'legal literacy'. NB: national research into safeguarding adult reviews describe legal literacy as *"knowing and using legal powers and duties in the pursuit of practitioner goals is a central element of practice"*[92]. Likewise, legal literacy is a core component appropriate decision making.

6.4.7 These poll results, however, should be treated with some caution as it's not indicative of there being an appropriate level of legal acumen across the workforce, in particular when it comes to the application of the legal rules in practice. On the contrary, discussions with practitioners about the legal powers and duties relevant to Jonathan's situation were rarely applied. It is clear from the combined chronology, that there was a lack of awareness about the range of legal options available to fulfil assessment and safeguarding functions, including the cooperation duties (section 6-7 of the Care Act 2014) of 'relevant partners'[93]. A list of the powers and duties applicable in Jonathan's case was given to practitioners at the learning event, leading to comments that highlighted both the complexity of the law that practitioners are required to navigate, but also increased awareness of how the law can facilitate positive practice.

6.4.8 Poor understanding and application of the law is no defence, not least in the application of assessment duties as in the case of Jonathan. A fundamental right under the Care Act 2014 is the duty to assess needs for any adult who may appear to have care and support needs (Section 9(1)). This means the core legal right to an assessment is not targeted at any specific individual or sets of needs and configurations. Only once the assessment has been completed is the local authority to determine whether the adult has eligible needs (section 13 of the Care Act 2014) followed by careful consideration as to how best to meet those needs (section 18 of the Care Act 2014)**.** Similarly, duties in connection to section 42 enquiries arise when there is 'reasonable cause to suspect'.

6.4.9 SARs have recognised the inherent challenges in identifying care and support needs in the context of adults experiencing MEH, including a lack of acknowledgement of severe substance misuse and complex trauma, and the impact of this on the adult's ability to achieve against the ten domains of the care and support eligibly criteria asset out in The Care and Support (Eligibility Criteria) Regulations 2015. There is no specific definition in the Care Act 2014 or accompanying statutory guidance for care and support needs, but there are clear indicators as to what to look for. However, supplementary

[90] Practitioners learning event on 21.10.20. Poll (1) "To what extent do you agree with the following statement: "I'm confident working with people experiencing Multiple Exclusion Homelessness" – options: strongly agree, agree, somewhat agree, disagree, strongly disagree.
[91] Practitioners learning event on 21.10.20. Poll (2) "From your perspective, what are the most common barriers to effective practice?" – options: Silo working, Poor communication & information sharing, Lack of leadership & coordination, Absence of challenge to poor service standards, Poor safeguarding literacy, Poor legal literacy and Normalisation of risk (missing the mundane and obvious)
[92] Page 129, Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement. London: LGA/ADASS.
[93] Defined by s6(7) of the Care Act 2014 as District councils, NHS bodies, Police, DWP, Probation services and prison staff.

guidance and toolkits from other sources like the Social Care Institute for Excellence (SCIE) and, more specifically, the 'Multiple Needs Care Act Toolkit' (Voices of Stoke, 2016)[94] and the 'Safeguarding Toolkit for Multiple Exclusion Homelessness' (Ornelas et al, 2020)[95] provide a way in which practitioners can best describe care and support needs for adult's experiencing a range of issues as a result of homelessness, including how these impact on the 'ability to achieve' and ability to self-protect.

6.4.10 Practitioners highlighted not knowing 'where to go' when challenges and disputes occurred in multi-agency practice, or the mechanisms available to resolve disagreements. NSAB now provides an escalation policy for resolving professional disagreements, including where there are concerns over *'another professional's decision making, including their action or lack of action as the case may be, timely professional challenge is paramount as any delay could put adults at further risk'*[96]. NSAB's escalation policy sets out five stages to dispute resolution with each phase having a set of checks and balances for practitioners to consider, aimed at resolving matters in a timely and proportionate way.

6.4.11 The six key principles of the Care Act 2014 (including safeguarding) also underline the importance of cross sector and multi-agency working through partnership, including accountability and flexibility to ensure transparency of decision-making (including how decisions can be challenged).These can link directly to the continuing obligations under the Equality Act 2010 and Human Rights Act 1998 as well as obligations to adhere to crucial procedural safeguards, including the duties to co-operate with relevant agencies, consult with the person and their support network and provide advocacy support.

6.4.12 Throughout the period of review, there was a one multi-agency meeting in September 2019. Professionals coming together for the purposes of working effectively was a significant omission in the case of Jonathan. At the learning event, including reflective discussions with agencies, practitioners commented that local procedures, such as Northamptonshire's multi-agency Adult Risk Management (ARM) process was not embedded in practice. There were diverging views in terms of the utility of the ARM process for complex cases like Jonathan, ranging from a lack of awareness of the aims and purposes of the ARM, to perceptions that it was not compatible with practice. The time it takes to arrange an ARM to secure the right professionals around the table was concerning for practitioners, with some viewing the process as 'bureaucratically burdensome' and a barrier to instigating an ARM process, including no guarantees that the right agencies would 'turn up'.

6.4.13 The combined chronology together with individual reflective agencies discussions and the practitioners event indicate that working in silos and a lack of coordination and case management were key omissions in Jonathan's case. There was a perceived lack of curiosity across disciplines to understanding each other's roles and responsibilities, including lack of consensus as to how the appointment of a lead agency to steer the team around Jonathan could be beneficial. Practitioners at the learning event highlighted the need to secure more timely responses when working together, to facilitate communication across sector boundaries and promote earlier interventions. It was suggested that a solution to overcoming these common barriers could be through regular (monthly) meetings, or through a 'complex needs' panel as a mechanism to engage in problem solving, information sharing, working flexibly and sharing of risk and responsibility across agencies. It was questioned, however, how such a process would be administered and chaired, including who would be responsible for holding partners to account and provide strategic oversight.

6.4.14 A positive practice briefing published in March 2020 on adult safeguarding and homelessness[97] delivered by the Local Government Association in collaboration with ADASS provides local authorities with a series of practical examples of multi-agency panels emerging in different parts of the country. There is no clear one-size-fits all and much depends on local arrangements and resources, however, what remains clear is that *'Safeguarding people experiencing multiple exclusion homelessness is*

[94] Multiple Needs Care Act Toolkit (2016)
[95] Multiple Exclusion Homelessness: A safeguarding toolkit for practitioners (2020)
[96] Northamptonshire Safeguarding Adults Board NORTHAMPTONSHIRE ESCALATION POLICY – RESOLVING PROFESSIONAL DISAGREEMENTS (2020: 2). See also page 3 'Stages of escalation – pathway'.
[97] Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness. A Briefing on Positive Practice. London: LGA and ADASS.

everyone's responsibility'.[98] Inevitably there will be challenges in getting the governance right and finding a place in which multiple exclusion homelessness, or indeed, practice panels can best reside.

6.4.15 Nonetheless, this should not be a barrier to finding what works including learning from SARs and the evidence-base of positive practice. Michael Preston-Shoot reminds us that "*what is required is a governance conversation, inclusive of elected members, partnership and board chairs and strategic leaders, where agreement is reached on a common and shared vision alongside roles and responsibilities for assuring the quality of policies, procedures and practice. Where one board or partnership forum takes lead responsibility, all agencies/ services with a potential contribution to offer must participate, represented by senior leaders with authority to commit their service to partnership working"* (2020:28). The way in which services and agencies responded to protect rough sleepers as a result of the Covid-19 pandemic provides an opportunity to build on the numerous innovations occurring across the system, so that partnership working and responses to some of society's most disadvantaged members may be sustained.

6.4.16 Making Safeguarding Personal practice is not evident in Jonathan's case, including a distinct lack of appreciative enquiry into Jonathan's history and exploration as to why he had come to be where he was. There is no record in the combined chronology that records his wishes, hopes and desired outcomes. The notes record examples of what Jonathan did not want and what he had 'failed' to do, for example, refusal to accept or follow through with treatment and missed appointments. On one occasion, when Jonathan presented with old magazines believing it was paperwork, when questioned he became verbally abusive, however there was a lack of appreciative enquiry as to what this meant for him. It is possible to discern a pattern that Jonathan's actions were not active rejections of help but driven by a sense of feeling overwhelmed by his circumstances.

6.4.17 It must be highlighted that Making Safeguarding Personal does not mean accepting at face value what the adult says without careful consideration as to the consequences they will likely face, nor does it absolve practitioners of their statutory responsibilities. Likewise, statutory definitions as to what constitutes abuse and neglect are not prescriptive, practitioners should take a tailored approach to understanding each person's unique circumstances and the wide range of factors that can have an impact on a person's ability to make sense of their circumstances, in particular how they may interpret information in the context of their lived experience and situation. Making Safeguarding Personal for Jonathan should have included consideration of the following factors:

a) The effects of drug (prescribed or not) and alcohol dependency;
b) Cognitive dysfunction (sometimes hidden or disguised which may present as challenging behaviours);
c) The individual's awareness of their ability to make decisions, including the person's previous experiences of institutions, or general lack of experience in making decisions about their welfare;
d) Self-stigma, low self-esteem or disregard for their own wellbeing;
e) The person's physical and mental health condition;
f) The person's communication needs, including level of literacy;
g) The involvement of others (sometimes associates acquired through street living) and being aware of the possibility that the person may be subject to undue influence, duress or coercion regarding their circumstances; and
h) Social and economic factors linked to poverty and meeting basic needs.

6.4.18 It remains clear, however, that there is an opportunity for agencies across Northamptonshire to come together, whether it is called a complex needs panel or something else, or through the amendment of current processes to unblock changes for people experiencing MEH and create learning for systems through shared responsibility. It is also clear that this is a view shared by practitioners involved in Jonathan's case. Equally, national research into SARs has questioned how well learning from SARs is being implemented. It is, therefore, timely to revisit policies and protocols, including the ARM, so that

[98] Preston-Shoot, M. (2020: 22) Adult Safeguarding and Homelessness. A Briefing on Positive Practice. London: LGA and ADASS.

duties owed to people with similar sets of characteristics, presentations and apparent needs, like Jonathan, are not being placed at a disadvantaged and can be helped through proactive and coordinated interventions. What is required is a strategic conversation, as highlighted by Northamptonshire Police and local government positive practice briefings that pulls together strategic leaders, elected members and Board Chairs to commit to partnership working for this vulnerable group.

7. Concluding discussion

7.1 Despite the concerns of how agencies worked together in this case, it is important to highlight evidence of positive practice. There were determined efforts, in particular from Housing, to work with agencies and share their concerns through regular and robust information sharing. Indeed, there is a good level of record keeping from Housing who clearly understood the risks Jonathan faced and they were proactive at highlighting their concerns. There were also examples of professional challenge and escalation from Housing when it was thought that agencies were not working together well enough. Arguably, it was Housing's persistent advocacy which led to Jonathan having an initial social care assessment in August 2019. Both Housing and the NCC CSC made determined efforts to make contact with Jonathan and to support him to address immediate risks and resolve his homelessness.

7.2 Adult social services provided management support with practical suggestions to support the team around Jonathan. There are examples where critical thinking was applied by management to encourage professional curiosity and inform purposeful multi-disciplinary meetings. The approach adopted by the social worker in the assessment in October 2019 should be highlighted as positive practice as they sought to assess Jonathan in locations amenable to him. This involved corresponding with voluntary sector services to find out Jonathan's whereabouts and devising a communication strategy so that an assessment would be possible. Given his levels of disability this is a reasonable adjustment to make to ensure that key assessments can be carried out, irrespective of his housing status. It was also positive that the social worker sought to engage with Jonathan's family as part of the assessment process, understanding that they were well placed to provide information about his history and difficulties. The police service regularly supported Jonathan to go to the night shelter or the Housing office and they would also take him to hospital in order to protect him from the harms of rough sleeping because of his vulnerabilities and health conditions.

7.3 The Hospitals understood that Jonathan was cold and hungry because he was homeless. He was regularly given clothing and food, whilst understanding that his presentation at the emergency department was often to seek shelter and respite from the dangers of rough sleeping. The Hospitals regularly paid for transportation to take him to places, like the night shelter or Housing office. There were only a few occasions when treatment was not completed because Jonathan had left, but on the occasions where treatment was successful much of this is owed to Hospital staff who were able to de-escalate Jonathan's challenging behaviours and provide him the assurances he needed at the time. To achieve this would take a great level of human kindness and compassion which was shown to Jonathan over and over again.

7.4 The night shelter and the Centre had regular contact with Jonathan, despite their limitations as to what they could reasonably offer him, they responded as best as they could, regularly providing him with clothing, blankets, arranging appointments with a GP and addressing his care needs as best as they felt able to. It must also be emphasised the positive practice by the local Job Centre who, despite not knowing much about Jonathan, were amenable to his circumstances displaying flexibility when he missed appointments. There is evidence of the Job Centre completing a notification to Housing services under the 'duty to refer' when they understood he was homeless and following up with services to rearrange appointments so that he could access his benefit entitlements.

7.5 Despite the numerous examples of positive practice and the determined efforts to support Jonathan, the evidence has nonetheless led the Overview Report Author to conclude that there was a lack of purposeful and effective multi-disciplinary working to address Jonathan's complex issues. This is most pressing during the period of his admission to Hospital in October 2019 and the manner of his discharge on the 18th December 2019. There was a clear failure to implement a meaningful and personalised plan of action and a failure to assess his social care needs so that these were not merely confined to just a housing issue.

7.6 In the opinion of the Overview Report Author the safeguarding threshold criteria under section 42(1) of the Care Act 2014 was met which should have instigated an enquiry. Given what was known about Jonathan including the additional information sent to support this review, in addition to the reflective discussions with agencies, it is clear that Jonathan would have most likely have had eligible care and support needs and therefore been entitled to some services under the Care Act 2014. The decision made by adult social services that Jonathan did not have care and support needs to justify an assessment was a departure from the requirements of the Care Act 2014 and the accompanying statutory guidance. This was an error and a significant omission that could have led to his needs being assessed much sooner.

7.7 Equally, there were missed opportunities for Housing to resolve his immediate homelessness when Jonathan was clearly struggling to manage his physical health needs and to attend appointments. Too much emphasis was placed on evidencing his vulnerability for housing, a decision that Housing could have made given his complex presentation and much sooner.

7.8 The professionals meeting in September 2019 lacked structure and meaningful action planning. There was undue confidence placed on Jonathan's ability to make capacitous decision. However as highlighted above, capacity to make decisions does not absolve practitioners of their duty of care. Even if it could reasonably be established that the presenting evidence would not meet the threshold criteria for safeguarding, nonetheless the evidence should have been sufficient to have activated the Adult Risk Management (ARM) process if Jonathan was deemed to have mental capacity to make decisions, but this did not happen. This brings into question how well agencies understand and apply the ARM procedure for complex cases such as Jonathan's.

7.9 It was left for agencies to work with Jonathan in times of crisis. This meant that the coordination of purposeful plans and responses were never instigated. In the reflective submissions by agencies, it was highlighted that Jonathan's case is not unique and other similar on-going cases involving MEH continue to exist and present considerable challenges to services.

7.10 This is particularly relevant in financial scarce contexts when the pressures to deliver are not always matched by resources, including time. Jonathan's complex needs and homelessness can be seen as residing at a critical juncture between adult social care and adult safeguarding, not neglecting the importance of Housing and Health. As such there is a risk that people with experiences of MEH fall through the cracks of state intervention/support in such a way that their risks and care needs are routinely considered not 'significant' enough for adult social care, or the assumption that the person is able to self-protect does not trigger actions through Adult Safeguarding. Equally, practitioners often do not consider section 11 of the Care Act 2014 in circumstances where the adult refuses an assessment and they either lack capacity in this area or at risk of abuse and neglect. This provision means that in such circumstances the local authority should not rely in the adult's refusal.

7.11 There is an important role for adult safeguarding governance to play in shaping and developing new narratives which needs to be backed by the commitment of relevant partner agencies to work differently and more creatively with these groups.

7.12 Referring to the questions agreed by the scoping panel as set out in the terms of reference for this review, the analysis of available information leads to the following conclusions:

7.12.1 There were missed opportunities to use powers and duties within the Care Act 2014, Housing Act 1996, Homelessness Reduction Act 2017 and Mental Capacity Act 2005 (assessment of decisional and executive capacity).

7.12.2 There was a lack of professional curiosity to understand Jonathan's complex needs and homelessness, with the exception on the occasions described above. Jonathan's history was not taken into account and the professionals' understanding of this was not considered. It can be concluded that making safeguarding personal was not adopted.

7.12.3 There was a general lack of service coordination to address safeguarding concerns and prevent the escalation of health/social care needs and harm through timely, coordinated assessments.

7.12.4 Transitions between services and institutions, such as from prison and admissions to and discharge from Hospital were not managed, which includes not activating the 'duty to refer' on most occasions where it was known that Jonathan was homeless.

7.12.5 Risk management pathways including NSAB's Adult Risk Management Process (ARM) was not utilised, which suggests that this is not embedded in practice.

8. Summary

8.1 It is important that practitioners are confident in working with people experiencing MEH as fragmented responses and lack of timely assessments on the part of adult social care, as well as health and housing services, have been identified in SARs into the deaths of people who are homeless[99]. The numbers of homeless deaths in England and Wales have increased by 24% in the last five years. In addition, statistics published in December 2020 by the Office for National Statistics (ONS)[100] showed that 778 people had died across England and Wales in 2019 as a result of homelessness and rough sleeping, with an average age of death for homeless men at 45 and slightly lower for women at 43.

8.2 It is not uncommon for people who are street homeless to be perceived as making "lifestyle choices" or deemed to have actively declined offers of help and support even though they may never have had the correct information to begin with. Perhaps unknowingly, practitioners may utilise mental capacity law terms to explain a person's situation. For example, this may often come under the guise of "unwise choice" when the reality could better be described as an "uninformed choice" and is altogether more nuanced and complex. Practitioners need to equip themselves with the relevant material and be able to adjust their ways of communicating and when presenting information, so that it is appropriate and proportionate to the person's needs and circumstances. Knowing the difference between a person's unwise but firm decisions and decisions which are misinformed is critical, as this avoids the pitfalls of potentially lengthy drawn out complaints, or indeed, deaths and further SAR referrals.

8.3 Asking the questions "Do you have you somewhere safe to stay tonight?" together with "Do you understand why I am concerned about the level of risk to your well-being?" may enable practitioners to properly explore the adult's capacity to understand the objective risk the adult faces[101].

[99] Martineau, S. J., Cornes, M., Manthorpe, J., Ornelas, B., & Fuller, J. (2019). Safeguarding, homelessness and rough sleeping: An analysis of Safeguarding Adults Reviews. London: NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London

[100] Office for National Statistics. Deaths of homeless people in England and Wales (2020)

[101] Questions are informed by Fiona Bateman (Independent Chairperson to SABs) as part of a practitioner's toolkit called Multiple Exclusion Homelessness: a safeguarding toolkit for practitioners (2020).

8.4 Nonetheless, it is still necessary to identify the person's current care and support needs and how these impact on their ability to protect themselves from abuse and neglect, including self-neglect. The importance of knowing the legislative framework and understanding how they can be applied in practice and within the context of individuals with similar sets of circumstances like Jonathan, is a key message from this review. Indeed, it is also a message the family wished to convey to agencies in Northamptonshire and beyond so others like Jonathan can be 'seen and heard' and better understood. Likewise, all agencies should endeavour to support practitioners to work with the relevant legislative frameworks and available guidance in ways that are inclusive of people's unique situations and abilities.

8.5 This review has explored the depth to which professionals who work with people that are experiencing MEH like Jonathan need to be prepared to exercise their professional judgement and in ways which incorporates the law, ethics and rights based-thinking. A good starting point is knowing what the legal framework and principles are so that practitioners feel well-equipped to apply the scope of different (sometimes overlapping) legal frameworks to cases. Michael Preston-Shoot (2020)[102] reminds us that opportunities for joint working become missed opportunities when professional boundaries become barriers, or when interpretations of policy and the legal rules are narrowed or misunderstood. Practitioners should also be mindful that reliance on the more procedural aspects of the law alone may not be sufficient and should endeavour to interpret and apply the law in ways that are underpinned by human rights principles and professional ethics.

9. Recommendations

Given the implications for current practice and the requirements to improve partnership working as highlighted by this report, in addition to the shared view that Jonathan's case is not an isolated occurrence and indicative of wider systemic issues, there is a clear need to secure impact from the findings of this review within agreed timescales.

All recommendations should be completed by 31s October 2021. Where this is not possible due to the Future Northants changes, then agencies will need to agree and propose an alternative date to the NSAB not beyond 31st March 2022.

1. NSAB to receive from the Chief Housing Officers Group a review of practice and decision-making regarding priority need for housing applications.

2. NSAB to receive from Adult Social Services and Housing, a joint multi-agency protocol on assessment and service provision with respect to homeless people with care and support needs, including:

   a) Pathways for people who are found to lack capacity to make homeless applications.
   b) Out-of-hours responses to ensure assistance is provided to mitigate against risks of rough sleeping.
   c) Outreach workers / social workers are better able to work together based on a trusted assessor model.

3. NSAB to conduct a multi-agency case file audit[103] of section 42 enquiry threshold decisions where homelessness or risk of homelessness is a factor and to agree proposals for service development based on the findings.

4. NSAB to receive from Adult Social Services a review of their professional oversight and management of safeguarding alerts to ensure that they are compliant with agreed standards. This should include assessment of risk, appropriate recording which captures professional judgement and collective agreement where a person's wellbeing is influenced by multiple agencies.

[102] Prof Michael Preston-Shoot is an Independent Chair to Safeguarding Adult Boards. Reference relates to a briefing called "Adult Safeguarding and Homelessness: a briefing on positive practice" LGA (2020).

[103] A Multi-Agency Case Audit (MACA) was carried out in respect of the death of a rough sleeper. See Learning Briefing dated August 2020.

5. NSAB to receive assurance and evidence from relevant agencies involved[104] in this review that processes are sufficiently robust that ensures the 'duty to refer' under the Homelessness Reduction Act 2017 is being activated when the responsibility arises. [105]

6. NSAB to receive from the Chief Housing Officers Group (CHOG) the local homelessness strategy/strategies together with assurances that the strategy/strategies addresses those experiencing multiple exclusion homelessness, including:

   a) How this gets identified, including staff awareness around multiple exclusion homelessness.
   b) How services are coordinated for this vulnerable cohort as to address safeguarding concerns and prevent the escalation of health/social care needs and harm through timely, coordinated assessments.

7. NSAB to receive from Northamptonshire Adult Social Care, NHS Northamptonshire Clinical Commissioning Group, Northampton General Hospital and Kettering General Hospital a review of co-operation regarding hospital discharges and proposals to improve communication, assessment and service provision with an emphasis on joint assessments for homeless people.

8. NSAB to receive from Northampton General Hospital and Kettering General Hospital suggestions for how the safeguarding teams inside a hospital can be made aware of homeless people in a timely and effective manner.

9. NSAB to conduct a multi-agency case audit to establish how embedded in practice the ARM procedure is, with particular focus on the timeliness for carrying out an ARM and the use of lead agencies to coordinate services and risk management plans, with proposals brought forward to address the findings. The findings should consider proposals from agencies with regards to establishing more regular meetings where information can be shared and decisions made for people experiencing multiple exclusion homelessness.

10. NSAB to receive assurance and evidence from all agencies involved[106] in this review that risk management processes have been reviewed and amended where necessary in relation to people experiencing MEH. Assurance should evidence that structures are sufficiently robust to ensure agencies understand each other's roles and responsibilities and include mechanisms that allow for effective operational relationships to develop across practice disciplines. This should be backed by learning from both local and national SARs and by drawing on the available evidence base of positive practice in adult safeguarding and homelessness[107].

11. NSAB to receive assurance and evidence from all agencies involved[108] in this review that training and knowledge gaps in respect of multiple exclusion homelessness, referrals and thresholds for section 42 Care Act 2014 enquiries and assessments under section 9 of the Care Act 2014, Mental Capacity Act 2005 assessments and the Homelessness Reduction Act 2017 have been addressed.

---

[104] Northamptonshire Adult Social Care, Housing (via the Chief Housing Officers Group), Acute settings, Northamptonshire Healthcare Foundation Trust (Mental Health), Northamptonshire Police, National Probation Service Northamptonshire, Daylight Centre Fellowship, Midland Heart, Rushden Night Shelter.

[105] The Homelessness Reduction Act 2017 significantly reformed England's homelessness legislation by placing duties on local housing authorities to intervene at earlier stages to prevent homelessness in their areas, and to provide homelessness services to all those who are eligible. Additionally, the Act introduced a duty [The Duty to refer] on specified public authorities (including hospitals) to refer service users who they think may be homeless or threatened with homelessness to local authority homelessness/housing options teams. Guidance on the duty to refer as it applies to healthcare.

[106] Northamptonshire Adult Social Care, Housing (via the Chief Housing Officers Group), Acute settings, Northamptonshire Healthcare Foundation Trust (Mental Health), Northamptonshire Police, National Probation Service Northamptonshire, Daylight Centre Fellowship, Midland Heart, Rushden Night Shelter

[107] Several local authorities and their partners have developed interdisciplinary practice panels to work on cases where complexity is high and where risk needs to be shared across agencies. See Plymouth's 'Creative Solutions Forum' and the 'Multi-agency Resolution Group' in Stoke-on-Trent.

[108] Northamptonshire Adult Social Care, Housing (via the Chief Housing Officers Group), Acute settings, Northamptonshire Healthcare Foundation Trust (Mental Health), Northamptonshire Police, National Probation Service Northamptonshire, Daylight Centre Fellowship, Rushden Night Shelter

Appendix One – Individual reflective questions for agencies

Every agency was asked a specific set of questions in relation to their involvement with Jonathan which was derived from the combined chronology. The author also asked a set of general questions which remained the same for all agencies involved in the case of Jonathan.

General Questions for all agencies:

1. Were there barriers for effective communication?
2. How effectively did you work with other agencies to support Jonathan?
3. How could you improve inter-agency working (including communication) with other agencies?
4. How well do agencies understand and work with people who experience multiple exclusion homelessness?
5. How could agencies improve their knowledge of working with people who experience multiple exclusion homelessness?
6. What could you do to improve working with people whose mental capacity fluctuates?
7. What gaps in services exist for people with a complex and challenging configuration of problems, risks and needs like Jonathan's?
8. What missed opportunities, if any, have been identified regarding your work with Jonathan?
9. Has your agency convened ARM meetings? If not, what are the barriers to doing so?
10. Do you think Northamptonshire's Adult Risk Management (ARM) provides an effective framework for addressing risks through timely information-sharing, and coordinated assessment and planning?
11. What examples of good practice were there in this case?
12. What are the key lessons that have emerged from Jonathan's case?
13. What learning and recommendations are there for you in the final SAR report?

Agency specific questions for:

Adult Social Care (ASC)

1. What need, risk and safeguarding assessments were undertaken since ASC became involved with Jonathan up to December 2019? What was the outcome of ASC assessments undertaken?
1. What mental capacity assessments were undertaken by ASC and what were the outcomes?
2. How were ASC involved in Jonathan's Hospital discharge in December 2019 and was this as effective as it could have been?
3. What was ASC involvement (communication and liaison) with Housing services regarding Jonathan's homelessness and was this as effective as it could have been?
4. How effective was ASC inter-agency working (communication and liaison) with NHS Trusts, and third sector agencies providing services to homeless people, and services for people using substances?
5. Why didn't ASC call a multi-agency professionals' meeting before September 2019, and why was only 1-days' notice given? Also, what information was gathered from the agencies who were unable to attend at such short notice (Homes Direct in particular)?
6. Was Jonathan offered advocacy by ASC? If not, why not?
7. How effective do you consider ASC's liaison between Housing, BeNCH and other services when Jonathan's needs were inextricably linked to meeting social care outcomes?
8. In hindsight, what observations do ASC have about the social care needs assessments undertaken for Jonathan?

BeNCH CRC

1. What need, risk and safeguarding assessments were undertaken since BeNCH became involved with Jonathan? What was the outcome of the assessments undertaken?
2. What mental capacity assessments were undertaken by BeNCH and what were the outcomes?
3. What consideration was given by BeNCH as to how Jonathan would access services, including housing, considering that his bail conditions restricted him from entering Northamptonshire?
4. In light of the concerns raised with BeNCH from other agencies regarding Jonathan needing support, why did BeNCH not raise safeguarding notifications with ASC?
5. Could BeNCH have done more to ensure an effective release from prison for Jonathan in respect of housing and support?
6. How effective was BeNCH communication and liaison with Housing Services regarding Jonathan's homelessness?
7. How effective was BeNCH inter-agency working with NHS Trusts, and third sector agencies providing services to homeless people, and services for people using substances?
8. Did BeNCH consider convening a multi-agency meeting or an Adult Risk Management (ARM)?
9. What consideration was given by BeNCH to use the duty to refer under the Homelessness Reduction Act 2017 with regards to Jonathan's homelessness and/or risk of homelessness?

Daylight Centre Fellowship (DCF)

1. What needs, risk and safeguarding assessments were undertaken since DCF became involved with Jonathan? What was the outcome of the assessments undertaken?
2. What mental capacity assessments were conducted by DCF and what were the outcomes?
3. In light of concerns regarding Jonathan, did DCF raise safeguarding notifications with ASC?
4. What referrals did DCF make to other agencies, why and with what outcome?
5. What risk assessments were conducted by DCF, with what outcomes?
6. How effective was DCF's communication and liaison with secondary healthcare settings, GPs, Adult Social Care, NHS Trusts and Housing Services, considering that Jonathan did not have a fixed abode?
7. Various patterns emerge from the case chronology – homelessness, lost or stolen medication, alleged assaults, alcohol/substance abuse, recurring physical health problems, self-neglect (unkempt), confusion. What consideration did DCF give to convening a multi-agency/multi-agency disciplinary meeting to co-ordinate a risk management plan?
8. Did DCF consider convening an Adult Risk Management (ARM) meeting?

East Northants Community Services (Rushden Night Shelter)

1. What need, risk and safeguarding assessments were undertaken since East Northants Community Services (ENCS) became involved with Jonathan? What was the outcome of the assessments undertaken?
2. What mental capacity assessments were conducted by ENCS and what were the outcomes?
3. In light of concerns regarding Jonathan, did ENCS raise safeguarding notifications with ASC?
4. What referrals did ENCS make to other agencies, why and with what outcome?
5. What risk assessments were conducted by ENCS, with what outcomes?
6. How effective was ENCS's communication and liaison with secondary healthcare settings, GPs, Adult Social Care, NHS Trusts and Housing Services, considering that Jonathan did not have a fixed abode?
7. Various patterns emerge from the case chronology – homelessness, lost or stolen medication, alleged assaults, alcohol/substance abuse, recurring physical health problems, self-neglect (unkempt), confusion. What consideration did ENCS give to convening a multi-agency/multi-agency disciplinary meeting to co-ordinate a risk management plan?
8. Did ENCS consider convening an Adult Risk Management (ARM) meeting?

Housing - East Northamptonshire Council (ENC) via Midland Heart

1. What assessments did ENC conduct when under the Housing Act 1996 in respect of Jonathan?
2. What was ENC's rationale for determining that Jonathan lacked capacity to make an application for support under the Housing Act 1996 or adhere to the conditions of accommodation?
3. What needs and risks did ENC consider in these assessments?
4. In light of concerns regarding Jonathan, did ENC raise safeguarding notifications with ASC? If not, why not? If you did, what was the outcome?
5. How did ENC work effectively with other agencies in gathering information to determine whether or not Jonathan was in priority need as a homeless person and that he lacked capacity under the Housing Act 1996?
6. What was ENC's rationale for deciding not to provide housing to Jonathan as part of your statutory duty?
7. What was ENC's involvement (communication and liaison) with housing services regarding Jonathan's homelessness and was this as effective as it could have been?
8. What was ENC's involvement (communication and liaison) with Adult Social Care and was this as effective as it could have been?
9. Did ENC consider convening a multi-agency meeting or an Adult Risk Management (ARM)?
10. What observations do you have about services in Northamptonshire for people experiencing multiple exclusion homelessness?

Kettering General Hospital (KGH)

1. Why were no safeguarding concerns raised? On reflection, should your agency have raised a safeguarding concern?
2. What referrals were made to Adult Social Care within the Hospital, with what outcomes? If referrals were not made, what was the rationale behind this decision?
3. What mental capacity assessments were conducted, with what outcomes?
4. What risk assessments were conducted, with what outcomes?
5. How effective was agency's liaison with Jonathan's GP, Adult Social Care, mental health services and Housing Services, considering that Jonathan did not have a fixed abode?
6. Various patterns emerge from the case chronology – homelessness, difficulties with medication management, poor eyesight, memory loss, confusion, alcohol and substance abuse, recurring physical health problems, challenging behaviours and poor mental health. Was any consideration given to convening a case conference to co-ordinate a risk management plan? If not, why not?
7. Was any consideration given to prevent early self-discharge, considering that Jonathan had substance misuse issues? If not, why not?
8. What consideration was given by KGH to use the duty to refer under the Homelessness Reduction Act 2017 with regards to Jonathan's homelessness and/or risk of homelessness?
9. What observations do you have about Hospital admissions and discharge arrangements for people with complex and challenging configurations of risks and needs like Jonathan's?

Northamptonshire Customer Service Centre (NCSC)

1. How effective do you consider liaison between Housing, BeNCH, ASC and other services when identifying Jonathan's care and support needs for the purposes of safeguarding?
2. Given the presence of risk factors such as mental health needs, homelessness and substance misuse and numerous incidents, what consideration did NCSC give to whether the criteria were met for a safeguarding enquiry due to these increased risk factors?
3. What alternative action did NCSC consider when concerns raised by agencies did not meet safeguarding?
4. What alternative action did NCSC consider when challenges occurred retrieving Jonathan's consent for the purposes of carrying out a section 9 needs assessment?
5. What did NCSC consider when evaluating risk, taking into account a challenging configuration of problems, risks and needs like Jonathan's?

6. What did NCSC consider when evaluating care and support needs for safeguarding, taking into account a challenging configuration of problems, risks and needs like Jonathan's?
7. What was NCSC's involvement (communication and liaison) with ASC regarding Jonathan's risks and needs and was this as effective as it could have been?
8. What consideration was given to understating the level of risk in Jonathan's case, given that numerous safeguarding concerns that were raised?
9. How effective was NCSC's liaison with agencies when communicating the outcome of safeguarding concerns raised?

NHS Trusts in Northamptonshire

Regarding hospital admissions/discharges, Emergency Departments and Urgent Treatment Centre contacts (Kettering General Hospital and Northampton General Hospital)

1. How many safeguarding concerns were raised with ASC? If concerns were not raised, what was the rationale for NGH behind this decision? On reflection, should your agency have raised a safeguarding concern?
2. What referrals were made to Adult Social Care, with what outcomes? If referrals were not made, what was the rationale behind this decision?
3. What mental capacity assessments were conducted, with what outcomes?
4. What risk assessments were conducted, with what outcomes?
5. How effective was agency's liaison with Jonathan's GP, Adult Social Care, mental health services and Housing Services, considering that Jonathan did not have a fixed abode?
6. Various patterns emerge from the case chronology – homelessness, difficulties with medication management, poor eyesight, memory loss, confusion, alcohol and substance abuse, recurring physical health problems, challenging behaviours and poor mental health. Was any consideration given to convening a case conference to co-ordinate a risk management plan? If not, why not?
7. Was any consideration given to prevent early self-discharge, considering that Jonathan had substance misuse issues? If not, why not?
8. What was the rationale behind his discharge arrangements in December 2019?
9. What consideration was given by KGH to use the duty to refer under the Homelessness Reduction Act 2017 with regards to Jonathan's homelessness and/or risk of homelessness?
10. What observations do you have about hospital admissions and discharge arrangements for people with complex and challenging configurations of risks and needs like Jonathan's?

Northamptonshire Healthcare Foundation Trust (NHFT)

1. Why were no safeguarding concerns raised by NHFT? On reflection, should your agency have raised a safeguarding concern?
2. What referrals were made to Adult Social Care within the Hospital, with what outcomes? If referrals were not made, what was the rationale behind this decision?
3. What mental capacity assessments were conducted, with what outcomes?
4. Various records show that Jonathan had historically experienced strokes and traumatised brain injuries, was any consideration given to the assessment of his cognitive / executive functioning. If not, why not?
5. What risk assessments were conducted, with what outcomes?
6. What consideration was given in your assessments to Jonathan's co-occurring issues (mental health and substance misuse)?
7. How effective was agency's liaison with Jonathan's GP, Adult Social Care, mental health services and Housing Services, considering that Jonathan did not have a fixed abode?
8. Various patterns emerge from the case chronology – homelessness, difficulties with medication management, poor eyesight, memory loss, confusion, alcohol and substance abuse, recurring physical health problems, challenging behaviours and poor mental health. Was any consideration given to convening a case conference to co-ordinate a risk management plan? If not, why not?
9. Was any consideration given to prevent early self-discharge, considering that Jonathan had substance misuse issues? If not, why not?

10. What consideration was given by NHFT to use the duty to refer under the Homelessness Reduction Act 2017 with regards to Jonathan's homelessness and/or risk of homelessness?
11. What observations do you have about Hospital admissions and discharge arrangements for people with complex and challenging configurations of risks and needs like Jonathan's?

Northamptonshire Police

1. When Jonathan reported as being the alleged victim of crimes did he express a wish to proceed with Police involvement, if not, why not? i.e. make an official statement, engage with victim support services?
2. What mental capacity assessments were undertaken by the police and what were the outcomes?
3. When Jonathan damaged police property (Police vehicle and building on 15.01.19 and 18.01.20) as he was 'cold and homeless', what was your response to this and why?
4. When submitting a police PPN, what were the expectations from the Police i.e. do the Police believe that CSC contact other services?
5. Were any of these referrals/PPN specifically recommending a section 42 enquiry under the Care Act 2014?
6. What were the outcomes of the police PPNs?
7. Were any referrals made by the police to services, if not, why not?
8. How effective was police communication and liaison regarding multi-agency working in Jonathan's case?
9. Was consideration was given by the police regarding the use of anti-social behaviour legislation either in respect of Jonathan or those with whom he associated? What was the police rationale behind whether or not to use such a legal option?
10. What consideration was given by the police to use the duty to refer under the Homelessness Reduction Act 2017 with regards to Jonathan's homelessness and/or risk of homelessness?

Appendix Two - Terms of Reference

SAFEGUARDING ADULT REVIEW

Ref: 019

TERMS OF REFERENCE

1. Introduction

The purpose of a Safeguarding Adults Review (SAR) is neither to investigate nor to apportion blame. It is only relevant when professionals can learn lessons and adjust practice in the light of lessons learnt. It therefore requires outcomes that:

- Establish what lessons can be learnt from the particular circumstances of a case in which professionals and agencies work together to safeguard adults;
- Identify what those lessons are, how they should be acted upon and what is expected to change as a result;
- Review the effectiveness of procedures both of individual organisations and multi-agency arrangements;
- Improve practice by acting on the findings and developing best practice across organisations;
- Improve inter-agency working to better safeguard adults; and
- Make a difference for adults at risk of abuse and neglect.

This Safeguarding Adults Review (SAR) concerns a male aged 46 at the time of his death, who was found dead in a hotel room in the county.

2. Background to the case

Date of Incident: 31st December 2019

The male was alcohol dependent and a class A drug user. He had a history of sleeping rough and had mental health issues. He was admitted to Hospital on 14th October 2019 following a seizure and initially required serious medical treatment. He was discharged from Hospital on 17th December 2019. He attended Hospital again due to a fall and was discharged on 23rd December 2019.

Social workers attended the address on 31st December 2019 to carry out a welfare check but sadly, the male was found dead. EMAS attended the address and pronounced the male deceased dead at 10:18.

The male was last seen alive at 11:45 on 27th December 2019.

3. Period to be covered by the Review

The time period for the chronology is:

1st January 2019 to 31st December 2019 (to include other key historic events and information prior to the 1st January 2019).

4. Methodology

In accordance with the Care Act 2014 and supporting guidance, 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 lessons can be learned from the case and applied to prevent similar harm occurring again in the future.

The review for this case will consider a hybrid approach i.e. detailed chronologies from partner agencies, a practitioners' event and individual agency reflective questions to ensure a fully inclusive and proportionate review.

5. Links to other Safeguarding Adults Boards

During the period of the review, the male also had links to Nottingham. In this respect, Nottingham City Safeguarding Adults Board were contacted by the Business Manager and asked for their assistance to ascertain which partners had contact with the male in their locality. Agencies that had supported the male were asked to contribute to the review by providing a chronology. The agencies are listed below.

6. Participating Agencies

The following agencies in Northamptonshire were asked to contribute to the case review by undertaking detailed chronologies *(however, some of the agencies may not have had any involvement with either individual and therefore did not submit)*:

- Borough Council of Wellingborough – Housing
- East Northamptonshire Community Services
- East Northamptonshire Council – Housing
- East Midlands Ambulance Service (EMAS)
- HMP Woodhill (via HMP Nottingham)
- NHS Nene & NHS Corby Clinical Commissioning Groups – for General Practitioners: Derby Road Health Centre, Nottingham & The Meadows Surgery, Thrapston, Kettering
- Kettering General Hospital
- Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Rehabilitation company (BeNCH CRC)
- Northampton Borough Council – Housing
- Northamptonshire County Council - Customer Service Centre
- Northamptonshire County Council – STEPS
- Northampton General Hospital
- Northamptonshire Healthcare NHS Foundation Trust
- Northamptonshire Police
- Wellingborough Daylight Centre

The following agencies in Nottingham were also asked to contribute to the case review:

- DLNR CRC (Community Rehabilitation Company)
- East Midlands Ambulance Service (EMAS)
- Framework Housing Association
- HMP Nottingham
- National Probation Service – Nottinghamshire
- Nottingham City Council
- Nottingham University Hospital
- Nottingham City Care Partnership
- Nottinghamshire Fire & Rescue Service
- Nottinghamshire Police
- Nottinghamshire Healthcare NHS Foundation Trust

The Panel reserves the right to request supplementary information from any Agency who has had contact with the above named person(s) where the information is pertinent to the case.

The Panel also requests agencies who have conducted any form of internal review into the above named person's case to submit a copy of their review to the NSAB as supplementary evidence. We are not requesting anyone writes a report specifically for this review, beyond the requested Chronology.

7. Governance

NSAB appointed Bruno Ornelas to act as Independent Author to lead the review and to write an Overview Report. It is anticipated that the Overview Report will be published together with a Learning Briefing for practical use by practitioners. Consideration will also be given to the publication of an Executive Summary.

The composition of the Panel is made up of representatives from the following agencies:

- Northamptonshire Safeguarding Adults Board
- Northamptonshire Clinical Commissioning Groups
- Northamptonshire County Council - Adult Social Services
- Northamptonshire Police
- Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Rehabilitation company (BeNCH CRC)

- East Northamptonshire Council – Housing
- East Northamptonshire Community Services
- Healthwatch Northamptonshire
- Northampton General Hospital
- Northamptonshire Healthcare Foundation Trust

8. Key Issues

The Panel is mindful of the benefit of hindsight but has identified the following issues to be addressed by the agencies contributing to the review. Some of these questions will not be relevant to all agencies, and, where that is judged to be the case, agencies should make that clear in their responses. A key element of the review is to explore whether the individual's life was influenced by Multiple-exclusion homelessness.

Multiple-exclusion homelessness is defined as[109] **:** *People who have been 'homeless' (including experience of temporary, unsuitable accommodation as well as sleeping rough) and have also experienced one or more of the following additional domains of deep social exclusion:*

- *'institutional care' (prison, local authority care, psychiatric hospitals or wards);*
- *'substance misuse' (drug problems, alcohol problems, abuse of solvents, glue or gas); or*
- *participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work)*

The Panel considered the following questions:

- What specific issues or questions does this case raise?
- Are there any unusual factors in this case, if so, what are they?
- Are there any agency failings which appear obvious at this stage?
- Is there evidence (or gaps) in multi–agency working and information sharing and effective communication? In particular, how did agencies work together with regards:

    a) Housing needs;
    b) Care and treatment with respect to his substance use issues;
    c) Transitions between services and institutions, such as from prison and admissions to and discharge form hospital. Taking into account any transitions across local authority areas; and
    d) Emergency situations (raised by the public or voluntary groups or otherwise) when there is reasonable cause to believe a person is experiencing chronic homelessness and at increased risk of abuse, neglect and exploitation.
- Were relevant policies, procedures and guidance adhered to? In particular:
    a) Explore how adult safeguarding procedures were used, including NSAB's Adult Risk Management Process (ARM)
- To find out the degree to which mental capacity, risk assessments and needs assessments (including the use of advocacy) were appropriate and whether they were done in a timely manner.
- To inquire as to how the Mental Capacity Act 2005, the Housing Act 1996, Homelessness Reduction Act 2017 and the Care Act 2014 were applied, including their appropriateness and effectiveness.
- Was the individual safeguarded appropriately and could more have been done to prevent harm/abuse/death?

    a) To inquire as to the degree to which agencies applied concerned curiosity in the assessment of Jonathan's challenging behaviours and circumstances.
    b) To inquire into the degree to which services were coordinated to address safeguarding concerns and prevent the escalation of health/social care needs and harm through timely, coordinated assessments.
    c) To inquire as to how Jonathan's history was taken into account and the professionals' understanding of this and investigate the degree to which making safeguarding personal was utilised.

[109] Reference Fitzpatrick, S., Johnsen, S. and White, M. (2011) *'Multiple exclusion homelessness in the UK: Key patterns and intersections'*, Social Policy and Society, 10(4), pp. 501–12.

- To explore Housing, health and care and support arrangements including hospital and prison discharge.
- To investigate how Jonathan's health and social care needs were managed and understood within the intersections of his housing needs and history of homelessness.
- Was a person-centred approach undertaken to understand the individual's wishes and outcomes?

The review should also explore these general themes where relevant:

- Mental capacity assessment and self-neglect;
- Mental and physical health including dependency on substance misuse;
- Learning disability (as necessary);
- What was the relevant agency involvement;
- Commissioning;
- Good practice;
- Risk assessment;
- Training and supervision; and
- Wider learning.

9. Family Involvement

In line with the guidance in the Local SAR Protocol, the draft Overview Report/Executive Summary will only be shared via a face to face meeting with family member(s) and only once the report(s) are made public will the report be shared electronically.

10. SAR Quality Markers

To ensure a robust approach to the Safeguarding Adults Review, the SCIE SAR Quality Markers will be followed as an integral part of the process.

11. Timescale for Completing the Review

The target for completing this review is December 2020.

The final report is expected to be tabled at SAR Sub Group on 13.10.2020.

The Independent Chair will decide whether to call an Extraordinary Board meeting for final sign off or wait until the Strategic Board which is scheduled on 12.11.2020.

12. Lessons Learned

The findings from this review will be considered alongside learning from other reviews and findings from relevant research.

13. Role of the NSAB Sub Groups

The Learning & Development Sub Group will make arrangements for the dissemination of lessons learned from this review i.e. Learning Briefing and Practitioner Learning Event(s). Those arrangements will include a feedback session with key staff as part of the process.

The Quality & Performance Sub Group will monitor agency progress on the composite action plan.

The Safeguarding Adult Review Sub Group will periodically review the progress made in the composite plan and where actions are not achieved within timescale will escalate to the Delivery Board to hold partners to account.

14. Local Safeguarding Adults Protocol

For further information, the Local Safeguarding Adult Review Protocol can be the NSAB Website on.

Appendix Three – Agencies and Acronyms

Agency	Acronym or shortened version
Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Rehabilitation company (BeNCH CRC)	'Probation'
Daylight Centre Fellowship	'The Centre'
East Northants Community Services	'Rushden Night Shelter' or 'night shelter'
East Northants Council – Housing (via Midland Heart)	'Housing' or 'Homes Direct'
Kettering General Hospital	'the hospital' (used in context) or 'KGH'
Northampton General Hospital	'the hospital' (used in context) or 'NGH'
Northamptonshire Adult Social Services	'NASS' or 'Social Services' or 'Adult Social Care'
Northamptonshire County Council – Customer Service Centre	'NCC CSC'
Northamptonshire Healthcare NHS Foundation Trust	'Mental Health' or with reference to the Acute Mental Health Liaison Team as 'AMLT'
Northamptonshire Police	'Police'

Other abbreviations used in the report

Abbreviation	Acronym or shortened version
Emergency Department	'ED'
Short Term Assessment and Reablement Team	'STEPS'