Safeguarding Adult Review Overview Report in respect of

‘Peter’

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1. Introduction

1.1 The subject of this review is Peter, who died after falling into the River Cam in December 2018. At the time of his death Peter was 45 years of age. The cause of death was cardiac arrest.

1.2 Peter was born in Poland and moved to the UK around 2007. He returned to Poland for a short time where he suffered a serious head injury. Peter returned to the UK and spent extensive periods as homeless and living on the streets. Peter suffered from an alcohol dependency and due to his lifestyle was regularly admitted to hospital.

1.3 A number of agencies worked extensively to support and work with Peter, this work intensified shortly before Peter's death, as the risk of him being unable to sustain his lifestyle and the harm it was causing his health was recognised.

1.4 In February 2019 a Safeguarding Adult Review (SAR) referral was made to the Cambridgeshire and Peterborough Adults Safeguarding Board by the GP, who had Peter in their care. The referral was made on the basis that Peter had died, was in need of care and support services and that there was learning that could be achieved from the circumstances of Peter's death.

1.5 The SAR subgroup agreed that the case met the criteria for a SAR and in August 2019, a panel met to discuss the case. The panel agreed that the review would be conducted by convening two events with practitioners to discuss the case and identify the relevant learning that emanates from it.

2. About the Author

The author in this review is Jonathan Chapman, he has no prior involvement with the case and is not connected to any of the agencies involved.
Mr Chapman is a retired senior police officer, who had responsibility for strategic and operational safeguarding and was a senior investigating officer.
He has undertaken serious case reviews, safeguarding adult reviews, MAPPA case reviews and domestic homicide reviews, with various boards across the country.
He has also worked with Clinical Commissioning Groups, The Church of England and the third sector on safeguarding matters.

3. Terms of reference and methodology

3.1 The purpose of a Safeguarding Adult Review (SAR) is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again.

3.2 The Care Act 2014 sets out the circumstances in which Safeguarding Boards should undertake Safeguarding Adult Reviews. This review was undertaken on the basis that: -

Peter resided in the area of the Safeguarding Board, that he had care and support needs and that Peter had experienced serious neglect. In addition, the board knew or suspected that there were concerns on how Board members worked effectively together to safeguard Peter.

3.3 Reviews should be proportionate to the complexity and nature of the particular case. In this case the review panel decided that a proportionate and strength-based review, using chronologies and practitioner events to draw out the learning regarding good practice would be used.

Practitioners from the agencies were then asked to attend a discussion event to explore the events and understand the challenges within the context at that particular time. There was also a focus to identify any good practice and learning opportunities to allow for continuous improvement.

3.4 This event was well attended, and practitioners engaged in a professional, frank and transparent exchange regarding their involvement in the case.

Throughout the review consideration was given to the six safeguarding principles of empowerment, prevention, proportionality, protection, partnership and accountability.

This review has also focused on, where appropriate, the SAR Quality Markers which are focused on the commissioning, conduct and quality assurance of the review process.

The SAR sub group identified the below agencies as being involved in the case and requested them to supply chronologies.

Cambridge County Council – Adult Social Care, Counting Every Adult Team, Physical Disability Team, Counting Every Adult Team (Chronically Excluded Adult Team)
Jimmys Cambridge – Supporting the homeless
Wintercomfort for the homeless, Cambridge
Cambridgeshire Constabulary
Cambridge Homeless Churches Project
Cambridgeshire and Peterborough Foundation Trust (including Dual Diagnosis Street Team)
Change, Grow, Live (CGL) Substance Misuse Service
General Practitioner

The panel for this review identified that the following areas should be discussed in the events and explored for potential learning opportunities.

- Mental Capacity.
- The challenge presented by supported persons who do not wish to engage and how organisations can work effectively together to provide that support.
- How support can be effectively coordinated.
- What legislation is available to support persons living in Peter's circumstances.
- What the safeguarding risk is to persons in Peter's circumstances.
- How services can be effectively accessed.
- What the impact of mental health was for Peter.

4. Contextual Information

4.1 Cambridge has a number of services which are focused on supporting the homeless and who feature in this review. The below gives some context as to the service that they provide.

- Wintercomfort, Cambridge – Wintercomfort is a day centre creating opportunities for the homeless and those at risk of losing their homes all year round, it is open seven days a week.

- Jimmys Cambridge - Work with the local Community, Volunteers and Partner agencies to deliver 24/7 emergency accommodation and supported housing for those who would otherwise be homeless or vulnerably housed.

- Dual Diagnosis Street Team (DDST) - The team was set up in June 2017 as a two-year pilot to work with entrenched rough sleepers with primary goal of creating a pathway into mainstream services to address mental health and substance misuse issues as well as to secure accommodation. The team was disbanded in June 2019.

- Cambridge Churches Homeless Project (CCHP) - The Cambridge Churches Homeless Project (CCHP) is a collection of churches and a synagogue that work together to offer practical care and support to people who would otherwise be sleeping rough in our city each winter. CCHP takes referrals of people who are sleeping rough; guests cannot refer themselves but must be referred from one of the partner agencies (eg Wintercomfort, Jimmys, Cambridge Street and Outreach Mental Health Team).

- The Adult Care Services teams were renamed in 2017, the Chronically Excluded Adult Team became the Counting Every Adult Team.

5. Background and family

5.1 Peter was born and raised in Poland and first came to the UK around 2008, he returned to Poland in 2015 and whilst there sustained a serious head injury. This involved an intracranial bleed to the brain and a craniotomy[1], which left Peter with a skull bone deficit measuring 10cm x 13cm. The full medical history and circumstances of how this injury was sustained are not available. The accident is described by Peter as being the result of an assault and on other occasions as being the result of a car accident.

5.2 Peter stated that the injury led to him being in a coma for 3 months and since the injury he had memory difficulties, although he also stated that he had memory difficulties since being a child.

5.3 Peter informed medical professionals that he had been raised by his mother, with whom he had limited contact and she remained in Poland. Peter stated that he had been married twice and his second wife had been in the UK, but he had lost contact with her.

5.4 Peter stated that he previously worked as an IT consultant but since coming to the UK had been unable to get work in this field and had become homeless. He had been supported by Wintercomfort (homeless day centre) to obtain some casual work.

5.5 In as early as 2012, Peter had sought support from his GP for headaches and blackouts, he was referred to neurology. It was established that he had well established changes of significant volume loss in the frontotemporal region[2], probably caused by trauma, as Peter had said that he had been a kick boxer. Damage to the frontotemporal region can lead to sudden changes in behaviour, impaired moral judgement, memory loss, reduced motor skills, declining intelligence, inability to understand social cues and dementia.

5.6 In 2012 and 2013 Peter presented to his GP as being depressed and having suicidal ideation, these seem to centre around his marriage breakdown. Peter was also abusing alcohol and was admitted to hospital following an overdose taken whilst

[1] A craniotomy is an operation where a disc of bone is removed from the skull using special tools to allow access to the underlying brain.
[2] The frontal lobes of the brain, found behind the forehead, deal with behaviour, problem-solving, planning and the control of emotions.

under the influence of alcohol. There was a break in Peter's medical records between June 2013 and January 2016, presumably while he returned to Poland.

5.7 In June 2016, Peter became known to Jimmys (all year-round night shelter and support for the homeless). After a short stay Peter stated that he was leaving to stay with a friend. Peter returned in August 2016 and was being assisted to achieve housing. This was complicated due to him having no recourse to public funding (NRPF) due to his immigration status. After a short time, Peter ceased to engage with services trying to support him and started to drink very heavily. Peter lost the employment that he had at the time due to his excessive drinking and chose to leave Jimmys to live on the streets.

5.8 Through late 2016 and into early 2017, Peter was supported by his GP and Wintercomfort, in terms of medical, finance, substance misuse and employment support.

5.9 In February 2017, Peter was admitted to hospital on three occasions having been conveyed by ambulance after reports by members of the public of him being incapacitated by alcohol. On the first two occasions Peter left the hospital upon becoming sober. On the third occasion Peter was assessed by a psychiatry liaison doctor and a substance misuse nurse. A history was taken from Peter, it was recorded that there had been numerous hospital attendances for alcohol related matters and suicidal ideation, although there were no current suicidal thoughts. Peter stated that he only had suicidal thoughts whilst sober and that he drank everyday if he could.

5.10 Peter stated that he suffered memory loss and the assessing medical staff undertook a cognitive assessment, which indicated a mild cognitive disorder. Peter was deemed to be vulnerable but not presenting any safeguarding issues that day.

5.11 Peter stated that he had no intention of terminating his alcohol consumption but agreed to make contact with the substance misuse service. Peter was referred to the street and mental health team.

5.12 In late April and early May 2017, Peter fell and suffered an injury to his hip which was operated on and Peter was discharged on crutches to stay in Jimmys for two weeks to rehabilitate.

5.13 In July 2017, Peter attended hospital having fallen from a bike, he was treated and discharged with advice.

5.14 In September 2017, Peter was taken to hospital on three occasions. On the first occasion he was intoxicated and stated he was suicidal. He stayed in overnight and was discharged when sober. On the second occasion he was conveyed to hospital having been witnessed to fall. He was seen by the substance misuse team. On this

occasion Peter spoke about alcohol abuse but disclosed for the first-time using heroin. Peter was discharged when medically fit, he was to see his GP regarding starting anti-depressants. He was also to continue to see an inclusion worker regarding substance misuse. The third hospital admission in September was one day after being previously discharged. Peter was brought into hospital having been found intoxicated and unconscious. He was detained overnight and again assessed by the specialist nurse. Peter was discharged with the same advice as two days previously.

5.15 During October and November 2017, Peter continued to be supported by the day centre with a capacity to work assessment, sport activity, first aid course and on welfare issues.

5.16 In November 2017, Peter had his first contact with the Dual Diagnosis Street Team (DDST). In his second meeting with the team Peter disclosed low mood and thoughts regarding suicide. The DDST maintained regular contact with Peter until his mood improved and he agreed to undertake a functional assessment. This assessment was started in late November and continued into December 2017.

5.17 During the Winter months of 2017/2018 (December 2017 to April 2018), Peter was able to access accommodation from the Severe Weather Emergency Provision (SWEP)[3] through the Cambridge Churches Homeless Project (CCHP).

6. Summary of facts (Chronology 1st January 2018 to 24th December 2018)

6.1 During the early part of January 2018 Peter continued to be supported by the day centre, CCHP and DDST. Peter continued to state that he would take his own life at some stage but refused to elaborate on any plans to do so.

6.2 Towards the end of January 2018, Peter was taken to hospital with a head injury having fallen over whilst intoxicated. Peter was treated and left the hospital once he had sobered up.

6.3 At the end of January Peter was seen and assessed in a psychiatry clinic as an outpatient. He was said to be alcohol dependent and probably suffering from recurrent depression. He said he was not motivated to reduce his alcohol intake. He was at risk of further mental health deterioration and at risk of suicide. He was asked to complete a mood diary and would be reviewed in two months.

6.4 The DDST continued to support Peter, seeing him at least every couple of days. In mid-February 2018, Peter was again admitted to hospital having been conveyed

[3] https://www.cambridge.gov.uk/media/1383/severe-weather-emergency-provision-guidance.pdf

there by ambulance following a fall whilst intoxicated. He was detained overnight and discharged the next day once sober.

6.5 At the beginning of March, the DDST reviewed their care plan. Peter felt that he had stabilised but had no desire to cease using alcohol. There was a concern regarding ongoing accommodation as Peter at that time was accessing the SWEP via CCHP, but that was due to finish at the end of March.

6.6. Around the same time, Peter was again admitted to hospital as he was intoxicated. It was noted at this attendance that there was a deterioration in Peter's functioning. He was seen as having poorer communication and ability to focus. The day centre continued to support Peter with welfare, employment and finance. Peter continued to take prescribed anti-depressants, which he said controlled his low mood.

6.7 At the end of April 2018, Peter was again admitted to hospital having been found wedged between two cars by members of the public who were unable to rouse him. Peter left the emergency department after a short time despite staff attempting to undertake an assessment.

6.8 During May and June 2018 the DDST and Wintercomfort supported Peter. In mid-June the DDST convened a professionals meeting to discuss Peter's decline, poor engagement and self-neglect. In this meeting is was agreed that the DDST would continue to support Peter and there would be a safeguarding referral.

6.9 Through July 2018, the DDST kept up regular contact with Peter, seeking him out and encouraging him to attend the Wintercomfort day centre for support. Towards the end of July Peter stated that he was tired of rough sleeping and approached Jimmys and the substance misuse outreach worker with a view to achieving accommodation.

6.10 Towards the end of July 2018, Peter was admitted to hospital. Initially he had been found in the street by DDST staff and taken to Wintercomfort and from there to Jimmys. It was thought that Peter was suffering from a stroke and he was conveyed to hospital. At the hospital it was difficult to determine a definitive diagnosis due to Peter's chronic alcohol abuse, but he was unwell. Peter was detained in hospital until he was well enough to be discharged to Jimmys.

6.11 At the beginning of August 2018, DDST staff accompanied Peter to his GP for a review. It was established that he was suffering from a decline in his cognitive ability and health. It was feared that this would be exacerbated should he have to return to rough sleeping. It was agreed that DDST would maintain daily contact with Peter, that a request would be made for bed a Jimmys to be available. Support was also

arranged with Wintercomfort, access to substance misuse services, finances and medication.

6.12 Peter was able to remain at Jimmys, supported by the DDST and Wintercomfort, in mid- August Peter attended hospital having been found intoxicated. There was no treatment required and Peter re-iterated to staff that he had no desire to reduce his alcohol intake. Should he change his mind he confirmed he was aware of where to receive support.

6.13 Peter remained at Jimmys and whilst there appeared to improve and was able, towards the end of August 2018, to be able to attend the day centre unassisted. At the beginning of September Peter was found rough sleeping. The DDST liaised with Jimmys staff as it was an expectation that Peter would not rough sleep and would engage with substance misuse services. The DDST continued to support Peter on a daily basis and asked him to consider using Antabuse[4], which he declined.

6.14 During September 2018, the DDST supported Peter on a daily basis but Peter started to revert to more rough sleeping and his place at Jimmys was jeopardised due to his consumption of alcohol. Towards the end of September, Peter attended the hospital on two occasions. Once with an acute head injury and the second occasion for being intoxicated. When seen again by staff from the DDST Peter looked like his condition had deteriorated and he was unable to recall why he had been in hospital. The DDST undertook a review of Peter's care plan. Peter was taking his medication daily and wished, if he was able, to remain at Jimmys.

6.15 On three occasions during October 2018, Peter was admitted to hospital for being intoxicated. On each occasion he stayed overnight, was given food and then discharged. The DDST recognised the risk of Peter's alcohol use.

6.16 At the beginning of November 2018, Peter reverted to rough sleeping and when seen by staff from the DDST was consuming alcohol. Whilst with Peter the DDST also witnessed the public donating money to Peter, this was seen as a risk and an incentive for Peter to maintain his life on the street. Peter, despite being offered support, declined assistance and did not want to visit Wintercomfort.

6.17 Around the same time Peter was admitted to hospital once again after a member of the public had called an ambulance. Peter was detained overnight and the following day he was assessed as being fit to be discharged and arrangements were made with Wintercomfort for Peter to be taken there by taxi.

6.18 Upon discharge Peter was seen by DDST and again asked whether he wished to address his use of alcohol, which he declined. The DDST arranged a professionals meeting with the GP, Wintercomfort and other professionals where their concerns

[4] Medication used with counselling and support to treat alcoholism

were discussed. It was determined that when Peter was sober that he demonstrated capacity. He was not engaging with services and had no desire to reduce his alcohol use. Peter was showing very low levels of self-care and was at times double incontinent. Alternatives to manage the presented risks were discussed. The possibility of enforcement against Peter being able to collect monies, which were being spent on alcohol was discussed. If there was no desire to change in behaviour it was recognised that Peter would have to be discharged from the DDST.

6.19 The professionals meeting initiated contact with other agencies to discuss the possible use of enforcement powers to limit Peter's access to certain areas where he was being given money. It was recognised that any meaningful engagement was not possible whilst Peter had the ability and desire to obtain money to feed his alcohol addiction.

6.20 During the latter part of November 2018, agencies worked together to formulate a Community Protection Warning Notice (CPWN) to prevent Peter being able to frequent the areas where he was known to have money donated in order that he would avail of the support being offered.

6.21 At the end of November 2018, Peter was seen by DDST staff in a very unclean state. He was obviously cold and was heavily soiled. Arrangements were made for Peter to access Jimmys and the CCHP via the SWEP. Peter was asked whether he would agree to a safeguarding referral being made on his behalf and he declined.

6.22 Peter was informed that due to his alcohol use and his lack of self-care that the church homeless project would not be able to accommodate him over the winter, but should he access Wintercomfort for support this would assist him. DDST were confident that Peter understood this and assessed that Peter was able to make decisions when not intoxicated.

6.23 In early December DDST located Peter on a daily basis, there were serious concerns over Peter's ability to care for himself, his deterioration and the cold conditions in which he was living. He intermittently attended Wintercomfort but was consistently encouraged to do so.

6.24 The DDST contacted professionals to arrange a meeting to discuss the risks to Peter. In the correspondence the DDST articulated that there was a real risk that Peter would be found deceased before the end of the winter if accommodation could not be sourced.

6.25 In Mid-December 2018, Peter consented for the DDST to be able to make a safeguarding referral on his behalf. There followed some correspondence between the Adult Care Services, the Counting Every Adult Team. The CEA agreed to accept

the case as a referral but were unable to discuss the case until a meeting next scheduled in mid-January 2019.

6.26 The Adult Early Help Team contacted the Reablement Team to establish if care could be provided either at Jimmys or Wintercomfort. The Reablement Team confirmed that care could not be provided until accommodation was secured. A Community Action Plan was completed by the Adult Early Help Team and sent to the Counting Every Adult Team to take forward.

6.27 The referral process and the search to secure accommodation was being driven by the DDST, who also maintained contact and support with Peter. The GP and CCHP both expressed concerns over the risk to Peter's health over the Winter should accommodation not be secured.

6.28 The DDST were advised by their safeguarding team that whilst there were clear concerns over Peter's welfare his case would not reach the threshold for a s42 enquiry under the Care Act as there was no abuse.

6.29 Over the following days in December there was a concerted effort to try to identify housing support for Peter. The DDST arranged a professionals meeting for early January 2019. This meeting was brought forward to the 21st December 2018, by the adult Early Help Team. The DDST also supported Peter at a meeting with housing from Cambridge City Council (CCC). Wintercomfort continued to support Peter when he attended the day centre.

6.30 The professional meeting took place on Friday 21st December 2018. The meeting was well attended by the DDST, Adult Early Help Team, Street Outreach Team, the Counting Every Adult Team, Cambridge Homeless Church Project, Cambridge City Council Housing Options and Advice Team and the Physically Disability Team. It was agreed that Housing option would provide Peter temporary accommodation, funded by ASC. The DDST were asked to locate Peter and assist the Physically Disability Team to complete an assessment. It was later established that Peter was at the hospital but had left prior to being located.

6.31 On 21st December 2018, Peter presented at the hospital. Peter stated that he had drunk heavily the night before. He was given a meal and left the hospital at around 2.30 pm. He re-attended the hospital at 7.30 pm and left again at 11.00 pm. There was no medical problem identified or treatment required.

6.32 Having been unable to locate Peter plans were put in place should he be located. The Physical Disabilities Team were tasked to undertake an urgent Mental Capacity Assessment and a Human Rights Assessment. Despite concerted attempts Peter was not located.

6.33 The next day Peter presented at the hospital, he had previously been seen wandering the streets naked and having soiled his clothes. Initially Peter seemed confused but was said to soon 'return to his old self'. He declined a shower and did not require any medical treatment. Peter left the hospital at 02.15 on 23rd December 2019. He had told staff that he was not able to stay at Jimmys as he was drinking again.

6.34 Later the same day Peter was conveyed to hospital having fallen in the river. Resuscitation had been attempted at the scene and continued at the hospital without success and Peter died.

7. Analysis of involvement

7.1 Overview

7.1.1 The death of Peter although very sad is unfortunately not rare. The case was referred as a SAR by the GP who, at the time, practiced at the surgery that treated a number of homeless people who live on the streets.

7.1.2 What is clear during the course of this review is that there a number of organisations, and individuals working within them, who worked very hard to support Peter but often Peter did not accept the support available or was unable to due to his alcohol dependency and inability or unwillingness to abstain from alcohol.

7.1.3 Gathering the information from agencies involved demonstrated a repeating pattern of behaviour. Peter was unable to sustain stable accommodation, mainly due to his excessive drinking, this is despite good support being offered. Peter then resorted to living on the streets. When Peter's health or safety reached a critical level he would be taken to hospital by ambulance or present himself at hospital, if he was able. On most occasions Peter's hospital attendance was initiated by calls from members of the public who witnessed him either incapacitated or suffer a fall and injury.

7.1.4 Peter would then be conveyed to hospital where he would be treated for any medical issues, allowed to sober up, he was offered facilities of food and personal hygiene and was either discharged or left the hospital before he was discharged. On a number of occasions Peter was assessed by the psychiatry liaison doctor and substance misuse nurse. Peter's history was taken and, on each occasion, Peter declined any assistance or intention to moderate his alcohol intake.

7.1.5 Peter would then return to the streets and support of the services before being again admitted to hospital. In the period 12th February 2017 to 23rd December 2018, Peter was either admitted to or attended hospital on 25 occasions. This was despite good and supportive services being involved and attempting to change the outcomes

for Peter. This review seeks to unpick some of the very difficult issues that are presented in this case and in the broader sense in other cases, to improve the outcomes for Peter and those in similar circumstances as him.

7.1.6 What is clear is that there is no one solution to the issue of street homelessness and there needs to be a coordinated and coherent multi agency response.

7.2 Mental Capacity

7.2.1 One of the issues in this case is being able to identify a clear medical history for Peter, this is partly due to his lifestyle whilst in the UK but more so due to the fact that he spent most of his life in Poland and it was there that he suffered what is described as a significant head injury. This injury is recorded as having an impact on his memory although Peter did state himself that he had suffered memory loss since childhood.

7.2.2 Peter sought advice from his GP at the time as early as 2012 after suffering headaches and blackouts. An MRI scan showed that Peter had well established changes of significant volume loss in his right frontotemporal region extending to the right parietal lobe, this was attributed to a trauma, thought to be kickboxing as Peter had practised this in the past.

7.2.3 Peter suffered from depression and was at various times prescribed anti - depressant medicine and suffered suicidal ideations on a number of occasions. Peter abused alcohol and to a lesser degree, controlled drugs and it was these factors that presented a challenge to effectively assess Peter's mental capacity. It was recorded on two occasions that Peter demonstrated capacity when he was sober, but it was often the case that he was not sober and spent long periods affected by alcohol and due to this not be able to effectively care for himself and this in turn led to repeated presentations to hospital.

7.2.4 Peter was assessed psychologically on three occasions after presenting at hospital (20/2/17, 21/9/19 and 25/9/19) on each occasion Peter had been conveyed to hospital having either fallen or been seen by a concerned member of the public. Peter was recognised as homeless and vulnerable and having had suicidal ideations, but on each occasion, it was recorded that there were no safeguarding or capacity issues. It was recognised that there had been a past head injury and that Peter suffered memory loss.

7.2.5 The GP in this case, who worked with Peter and this client group, drew attention to the work and report produced on Alcohol Related Brain Damage (ARBD). The report Alcohol and Brain Damage – with reference to high risk groups[5]. This

[5] The report Alcohol and Brain Damage – with reference to high risk groups –

report describes the impact of alcohol and the lack of awareness of ARBD as a mental health condition. It also seeks to give assistance in assessing mental capacity with those who are suffering ARBD.

7.2.6 The NICE[6] guidelines for Health and Care Excellence recommend that all new cases referred to alcohol treatment services should have an assessment of cognitive function. The issue was that, despite a number of requests, Peter declined any support from alcohol services. The report on ARBD recognises that the condition may have an impact on the individual's awareness and understanding of their current circumstances and it may have implications in terms of adherence to, and understanding of, interventions. Thus, impacting on their engagement or willingness to access support. It was also intimated by Peter that excessive alcohol intake for him was a cultural issue.

7.2.7 The report and subsequent presentations by one of the authors (Professor Kenneth Wilson) has concluded that the recognition and commissioning of services for ARBD are limited and suggests that investment into treating ARBD will lead to positive outcomes and significantly reduce presentations of sufferers at hospital.

7.2.8 In 2019 Alcohol Change UK published a review of eleven SARs form 2017 where alcohol dependency had been a factor – Learning from tragedies[7]. One of the themes that emerged was that despite the Care Act (2014) identifying people with alcohol problems as possibly needing care and support, there is little guidance in applying this legislation, or the equally relevant Mental Capacity Act (2005), to this group of people. The report concludes '*At the national level, work is required to clarify how the Mental Capacity Act and the Care Act should be intelligently applied to vulnerable adults who are misusing alcohol. In particular, the challenges of applying the concept of self-neglect to substance misusers and applying the Mental Capacity framework to people with fluctuating capacity need to be urgently addressed if more unnecessary deaths are to be avoided*'

7.3 Were there barriers to Peter accessing services?

7.3.1 One of the keys areas for Peter not accessing some services, in particular alcohol services, was his own reticence to do so. The discussion events sought to understand what the barriers to this were. As previously discussed, this may in some part be due to his own mental health. What measures may be available to those reticent to accept support is discussed later within this report.

https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr185.pdf?sfvrsn=66534d91_2

[6] NICE - National Institute for Health and Care Excellence
[7] Alcohol Change UK – Learning from Tragedies 2019 - https://alcoholchange.org.uk/publication/learning-from-tragedies-an-analysis-of-alcohol-related-safeguarding-adult-reviews-published-in-2017

7.3.2 It was identified in the practitioner discussion that one aspect Peter desired and lacked was secure accommodation, this was difficult to achieve due to a number of factors. One of the main areas for accommodation support was Jimmys, who consistently provided support to Peter when required to do so. On one occasion Peter removed himself from their support and on other occasions his accommodation there could not be sustained due to his continued use of alcohol.

7.3.3 Peter was able to access the support of the Cambridge Churches Homeless Project through the SWEP and was supported well by this provision, but support given to Peter became more difficult to deliver when Peter's health deteriorated, and he became double incontinent.

7.3.4 Another constant in support for Peter was the DDST, often seeking Peter out and ensuring that he was able to attend either Wintercomfort, CCHP or Jimmys. It was acknowledged in the practitioner's discussion that DDST provided a valuable service to Peter and other persons in similar circumstances. The staff who were involved with the DDST felt that having social worker involvement in the team was a real benefit, although this post was provided by CPFT. It would have been further enhanced if there was closer links and social worker involvement from Adult Social Care. The DDST as a team has ceased to exist, it being funded for a 2 year period, there is a concern that the DDST not being present will leave a further gap in service for persons in Peter's circumstance.

7.3.5 In December 2018, two weeks prior to Peter's death there was a striking acceleration in services attempting to provide support to Peter, in particular accommodation. This was initiated and driven by DDST and CCHP with the stark assertion that failure to act would inevitably see the death of Peter over the winter period.

7.3.6 The local authority progressed a housing application, that had been supported by the DDST and the GP, with a result that Peter was found to be 'not eligible' due to him not having any right to reside in the UK. The local authority was able to provide accommodation once the County Council ASC accepted that there was a duty under the Care Act 2014 and funding would be made available.

7.3.7 Earlier attempts had been made to involve ASC with a referral being made by the Drug and Alcohol service in June 2018. At this time, it was deemed that Peter did not meet the threshold for services or further enquiry. In December 2018, staff from the DDST discussed the safeguarding concerns with their safeguarding team but were informed that whilst there were concerns for Peter, he would not meet the criteria for a section 42 enquiry[8] as there was no evidence of abuse. The act states that where a person has care and support needs, is experiencing or at risk of abuse or neglect and is unable to protect themselves due to their care and support needs. It would be difficult to see how Peter in December 2018, or indeed previously did not

[8] S42 Care Act 2014 – Enquiry by Local Authority - http://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted

meet these criteria demonstrating severe self-neglect, which impacted significantly on his health and wellbeing.

7.3.8 The decision was ultimately made that the County Council had a responsibility under s18 Care Act 2014[9] and with this funding in place the Local Authority Housing Department was able to identify accommodation. This joint working was put in place when the situation for Peter was critical and an earlier decision on the duty of care would have allowed for a measured and planned approach. It was the view at the practitioner's discussion that there needed to be a greater awareness of the Care Act across agencies and more work to ensure that there is closer working at early opportunities.

7.3.9 At the time of this case the Multi Agency Risk Management Guidance (MARM)[10] was not in place in Cambridgeshire and Peterborough. It is recognised that if it was deemed that Peter had capacity, continued to place himself at risk of serious risk or harm and failed to engage with services that the MARM process would have provided a more structured approach to identify and put in place a multi-agency response.

7.3.10 There was some early positive feedback regarding the use of the MARM and how the coordinated multi agency support can make a difference in challenging cases. It was agreed that where a case did not fit the criteria of a MARM that the model could still be adopted to coordinate services.

7.4 What can be done to influence change resistant drinkers?

7.4.1 The damaging effect of Peter's alcohol use was recognised but despite numerous attempts to engage Peter with Alcohol and Substance misuse services he chose not to engage and regularly articulated his lack of desire to alter his drinking habits. Much of Peter's money to fund his lifestyle was achieved by street donations from well-meaning members of the public. Towards of the end of Peter's life professionals were considering a number of enforcement tactics, aimed at preventing Peter being able to fund his lifestyle by public donation and therefore direct him towards support and services.

7.4.2 The identification of alcohol dependency is not the challenge but working with those who are change resistant is, this is recognised in the guidance published by Alcohol Concern in Working with Change Resistant Drinkers[11] which identifies the

[9] S18 care Act 2014 – Duty to meet care needs
http://www.legislation.gov.uk/ukpga/2014/23/section/18/enacted

[10] Multi Agency Risk Management Guidance (MARM) -
http://www.safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/cpsabprocedures/multi-agency-risk-management-guidance/

[11] Working with Change Resistant Drinkers, Alcohol Concern, Ward and Holmes, 2014 - https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/The-Blue-Light-Manual.pdf?mtime=20181118115002

client group using the three criteria of alcohol dependence, non-engagement with treatment and burden on public services. Peter would have fitted within these criteria. The project, referred to as the Bluelight Project, has been adopted and evaluated in a number of areas including Nottingham, Sandwell, Lincolnshire and Surrey.[12]

7.4.3 The Bluelight Project hold at it's heart the most important message of a belief that a person has the ability to change. This message was enforced in the practitioner's event when those who were supporting Peter were asked what the most important factor was for those in Peter's circumstance and they responded, ***'Come what may, do not give up on them'.***

7.4.4 The Bluelight Project is built on seven important principles. These same principles were discussed and identified, in the most part, in the practitioner's discussion. It was clear that it was strongly believed that there needed to be a whole systems and holistic approach. This approach was also highlighted in the guidance issued by Police and Crime Commissioners on Tackling Street Drinking.[13]

[12] The Bluelight Project - https://alcoholchange.org.uk/help-and-support/get-help-now/for-practitioners/blue-light-training/the-blue-light-project

[13] Tackling Street Drinking, Guidance for Police and Crime Commissioners, 2016, - https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Police-and-Crime-Commissioner-Report-Final.pdf?mtime=20181126165741

Bluelight Principles

- Take every opportunity – we need to take every opportunity to engage treatment resistant drinkers and reduce the harms they pose
- Not everyone will change – this guide sets out best practice, but it does not guarantee success. Some people will die as a result of drinking and some people will only change after causing immense suffering to other people. The aim of this guide is to minimise this harm through driving best practice in to the system: it will not solve every problem
- Change is not the only option – ideally, we will work with clients to bring them to the point at which they decide to change; however, we recognise that at some point the focus will need to be on managing and containing harm
- Whole system approach – the response to this client group will usually need to be the responsibility of a range of specialist and non-specialist services, not just a single agency or worker.
- Holistic approach – the focus cannot be solely on the alcohol; the response will need to address the range of needs presented by the client
- Recording unmet need – no system of treatment and care can provide for every client need. If gaps are being identified, especially consistent or serious gaps, staff should have mechanisms for recording and reporting these to those who commission services.
- Learning lessons – when things go wrong staff and services should have the courage to review the case and learn lessons for the future.

(Bluelight Manual 2014)

7.4.5 Both the Bluelight Project and guidance for Police and Crime Commissioners identify that there is scope in utilising enforcement measures in a positive way to assist to change the behaviour of persons resistant to change. This was considered and initiated in this case with the consideration of the use of Community Protection warning Notices in November 2018, to prevent areas frequented by Peter to gain his income and thereby initiate change. What is apparent is that consideration was given to this at quite a late stage and there may have been benefit from an earlier initiated multi-agency care and coordination plan. Any such plan would benefit from an identified coordinating professional. This coordinating role would be best fulfilled by the most appropriate professional involved in the case.

7.4.6 As this is such a complex area there has been much work locally, regionally and nationally, with the design, implementation and evaluation of projects to improve outcomes. There would be considerable value in reviewing what is currently in place, identifying good working practice elsewhere and developing a local strategy to ensure that services are coordinated when delivering services to street drinking homeless clients.

7.4.7 It was identified in the practitioner's event that any discussion or further work on the development of a multi-agency response in the form of strategy or services would benefit substantially from the input of services users. The discussion events indicated that that this was eminently achievable.

7.4.8 One area of concern discussed was the ability for Peter and others in similar circumstances to gain quite substantial sums of money on a daily basis from well-intentioned donations. These donations are inevitably used to fund drink or other substance abuse. Whilst this funding is in place it is difficult for services to engage and remain engaged with those requiring support.

7.4.9 There was a recognition that agencies need to re-double their efforts to encourage members of the public to give support to the homeless by other means other than direct cash donations. Cambridge Street Aid[14] was established for this purpose. Donors are able to give both online and at designated and signposted locations in the City. Those who are in need of support are able to make application for a grant. This initiative needs to be more widely publicised, with key messages as to why direct giving can be counter-productive, building on the work already undertaken (Cambridge News October 2019)[15]

7.4.10 The point was also made that the risk of persons giving directly to street homeless has to be balanced against the risk of not giving. The lack of money by street homeless people may not drive them into the reach of services and may drive them into other risk behaviours to raise money. It was agreed that what was required is more education and this should include input from those with the lived experience.

7.5 Homeless street drinking - hospital attendance and discharge

7.5.1 In a period of less than two years Peter attended the urgent care hospital department on 25 occasions, each stay being of varying duration. On most occasions Peter was identified as being homeless. The Cambridge University Hospitals NHS Foundation Trust and Cambridge City Council has in place a Hospital Discharge Protocol for patients in Cambridge City who are homeless (Appendix A). The overarching aim of the protocol is to ensure that patients who are resident within Cambridge City and are, or are likely to become, homeless receive access to the appropriate support to find suitable accommodation on discharge from hospital.

7.5.2 The Homelessness Reduction Act 2017[16], introduced a duty for certain bodies to notify a housing authority where a person is homeless or likely to become

[14] Cambridge Street Aid - https://www.cambscf.org.uk/cambridge-street-aid.html

[15] Cambridge News October 2019 - https://www.cambridge-news.co.uk/news/cambridge-news/cambridge-homeless-everything-need-know-17017512

[16] Homelessness Reduction Act 2017 - http://www.legislation.gov.uk/ukpga/2017/13/contents

homeless, this duty includes hospital emergency departments. The homeless person must consent to the notification and their details being passed to the local authority. This duty is included in the protocol, albeit under the Housing Act 1996.

7.5.3 The protocol would dictate that on each occasion Peter presented to hospital and was identified as homeless the position should have been ascertained as to whether he had a nominated accommodation provider e.g Jimmys and if so a suitable notification was made to the accommodation provider. If there was not a nominated accommodation provider, then a notification would be made to the Outreach team or Out of hours service.

7.5.4 Peter 'self-discharged' himself on a number of occasions, where he was formally discharged there is little evidence that the protocol was adhered to. Peter was either discharged as being of no fixed abode or on two occasions he was discharged to the Wintercomfort day centre, which whilst offering significant support does not offer accommodation. Records would indicate that Jimmys were contacted on just two occasions on discharge. This would accord with the discussion event which indicated that most hospital attendances were not known about by those dealing with Peter until after the event and then mostly by means of self-disclosure.

7.5.5 The discharge protocol may benefit from being updated in light of the Homelessness Act and in conjunction with a working group currently convened to review and develop hospital discharge.

7.5.6 It was recognised in the discussion event that a homelessness officer role in the hospital would support and liaise with those who were deemed as homeless or likely to be so. There is currently a part time role within the University Hospitals NHS Trust performing this role, but the practitioners felt that this was not sufficient for the level of need.

7.5.7 It was also felt that Peter and persons in his circumstance, who are regularly presenting to the hospital, would benefit from a form of marker or alert indicating their vulnerability being on their record. This could link to a named coordinating professional and in turn link to a coherent multi agency plan.

7.6 What improvements are currently being developed.

7.6.1 The area of homelessness and street drinking has been subject of considerable ongoing focus and as a result a number of initiatives have been identified and are in the process of being developed and it is important to recognise these.

7.6.2 Cambridge City Council is undertaking the below actions.

- They have commenced the process of developing a protocol for adults in need, akin to the existing protocol that exists for 16- and 17-year olds.
- They have invited the council's Homelessness Prevention Officer to attend the fortnightly Streetlife Working Group. The officer has been

working hard over the past few months to further develop working relationships between the hospital and the housing advice service and to encourage all staff to make use of the protocol.
- They have procured a 4-bed property (through our social lettings agency) for the benefit of adults with no recourse to public funds.
- They have produced a revised information sheet for the benefit of individuals who are ineligible for assistance, for similar reasons to Peter.

7.6.3 The Greater Cambridge Housing Strategy – Homes for our future[17] sets out seven priorities. Priority six deals with preventing and tackling homelessness and rough sleeping. Included in the strategy Cambridge City Council is working to pilot a number of Housing First models. Housing First is a relatively new approach in England aimed at supporting homeless people with multiple and complex needs. (Annex 6 of the report sets out the support currently in place in the Greater Cambridge area[18])

7.7 Discussion at the second learning event

7.7.1 A second learning event was convened, and the draft report and recommendations were discussed. Some of the discussion has been reflected in the second version of the report.

7.7.2 It was confirmed at the event that the Dual Diagnosis Street Team was being funded again but this funding was time limited and there was a need to establish long term funding for this team, which was seen as instrumental in supporting and coordinating the response to those who are street homeless.

8. Recommendations

1. The Cambridgeshire and Peterborough Safeguarding Adults Board should seek to ensure that there is greater awareness of the long-term effect of alcohol misuse on mental capacity and the recognition of Alcohol Related Brian Damage.

2. The Cambridgeshire and Peterborough Safeguarding Adults Board should initiate a discussion with commissioners on the future funding of the Dual Diagnosis Street Team.

3. The Cambridgeshire and Peterborough Safeguarding Adults Board should seek to raise the greater joint understanding of the duty of care under the Care Act

[17] Greater Cambridge Housing Strategy 2019-2023 – Homes for our Future - https://www.cambridge.gov.uk/media/7296/greater-cambridge-housing-strategy-2019.pdf

[18] Greater Cambridge Housing Strategy 2019-2023 – Homes for our Future – annexes - Greater Cambridge Housing Strategy 2019-2023 – Homes for our Future - https://www.cambridge.gov.uk/media/7297/greater-cambridge-housing-strategy-2019-annexes.pdf

2014 and what is achievable for those persons who have no recourse to public funding.

4. The Cambridgeshire and Peterborough Safeguarding Adults Board should ensure that there is continued training and understanding of the Multi Agency Risk Management Guidance (MARM).

5. The Cambridgeshire and Peterborough Safeguarding Adults Board should seek to review what services are available locally for street drinking persons, particularly those who are resistant to change. Review what good practice is recognised nationally and develop a multi-agency, holistic and whole system-based approach strategy. Any work in this area should include input from a service user group.

6. The Cambridgeshire and Peterborough Safeguarding Adults Board should work with partners to promote the Street Aid Scheme and seek to educate on the risks of direct street donation to the homeless. This work should include the views of those with lived experience.

7. The Cambridgeshire and Peterborough Safeguarding Adults Board should request that Cambridge City Council Housing Department and Cambridge University Hospitals NHS Foundation Trust review the Homeless Hospital Discharge Protocol in light of this review.

8. The Cambridgeshire and Peterborough Safeguarding Adults Board should liaise with health providers of accident and emergency services to establish whether a marker can be added to frequent vulnerable homeless hospital attenders, with a link to a lead professional.

APPENDIX A

Protocol
Hospital discharge protocol for patients in Cambridge City who are homeless
Key messages

- This protocol defines how Cambridge City Housing Department and Cambridge University Hospitals NHS Foundation Trust will collaborate to ensure that patients who are homeless or have become homeless as a result of their admission, are appropriately assessed and supported to access accommodation following their admission to hospital.

- Each organisation will make every effort to discharge patients with housing needs, who meet the eligibility criteria for temporary housing in a timely manner.

Summary

The overarching aim of this protocol is to ensure that patients who are resident within Cambridge City and are / become homeless receive access to the appropriate support to find suitable accommodation on discharge from hospital.

1 Scope

- Cambridge City Council Housing Department
- Cambridge University Hospitals NHS Foundation Trust: Trust-wide

2 Purpose

This document concerns the processes to be followed when a visit to a hospital (whether planned or emergency) reveals a housing problem which may impact on a patient's health and recovery on their discharge.
The problem might concern:
- homelessness – the patient has no accommodation of their own to return to
- inappropriate housing – formerly suitable housing may be difficult to return to

The protocol does not concern older people's (non-homeless) hospital discharges which are subject to a separate set of arrangements.

3 Patient groups included within the protocol

3.1 Homeless people

Homeless people are frequent and prolonged users of health services. Research carried out by the Department of Health (DH) in 2010 showed that homeless people use four times as many acute health services and eight times as many inpatient health services as the general population. The same research found that homeless people have an average length of stay in hospital three times as long as the general population.

The 2003 DH guidance document, *Discharge from hospital: pathway, process and practice*, recommended that all acute hospitals should have a formal policy to deal with homeless people. In 2006, further guidance set an expectation that hospitals, local authorities and the voluntary sector would agree a protocol to ensure that no one is discharged from hospital to the streets or into inappropriate accommodation.

It is anticipated that the arrangements agreed here will result in a better service to homeless patients at a reduced cost to the public purse, and will also contribute to improved scores for NHS indicators, in particular reducing emergency readmissions within 30 days and unplanned emergency department (ED) use within seven days.

3.2 People in hostel accommodation

Cambridge contains a number of hostels providing accommodation for formerly homeless people. Given that many hostel residents will continue to maintain a street-based lifestyle even though they are housed, it is likely that some will be frequent attenders at the ED and be disproportionately represented as emergency admissions.

The main Cambridge hostels are listed at appendix 2. In the case of a person presenting for emergency treatment and giving a Cambridge hostel as their address, the hospital should provide the hostel with the information listed in section 4.3 below. The hostel will, in turn, provide the hospital with the name and contact details of the individual's key worker, if the patient has been assigned one.

3.3 People whose accommodation is now unsuitable

The main focus of this protocol is on street homeless people. However, a stay in hospital, whether planned or unplanned, may also result in a patient being unable to return to their accommodation because it is no longer suitable for them.

It is a policy presumption within public services that a person will return to their own home after accident or illness whenever it is possible, and economical, to adapt their home to meet their post-admission needs.

A disability adaptation, supported in many cases by a disabled facilities grant, will often be able to make a home suitable.

This protocol is concerned only with those cases where it has been shown to

be impossible to economically adapt the property, so that the patient is effectively homeless.

4 Hospital responsibilities – On admission/ attendance in ED where a housing related problem has been identified

4.1 Following the protocol

The Trust is responsible for ensuring this protocol is followed for appropriate patients when they attend ED or are admitted to a ward.

4.2 Contacting SOT & OOH

If a person is found to be homeless, or is at risk of being homeless on discharge, the Trust will, with the patient's consent, contact the Street Outreach Team (SOT) or, after 17:00hrs, the Out-Of-Hours service (OOH).

4.3 Information provision

The hospital will provide the SOT or OOH service with the following information:

- The patient's name.
- The patient's date of birth.
- The patient's address (if any).
- The nature of the health problem.
- Any possible difficulties with mobility and access due to the health problem.
- (If admitted) their likely date of discharge.
- Details of any aftercare required, including details of medication prescribed.

The SOT may be contacted by secure email or telephone.

5 Hospital responsibilities: discharge

The hospital undertakes to avoid discharging a homeless inpatient outside of normal office hours or at weekends, whenever possible; however, it is recognised that those receiving emergency care may be discharged from ED at the point that they are deemed clinically fit to leave.

Where a discharge on a weekend or out of hours cannot be avoided, the hospital will contact the Council's **Out of Hours service.**

The hospital will involve the SOT in planning discharge arrangements for a homeless inpatient.

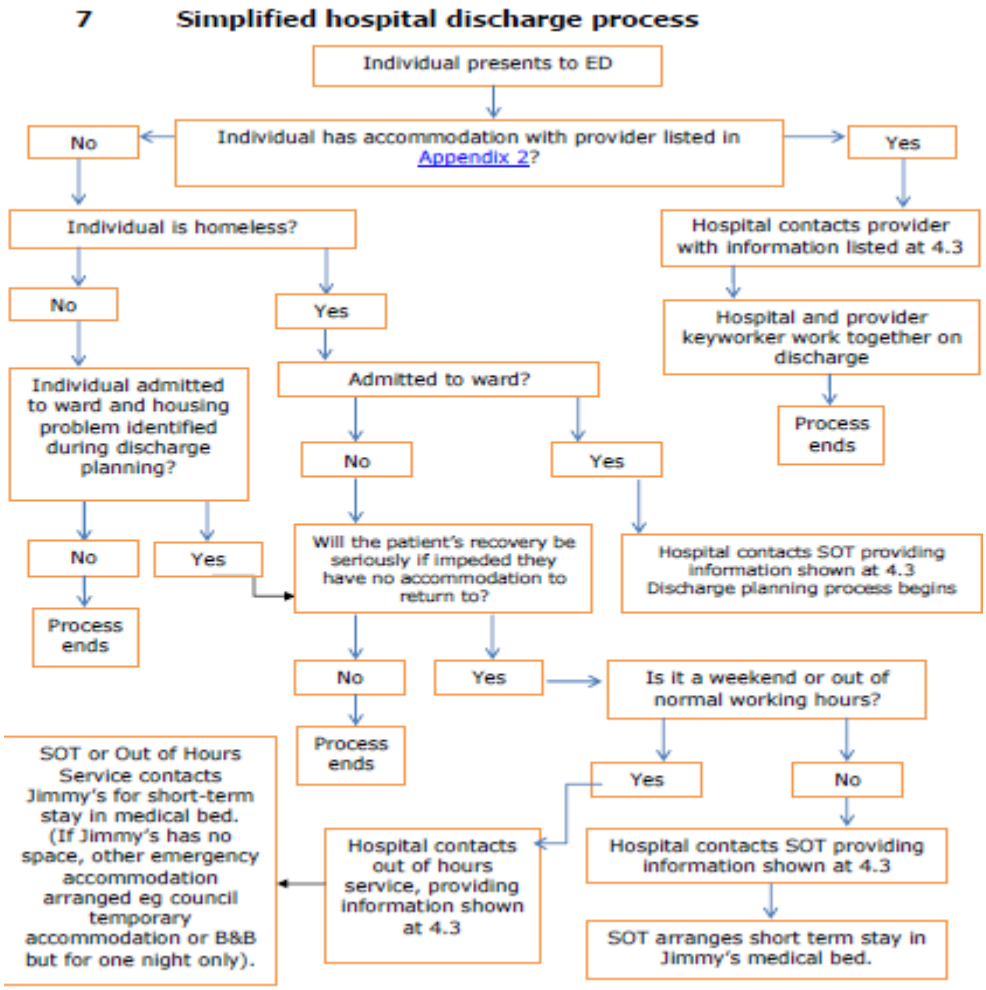
Where an inpatient lives at accommodation listed at appendix 2, the hospital will involve that housing provider in discharge planning arrangements.

6 SOT and out of hours service responsibilities

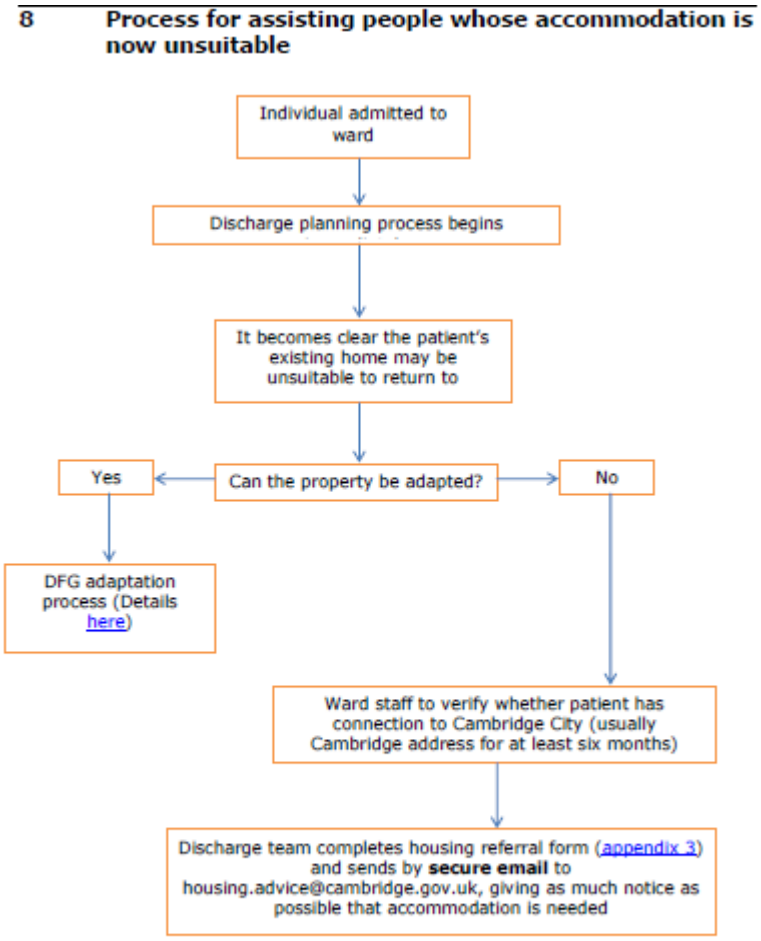
During normal working hours the SOT will be the point of contact between the hospital, the homeless individual, any accommodation provider and any

other welfare organisation involved.
The SOT will refer to Cambridge City Council any homeless person whose medical condition on discharge makes it possible they may be in priority need under the Homelessness Act 1996.
In cases where it is clear that the individual is not in priority need but where their recovery may be impeded by their homelessness, the SOT will refer the individual to Jimmy's Cambridge. Jimmy's Cambridge will decide whether it can assist this individual as a medical admission.
In cases where the individual may be in priority need but is likely to be ineligible for assistance under the Homelessness Act 1996, the SOT may refer the individual to Jimmy's Cambridge. Jimmy's Cambridge will decide whether it can assist this individual as a medical admission. Alternatively, in consultation (as necessary) with the hospital and the Cambridge Access Surgery, the SOT may refer the individual to Cambridgeshire County Council adult services or to local public health services.
At weekends and outside normal office hours, Cambridge out of hours service will carry out the responsibilities of the SOT until such time as the SOT is able to take over responsibility.

7 Simplified hospital discharge process



8 Process for assisting people whose accommodation is now unsuitable



9 References

DH (2003) Discharge from hospital: pathway, process and practice

10 Associated documents

- Leaving hospital: What you need to know
- Getting ready for discharge
- Patient Choices Policy

Equality and diversity statement

This document complies with the Cambridge University Hospitals NHS Foundation Trust service equality and diversity statement.

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