Taking action following the death of someone sleeping rough

Briefing for homelessness services

Let's end homelessness together

Homeless Link, Minories House, 2-5 Minories, London EC3N 1BJ | 020 7840 4430

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Contents

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The Innovation and Good Practice Team

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Introduction

Homeless Link saw an increase in media coverage of deaths of people sleeping rough over the winter of 2016-17. However, the number of people who die on the streets is difficult to quantify as this information is not always publicised and isn't collated nationally.

There are a number of ways in which the death of a person sleeping rough can lead to positive changes in policies and procedures with the intention of enabling agencies to work together to prevent further mortalities. Where certain criteria are met, the Care Act 2014 has established an official process that can be taken, known as a Safeguarding Adults Review (previously Serious Case Review). Other forms of review can also be taken.

Over recent years, Homeless Link has collected examples of good practice from agencies that have taken action following deaths of homeless people. Responses have been varied, but all have reviewed working practices with the aim of improving service provision, and outcomes, for people sleeping rough.

Deaths of people sleeping rough rarely instigate a formal review. In 2012, we were aware of one Local Authority that had undertaken this procedure and, whilst other areas are known to have conducted them since, it is not commonplace.

Homelessness is often a symptom of other problems, and nobody should die while living on the streets. We recommend that any death of someone living on the street should raise the questions "what went wrong?", "what can we learn?" and "what can we do differently next time?"

We have published this briefing to raise awareness of official procedures, good practice examples and recommendations to the sector and their partners.

Preventing Death

This guidance details the steps that agencies can take should there be a death of a rough sleeper in their area. However, we urge that action is taken to prevent deaths by ensuring that statutory and voluntary sector provision is available to those sleeping rough, and that where possible relevant legislation (e.g. the Care Act and the Mental Capacity Act) is used to safeguard those at risk.

We recommend that managers of teams that have contact with people sleeping rough undertake the following actions:

- Establish which local team/people will be responsible for responding to, and investigating, safeguarding alerts within statutory services.
- Ensure that their team is aware of how to report safeguarding concerns to statutory services.

- Build relationships with these contacts to establish connections (e.g. a lead contact) which can be used to raise adult safeguarding concerns and to discuss issues and actions.

- Ensure that a contact is established with a member of staff who has responsibility for leading safeguarding cases relating to people with multiple and complex needs to prevent safeguarding concerns being bounced between services.

- Ensure that the details of any care co-ordinating team involved with an individual is recorded in an individual's files and accessible when needed to raise concerns.

- Ensure teams are aware of the legislation that can be used to safeguard rough sleepers – e.g. refer to this toolkit: http://www.pathway.org.uk/mental-health-service-interventions-for-rough-sleepers/ and take necessary action to make referrals to statutory services.

Safeguarding Adult Reviews (SAR)

What is a SAR?

An SAR is a statutory multi-agency learning process that reviews cases where:

1. an adult with care and support needs has
2. died (including suicide) or come to serious harm as a result of abuse or neglect (may be suspected)
3. and there is a concern about the way in which local professionals or agencies worked together to safeguard the adult at risk

Under the Care Act (2014), Safeguarding Adults Boards are responsible for commissioning an SAR in order to consider what agencies and individuals could have done differently to prevent harm or death. They may also arrange an SAR in any other situations relating to an adult in its area with needs for care and support. Every local authority has a Safeguarding Adult Board.

SARs were previously known as Serious Case Reviews (SCR). Under the new legislation, the local Safeguarding Adults Board (SAB) will determine how to undertake the review in a sensitive and proportionate manner to best promote effective learning and improvement actions to prevent future deaths or serious harm from happening again. This will be agreed at a local level depending on the individual case. Information about some different models of SARs can be found on the SCIE website.

SARs may also be undertaken when a person has suffered serious injury or harm, but which has not necessarily resulted in their death.

Why do an SAR?

An SAR should be a transparent and non-blaming procedure which aims to learn from the incident rather than investigate it. The SAR is used to establish what learning can be achieved from the case

about the way in which local professionals and agencies work together to safeguard vulnerable adults. This will include:

- Reviewing how effective procedures within, and across, agencies are
- Informing and improving local multi-agency working
- Developing good practice actions from the learning
- To prepare a report about the incident and findings which includes recommendations for future action to changing policies and working practices
- The Safeguarding Adults Board has a duty for ensuring that lessons learned are applied to future cases

In the interest of transparency and disseminating learning, the SAB will look to publish the SAR, in full or summary form, but this will depend on the individual needs of the case. Reports may be published, for example, on local authority or SAB websites. The SAB is also required to include the findings of any SAR it has completed, and what actions it has taken or intends to take in response, in its end of year Annual Report.

Who conducts an SAR?

Under the Care Act (2014) each local authority must have a Safeguarding Adults Board which involves representatives from a number of agencies. The Board is there to safeguard and promote the welfare of people at risk and is responsible for commissioning SARs. More information can be found at: www.scie.org.uk/care-act-2014/safeguarding-adults/.

How can I request an SAR?

Every local authority has a Safeguarding Adults Board which is hosted within the adult social care function in the Council. There should be information on the local authority or SAB website about how to raise safeguarding concerns and how you can refer a case to be considered for an SAR. You may also find a local policy around SARs and more information on their Safeguarding Adults Board.

How does this apply to homelessness?

Homeless people can be vulnerable to many types of abuse and neglect. More information about the different types of abuse and neglect, and indicators, can be found at: www.scie.org.uk/publications/ataglance/69-adults-safeguarding-types-and-indicators-of-abuse.asp

The types of abuse listed on this website are:

- Physical abuse
- Domestic violence or abuse
- Sexual abuse
- Psychological or emotional abuse
- Financial or material abuse
- Modern slavery
- Discriminatory abuse
- Organisational or institutional abuse

- Neglects or acts of omission
- Self-neglect

Case study: Harrogate

A person with a long history of rough sleeping, and deteriorating health, died in temporary accommodation over the Christmas period in 2011. The support he received from statutory and voluntary agencies at the time was thought to be impacted by the time of the year and out of hours services. Agencies in Harrogate conducted a serious case review in 2012. This was led by the safeguarding board and involved senior managers from the agencies that had been involved with the client. A report was accompanied by a detailed action plan for agencies involved.

The review enabled agencies to identify gaps in knowledge and learn more about local services so that in turn they could provide this information to their clients. This included learning about the out of hours service and what could be expected when someone contacts them. This has increased access to emergency provision for people who need it. The review also improved communication and working across agencies including between voluntary and statutory organisations. They now regularly discuss mutual clients and are clear on the role and remit of each other.

Case study: Lambeth

A person with poor physical and mental health died in cold weather on the street in 2010. His physical health problems were likely to have been exacerbated by the cold. A serious case review took place involving a number of statutory and voluntary sector agencies. The review established a number of learning points including improving information sharing and risk assessment across agencies when decisions are taken to withdraw services, increasing knowledge of legislation that could have been used to safeguard him and requiring local agencies to review their eviction protocols.

The serious case review led to a number of agencies partnering to fund a project to improve interventions for people sleeping rough. The project undertook a number of activities in response to the learning and recommendations of the serious case review. These were:

1. Delivering training on mental health legislation and actions that homelessness and other service providers (e.g. ambulance staff and the police) can take
2. Delivering training and improving understanding of homelessness and homelessness services to mental health professionals
3. Producing a practical toolkit which can be used by services to improve access to mental health services for people sleeping rough.

The toolkit can be found here: www.pathway.org.uk/services/mental-health-guidance-advice/ and information about the training here: www.homeless.org.uk/events/training/stayingalive

The role of the Coroner's office

A Coroner independently investigates unexpected or suspicious deaths by collecting information relating to the case to establish the circumstances surrounding the death; including who the person was and how, when and why the death occurred. The death certificate cannot be issued until the Coroner has finished their investigation. There are a number of factors which may trigger the involvement of the Coroner and the case is usually referred by a doctor or the police. However anyone can refer a case to the Coroner's office and must do so quickly (before the death certificate is completed) if it is felt that the circumstances surrounding the death require further investigation.

A coroner will hold an inquest in cases when:

- Cause of death is unknown
- Death was sudden, violent or unnatural
- Death occurred in prison or police custody

For more information on the role of the Coroner, and when a death should be reported to them, visit www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner.

A Safeguarding Adults Board should liaise with the Coroner's Office to ensure there is effective partnership working in cases that may be subject to both an inquest and an SAR.

Other Actions

The Safeguarding Adults Board may decide that a case does not meet the criteria for an SAR. However there are many other effective ways in which the death of someone who is homeless can be used to instigate change and improve practice.

Internal reviews

A senior member of staff in an organisation can review all contacts they had with the person in order to identify opportunities where improvements can be made to policies and procedures. An internal review, once complete, should have clear actions and expected outcomes with a timescale in which these will be achieved. Key things to consider are:

Resources

- What resources are available to clients and how effective are they?
- Is there potential to adapt existing resources to meet new needs?

Internal and external communication

- Is communication between team members, between teams and between agencies effective?
- Could this change to improve outcomes?
- Do informal conversations need to happen in a formal setting and/or be recorded so everyone is clear on what is happening with a client or situation?

Knowledge and training

- Are staff aware of the roles and remits within their own and other agencies?
- Have people had the training they need to safeguard the people they work with?

- *Accessibility*
    - Can the client access help and advice when they need it?

Case study: Liverpool
Following the murder of a person who was sleeping rough in 2012, one organisation ensured that they amended their outreach provision to safeguard other people from potential harm. They began to conduct outreach in the area that the person had died to ensure nobody else was sleeping there. They also provided leaflets to shops and pubs in the area to increase awareness of No Second Night Out provision within the community.

Multi-agency reviews
If the Safeguarding Adults Board are not going to conduct an official SAR, they or a senior member of another organisation, can invite agencies involved with the client to attend a multi-agency review to consider the questions posed above and to discuss potential recommendations.

Case study: Breckland
Following the death of someone sleeping rough during freezing temperatures in 2009, agencies in Breckland:

Improved multi agency working
A multi-agency accommodation forum was set up and is attended by the Council and key partners. Individuals at risk of eviction from hostels, and those rough sleeping, are discussed. The forum establishes support plans to prevent eviction and to support those rough sleeping away from the street. All agencies commit to delivering the action plans which are reviewed at each meeting.

Reviewed internal protocols
Local authority housing services reviewed their SWEP (Severe Weather Emergency Protocol), and were subsequently able to offer cold weather provision to people on the street.

Case study: Totnes
Following the death of someone sleeping rough, during cold and wet weather in 2012, agencies in Totnes:

Improved multi agency working
A quarterly multi-agency forum was established to look at provision for rough sleepers. Those attending included senior managers of local voluntary and statutory services, Councillors and the

local MP. Local authority housing services also worked to accommodate rough sleepers, where possible, through No Second Night Out provision. Voluntary sector agencies and the council then collaborated to source appropriate move on accommodation.

Targeted their resources differently
One voluntary sector agency recruited a part time outreach worker to offer services in the area the person died. Drug and alcohol agencies also increased their provision in the area.

Improved accessibility to services
Local authority housing services scheduled a satellite drop in service once a week at a local day centre, in addition to the traditional service operating from the Council offices.

Recommendations

We recommend that:

1. As much work is done to prevent the deaths of people sleeping rough by voluntary and statutory agencies responsible for safeguarding and supporting vulnerable people.

2. Every organisation has a procedure to follow in the event of a death which includes details of how to request a Safeguarding Adults Review (SAR) locally.

3. The death of a person who is homeless should always result in a review even if this is not a Safeguarding Adults Review.

4. Reviews should involve a range of agencies and result in an action plan. The plan should have a review date and one or more professionals should be responsible and accountable for its completion.

5. Learning from reviews should be shared with agencies beyond those directly involved so that the sector and partner agencies can implement recommendations in order to prevent deaths.

6. This briefing is used by homelessness services to think about how the sector responds to the death of people on the street, and whether there should be sector-wide standards, recording and action.

If you have any good practice to share with us relating to this briefing please contact: joanne.prestidge@homelesslink.org.uk

homeless link

What we do

Homeless Link is the national membership charity for organisations working directly with people who become homeless in England. We work to make services better and campaign for policy change that will help end homelessness.

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London EC3N 1BJ

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