Safeguarding Adults Review (SAR) 'Caleb'

Overview Report
May 2024

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1. Introduction

1.1 In May 2023, Redbridge Safeguarding Adults Board (RSAB) received and considered a referral in respect of 'Caleb'[1], following his suicide in July 2022. Caleb was a white British man and was 32 years old at the time of his death.

1.2 Caleb was vulnerable to physical, emotional and financial abuse from others and self-neglect. Evidence provided to reviewers indicates that during the review period he was particularly vulnerable as a result of unmet mental health needs, chronic drug and alcohol dependency, social isolation and severely low self-esteem.

1.3 The Redbridge 'One Panel' discussed the referral on 16 May 2023, which was made by NELFT. Following a scoping exercise and use of the decision-making tool (Redbridge 'One Panel' Guidance), it was agreed that the case met the threshold for a statutory Safeguarding Adult Review (SAR), as there would be valuable learning in respect of mental health discharge planning and multi-agency coordination.

1.4 Safeguarding Circle were instructed on the 01August 2023, who identified Gill Taylor and Fiona Bateman as independent lead reviewers.

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1.5 The reviewers wish to express their sincere condolences to Caleb's family for their loss, and the especially distressing circumstances in which it occurred. It is clear that his siblings in particular went to great personal lengths to care for Caleb when he needed it.

1.6 We are also grateful to the professionals who worked with him, for sharing their insights honestly and conscientiously. As noted below, the efforts of some frontline practitioners to get to know Caleb and offer him support was apparent. As was the positive regard in which they held him.

2. Pen Portrait

2.1 Caleb was 32 years old, but his circumstances and behaviours meant that he often appeared younger than his years to professionals who met him. He played guitar and was interested in teaching sports. He loved Kung Fu and often spoke about how it made him feel better in himself when he was practising it.

2.2 He was neurodivergent, diagnosed with ADHD and suspected Aspergers as a child. It wasn't clear how his neurodiversity shaped his sense of himself or if those diagnoses were confirmed in later life or if he agreed with them. It is understood he had also received a diagnosis of emotionally unstable personality disorder.

2.3 He was a much-loved youngest brother, with a sister and brother who he remained close with until his death. All three children were taken into local authority care when Caleb was just two years old, when their mother died by suicide and their father was serving a long prison sentence. Caleb had no contact with any other family members, and it is recorded that he experienced familial exploitation, although there are no further details about this. Caleb and his siblings were exposed to violence, drug use and insecurity in the family home as young children. In brief

[1] To protect anonymity a pseudonym has been used throughout this document.

records shared with the review from childhood it is noted that Caleb experienced “*deep feelings of loss and insecurity which must have impacted on his behaviour*”, indicating the presence of trauma from a very young age.

2.4 Caleb’s childhood was spent in local authority care, primarily in residential homes and occasionally in foster care. He had a good relationship with one foster carer in particular and remained in contact with her until his death, spending the night before he died at her home. In general though, his childhood was characterised by the instability of frequent home and school moves, which professionals stated he believed were due to his ‘bad behaviour’. It’s perhaps unsurprising then that Caleb had very low self-esteem and blamed himself squarely for his difficulties in life. He experienced significant isolation and did not appear to have any close or sustained friendships.

2.5 Despite the challenges he had faced, Caleb didn’t blame other people for his circumstances and would readily admit when he had behaved badly or criminally. He spoke about his siblings often and felt that he was a burden to them. In a meeting in August 2021, he stated that “*I want to live my life without needing help from services*”.

Protected Characteristics

2.6 Caleb was a white British man who had lived experience of local authority care, trauma, homelessness and addiction. Evidence suggests that agencies were not formally aware of his sexuality or religious beliefs, although he is said to have spoken about having a girlfriend at one time.

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2.7 Caleb’s ‘protected characteristics’, such as gender, age, sexuality and religion, as defined by Equality Act (2010), do not appear to have been explicitly considered in agency responses to his care and support needs, homelessness or health concerns, nor in how the risk and vulnerability he experienced was understood and responded to. As such, the review is unable to draw meaningful conclusions about how the support offered to him was informed by understandings of inequality and discrimination that he may have faced, or by how he understood himself.

2.8 He was neurodivergent and, according to the social model of disability[2], a disabled young man due to his chronic mental ill health. It is unclear from the documentation provided if Caleb understood himself to be disabled. Documentation provided does not identify if and how the social model of disability was applied by agencies when considering the barriers he faced in accessing services and living safely.

[2] The social model of disability is a way of viewing the world, developed by disabled people. The model says that people are disabled by barriers in society, not by their impairment or difference. Barriers can be physical, like buildings not having accessible toilets. Or they can be caused by people's attitudes to difference, like assuming disabled people can't do certain things. Read more here: Social model of disability | Disability charity Scope UK

3. Approach to Review

Purpose of a Safeguarding Adult Review

3.1 The purpose of a SAR is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died. The purpose of a Safeguarding Adult Review (SAR) is to establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults. This often involves reviewing the effectiveness of procedures (both multi agency and those of individual organisations) and informing the improvement of local interagency practice. There is a strong focus on understanding the underlying issues that informed professional actions and what, if anything, prevented them from being able to help and protect Caleb from harm.

Key Lines of Enquiry

3.2 The review will explore the period 09 March 2022 – 09 July 2022, which is the period from Caleb's most recent mental health in-patient admission to hospital, until his death.

3.3 The SAR Panel agreed the following key lines of enquiry for this Review:

- How did agencies work together to assess and address Caleb's concerns regarding the suitability of his accommodation, did these take into consideration local and national policy and best practice guidance regarding self-neglect?
- What risk assessments were completed for Caleb, and were risk assessment tools used informed by best practice guidance on suicide prevention? Were the outcomes of these assessments appropriately shared/discussed with partner agencies, with Caleb himself and his family support network?
- Were the experiences and effects of severe and multiple disadvantages considered in the multi-agency approach to assessing and supporting Caleb, did this factor in decisions to discharge him in April 2022 from the in-patient unit and to allocate his care from secondary mental health support to MHWT?
- Did agencies follow their own internal policies and procedures and multi-agency safeguarding policy and procedures? Were the policies and procedures fit for purpose and trauma-informed[3]?
- Was there any outstanding or innovative practice in this case?

3.4 The key lines of enquiry will be explored by looking at three key episodes in Caleb's engagement with agencies in the four-month period preceding his death. The episodes were chosen because they reflected key points where learning opportunities were identified by the Panel and reviewers.

Methodology

3.5 RSAB commissioned independent reviewers to conduct a SAR using a hybrid methodology which combined elements of the Social Care Institute for Excellence 'Learning Together' methodology and tools from the 'SAR In Rapid Time' method.

3.6 The learning was produced through a SAR concerns systems findings. Systems findings identify organisational, local, and national factors that make it harder or easier for practitioners to proactively safeguard people, within and between agencies.

3.7 The Review was informed by summary evidence submitted by key agencies and from this, a chronological approach was taken to understanding and analysing key events.

3.8 The Review included a multi-agency practitioners' event in November 2023. The event brought together professionals who worked directly and indirectly with Caleb, to explore factors relating to how his care and support needs were identified, understood and met by agencies, looking at barriers and enablers to current practice and developments that have emerged since he passed away. This was followed by a managers' event, where organisational and strategic factors relating to the provision of direct support and multi-agency practice were explored.

3.9 The following agencies were represented on the SAR Panel, provided documentation to support the SAR and/or representatives at the learning events:

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- Redbridge Council - Adult Health & Social Care Service
- Redbridge Council - Housing Service
- North East London Foundation Trust (NELFT) – Adult Mental Health Services
- East London Foundation Trust (ELFT) Rough Sleepers Mental Health Project
- Change Grow Live - Newham Integrated Rough Sleeping Support Service
- Barking, Havering & Redbridge University Hospitals NHS Trust (BHRUT) Safeguarding Team
- Metropolitan Police Service (MPS)
- VIA – Drug and Alcohol Service, Alcohol Ward Liaison and Street Outreach Team
- GP
- London Ambulance Service (LAS)

Involvement of Family and Friends

3.10 The RSAB Board Manager attempted to contact Caleb's siblings as part of the review. Unfortunately, after an initial conversation it has not been possible to establish further contact with either his brother or sister and the review concludes without their input. His brother explained they found his Inquest distressing. His brother explained he didn't want to relive his loss as he wasn't confident the system would change.

3.11 There is an acknowledged gap in opportunities afforded to people affected by homelessness and multiple disadvantage to make their voices heard. A key learning point arising from this review is to ensure that changes which come about through the recommendations of this review are discussed with and co-produced by people with lived experience of the issues described.

Parallel Processes

3.12 A Serious Incident Investigation was conducted by NELFT following Caleb's death. This review triggered the submission of the Safeguarding Adult Review referral.

3.13 A Coroner's inquest was held to determine the cause and nature of Caleb's death. The inquest concluded in January 2023 with the determination that Caleb died by suicide.

SAR Process

3.14 The completion of this SAR was slowed due to challenges with appropriate engagement from key agencies, namely the NELFT and Redbridge Council Housing Department. At SAR Panel meetings, appropriately senior officers from these agencies did not attend meetings regularly, and delegation to more junior officers was not always appropriate, with those attending not always fully briefed.

3.15 At what was to be the final panel meeting, this issue was raised strongly by those in attendance, who highlighted that this had led to gaps in the draft overview report. The Panel felt that issues with engagement in the SAR needed to be noted in the Overview Report, and further, that the gaps in the care and support available to Caleb needed to be more explicitly stated in this report. In discussion with the SAB Chair, it was agreed that presentation of the Overview Report would be delayed, enabling sufficient time to make these changes. It was further agreed that this SAR should make recommendations about engagement with SAR process and with the SAB more generally, so, whilst this did not form part of the initial scope, we have included this within Section 10.

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4. Research & Best Practice

4.1 Michael Preston-Shoot (2019) posits that "*drawing on existing evidence about effective practice would mean that reviewers are not starting out with a blank canvas. What is proposed here is that SARs begin explicitly with the available evidence-base, using it as a lens with which to scrutinise case chronology and explore through panel meetings, interviews and learning events with practitioners and managers what facilitates good practice and what presents barriers to effective practice*". The advantage of this approach is that reviewers can build reflection and systemic analysis into the SAR process from the outset.

4.2 Research into safeguarding practice around homelessness, self-neglect and substance dependency has underlined the need for a holistic whole-systems approach for people with intersecting compound needs, who may fall outside of statutory thresholds and eligibility criterion. As such, review findings and recommendations will consider four domains of effective practice outlined by the Local Government Association[4]:

- Direct Practice with Individuals
- Multi-Agency Team Around the Person
- Organisations Supporting the Team
- Strategic Governance

[4] Michael Preston Shoot (2021) 'Adult Safeguarding and Homelessness: A briefing on positive practice', Local Government Association. Available at: https://www.local.gov.uk/publications/adult-safeguarding-and-homelessness-experience-informed-practice

4.3 In addition to the whole-systems approach to understanding practice examples submitted by agencies, the review will be informed by research and best practice around key issues of concern for Caleb and those working with him. Given the multiple and complex needs that he lived with and the vast array of related practice approaches, not all the research evidence considered has been described in this report.

Adverse Childhood Experiences & Trauma

4.4 There are strong evidential, as well as intuitive, links to Caleb's childhood abuse and neglect and the experience in adulthood of mental ill health, excessive use of drugs and/or alcohol, self-neglect and chaotic and abusive personal relationships (Lewis et al, 2021; Maniglio, 2019; Greenfield, 2010).

4.5 These traumatic events in childhood are often referred to as adverse childhood experiences ('ACEs') (Felitti et al, 1998). There is not a finite list of ACEs, but they include witnessing domestic abuse and violence, parental substance misuse and mental ill-health, poverty and losing a parent (WHO, 2012). Exposure to ACEs has been associated with poor health outcomes in adulthood including substance use, mental distress, obesity, heart disease and cancer, as well as unemployment and continued involvement in violence. Importantly, the impact of ACEs appears to be cumulative, with risks of poor outcomes increasing with the number of ACEs suffered. Significantly, people who have been exposed to multiple ACEs are more likely to die at a young age from natural causes, suicide or homicide (Bellis et al, 2013) and more likely to struggle to engage with support services.

4.6 Best practice guidance in working with the expression of trauma in adulthood abounds as the approach becomes established practice in working with vulnerable adults and children. The Office for Health Improvement & Disparities sets out six principles as the foundation for trauma-informed practice: safety, trust, choice, collaboration, empowerment and cultural consideration[5]. The emphasis, across the wide variety of trauma-related research and practice guidance, is on working with people in ways that recognise how their current behaviour is shaped and triggered by past events and then adapting professional practice to create safe environments and relationships that not only do not repeat and trigger those previous experiences, but that enable new and safer coping mechanisms and behaviours to emerge (Homeless Link, 2017; Shemmings, D. 2019; Young Minds, 2018).

4.7 There is also increasing neurological evidence, that the brains of young adults undergo significant changes through adolescence and into young adulthood. These developments are not complete until approximately the age of 25 (Giedd et al, 2004). This mid-twenty mental maturation is complicated and sometimes delayed by the experience of mental ill health and trauma (Davis and Vander Stoep, 1997). There are differences in "executive information processing" between "immature and maturing brains" i.e., those generally under the age of 25 years old, and "mature" brains i.e., those people aged 25 years and over who have not experienced life trauma and have not developed mental health problems (Casey et al, 2008). The features of "immature and maturing brains" include reduced representational knowledge

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[5] https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice#key-principles-of-trauma-informed-practice

(of rules, conventions and social and cultural norms); reduced operational processing skills (planning ahead, being organised and the ability to connect intentions and goals with the actions necessary to implement and achieve them) and reduced self-regulation (the ability to resist distractions, impulses and to generally resist behaving in unhelpful and unproductive ways), compared to "mature" brains.

4.8 It is unlikely, especially given the impact of his early life experience and his development of mental health problems, that Caleb's brain and consequent executive skills had matured at the same rate as his peers. This may account for why he appeared much younger than he was, for some of his impulsive behaviour and for the difficulties he faced in maintaining a home.

Self-Neglect

4.9 Research about self-neglect and people who've experienced homelessness and multiple disadvantage concludes that there are uncertainties within contemporary social work, including whether people fall under the 'umbrella' of Adult Social Care and adult safeguarding (Harris et al, 2022). Learning from practice also concludes that narratives of 'lifestyle choice' and mental capacity sometimes derail responses to referred adult safeguarding concerns (Preston-Shoot, 2021) which indicates the need to reshape attitudes of professionals and the structures that enable successful multi-disciplinary support for adults who self-neglect but who may appear not to fall easily into established definitions and categories.

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4.10 During the period under review, RSAB published multi-agency self-neglect and hoarding policy, which reminds practitioners that this may be as a result of care and support needs and, in the case of hoarding, may be of a severity to be considered a mental health disorder in its own right. The local policy advises '*a timely response is crucial, and a decision made as to whether the situation can be managed within care management procedures*.' The policy includes assessment tool guidelines to support agencies to consider if this requires a multi-agency response including safeguarding adult powers (by way of a RAG rating linked to the clutter image rating).

4.11 Importantly, self-neglect in younger adults who've experienced homelessness and exclusion may be harder to detect and may less easily fall within established processes for harm reduction and risk management. Learning from practice encourages practitioners to actively listen to people, to embed professional curiosity and person-centred approaches and by reflecting on pre-judgements they may make about the person in front of them (London ADASS, 2020).

Suicide Prevention

4.12 Caleb was living at the intersection of several experiences that, research shows, made him vulnerable to dying by suicide. Suicide prevalence data[6] shows men are almost three times more likely to die by suicide than women. It is also more prevalent for people who are living in poverty to end their own lives[7], with suicide accounting for 13.4% of deaths affecting people experiencing

[6] https://www.samaritans.org/about-samaritans/research-policy/suicide-facts-and-figures/latest-suicide-data/

[7] https://www.samaritans.org/about-samaritans/research-policy/inequality-suicide/

homelessness[8]. Studies show that suicide attempts were around three times more likely to occur in people who have experienced abuse and neglect as children[9].

4.13 Research shows an association between a wide range of mental health needs and suicide, to the extent that suicide is a relevant risk factor in all people with diagnosed or suspected mental health difficulties (Harris et al, 2020). This presents the difficulty in practice that a diagnosis of mental illness does not necessarily help in identifying the people who may try to take their own lives. It is essential to consider the relevance of other risk factors.

4.14 It is well understood that previous suicide attempts are a strong predictor of subsequent death by suicide. The local strategy reports that 50% of people who die by suicide had a history of self-harm. Equally, it reports less than 50% of NHS Trusts use NICE guidance[10] and quality standards on suicide prevention in their day-to-day work. Guidance, including that reference in the recent *Suicide prevention strategy for England: 2023 to 2028*[11], encourage agencies to respond to suicidal concerns, not with a risk assessment that distinguishes based on method and a statement of intent, but a comprehensive and immediate psychosocial assessment and engagement in a therapeutic relationship. This should then facilitate development of a care plan to prevent the escalation of self-harm and risk management plan to include a crisis plan outlining self-management strategies and how to access services during a crisis when self-management strategies fail. GPs need to be an integral part of the inter-professional risk holding network.

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4.15 Article 2 of the European Convention on Human Rights (ECHR) places a duty on public bodies to prevent avoidable deaths. This must be balanced against the right to freedom from inhumane treatment (Article 3), the right to liberty (Article 5) and respect for private and family life (Article 8). The right to life is an absolute right and there are numerous examples of SARs, case law and from PFDR of breaches of article 2 when service users complete suicide after failures to adhere to policy or operational practice/ clinical guidance.

4.16 In 2018, Redbridge Council published a suicide prevention strategy that has a key aim to tackle stigma associated with mental health, reduce health inequalities and tailor approaches to improve mental health in specific groups.

Personality Disorder

4.17 People experiencing homelessness face systemic barriers when seeking access to mental health services. In real terms, this means that many people who rough sleep or stay in hostels are living through acute episodes of emotional and mental disturbance as well as enduring distress, resulting in high rates of suicide, acute hospital admissions, interactions with criminal justice agencies and without the ongoing therapeutic input they need to regain a sense of stability[12].

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8 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2021registrations

9 https://www.manchester.ac.uk/discover/news/child-abuse-linked-to-risk-of-suicide-in-later-life/

10 NICE (2018) Preventing suicide in community and custodial settings. Available at: https://www.nice.org.uk/guidance/ng105

11 Department for Health and Social Care (2023) Suicide prevention strategy for England: 2023 to 2028. Available at: https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028

12 https://www.england.nhs.uk/wp-content/uploads/2016/07/stop-the-scandal.pdf

4.18 People experiencing homelessness are disproportionately affected by adverse childhood experiences, such as neglect, exposure to violence, unexpected bereavements, poverty, and physical or emotional abuse[13], which may go some way to explaining the high prevalence of personality disorder traits and diagnoses amongst homeless populations[14].

4.19 There is a recognised social and professional stigma towards people whose behaviours are characterised as 'Personality Disorder' (Mind, 2022). A Royal College of Psychiatry (2018) study identifies the negative attitudes of clinical staff towards patients with diagnosis of personality disorder. The study specifically referenced nurses as scoring lowest, using self-rating scales, on caring attitude towards patients. Professional attitudes influence care planning and responses to risky behaviour and distress; people diagnosed with personality disorder experience high levels of criminalisation, excessive detention and containment, and disproportionate deaths by suicide[15] compared with people living with other diagnoses. This prevails despite more than twenty years of intentional government policy to 'break the cycle of rejection' where personality disorder is a diagnosis of exclusion[16]. Disappointingly, Royal College of Psychiatry supported research in 2018 identifies the continued presence of negative attitudes of clinical staff towards patients with diagnosis of personality disorder. The study referenced nurses as scoring lowest in self-rating scales on caring attitude towards patients with personality disorder.

4.20 There are examples of innovative practice around personality disorder stigma from Scotland, where attempts to improve responses to people living with personality disorder through the provision of multi-agency training and learning spaces for practitioners have been effective in improving care[17]. Given the prevalence of personality disorder diagnoses in the population of people living with multiple disadvantage and homelessness, as well as it's clear links with trauma and social exclusion, there is value in exploring local policy and practice in this area further.

Multiple Disadvantage

4.21 According to the Making Every Adult Matter coalition:

> *"people facing multiple disadvantage experience a combination of problems. For many, their current circumstances are shaped by long-term experiences of poverty, deprivation, trauma, abuse and neglect. Many also face racism, sexism and homophobia. These structural inequalities intersect in different ways, manifesting in a combination of experiences including homelessness, substance misuse, domestic violence, contact with the criminal justice system and mental ill health.*
>
> *Multiple disadvantage is a systemic, not an individual issue. People facing multiple disadvantage live in every area of the country. They are often failed by services*

[13] Herman D. B., Susser E. S., Struening E. L., Link B. L. (1997). Adverse childhood experiences: Are they risk factors for adult homelessness? *American Journal of Public Health*, 87(2), 249–255. https://doi.org/10.2105/AJPH.87.2.249 and Koegel P., Melamid E., Burnam M. A. (1995). Childhood risk factors for homelessness among homeless adults. *American Journal of Public Health*, 85(12), 1642–1649. https://doi.org/10.2105/AJPH.85.12.1642

[14] Fazel S., Khosla V., Doll H., Geddes J. (2008). The prevalence of mental disorders among the homeless in western countries: Systematic review and meta-regression analysis. *PLoS Medicine*, 5(12), e225. https://doi.org/10.1371/journal.pmed.0050225

[15] https://www.nhsconfed.org/events/watch-personality-disorder-no-longer-diagnosis-exclusion-call-action

[16] Department of Health (2003) Available at: https://www.candi.nhs.uk/sites/default/files/Documents/pd_no_longer_a_diagnosis_of_exclusion.pdf

[17] https://blogs.iriss.org.uk/homelessness/personality-disorder/

and systems that focus on singular issues. This makes it harder for individuals to address their problems, lead fulfilling lives and contribute fully to their communities."

4.22 The Hard Edges report (2015) estimated that 58,000 people face problems of homelessness, substance misuse and offending in any one year. When the research was expanded to considered gendered violence and mental health, in a report called Gender Matters (2020), this figure rose to an estimated 336,000 people.

4.23 Research exploring multiple disadvantage is growing, and with it the evidence base of effective practice. One of the most comprehensive and relevant considerations of effective practice with people living with multiple disadvantages arose from the Fulfilling Lives programme, which worked between 2014 and 2021 in twelve areas of the country. Their evaluation[18] made clear the following foundations for effective work with people living with the effects of multiple deprivation, trauma and co-occurring conditions:

- Removing arbitrary barriers to accessing support services
- Co-production of new and changed services, with the people who use them
- Improving the training and learning opportunities available for frontline practitioners, and giving them the flexibility to use it in their practice
- Improving access to mental health services
- Improving transitions between services and settings

Wellbeing

4.24 The wellbeing principle and safeguarding obligation to adults with care and support needs was deliberately widely defined in the Care Act 2014 by Parliament. It goes beyond the issue of mental capacity as defined by the Mental Capacity Act 2005. Since April 2015, s1 Care Act requires local authorities to promote an individual's wellbeing whenever it is carrying out any care and support function. Section 2 obligates local authorities and relevant partners[19] to provide services or take other steps it considers will prevent or delay the development of care and support needs by adults in its area.

4.25 The Care and Support Guidance, which accompanies the Care Act, dictates an early response to emerging harm is essential to stop risks from escalating. It also clarifies that local authorities have duties when the adult's needs for care and support are due to a physical or mental impairment or illness and that they are not caused by other circumstantial factors. This includes '*physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury. The authority should base their judgment on the assessment of the adult and a formal diagnosis of the condition should not be required.*'[20] Section 11(2) provides an enduring

[18] https://www.tnlcommunityfund.org.uk/media/insights/documents/Summary-of-programme-achievements-evaluation-findings-learning-and-resources-2022.pdf?mtime=20221128143121&focal=none

[19] Section 6 and 7 of the Care Act 2014 obligates relevant partners (police, NHS, district or county councils, prison, probation, department of work and pensions and providers of health or social care services) to cooperate in the delivery of respective functions to adults with care and support needs and their carers.

[20] Paragraph 6.104 Care and Support guidance, DHSC

duty to offer an assessment when an adult with care and support needs has experienced, or is at risk of abuse or neglect, including self-neglect.

4.26 Finally, s.42 of the Care Act 2014 requires that each local authority must make (or cause others to make) enquiries, decide what must be done and by whom whenever an adult with care and support needs is at risk of, or experiencing, abuse or neglect.

5. Chronology & Analysis

Relevant Background

Housing

5.1 Caleb moved to Chigwell, Essex, in December 2015 and was a Council tenant, having moved into his flat as it's very first occupant when it was newly built. This tenancy remained available to him throughout the review period and until his death although it's clear that he stayed there as little as possible in the months leading to his death. Both Caleb and the agencies supporting him had concerns regarding his ability to maintain the flat and to live without support. He moved in without any furniture and never managed to make the house a home, something that features regularly in the evidence provided to reviewers. His Tenancy Sustainment Officer and Police Officers who attended his flat spoke of a property that was largely empty, except for rubbish, drug paraphernalia and a few personal possessions. Caleb was concerned and embarrassed by this and wanted his home to feel like a safe and welcoming place; he frequently said that he wanted it to be clean, tidy and secure but was unable to make that happen for himself.

5.3 One of the most meaningful professional relationships Caleb had been with his Tenancy Sustainment Officer ['TSO'], someone who made an effort to get to know him and held him in genuinely positive regard even when his behaviour was unusual or challenging. It is clear from the evidence provided that the TSO made significant efforts to personalise his approach to working with Caleb, to accommodate the recurrent issues with his phone, his challenges executing decisions and his vulnerabilities around money and illicit substances. There are several examples of this officer going significantly beyond what might be expected to support Caleb's engagement with drugs services, to resolve issues with his benefits and to communicate with Caleb's concerned siblings. It is apparent from the documentation that Caleb trusted this officer, calling him and asking for help, sharing things he was concerned about and giving consent for him to act on his behalf on several occasions.

5.4 During and before the review period Caleb raised concerns about anti-social behaviour and harassment from his neighbours and others. He believed they were compromising the safety of his home. His mental health significantly declined in late 2021 and at around the same time he began mentioning concerns about people (known and unknown) stealing his keys, trying to get into his home, shouting at him from other flats and posting things about him on the internet. He repeatedly stated he could not live in his home anymore because of this and made several complaints via Police and the Council. These concerns were acted on to some degree, but closed when agencies could not get in touch with Caleb by phone. His experiences are not substantiated by evidence from agencies; it is the reviewer's opinion that whether or not he was experiencing harassment is less important than the fact that he was expressing that he felt unsafe and unable to protect himself from harm and persecution. Positive practice here might have included raising

the issue with Caleb's Care Coordinator, who could have had a conversation about what safety might look like, and to support Caleb to take actions towards this which may have been practical or psychological. If Caleb's concerns were indeed not backed up by evidence, it may have been determined that his medication and mental health care would benefit from review.

5.5 Although this review will underscore that Caleb's accommodation moves were frequent, short-term, and often precarious, he was not known to rough sleeping services and had not been recorded on the Combined Homelessness Assessment and Information Network ('CHAIN') prior to July 2022. He is recorded as living in hostel accommodation in the years between 2011 and 2014 in what appear to have been largely uneventful stays. It is during this time that he is believed to have begun using heroin.

5.6 Whilst it is positive that he maintained his tenancy for upwards of 7 years prior to his passing, this means he lived alone, without support and with limited positive contact with other people. The evidence around Caleb's housing paints a picture of a young man who struggled to live independently and didn't know how to make a home feel safe and comfortable, perhaps due in part to simply not knowing or experiencing what a settled home environment is like.

Substance Use

5.7 Caleb reported using substances since his childhood and is known to have been dependent on heroin on and off in the ten years leading up to his death. He is also known to have smoked cannabis and crack cocaine as well as drinking alcohol and taking LSD and amphetamines in his early twenties. He was clear that he wanted to be free of addiction and that he felt ashamed of it.

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5.8 Caleb stated on several occasions, during the review period and prior, that he was using drugs to self-medicate – either to relieve the side-effects of medication, to cope with the threats and harassment he was experiencing or to make other thoughts go away. As reviewers, we were disappointed to see self-medication dismissed in notes of a conversation recorded by a mental health clinician, using scare quotes. Good practice would have been to employ professional curiosity to learn more about why he was self-medicating, what he was trying to relieve with drugs and what alternatives there might be that could help.

5.9 In 2019, he referred himself to VIA to get support around his drug use. Although he struggled to attend scheduled appointments and was discharged, he did persist in approaching the service for help and it is evident they were flexible in their approach to working with him. It seems irrefutable from the documentation provided that ending his dependency on drugs was important to Caleb. The VIA service knew Caleb quite well, and although he engaged sporadically there were periods where this was more consistent, and he seemed to be making good progress in his recovery. During these periods he attended group and 1:1 appointments and his outlook is noted as brighter, more positive and forward looking. They noted on several occasions that he approached the service proactively and without referral, which is somewhat unusual. As he was understood to be a very vulnerable young man, they acted flexibly and saw him at short notice on several occasions. Undoubtedly this demonstration of care and understanding contributed to his decision to return to the service.

5.11 In October 2021, VIA noted concerns about his declining mental health and made a referral to the NELFT's RAABIT team, now known as Mental Health and Wellbeing Team (MHWT). This referral was triggered by a conversation with his VIA keyworker, where he stated that:

"*he's got a plan with God to come here before he dies. Caleb gave the figure of 9 months left, he said that he's going to do something in 9 months but it's a secret between him and God. I asked him what it was, and he said he cannot say it's between him and God. This was very concerning as it sounded like he was plotting something and counting down the days. I asked if he was going to commit a crime and he said no, I asked if he was going to commit suicide and he said no.*"

5.12 He didn't speak of this plan again to VIA, and it's not recorded in notes with other agencies either. It is poignant that, whether by intent or accident, he passed away nine months later at his own hand.

Mental Health and Wellbeing

5.13 Caleb was known to NELFT mental health services on and off from 2011. Prior to that he was engaged with CAMHS for much of his childhood, although the detail of this was not shared as part of this SAR.

5.14 In the years between 2011 and his death there were multiple records of him reporting feeling suicidal, sometimes reaching out for help from services himself and other times being referred by those he expressed these feelings too. There are no recorded instances were Caleb tried to take his own life prior to 2022.

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5.15 Caleb lived with very low self-esteem, something several agencies commented on during the Review. This was apparent in the way he spoke about himself, his increasingly unkempt appearance. He frequently mentioned hearing voices, and said they were encouraging him to hurt himself and others. On several occasions, Caleb told stories about hurting other people and wanting to hurt other people, but there is limited evidence that these incidents happened. As an adult, he was accused of assaulting another person experiencing homelessness in 2014 and was charged with assaulting a police officer in 2022. It is the reviewers view, in considering accounts from all agencies, that his statements about hurting other people were largely fuelled by bravado and a desire to appear less vulnerable than he was. This is not to downplay the violence he did enact on others but is to establish that violence was not a defining characteristic of Caleb and nor was it a typical response from him during mental distress or when intoxicated. He was more prone to making verbal threats, although this too was relatively uncommon.

5.17 In documentation from the review period, it's stated that his primary diagnosis was one of Emotionally Unstable Personality Disorder although it's unclear when or how this diagnosis was reached. His engagement with NELFT was limited to acute episodes like those selected for the review period, so it seems unlikely that he accessed support to understand this diagnosis from a specialist trauma or personality disorder service.

Criminal Justice

5.18 Caleb had nine convictions and six cautions/reprimands between 2005 (when he was 16 years old) and his death in July 2022. Most of these offences relate to possession of drugs, acquisitive crimes and possession of offensive weapons (not stated what). It does not appear that he was ever given a custodial sentence. He was stop-searched on several occasions in the final three years of his life and on all but one occasion (where he was cautioned for possession of heroin) nothing of note was found.

5.19 He was arrested and charged with assault of a police officer in March 2022, and days later he jumped on a stationary police car in Islington. Both these episodes took place days after Caleb attempted to take his own life. In comparison with people with similar long-term drug dependency issues, homelessness and financial deprivation his criminal record and interaction with police is relatively light.

5.20 In the latter months of his life, Caleb's engagement with Police was frequently related to his welfare, which will be explored in detail in the three episodes that form the central focus of this review. It is noteworthy that on more than one occasion, Police officers responded rapidly and generously to formal and informal requests to conduct a welfare check to establish his location and state of mind, something which alleviated the concerns of his relatives and agencies supporting him.

Episode 1: Detention under Section 136 of Mental Health Act (1983)

5.21 On 09 March 2022 London Ambulance Service were called to provide medical assistance to Caleb following a report he had jumped in front of a train and was being held by British Transport Police. On their arrival he was alert and orientated. Caleb reported that he deliberately jumped but changed his mind when the train was coming towards him and that it was a cry for help. British Transport Police's statement said he climbed down onto the train tracks, sat down and waited to be hit by a train; he was subsequently hit by a train and received minor injuries. He received a glancing blow to his right shoulder from the passing train and slight grazing to his hand. BTP detained him under s136 Mental Health Act 1983, and he was conveyed to King George Hospital ['KGH'] where a handover of care was conducted with hospital staff.[21]

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5.22 He received medical care for his physical injuries and was cleared by the attending medical doctors. He was then referred to the Psychiatric Liaison Service (PLS) at KGH and subsequently transferred to the Section 136 Suite at Hospital A, for Mental Health Act assessment. NELFT states that the assessment concluded that it was an impulsive suicide attempt in the context of drug use and triggered by social stressors (a relationship breakdown was indicated but professionals working most closely with Caleb are unaware of him ever being in a relationship) and financial stressors (having spent his money). When he was asked why he did it, he stated that he heard voices calling him a 'mug.' Caleb also reported that he was always followed by people, and he heard voices constantly. Information was shared from British Transport Police and a MERLIN was completed.

5.23 On 10 March 2022, following an assessment to ascertain if he was eligible for compulsory detention (which concluded he wasn't) he was discharged from the s136 MHA and allowed to leave with his brother. His risk assessment rating level had reduced from high to medium. Caleb was found to have mental capacity to make decisions about his mental health support and continue with his management plan in the community. He was referred to Islington HTT (IHTT) for community treatment as he was returning to his brother's address. IHTT accepted the referral.

5.24 On 13 March 2022 Caleb was picked up by police running in between traffic and whilst officers searched him for drugs, he threw his head back connecting with an officer's mouth. Caleb

[21] The file states that VIA's Hospital Alcohol Liaison nurse passed information to his VIA support worker on the 09/03/2022 that Caleb had been admitted on s136 section. A continuity of care appointment with VIA was made for Caleb for the next day in the case that he was discharged (he was not). This is good practice demonstrating timely communication, coordination and continuity of care.

reported that he was trying to get away from people and stated that he was being filmed in the street and his flat. He also claimed that there was a video online which is claiming he is a mug for not flicking his cigarette ash properly (no evidence of such a video was found by NELFT staff upon investigation). Caleb was arrested and charged with assaulting an emergency worker, he was bailed to his home address (not back to his brothers in Islington) and required to attend Highbury Corner Magistrates Court on 04 April 2022. A new MERLIN report was not made at this time which is not in line with the Metropolitan Police Vulnerability Assessment Framework[22]. This was identified by MPS when compiling the summary evidence for this Review and action was taken to remind officers of their responsibilities to comply with relevant procedures.

5.25 On 14 March 2022 Islington and Enfield Liaison and Diversion Team informed the Integrated Care Access Hub (ICAH) in Redbridge about this incident. ICAH went to Caleb's address on several occasions (on 14 March 2022) but did not find him. They made further attempts on the 16 March 2022 and 20 March 2022 but were unsuccessful. The ICAH clinician contacted his brother, who confirmed he had seen Caleb two days previously. The following day his brother notified ICAH Caleb had been seen in a village in Bedfordshire, where he was in foster care as a child, and that he was going to pick him up. Caleb stayed with his brother overnight and returned to Redbridge the following day. Whilst at his brother's residence, Caleb told NELFT staff that he was feeling better and would be at his home address the next day.

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5.26 ICAH arranged a home visit on 24 March 2022 but when mental health staff visited there was no response. Caleb later confirmed over the phone he was not living at the address but wouldn't say where he was living. He reported feeling:

> '*angry as people are fighting against him, following him and causing him distress. Stated he just wants to get away. Caleb reported that he was on a train to Hertfordshire and will be staying there. Caleb stated he needs help (i.e. feel less distressed) but mental health services only interested in giving him medicine. He then stated he does sometimes have suicidal thoughts but again would not elaborate when probed. He was advised to go to the A&E in Hertfordshire to be seen and he agreed to do so. Caleb was calm, coherent and demonstrated that he had capacity*'.

Analysis

5.27 Despite evidence of vulnerability that met the thresholds for MERLIN and Section 42 concerns to be raised and explored (either through safeguarding duties or powers), there were missed opportunities to share information between agencies and to coordinate appropriately regarding his time under s136 detention and his ongoing need for safeguarding and care and support. MPS identified this whilst compiling the evidence for this review and have proactively addressed this in training for officers. Nonetheless, it would have been good practice for a multi-agency discussion to take place about the possibilities and remedies of possible of self-neglect, the risk of suicide and the possibility that Caleb was experiencing harassment from others.

5.28 No evidence was provided to reviewers that discussions took place with, that the concerns raised by Caleb were shared with the Council's Housing Department, his landlord. It had not

[22] https://www.met.police.uk/cy-GB/SysSiteAssets/foi-media/metropolitan-police/disclosure_2023/january_2023/assistance-victims-english- second-language-vulnerability-assessment-framework-quick-tool-guide.pdf

been established if Caleb's concerns about being filmed at home were true or if they arose from his mental health, but nonetheless this should have been taken seriously by agencies and an exploration of his concerns been conducted by the Council. Had the concerns been unsubstantiated following, this could have triggered the raising of safeguarding concerns about his care and support needs, that he was unable to protect himself in the context of possible self-neglect and further that his housing wasn't meeting his needs effectively resulting in him not staying at the property.

5.29 There does not appear to have been multi-agency coordination to assess the risks Caleb experienced, or to understand the full context within which they occurred, despite a documented history of mental ill-health, his neurodiversity, recent and historic suicidal ideation and poly-substance use. Equally, given he had expressed that he didn't have any money and that this was a stressor that triggered his suicide attempt it's unclear if any action was considered to ensure he would be able to provide for his basic needs. As such, it's unclear how the risk of a further detention under the MHA could be prevented, and how Caleb's distress would be responded to sensitively with the view to longer term resolution and risk management in the community. Caleb told agencies that his attempt at suicide was 'a cry for help' but it's unclear what help precipitated from this episode.

5.30 Documentation shows that ICAH were proactive in their use of varied approaches to engage with Caleb via home visits, phone calls and liaison with family. However, there appears to be a gap in the professional curiosity required to truly understand his concerns or to understand where he was living. Whilst he was entitled to share with professionals only what he wanted to, the fact he was moving rapidly between addresses in London and Hertfordshire immediately after a suicide attempt should have precipitated more meaningful enquiry into his circumstances.

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5.31 Caleb was assessed as being able to make capacious decisions about his mental health support and ongoing treatment in the community. However, this assessment does not appear to have considered his executive functioning, particularly given the known challenges for people living with ADHD and Aspergers. Good practice would have been to conduct a more in-depth assessment of his ability to execute decisions he made in relation to his health and housing, and to understand the impact of his EUPD, neurodiversity and his drug use on executing decisions.

5.32 Trauma-informed practice undergirds the need to create trust through psychological safety. One of the ways is delivered in practice is by actively listening to people's concerns and acting on them. Caleb told professionals he was being harassed and that he didn't feel safe at home but there is little evidence that his concerns were taken seriously which is likely to have impacted his trust in agencies.

Episode 2: Admission under Section 2 Mental Health Act

5.33 On the 26 March 2022 Caleb presented to Hertfordshire Mental Health Centre, taken there by his former foster carer who was so concerned about him that she called his brother and together they took Caleb to hospital. The hospital made contact by telephone with ICAH to request information and advised that whilst he was waiting for his MHA assessment, he had attempted to abscond by jumping on top of an ambulance but was brought back to A&E in Hertfordshire.

5.34 This call was followed up by an email containing relevant evidence and details. Caleb was assessed on 27 March 2022 in hospital, admitted under s.2 MHA and transferred to Hospital A. VIA reported confusion about where he had been detained and were only advised on the 01 April 2022 that he was in a mental health inpatient. That day Caleb transferred to Monet Ward for continued inpatient mental health care and treatment. During his stay on Monet Ward his mental health was reported to have 'gradually improved' and although there were two incidents of note there was no evidence of the intention to cause harm to self or others during either.

5.35 On 06 April 2022 during VIA's MDT meeting VIA's Hospital Alcohol Liaison nurse confirmed that Caleb was still in Hospital A. His allocated worker contacted him by phone on 08 April 2022. Caleb reported he felt well and abstinent from all substances since being in hospital. His keyworker made a request to ward staff to be invited to the ward discharge meeting, although at that stage it was unclear when he would be discharged as the hospital were trying to arrange supported accommodation upon discharge. There is no evidence in the information provided about how the decision to secure supported housing was reached if Caleb wanted this or was aware of it or what this would mean for his tenancy. There does not appear from the records to have been any liaison with the Council's Housing Department at this time and ultimately a supported housing placement was not Caleb's destination post-discharge.

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5.36 As Caleb had failed to attend his Court appearance due to being in hospital, a 'no bail' warrant was issued by the Court. Police attended his home on 11 April 2022 but he was still in hospital at the time. There is no evidence that Police or Court were informed of Caleb's inpatient stay at Hospital A, and nor that his solicitor had been made aware. As such no representation could be made on his behalf about his failure to appear. Equally there is no evidence that Police or Courts attempted to locate him in recognition of his known vulnerability.

5.37 On 12 April 2022 the MERLIN reported submitted following his suicide attempt on 09 March 2022 was uploaded to Liquid Logic and sent to Redbridge access and assessment team. It remains unclear why this took over a month to be passed to the relevant local authority by the police's internal adult safeguarding triage process.

5.38 On 26 April 2022 case records from Hospital A paint a picture of Caleb as much calmer and clearer in terms of his wishes for the immediate future. He clearly articulates that, despite being drug and alcohol free (confirmed in a screening on 25 April 2022), he is hearing voices and experiencing the feeling of persecution from unknown others. He had some insight that these feelings were related to his mental health, but it was clear he was sceptical this was the cause of these feelings. He maintained that he wanted to speak to his solicitor to take legal action against the people who were posting things about him online (for which there is no evidence). In these notes, Caleb stated that he wanted several things:

- Deep clean of his flat, to stay with brother until complete, but get a few items from the flat first
- Speak to his solicitor
- A letter to take to the jobcentre and accompanying sick notes, to make sure his income was not stopped
- Go back to Kung Fu training to help his wellbeing

5.39 In these notes, it is noted that Caleb's Care Plan was last updated on 21 April 2022, Risk Assessment last updated on 24 April 2022 (identifying low risk to self, others and from other and that he had capacity). He was informed in this interaction that he would have a care coordinator upon leaving hospital. At the time of these notes Caleb's address after discharge was not confirmed and it was noted that the Liaison Coordinator would liaise with his brother and then the Consultant Psychiatrist would confirm the destination with him the following day. It was noted that someone would chase the allocation of a Care Coordinator, which had not yet taken place.

5.40 Similar case notes were entered for 27 April 2022 and 28 April 2022 which appear to be duplicated. As part of the collation of summary evidence for this Safeguarding Adult Review, this was brought to the attention of Ward Managers who were reminded of the Trust's Electronic and Paper Based Records Record Keeping Policy that advises against copying and pasting information even if it remains largely the same from one day to the next.

5.41 It is noteworthy that at this time that Caleb had been in hospital for more than 28 days. NELFT staff confirmed that he had been admitted under Section 2 of the Mental Health Act, but this ended on 22 April 2023 and following this he was an informal patient until his accommodation was made suitable for his return. It is unclear if Caleb understood the legal basis under which he was in hospital and how this changed during his stay. It is unclear if he was offered the opportunity to speak to an Independent Mental Health Advocate to understand his legal rights whilst detained and following discharge. Given the concerns noted above about his continued limited insight into auditory hallucinations, it remains unclear whether proper consideration was given to whether the criteria for continued detention under s3 MHA would have provided a more comprehensive legal framework to plan his care and aftercare post discharge.

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5.42 Ward Liaison contacted Caleb's brother who confirmed he was willing to accommodate Caleb for a short period until his accommodation was habitable. He repeated the request that Caleb's flat be blitz cleaned since he was unable to assist with the cleaning himself. He also stated that he did not intend to accept responsibility for administering Caleb's medication. He was reassured that there would be professionals involved in Caleb's care and treatment whilst he was in the community. His brother stated that he was unable to support Caleb financially so requested his benefits should be reinstated prior to discharge. His brother was given an update on Caleb's mental state and was further informed that Caleb would be referred to the Islington HTT. The ward then agreed a discharge care plan that included all these elements; there is evidence that actions were taken around Caleb's benefits and the notes suggest an email was sent to another NELFT Team (Redbridge Community Recovery Team) regarding the blitz clean. There is no evidence that Adults Social Care were engaged to begin a Care Act Assessment or that Redbridge Tenancy Management were informed of either the admission or the discharge to Islington.

5.43 On the 29 April 2022 NELFT's newly formed Mental Health & Wellness Team (MHWT) accepted the referral and allocated a Case Coordinator who supported Caleb until his death in July 2022. Ward Liaison also contacted his brother to confirm Caleb's allocated new Care Coordinator was on leave but will organize the blitz clean for his flat upon her return on 10 May 2022. Caleb's brother stated that he was happy for him to be discharged into his care and requested that he arrive between 18:30 and 19:30 and that the ward call him to let him know he

was on his way. This is not what happened and in the individual agency reflections following Caleb's death it was noted that the wishes of his next of kin to support a smooth discharge had not been prioritised.

5.44 It is stated in the notes that the MHWT requested LBR Adult Social Care (ASC) to blitz clean Caleb's flat, although there is no record of this. There is no evidence that a clean was arranged and there are no records of liaison with the Tenancy Management service to achieve this either. In discussion with NELFT it came to light the MHWT would have arranged the clean and have a procedure for doing so, although it was acknowledged that this can take up to 6 weeks and should be prioritised at admission to enable timely discharge. It's unclear why this didn't happen for Caleb and learning from his experience has shaped a recent review and change of policy (described in Section 7).

5.45 As part of the Review LBR's Tenancy Management Service noted that arranging this type of clean was straightforward in their service and within their remit as landlord in circumstances such as this. However, they do not have a record of ever receiving a request (or of being notified that he was in hospital) and so no clean was actioned and no follow-up support offered to Caleb by his TSO.

5.46 A follow up call was made by ward staff to Caleb on the 02 May 2022. He reported that he was doing well with no issues and that he was seen by the staff from IHTT. Caleb agreed to speak to Islington's Home Treatment Team as he reported that he feels like his hands are shaking and was requesting medication.

Analysis

5.47 The approach to discharging Caleb from hospital was uncoordinated and did not meet the expected standards in several key areas. As such arrangements broke down quickly and his health and housing situation deteriorated. Although there is some evidence that discharge planning considered his wishes not to return immediately to his flat, action to implement this safely was inadequate and uncoordinated. His request for a blitz clean of his flat was significantly delayed (it did not take place until after he passed away) and there is no evidence of liaison with the Council's Housing Dept until after Caleb had been discharged from hospital and was allocated a Care Coordinator. The Council's Housing Dept, both Housing Needs and Tenancy Management could and should have played a key role in discharge planning, and this was a missed opportunity that highlights gaps in legal literacy, in multi-agency coordination and in person-centered care planning.

5.48 This extends to coordination with the drugs service VIA who were supporting Caleb in the community around his drug use and had staff working in inpatient settings specifically tasked with supporting patients in hospital with drug and alcohol dependency issues. VIA made an explicit request to participate in discharge planning early in his admission, but this was missed by Ward staff, and they were only informed about his discharge sometime later. Discussions with these key external agencies should have begun when Caleb was admitted to hospital and not when he was ready to leave. Not only could this have reduced his time in hospital by around a week, but it would also have improved the quality and safety of his discharge and the likelihood it would not have broken down.

5.49 It is noted that supported accommodation was being explored for Caleb upon leaving hospital. The records don't bring that to any conclusion so it's unclear if accommodation was explored and not found or if other considerations led to the decision that he should be discharged to his brother's address. Again, it's not clear how this was understood in the context of his ongoing general needs tenancy, or if this is something Caleb himself had requested or was sought because of professional views into his ability to live independently. This lack of clarity came across in the documentation provided as part of the review and from the practitioners and managers involved in learning events and discussions.

5.50 Given that Caleb was at increased risk of completing suicide, displaying several known acute and chronic indicators. It is concerning that NELFT did not explore these risks with agencies who could have acted as 'eyes and ears' in the community, namely VIA and the Council's Tenancy Management Service. Both agencies had established relationships with Caleb and continued to work with him even though he was moving about between locations. There is no explanation given by NELFT as to why they did not hold a meeting with professionals already involved in his care to discuss actions that could potentially reduce immediate suicide triggers and longer-term risks. In discussion with practitioners, it was reflected that suicide prevention activity felt 'strategic' and that clear operational plans and guidance would be beneficial to frontline agencies and practitioners working with people in 'at risk' groups.

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5.51 Caleb moved from one geographical area to another on several occasions. There was limited evidence that anyone had oversight of this, especially due to gaps in the care coordination. This meant that when arrangements at his brothers broke down it was by chance that professionals were made aware of this, and they rarely knew of his whereabouts when he had left. His siblings were so concerned about his safety that they went out looking for him on several occasions.

5.52 NELFT mental health services were going through major changes during this time, as one of 12 Integrated Care Systems awarded funding to test new models of integrated community-based care as part of a national transformation program[23]. In practice, this meant that the new Mental Health and Wellbeing Team (MHWT) was not fully established during this episode, and with that there were insufficient staffing levels, issues with workload management and new working practices were not fully embedded. This resulted in delays allocating Caleb a Care Coordinator when he was admitted to hospital, which in turn delayed actions needed to enable a safe discharge, such as an occupational therapy assessment (not completed) and cleaning his flat (completed after his death). In discussion with senior managers at NELFT as part of this review, it is reported that the new approach has improved continuity of care and integration of practice in the community. However acute funding pressures and significant challenges in recruiting and retaining staff are challenging the ability of services to deliver the quality of care they aspire to. Adequate funding and robust workforce development plans are required for agencies to respond effectively to the needs of vulnerable people, especially those who require additional flexibility and persistence to access support.

Episode 3: Community Support after Discharge from Hospital

5.53 Eight days after Caleb was discharged from hospital his brothers partner informed Islington HTT that he was no longer living at his brother's residence. She explained that there was a physical

[23] https://www.england.nhs.uk/mental-health/adults/cmhs/

altercation between Caleb and his brother preceding this. She reported that Caleb had planned to return to Chigwell but was unsure if he managed to get into his property. His brother contacted the council to enquire if Caleb had gained access to his flat but was not made aware of the outcome of the Council's enquiries. Caleb's Tenancy Sustainment Team confirmed that although they frequently made home visits to him and had a good relationship with him, they did not have his consent to share information with anyone else and so would not have been able to let his brother know if he was located in the flat. The TSO who knew Caleb best, expressed his concern that he was not made aware of Caleb's admissions to hospital or about the severity of concerns for his mental health and wellbeing. As such, although there was a flag on the housing system about the risk of violence he posed to staff, there was nothing about his vulnerability or about the other agencies supporting him besides VIA.

5.54 Caleb did not have a working phone at the time, so Islington MH Crisis Team contacted police to conduct a welfare check, which located Caleb at his home in Chigwell. As there was an outstanding 'no bail warrant' he was arrested and detained. Caleb disclosed to police officers he was struggling with his mental health and was not getting enough support since leaving hospital. He was noted to be thin and unclean, and his flat in total disarray with drug paraphernalia in every room. The custody record shows good liaison between the NELFT, Health Care Professionals, custody staff and the mental health team at Barkingside Magistrates Court, in preparation for the court hearing. On the 08 May 2022 Islington Mental Health Liaison and Diversion Team conducted an assessment at the Fresh Wharf Custody suite. Caleb denied having any thoughts of self-harm or suicide. He denied any thoughts of harming others. On assessment he did not present with any acute psychiatric concerns to warrant diversion away from the Criminal Justice System or into hospital. Caleb was remanded into custody to appear at court on 09 May 2022. This means he was detained in a cell for 36 hours. There was no access to his mental health records at the time, due to planned ICT maintenance on the NELFT Rio case management system, making it unclear if Police were aware that his earlier non-attendance at court was due to being in hospital. Risk concerns identified by Police were shared with the NELFT and ASC in Redbridge via the MERLIN system.

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5.55 On 09 May 2022 Caleb was taken to Barkingside Magistrates Court and pled guilty to the offence of assault on an emergency worker and was released on unconditional bail to attend court again a month later. This hearing was subsequently adjourned on two more occasions as Caleb's defence sought to 'vacate the plea' due to his known mental health needs. The case was never heard and was withdrawn when Caleb died.

5.56 Over the next two days there was various communication between mental health teams in North East London, East London and North Central London, moving Caleb between them as he moved from his brother's address back to Chigwell. As he did not have a working phone at this time it's unclear if he was aware of these referrals, and agencies did not know his whereabouts. This hindered the ability of agencies to take responsibility for his immediate care or effectively manage the risks he faced.

5.57 On 11 May 2022 Caleb's VIA keyworker was advised by email from the Clinical Lead at Hospital A, that he had been discharged from hospital – a communication delay of almost two weeks. The keyworker had not been invited to a discharge planning meeting despite contacting the hospital to request this. His VIA keyworker wrote offering Caleb an appointment for Hepatitis C

testing on the 20 May 2022 at 3.30pm, he did not attend. A further letter was sent by VIA on 16 May 2022 offering an appointment for 24 May 2022, again he did not attend.

5.58 On 17 May 2022 MHWT attempted to contact Caleb via telephone but there was no response, and a voicemail was left. They were able to speak with him on 18 May 2022. Caleb informed his Care Coordinator that he was experiencing ups and downs, and reported he found the medication hard to navigate. A face-to-face medical review appointment was scheduled for the same day where he was observed as unwashed, covered in scabs on his arms, glazed eyes and erratic speech although he was generally calm in manner. Caleb disclosed that the prescribed medication made him feel restless and he continued to misuse illicit substances to self-medicate against the feeling the medication gave him. Caleb stated that he had not self-harmed and had no thoughts of self-harm or suicide. He had not been attending his drug and alcohol support sessions. He spent his days watching TV and going for walks, he felt he always must be doing something active. He ate when hungry and this was predominantly takeaways. Caleb had asked for a blitz clean, as he is living in chaos and would like to have an emptier flat so he can keep it tidy and clean. He also wanted to do a flat swap to move closer to his brother. A referral to psychology was discussed with Caleb and he felt that it would be helpful. The care coordinator noted within his plan that a '*Medical review is booked; Care coordinator to follow up on blitz clean request; Care coordinator to refer to psychology*.' There is no evidence that readmission to hospital was considered as part of this review or that the risk of suicide or other significant health event was considered in relation to his stated drug use and medication non-compliance. No evidence that a referral for a Care Act assessment was made despite the clear indication that Caleb was not managing his personal care or maintain his home.[24]

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5.59 On 24 May 2022 Caleb attended his medical review. He appeared again to be un-showered and dishevelled. He stated that he was taking promethazine which was making him shaky, and he was nearly out of his medication. He was advised to contact his GP to refill his prescription and there does not appear to have been any consideration of his capacity to do this or the likelihood that he would, based on his case history. He spoke about needing to get his life together. He once again requested a blitz clean but was told that he needed an assessment to determine if the service was needed, although there is no indication who would conduct this assessment or when. Caleb stated he was a feeling depressed and had suicidal thoughts but had no plans to enact them. He spoke about life being pointless and that he wanted to die. The notes indicate that he was reassured that his life was full of hope which feels like an entirely hollow and poorly conceived consolation given the extreme isolation he was experiencing, the continued poor condition of his home, his deteriorating mental health and, at that time, his estrangement from his brother following an argument.

5.60 During this period, Caleb remained a client of the drugs service VIA, who continued to work with him even though he was moving between boroughs, because his GP and permanent address remained in Redbridge. He knew the service and engaged sporadically as and when suited him. They acted flexibly outside of standard operating policies to enable his engagement, both before and during this episode, to keep working with him even though he had reached and passed the threshold to be discharged (due to missed appts and long-stays in hospital). They were

[24] Eligibility for support under the Care Act is determined by inability to meet at least 2 out of 10 outcomes and that this is impacting on the person's wellbeing. Based on information available to this review, his presentation at that meeting should have prompted a decision he was eligible and an offer of support made in line with duties under s18 Care Act 2014.

responsive when he presented at the service without an appointment and clearly recognised the risk and vulnerability Caleb was living with. There is also evidence that VIA worked well with his Tenancy Sustainment Officer during this period and consistently reached out to other agencies to seek information and involvement in Caleb's care planning.

5.61 On the 08 June 2022 he attended CMHT Setting A, but his Care Coordinator was not in attendance. He left a message with the administrative staff to inform the care coordinator that he had lent his phone to someone who had not given it back. He asked for confirmation of his next appointment and spoke with another Care Coordinator about attending the Jobcentre to let the DWP know about his phone, which he was advised to do. This proactive interaction, and others like them in his notes, indicates that despite the chaotic nature of his life making his engagement with services inconsistent, he regularly reached out for help and wanted very much to improve his situation.

5.62 On the 14 June 2022 Caleb attended his CPA review with his care coordinator and consultant psychiatrist. He repeated the same goals and requests for help in this meeting as he had in the various interactions with agencies in the preceding two months as quoted:

> "*Caleb reported that his life was okay but needed a blitz clean for his flat, needed assistance with his state benefits, and did not wish to be on the prescribed medication.*
>
> *Overview of the meeting: concerns about medication compliance. Caleb was quite vague with a lot of his answers and could not specify details of how he was feeling or why he may be feeling things. He also could not expand on what he has been doing with his days. He explained that he had not been taking his medication as prescribed because he stated that it was running out. It was explained to him that medication would be renewed so he can ask his GP for a repeat prescription. Caleb reported hearing voices and experiencing paranoia. He stated that he was not sure if he needed medication and could not say what his diagnosis was. He complained of feeling "fidgety" as a side effect of his medication. Caleb agreed to continue taking his medication as prescribed and it can be evaluated at his next medical review in three months, or earlier if required."*

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5.63 Caleb did not attend the VIA appointment on 17 June 2022 and so his keyworker attempted to contact him via his mobile phone, but it had been disconnected and they had not been made aware by NELFT that he had a new number. His keyworker also attempted to call Caleb's brother unsuccessfully. The keyworker gave VIA's Outreach Team a letter to give to Caleb should they encounter him during their outreach activities in the community. Although he was not contacted on this day, the proactive nature of VIA's response to his non-attendance is evidence of positive practice in supporting vulnerable adults with histories of missing episodes, suicide attempts and sporadic engagement with services.

5.64 The Redbridge Psychology Service/Psychology Psychosis called Caleb to offer him appointment for psychology assessment to assess suitability for CBT or Mood, Anxiety, and Personality (MAP) pathway psychology. He agreed to meet at CMHT Setting A on 23 June 2022 and kept this appointment. He was placed on a waiting list for Cognitive Behavioural Therapy but at the time of his death he had not yet been offered the service which is not unusual given the demands on this service.

5.65 On the 05 July 2022 Caleb failed to attend his psychology session. Attempts to contact him via telephone were unsuccessful. The following day he was stopped by Police for 'going equipped' when members of the public alerted them to a man climbing scaffolding on a block of flats. Nothing was found to support the suggestion that Caleb was attempting to break into the property, and he stated he had attended to conduct a lie detector test, something he repeated several times causing concern to officers about his mental state. No MERLIN was completed following this incident, although evidence that he was vulnerable and behaving unusually and unsafely is clear, suggesting action not compliant with Police procedure.

5.66 On 06 July 2022 at around 07:00, Caleb was seen rough sleeping on a joint street outreach shift between the specialist ELFT Rough Sleepers Adult Mental Health Project (RAMHP) service and the Newham Street Outreach Team (SORT). He appeared distressed and told Outreach Workers that he was rough sleeping because of being bullied and other issues in his current accommodation and wanted to leave the accommodation because of this. Caleb spoke about his neighbours x-raying him through the walls and putting things on the internet about him. This was his first interaction with RAMHP and so he didn't initially disclose his name or DOB. Outreach workers took him to a café for some breakfast and a hot drink where he felt more comfortable to speak freely. Although this interaction was a brief one, the outreach worker who participated in the review clearly showed Caleb care and attention, taking small actions like buying him breakfast and sitting with him in the café for a chat, that made him feel comfortable and enabled him to loosen up. This is the only occasion of rough sleeping listed for Caleb on CHAIN, although he is known to have slept outside on multiple occasions for short periods and was previously identified as rough sleeping in Newham (Stratford Mall) by Police. The RAMHP worker expressed to reviewers that she was initially surprised how old Caleb was because he came across "*very innocent, lost and inexperienced*". After checking Caleb had his phone turned on to receive calls, they left him in the café to return to the office and contact services who knew him. This was complicated by the fact that NELFT and ELFT use different Rio systems and because his Care Coordinator was on leave. Calls to the Duty Team were followed up with an e-mail. When the NELFT were informed that Caleb was rough sleeping an urgent medical review was scheduled for 07 July 2022 but opportunities were missed to share information and coordinate actions ahead of this in the absence of his Care Coordinator.

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5.67 Although his Care Coordinator returned to work on 07 July 2022, she was unable to do a welfare check at his home as she was working from home whilst still recovering. She attempted, unsuccessfully, to contact Caleb via telephone and escalated her concerns to the service manager of MHWT who advised an urgent medical review was needed. Caleb spoke to a Newham SORT Caseworker on 08 July 2022 and confirmed he was back in in Redbridge but wanted another place as he was being bullied. In fact, he was not in Redbridge he was staying overnight with his former foster parents in Hertfordshire. Newham SORT contacted his Care Coordinator to update and ask that his care be prioritised due to concerns for his wellbeing. The Care Coordinator did not initially have his current telephone number although this was later shared by the RAMHP Team who then discharged his case as he was out of area.

5.68 Caleb died on 09 July 2022. He was found in a wooded area close to his former foster mother's house in Hertfordshire, where he had stayed the night before and then left that morning with equipment to hang himself. There was some confusion between Police forces about who would notify his family of his death, which was as a result a little delayed, and no MERLIN was completed.

5.69 Due to the lack of coordination around leadership of the incident between Police forces, there was inadequate communication between agencies surrounding notification of Caleb's death. NELFT were not made aware of his death for four days, ELFT became aware of the death by accident, when checking if NELFT had picked up the concerns they raised on 08.07.2022, because, coincidentally, they share a Rio system with Hertfordshire. Redbridge Council's Tenancy Management Service were not informed of his death for more than six months and were only made aware when they sought to force entry into his property in February 2023 to comply with gas safety requirements. As the last support service who had direct contact with Caleb, the RAMHP Team Manager from ELFT called his brother on 14 July 2022, in line with the Duty of Candour, to speak to him about Caleb's passing and the agency actions surrounding his death.

5.70 Poignantly, Caleb's house was cleaned following his death but before it was known he had passed away. His brother expressed his disappointment to NELFT staff investigating his death, that the Council disposed of his brother's personal belongings without giving the family an opportunity to obtain items of sentimental value. It is of concern to the reviewer that had Caleb still been alive he would have returned to his flat to find that everything he owned had been cleared, without any discussion of items of importance to him.

Analysis

5.71 The frequency of moves between mental health services during the review period is hard to follow. One practitioner engaged in the review reflected on Caleb's care as a '*bit of a game of ping pong between agencies who were probably quite glad to hand him off*'. Certainly, the evidence shows that whilst a lot of effort went into the administration of moves between mental health teams, significantly less time was spent engaging with him, to work creatively with his known needs and vulnerabilities or to effectively coordinate his care with the other agencies involved in supporting him, especially those that continued to do so whether he lived in Islington temporarily or at home in Redbridge; VIA and Redbridge Council's Tenancy Management Service. The chaotic nature of Caleb's living situation following discharge from hospital certainly didn't help agencies to establish effective working practices, but based on recent weeks in his life this was somewhat predictable so it would have been prudent to establish a contingency plan that reduced the administrative 'ping pong'.

5.72 Whilst a strengths-based approach encourages agencies to plan for successful outcomes by working with the person towards their goals and in accordance with their strengths, Caleb's situation in the few weeks post-discharge raises questions about how agencies plan effectively for the possibility or likelihood that discharge plans will break down. In his case, this might have included more robust contingency planning with his brother should the arrangement in Islington breakdown and a multi-agency planning meeting before and/or after his CPA review to discuss his compliance with medication and agreement about assertive approaches to locating him and assessing his ability to protect himself at this time given that he wasn't actively engaged with any agency.

5.73 The notes from the meeting on 14 June 2022 suggest an unfounded professional optimism about Caleb's ability to comply with medication, to access the crisis team and to engage with his GP. He stated he was misusing drugs and was non-compliant with medication because he didn't like the side-effects and it was understood by agencies that illicit substances triggered his mental health deterioration. No referral for a Care Act assessment was made and there is no

evidence of progress to get his flat cleaned, an action originally noted more than six weeks earlier. A practitioner engaged in the review noted that *“There is a huge disconnect between these words and how Caleb actually behaved”.* Caleb’s GP received the notes from this meeting two days after his death, a month after the meeting took place, which had he been alive would have been very late considering the level of vulnerability.

5.74 The TSO also demonstrated proactive and personalised practice when working with VIA to support Caleb, and VIA acted quickly (same day) to prescribe opiate substitution treatment on 01 June 2022, acknowledging the risks and taking the lead from Caleb. This is good practice even though Caleb was unable to maintain compliance with medication after two weeks. VIA reflected that he needed much more mental health support in the community and that this support should have acted as the lead agency in coordinating his care and a multi-agency plan. His GP commented that there was an unrealistic expectation that people suffering poor mental health will pro-actively seek support. The GP commented what is needed is a better understanding of how secondary services might need to increase support during periods of acute need. He noted how primary care and secondary support can provide this in the context of palliative care and wondered if a similar approach could make meaningful difference for those identified at higher risks of suicide because of the numerous factors present within their lives (e.g. ACEs, ongoing acute mental ill health, isolation and expressed hopelessness).

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5.75 Learning from research and practice underscores how people living with the effects of trauma and multiple disadvantage struggle to maintain engagement with services. Agencies knew that Caleb frequently changed and lost his phone and moved between multiple locations, however there was no multi-agency plan in place to escalate concerns about him, or to trigger informal or formal searches when he was missing. Gaps in care coordination or other form of lead professional arrangements are a real cause for concern in this case given the level of vulnerability and complexity he lived with. Sadly though, in discussions with reviewers, practitioners explained Caleb was not an isolated case.

5.76 When Caleb died the process to notify agencies about his death was uncoordinated and inadequate. It is concerning that the Council’s Tenancy Management Service were not made aware of his death for more than six months, and that others found out by accident. It is of further concern that the blitz clean of his flat also seems to have taken place without the knowledge he had passed away and the subsequent importance of his personal effects to his surviving family members. Again, geographical boundaries played a role in these issues, but nonetheless there should have been clear agreement about who would notify family and the statutory agencies supporting Caleb, so that appropriate and sensitive actions could be taken by all involved.

6. Positive Practice

6.1 The purpose of a Safeguarding Adult Review is to identify opportunities for learning and improvement to the safeguarding system. As such, much of the analysis presented is rightly critical and challenging of practice that fell short of expectations. However, it is clear from the review that several practitioners took the time to get to know Caleb, to tailor the support they offered to his needs and wishes and to take seriously the concerns he had about his safety.

6.2 The Council’s Tenancy Sustainment Officer knew him for several years. In a one-to-one meeting he shared some of the most personal reflections about Caleb available to the reviewers,

indicating not only the care he showed to Caleb in undertaking his duties, but also the immense value of relationships between vulnerable tenants and social landlords. Caleb trusted him and reached out to him for help, as did his brother and sister. He acted both proactively and reactively to Caleb's needs, working closely with VIA to support him around his benefits and even going as far as bringing him small items to make his home a nicer place to live in.

6.2 VIA staff demonstrated significant flexibility in their approach to supporting Caleb, taking the lead from him and acting quickly when he showed motivation to address his heroin use. They proactively sought to work with other agencies and utilised the strengths, locations and working practices of their internal teams to share information effectively and to locate Caleb when he was missing. As the only agency who straddled hospital and community settings they played a key role, which could have been significantly better utilised by others in the system.

6.3 Although only one interaction, Caleb's interaction with the RAMHP service two days before he passed away was warm, person-centred and proactive. In a very short time they developed some rapport, listened to him and demonstrated he was valued. They followed up immediately with relevant teams both by telephone and in-person and acted responsibly in taking the lead on Duty of Candour phone call with his brother. In the learning events that supported this SAR, the RAMHP team were able to share much more about the things Caleb liked and wanted for himself than all other professional involved, except for his Tenancy Management Officer. This feels poignant given that they met him only once and suggests that he responded positively to their relational and informal approach.

6.4 Caleb was allocated a Care Coordinator six weeks before he passed. In a short time, she was proactive in engaging with other agencies, responded quickly to him when he reached out and demonstrated good practice in escalating her concerns to managers on 08 July 2022 when she was unable to establish contact with Caleb by telephone, indicating a commendable resistance to risk normalisation.

7. Learning Points

Learning Point 1: Best practice in supporting people whose lives are characterised by complex trauma, and where self-neglect is a feature, is to adopt relational approaches that enable the building of trusted relationships with a 'lead professional'. In turn, using a 'team around the person' model ensures ongoing coordination between relevant agencies, enables joint planning and supports dynamic risk assessment. Professional curiosity, flexibility, a willingness to work creatively and the desire to understand challenging behaviour in the context of trauma and coping skills, is key to successful outcomes.

Learning Point 2: People with histories of trauma, drug dependency, previous suicide attempts and homelessness are all at greater risk of death by suicide. Although suicide is very difficult to predict, professional curiosity in risk assessment can identify life experiences, trigger events and health issues that are known to increase the risk as well as understanding protective factors, support networks and coping strategies. Building trust begins with the creation of psychological safety.

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Learning Point 3: Research shows that neurodivergent people often find it more difficult to establish friendships and to stay on top of their responsibilities, such as attending appointments and following rules around their housing. This can lead many neurodivergent people to have low self-esteem because they are viewed as incapable of doing things others find easy. Take the time to understand someone and think about what they are good at, not just what they find difficult. Consider how this might relate to risks and vulnerabilities they face, how they make decisions and how this might affect the way they understand and relate to professionals.

Learning Point 4: Housing security is more than just the roof over our heads. Research shows that investing in housing support for vulnerable people improves health outcomes and saves the public purse by reducing hospital admissions, anti-social behaviour and evictions for nuisance and rent arrears. As a starting point, the involvement of housing professionals, landlords and tenancy sustainment officers in care and discharge planning is critical to supporting vulnerable people to live safely and independently in the community and to ensure that housing decisions take into consideration health and care needs.

Learning Point 5: When someone with previous mental health input is detained under S136 of the Mental Health Act for something considered a suicide attempt, a coordinated multi-agency plan should be brought together to reduce the risk of further deterioration and repeat crisis episodes. The foundation of this must consider the wishes of the person themselves, supported by effective and rapid information sharing between agencies about what happened, what action should be taken to prevent re-occurrence and who will support the person in the community.

Learning Point 6: Multi-agency discharge planning after a long stay in hospital is a key opportunity to prevent future crisis admissions by establishing robust mechanisms for information sharing between agencies, arranging joint assessments and visits, and agreeing risk mitigation and escalation measures in the event that health deteriorates. Planning should involve statutory and voluntary agencies and should seek to avoid unfounded professional optimism and risk normalisation by properly considering the person's history and considering differences in the risk profile when moving from a controlled environment back into the community. The patient's goals and concerns should form the priorities for discharge arrangements and should not be dismissed in favour of professional priorities.

Learning Point 7: people living with multiple disadvantage often have overlapping needs that require a multi-agency approach, with agreed actions and named officers identified to follow them through. Caleb repeatedly asked for the same thing (a deep clean of his flat) which was not actioned and neither was he updated about delays. Not only did this mean his home was not a safe place for him to return to, it would have indicated to him that professionals were unreliable and did not follow through with actions as promised. Although Caleb was allocated a Care Coordinator, there was no multi-agency planning to identify how professionals should coordinate a holistic plan around his care, health and housing and to ensure that his wishes, feelings and aspirations were central to agency actions.

Learning Point 8: Family members can and do play key roles in supporting people with care and support needs. Not only do they typically have established relationships of trust, they are not limited by geographical or professional boundaries. Good practice established through approaches such as 'Think Family' and in guidance by Skills for Care highlights the importance of understanding family relationships, establishing and maintaining good communication and drawing on the expertise of family to better understand how to support adults with care and support needs. It is also important to recognise family members as carers, who may have needs in their own right. Good practice here is about more than just phone calls, it's about building relationships and meaningfully working together.

8. Changes Since Caleb’s Death

8.1 NELFT have reviewed and updated the process for securing blitz cleaning for people they are supporting, as a direct result of their enquiries following Caleb’s death. The process has been streamlined, with clear roles and responsibilities identified.

8.2 The Officer from the MPS who was tasked with compiling the summary information for this review identified that procedures for submitting MERLIN reports were not followed in two instances where Police interacted with Caleb. Since then, additional training has been rolled out for all officers, clarifying the procedures and ensuring their understanding of how to respond to vulnerability.

8.3 The VIA service has recruited a psychologist, whose role is to support their staff with clinical supervision and reflective practice. This change was brought about in recognition that reducing burn out and maximising opportunities for reflection and risk-sharing aids staff retention and wellbeing as well as improving practice.

8.4 In 2022 Redbridge commissioned the ECINS system to record and collate information and coordinate responses to community issues such as anti-social behaviour and hate crime. Although it has a focus on community safety, there is an opportunity to consider utilising this system for relevant information sharing about vulnerable people in the community who live complex lives.

8.5 The introduction of Right Care Right Person (RCRP) by the Metropolitan Police Service began in late 2023. RCRP “is aimed at making sure the right agency deals with health-related calls, instead of the police being the default first responder as is currently the case in most areas. It has been shown [in other police forces outside of London] to improve outcomes, reduce demand on all services, and make sure the right care is being delivered by the right person.” In real terms, this will reduce the responsiveness of the Police to requests for welfare checks. Where, as in Caleb’s case, people are known to mental health services the expectation is for that agency to put in place plans and act to ensure wellbeing. At the time of writing, new policies are yet to be socialised across agencies so it is unclear how the approach will be delivered locally to safeguard adults at risk of self-neglect, or how this will be applied where there are escalating risks of suicidal ideation.

9. Conclusion

9.1 Despite the tragic outcome of the case, it would be unfounded to conclude that Caleb’s death was immediately preventable. International studies[25] have established that 93% of people admitted to hospital following a suicide attempt will not go on to take their lives at a later point. Further, in light of his repeated statements that he did not have a plan to commit suicide, and that his earlier attempts had been a ‘cry for help’, it is reasonable that professionals did not consider him at immediately high risk of suicide.

9.2 However multiple agencies knew he was highly vulnerable, his mental health was clearly deteriorating, as was his housing stability and ability to care for himself. More should have been done in the months preceding his death to understand and reduce the combined risks he faced, to listen to his concerns and to show him compassionate care he so clearly sought out.

9.3 There were significant gaps in practice around Caleb’s mental health care. In particular, there were shortcomings in multi-agency coordination around his discharge from hospital and the support available to him in the community. NELFT worked in silo, meaning that key agencies were not involved in discharge planning discussions or made aware of plans for his care upon leaving hospital. His discharge from hospital was completed without comprehensive understanding of the situation he was being discharged into, without the appropriate assurance that support would be in place in the receiving borough and without a Care Coordinator or Occupational Therapy assessment. As a result, his discharge after a month in hospital was unsafe, uncoordinated and broke down rapidly.

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9.4 There was a significant missed opportunity to involve the Council’s Tenancy Management Service in assessment and planning. Attempts to support Caleb to maintain his tenancy and to live safely in his home were not prioritised and coordination between agencies was inadequate; this is underscored by the failure to take coordinated action to deep clean his flat, something he repeatedly asked for. Although his Tenancy Sustainment Officer showed Caleb genuine care and positive regard, as his landlord, officers in the Council’s Housing Department could have played a more proactive role in multi-agency risk management for such a vulnerable tenant had they been invited to participate in discharge planning or to share information his housing conditions and escalating concerns that he was being harassed. It also appears that it would have been possible for them to arrange the deep clean of Caleb’s flat directly, had they been involved in conversations where this was made known to them. This SAR has identified gaps in the provision of safeguarding training for frontline Housing staff and managers, which may have resulted in their uncertainty about who to share concerns with, this speaks to a lack of engagement from the departments senior managers in the Safeguarding Adult Board.

9.6 The impact of unfounded professional optimism in the management of Caleb’s care is notable, such that his brother’s distress following the Inquest and NELFT’s investigation are wholly understandable. There were several occasions in the planning and provision of his care where, despite evidence to the contrary, it was assumed Caleb would be able to comply with medication and treatment regimens, without any contingency plan in place should this not happen. On more than one occasion this optimism also had the effect of silencing Caleb’s concerns about the side

[25] Owens D, Horrocks J, and House A. (2002) ‘Fatal and non-fatal repetition of self-harm: systematic review’, British Journal of Psychiatry (181) pp.193-199

effects of medication, of minimising the risks of self-medication and of overlooking the unsuitability of discharging him into his brother's care. Positive risk-taking should of course be considered. But this should be an active process that acknowledges the wishes and capacities of the person, to stretch themselves towards their goals, within the context of the relevant statutory and professional duty of care; that is not what happened in this case.

10. Recommendations

10.1 Caleb died prematurely and in tragic circumstances. Despite the conclusion that his death was not immediately preventable, the evidence and insights explored as part of this Review have identified several learning points and recommendations. Their aim is to enable Redbridge Safeguarding Adult Board to initiate and support improvements to the quality and outcomes of health, social care and safeguarding activity for people living with the effects of multiple disadvantage.

10.2 This SAR concerns the specific multi-agency care and support around Caleb. However, earlier SAR's identified similar gaps in policy and practice for other adults with care and support needs like his.. In turn they made relevant learning and improvement recommendations. To avoid duplication of effort, it is advised that recommendations made in the following SARs are revisited, and assurance given to the SAB Chair about their implementation and impact:

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- **SAR JS (2023):** It was recommended that improvements were made to multi-agency involvement in hospital discharge planning, and that an out-of-borough placement checklist was developed.
- **SAR Hilary (2023):** It was recommended that a Complex Safeguarding Strategy was developed, that alignment between RSAB and Community Safety Partnership was strengthened, and that staff were adequately informed and trained around Making Safeguarding Personal principles and identifying and working with self-neglect
- **SAR George (2021):** It was recommended that SAB Chair seeks assurance that practice standards are met around hospital discharge, assessing needs and risks related to mental health and ensuring person-centred approaches.

Recommendation 1: Redbridge SAB should consider developing a local 'Think Family' approach to strengthen practice in working with family members and supporters of younger adults with care and support needs, particularly those living with complex co-morbidities, care histories and homelessness.

Recommendation 2: RSAB to receive written assurance about how the high-level commitments described in the Redbridge Suicide Prevention Strategy 2023-2028, in particular Ambition 5 'reducing suicide in high-risk groups' are being operationalised. This might include updates on the creation of operational guidance, notification and escalation flowcharts and relevant staff training as required.

Recommendation 3: Redbridge SAB, NELFT and Police to describe and publish how the implementation of Right Care, Right Person will operate locally to respond to concerns about vulnerable adults in mental health crisis or at risk of death by suicide.

Recommendation 4: SAB to work with statutory and voluntary health partners to ensure that mental health care is a key feature of local inclusion health planning as per direction in NHS England's A national framework for NHS – action on inclusion health and the newly published statutory guidance on Discharge from mental health inpatient settings.

Recommendation 5: Redbridge SAB should review membership and engagement at SAB from the Council's Housing Dept and agree mechanisms for active engagement with registered social landlords ['RSL'] in their area. This should include supporting strategic leaders within the Council's housing department, supported living commissioners and RSL complete self-assessments in respect of their ability to support quality safeguarding and preventative interventions (in line with s2, s42, s6-7 Care Act) by reviewing safeguarding training offered to staff, engagement with local risk management forums and case management senior leaders' oversight so they can demonstrate practice improvements implemented in light of the findings within this review.

Recommendation 6: In light of the procedural issues highlighted by insufficient engagement within this review, SAB member agencies and particularly NELFT should provide assurance to RSAB's Independent Chair as to how they will ensure the learning is disseminated (in line with duties under s44(5) Care Act) and confirm what actions they have taken to review their organisational safeguarding policy, how they monitor practice reflects those changes and what steps they have taken so that engagement with the SAR process is meaningful and appropriately delegated.

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