Camden Safeguarding Adults Partnership Board
7-minute briefing Regarding: 'Joe' Safeguarding Adults Review (SAR)

1.Rational for Safeguarding Adults Review

Camden Safeguarding Adults Partnership Board (Camden SAPB) has a statutory duty to arrange a Safeguarding Adults Review (SAR) where:

An adult with care and support needs has died and the Camden SAPB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the Camden SAPB knows or suspects that they have experienced serious abuse or neglect, and there is reasonable cause for concern about how the Camden SAPB, its members or others worked together to safeguard the adult.

The Camden Safeguarding Adult Review subgroup met in January 2024 and agreed that the criteria for a mandatory Safeguarding Adult Review were met and this review was subsequently commissioned.

This Safeguarding Adult Review was commissioned because it was thought that agencies could have worked more cohesively to support Joe.

2. What happened?

Joe was aged 39 when he sadly passed away in a hostel in Camden. He had moved there in July 2021 following an incidence of "cuckooing" in his privately rented accommodation. By definition, "cuckooing" targets those people who are vulnerable, as was Joe.

At the time of his death, Joe had a mental ill-health diagnosis. He had continued to use drugs and alcohol as self-medication whilst resident at the hostel. Joe also reported low mood, insomnia and social isolation. In December 2024 the Coroner's inquest determined that Joe's death was "Drug-related". The Inquest was held from 9 to 12 December 2024.

3. Safeguarding Adult Review Methodology/ Engagement with Joe's family and the services that worked with him

Multiple meetings took place with an agreed core group of involved professionals representing the key agencies involved with Joe.

Joe's family were invited to engage in this review process at various times throughout the process and did so. Joe's family have also contributed to the writing of this review.

4. Learning Point

Camden Council and the North London Mental Health Partnership have both undertaken reviews into the circumstances of Joe's death; both have made recommendations for change. Both should satisfy the Camden SAPB that the recommendations from their reviews have been implemented and that the hostel, and other hostels as relevant, provide both good support and housing to vulnerable residents. The Provider Oversight Review has made a suite of 14 recommendations relevant to Holmes Road and other linked hostels. The Patient Safety Incident Review (PSIR), approved August 2024, has provided 7 outcomes and findings.

A recommendation (Recommendation 5) is made that Camden Council and the North London Mental Health Partnership update the Camden SAPB on the outcomes and recommendations of the Provider Oversight Review and the Patient Safety Incident Review respectively. This to be done through a report to the Camden SAPB on progress.

5. Learning Point

This review, and the Patient Safety Incident Review, found that agencies were largely unaware of the Co-Occurring Diagnosis Protocol. It contains very helpful advice about how to work with individuals who suffer from mental ill-health and have substance misuse issues. Working holistically is particularly important in these circumstances, and the document sets out helpful ways of working.

A recommendation (Recommendation 1) is made that the Co-Occurring Diagnosis Protocol should be re-launched, and all relevant constituent agencies of the Camden Safeguarding Adults Partnership Board should confirm rollout to staff.

6. Learning Point

The Care Quality Commission regulates health and adult social care services. Hostels, such as Holmes Road, that provide valuable support to some of the most vulnerable in society are not subject to inspection from this regulator. This has potential for inconsistency of how support is provided with no national oversight.

A recommendation (Recommendation 2) is made to the Ministry of Housing, Communities and Local Government to consider that the implementation of measures in the Supported Housing (Regulatory Oversight) Act 2023 strengthen regulation of support providers which are not subject to CQC inspection by an appropriate regulatory body rather than relying on local authorities to enforce National Supported Housing Standards through licensing.

7. Learning Point

Relevant agencies should ensure that they have guidance/advice for their staff and contractors on the positive involvement of family and friends in the care of individuals and how this can be achieved. The legal position regarding consent should also be set out with a reminder that this might change as circumstances/need changes.

(Recommendation 4) is made that where possible family/friends should be involved in the care and treatment of individuals. This is subject to consent, but "consent" may not be fixed and will need to be tested from time to time