Camden Safeguarding Adults Partnership Board

Safeguarding Adults Review Joe

Author: Alan Critchley
Date: July2025

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1.Introduction to Joseph aka Joe

This section is a heartfelt tribute from Joe's family, sharing a personal reflection on his life and legacy. Their reflection and contribution has been instrumental in capturing the essence of who Joe was, offering insight into the lasting impact he had on his loved ones.

A contribution from Joe's family

"*Joe was born at home in Manchester in September 1983. He is a much and forever loved and deeply cherished son, brother and uncle. Our hearts and lives are shattered by his tragic death whilst he was living in a Camden run hostel. He died whilst under the care of a North London Mental Health Team, GP practice and Camden Council's Homelessness Team.*

Joe was an extremely caring, gentle and sensitive person. He was compassionate, highly intelligent and aware of the cruelty and injustices in the world around him. He was a loyal and devoted friend and was full of empathy for people who struggled in their life. Throughout his life, he maintained a sense of humour and hope. Joe would do anything he could to help anyone who was in distress, in need or under threat.

Joe's positivity and warmth shone out from when he was a small child. He was beautiful, bright and playful, with a heart full of happiness and love for others. His teachers often remarked on what a delightful child he was and that he was a delight to teach.

He was outgoing and popular amongst his peers and always had a very creative and dynamic mind.

At a very young age, Joe's exceptional musical talent was evident. He was selected at the age of 7 to take part in the Royal Northern College of Music junior strings project and went on to be an amazing bass player, music writer and producer. His bass teacher described Joe as 'a phenomenal talent and a joy to teach'. When he took the Grade 8 Bass Guitar exam, he achieved the highest Distinction mark in the UK, impressing the examiner with his outstanding ability, skills and natural talent.

Joe achieved a degree in Creative Music Production and Business and went on to study for a part time Masters Degree in the same subjects. This was at a time when he was struggling with his mental health, following a diagnosis of schizophrenia. He was brave and courageous, doing his utmost to live with his negative symptoms and with an acute awareness of the stigma that surrounds mental illness. Joe used drugs and alcohol as a 'self medication' to help him manage his terrible symptoms of schizophrenia and the difficult side effects of his prescription medications.

The manager of the record company who released Joe's music described him as 'deeply committed, fiercely joyous and passionate' about the music he produced, that his 'sound was unique and of a very rare quality' and 'how proud' Joe was 'of all the music he made'. In

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summary, he said Joe was 'an extremely talented, natural musician and composer with a real style of his own'.

Music was Joe's constant joy that sustained him throughout his life. Music was Joe's absolute passion. In Joe's words, 'Music keeps me alive mum'. In the words of Joe's younger sister, 'Joe felt music's power to bring people together, express deep emotions and help people feel less alone'.

Joe loved his immediate family deeply and was delighted to become an uncle in November 2022. He said he could not wait to hear his niece start to talk. Tragically, Joe died before this was possible.

Joe is adored by his family and friends. His tragic death has shattered our lives. We miss our beautiful, courageous Joe forevermore and life feels so very painful and empty without him"

2.Case Background

Joe was aged 39 when he died in a hostel in Camden. He had moved there in July 2021 following an incidence of "cuckooing" in his privately rented accommodation.

"Cuckooing" [1] involves known drug dealers, or a network of dealers, take over the home of a vulnerable individual to prepare, store or deal drugs. By definition "cuckooing" targets those people who are vulnerable people, as was Joe.

His family loved him and were very concerned for him. As are so many family members, they were caught in the dilemma of trying to do the best for him whilst not giving in to his requests for money, which they thought would possibly be used for drugs. A key finding from this review is that Joe's family could have been more closely involved in partnership working to support him. They knew him far better than the professionals working with him, and they wanted to play their part in supporting him. (Recommendation 4)

With regard to Joe's heritage his family said that he would identify as Mixed White and Black Caribbean/Jewish. He also had Irish heritage. When Joe was seven years-old he was selected to join the Junior Strings Project at the Royal Northern College of Music. He was an accomplished musician. At the time of his death Joe was working for a few hours a week delivering food on his bicycle.

The view of Joe's family was that his diagnosis of mental illness, his placement in a homeless hostel, his awareness of his mixed heritage and racism in society, his passion and talent for music and music production, his scholarship place at an independent school in the past and his part time work as a food delivery driver all contributed to his feelings of not having a clear identity amongst other people. Joe often said he felt isolated and lonely, and he struggled to feel accepted, understood and welcomed socially by people.

[1] https://hmicfrs.justiceinspectorates.gov.uk/glossary/cuckooing/

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In the early stages of preparing this review Joe's mother sent the author photographs of Joe at various stages in his life. From his bright and promising childhood, there is one of him as a young child with a double bass, through to a recent one where he was holding his baby niece. The photographs are a powerful reminder of a life lost.

Joe's family told this review that he began to suffer from psychosis in his late teens, this was later diagnosed as paranoid schizophrenia. As his illness developed, his drug and alcohol use became more frequent and problematic.

This continued throughout Joe's twenties and thirties. In 2011/12, Joe went missing for a year and a half, he was eventually found in a state of psychosis and in very poor physical and mental health. He was taken into hospital under section, where he stayed for four months.

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. He also reported low mood, insomnia and social isolation. Over the time that the North Camden Rehabilitation and Recovery Team worked with Joe he was known to use cannabis, ketamine, cocaine, crack cocaine and alcohol.

In December 2024 the Coroners determined that Joe's death was "Drug-related". The Inquest was held 9th – 12th December . The medical cause of death was:

1a. Acute Polydrug toxicity (heroin, cocaine, metonitazine, protonitazine)

1b. Substance Misuse Disorder

11. Mental Health Disorder.

3.Case Reviewer/ Author

The Independent Reviewer/ Author of this Safeguarding Adults Review is a safeguarding consultant. They are a qualified Social Worker and has held a number of safeguarding roles including, the Independent Chair of the Walsall Safeguarding Children and Adults Board 2015 - 2018. The Reviewer has provided the safeguarding expertise into a review of safeguarding failures at the Royal National Institute for the Blind (publ. Charity Commission 2020) and is the Independent Safeguarding Chair for Dimensions UK. Apart from authorship of Safeguarding Adult Reviews and Domestic Homicide Reviews they have no connections with any agencies in The London Borough of Camden and does not reside in the area. The reviewer is therefore independent of all agencies and people involved in this Safeguarding Adults Review.

The review was allocated to the author on 31st May 2024.

4.Methodology

1. Camden Safeguarding Adults Partnership Board (Camden SAPB) has a statutory duty[2] to arrange a Safeguarding Adults Review (SAR) where:

[2] https://www.legislation.gov.uk/ukpga/2014/23/section/44

- 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 Board, its members or others

  worked together to safeguard the adult.

2. The Camden SAPB has discretion to commission reviews in other circumstances where there is learning to be derived from how agencies worked together in cases involving abuse or neglect. Thus, all reviews are statutory, the difference being whether the case circumstances have been judged to meet the mandatory criteria or whether the review is discretionary.

   2.1 Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect and are unable to protect themselves. The categories of abuse include self-neglect.

3. The Camden Safeguarding Adult Review sub group met on 23rd January 2024 and agreed that the criteria for a mandatory Safeguarding Adult Review were met and this review was subsequently commissioned.

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

5.Core Group and Terms of Reference (ToR)

The terms of reference for this review were agreed by a core group consisting of the following agencies:

- Adult Social Care
- Housing
- Camden and Islington NHS Foundation Trust
- Public Health (Substance Misuse)
- North Central London Integrated Care Board
- Mental Health Services
- Metropolitan Police

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The Terms of Reference are:

1. The circumstances of Joe being "cuckooed", why and how this took place and what lessons can be learned from what we know of the "cuckooing".
2. The timeline of the Safeguarding Adults Review to be from Joe's move from his flat where he had been "cuckooed" through to his death.
3. The reasons why the hostel was chosen. To include the assessment and commissioning arrangements that led to the hostel placement. In what ways was it intended Joe would be supported at the hostel and by whom?
4. How effectively did community agencies work together to support Joe?
5. Should/could Joe have had a lead worker, and what difference might this have made? Could the risk to Joe have been held by a multi-agency partnership?
6. Was there an agreed understanding of Joe's vulnerabilities and areas of risk? If so, who held this risk and how was it managed?
7. Had capacity assessments been undertaken, if so, were these effective and used appropriately?
8. Was the dual diagnosis policy/protocol followed and used?
9. How effectively were Joe's family included in his support and treatment?
10. Can any circumstances/actions be identified that might have averted Joe's death?
11. To include Joe's "voice" as far as is possible.
12. The documents to be provided to this review: Safety Incident Review from the Mental Health Trust, internal review from Adult Social Care on hostel provision, s42 safeguarding enquiry.
13. Full Individual Management Reports from agencies have not been requested.

These terms of reference were shared with Joe's family in June 2024.

6.Sources of Information

The sources of information for this review were:

- The Provider Oversight Review undertaken by Camden Council Commissioners following the death of Joe.
- An update has been provided to this review on improvements introduced at the hostel since Joe's death. This has been provided in the form a report from the relevant Service Manager.
- The Patient Safety Incident Review (PSIR) internal report written at the request of the North London Mental Health Partnership.
- Hostel records from the time of Joe's residence in Holmes Road
- Documents detailing the changes that have taken place in the hostel since Joe's death.
- Three meetings of the Core Group have taken place.
  - 11th June 2024 to agree the terms of reference
  - 6th November to consider draft review
  - 31st March 2025 Final Draft Sign off

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Family Discussions. These took place between June 2024 and February 2025

- One discussion with Joe's mother alone
- One meeting with Joe's mother and father
- Two with his mother, his father and his sister.

Visit to Holmes Road Hostel

- The author of this SAR visited Holmes Road Hostel in February 2025 and met the Service Manager responsible for the Single Pathway Service and other staff who were on duty at the time.

7.Significant Incidents and Review findings

ToR 1 - The circumstances of Joe being "cuckooed", why and how this took place and what lessons can be learned from what we know of the "cuckooing".

In June 2016 Joe was "cuckooed" [3] in his privately rented flat. The account given in the Patient Safety Incident Review is that drug dealers took over Joe's flat and that they had threatened to kill him. The gang had posed as people offering to help Joe by decorating his flat.

Any victim of "cuckooing" is, by definition, vulnerable and Joe was undoubtedly vulnerable at this stage by virtue of his mental ill-health and his substance misuse. Although Joe was rehoused following the "cuckooing" incident his vulnerability does not appear to have been fully recognised.

In the forthcoming, at the time of writing this review, Crime and Policing Bill it is intended that "cuckooing" should become a bespoke criminal offence[4]. "Cuckooing" is referenced within other Camden Safeguarding Adult Reviews (SARs "Paul" and "Sidney") and, as work is ongoing within the Borough with regard to "cuckooing", there is no need to make a separate recommendation from this review.

ToR 2 and 3

The reasons why the hostel was chosen. To include the assessment and commissioning arrangements that led to the hostel placement. In what ways was it intended would Joe be supported at the hostel and by whom?

Following the "cuckooing" incident Joe initially moved to live with a friend in Westminster, but he was effectively homeless because it was unsafe for him to return to his privately rented flat. In July 2021, following discussions between his allocated North London Mental Health

[3] https://www.camden.gov.uk/cuckooing

[4] https://www.gov.uk/government/publications/crime-and-policing-bill-2025-factsheets/crime-and-policing-bill-child-criminal-exploitation-and-cuckooing-factsheet

Partnership Safeguarding worker and housing in Camden he was accepted as homeless and he moved to an emergency bed in a hostel.

In September 2021 Joe moved to a main room. Holmes Road is a hostel for single, homeless people with support needs. Camden have a number of hostels, totalling some 700 beds. Apart from specialist hostels for women, children and the older people, the hostels for adults with support needs are linked to the same commissioned services and so there is little difference between them. The decision to place Joe at Holmes Road was simply because there was a vacant bed there at that time.

Holmes Road is one of 4 hostels managed under the Single Pathways Service for homeless people. It has 58 beds with each resident having their own space.

A case note from Joe's Recovery Worker when he moved to the hostel was that he "*might be tempted back into drug use by other residents who may still be users*". At that point the same case note says that Joe "*reportedly used drugs recreationally….but at the time of moving into the hostel he had not taken any since the incidence of "cuckooing*" It went on to say that Joe had "*no interest*" in using drugs again. Whilst drug use was clearly a risk, it would have been hard, if not impossible, to find somewhere for Joe that was drug-free given that he was homeless and in need of immediate accommodation. It was, however, a comment that should have been picked up for an overall risk assessment and should have been seen as a theme throughout Joe's support planning and risk assessments whilst he was at Holmes Road.

On arrival at the hostel Joe would have been given a "*New Resident Welcome Pack*" and he would have signed a licence document. Both documents from the time have been provided to this review. The "*Welcome Pack*" is very much a document about the practicalities of living in the hostel, housekeeping, fire alarms, repairs, local services etc. It is a useful, helpful and readable document that focuses on the practicalities of housing.

The Licence Agreement is longer more specific and more relevant to Joe's needs and vulnerabilities. Two conditions at the very beginning of the document are:

- "*Cooperate with our staff and staff from other agencies, such as health workers and the police*
- *Work with services that we ask you to work with, such as substance misuse and health workers"*.

The document sets out the Hostels Pathways Model and explains the four stages, assessment which determines appropriate services for a resident to receive. A plan should then be then written and agreed between the support worker and the resident. A "*specialist and supported"* stage follows, during this stage the resident works with their support worker towards the targets agreed in their case plan. The final stage is the "*move through stage*", where the targets have been met and the resident is ready to live independently.

The Licence Agreement is full, well-written and potentially helpful if it is kept to by both the resident and the hostel staff. Whilst it is tempting to suggest that the agreement must be kept

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to, the reality of course is that people who take drugs and suffer from mental ill-health lead chaotic lives and being in accommodation will always be better than being street-homeless. Holmes Road and other hostels have a delicate balance to maintain; it is inevitable that a number of residents will continue to use drugs. Whilst we might rather that they didn't it is better that they use drugs, if they are going to, in a supportive environment where harm reduction is practiced. A breach of licence conditions should always trigger other actions, such as a review of the support plan and risk assessment. There is little point in having a licence agreement unless it is kept to and used as a working tool as necessary.

The hostel's focus on harm reduction appears to this reviewer to be the right one. This is set out in a recent document provided to this review, "Single Hostel Pathways/Families Drugs Misuse Policy Reviewed 17th July 2024". There is clarification that there will be "*zero tolerance in relation to people and/or service users and their visitors producing, dealing or supplying drugs on the premises (including preparing opium for smoking, smoking cannabis, cannabis resin or prepared opium*". (5.3 of the document). With regard to harm reduction the document sets out, "*Hostels should seek to minimise harm done to service users, workers and volunteers by drug related activity. Focusing on harm reduction strategies that are sensitive to the experiences of trauma survivors"*.

This strategy had not been made explicit through any documentation supplied to this review, at the time of Joe's residence at Holmes Road. Now that it has been acknowledged as a clear strategy it is more likely to be successful.

The Government have provided some relevant resources regarding harm reduction as an approach. [5]

Evicting Joe would have been in nobody's interests, but the licence agreement did provide the vehicle and framework to work with Joe and to see him through the four stages in the Pathways Model described above. This could have involved closer working with Joe, referral to support agencies and/or moving him to one of the other hostels if that might have been better for Joe.

When Joe was initially placed at Holmes Road he was given an "Emergency Room", this is a room given to people on arrival and is intended to be short-term. Case records show that Joe was becoming distressed in the interim "Emergency Room" in the hostel and, on 18th August 2021 he was taken to hospital having taken an overdose. He said that he wasn't having enough support, that he was short of money, he'd asked his mother for some, but she had, understandably, declined on the basis that he might spend it on drugs. His mother said that he

[5] https://www.gov.uk/government/collections/preventing-and-reducing-drug-related-harm

had called her 62 times on the previous day. The medical/psychiatric assessment on admission to hospital was that he was not in crisis and he was discharged back to the hostel with a notification sent to the Rehabilitation and Recovery Team in Camden including a comment that Joe should return to hospital if he was in crisis. On Joe's return to the hostel he was given accommodation for a long-term resident. Hostel records note that by October 2021 that Joe was more settled and his support worker recorded on 18th October 2021 that Joe, "*seemed happy at the hostel*".

ToR 4 How effectively did community agencies work together to support Joe?

Work was undertaken with Joe, primarily by mental health workers and the hostel.

A finding of this review is that work to support Joe could have been more effective and better coordinated. After the "cuckooing" incident in June 2021 a safeguarding enquiry was opened by the allocated safeguarding worker from the Rehabilitation and Recovery team and a planning meeting was held the following month. The plan at that meeting was to hold subsequent Multi-disciplinary Meetings involving other agencies. The aims were to ascertain the current level of risk to Joe and to assist him to fill in a homeless application form. No further meetings took place, this may well be because the safeguarding worker referred Joe to Camden Housing and he was allocated a hostel placement fairly swiftly. Once he was in the hostel, with the expectation that they would support him there was no further pressing need at that point for a multi-agency meeting.

Regardless of whether or not further meetings were held, one outcome of the safeguarding planning meeting could have been that a Care Act Assessment was undertaken by the Mental Health Trust. Anyone known, or thought to have care and support needs can be considered for a Care Act Assessment[6]. Joe was already known to be vulnerable due to his mental ill-health and substance misuse. That he was a victim of "cuckooing" added to his vulnerability.

A Care Act Assessment is sometimes seen, inaccurately, as a gateway to the provision of other services. Undertaken correctly it is an assessment in its own right and it can be helpful to the individual, those working with them and their family and friends. It is a way of identifying the needs of the individual, but also a way of meeting the needs. The North London Mental Health Partnership had social workers seconded to them under what is known as a Section 75 agreement (this enables collaboration between NHS and local authorities) and a referral to Adult Social Care would not have been needed to undertake the assessment. A Care Needs Assessment should have been undertaken. Joe's strengths and his vulnerabilities would have been highlighted through this and would have been helpful for those working with Joe as well as for Joe himself.

[6] https://www.mind.org.uk/information-support/legal-rights/health-and-social-care-rights/needs-assessments/#WhatIsASocialCareNeedsAssessment

Joe was allocated a support worker at the hostel as set out in the Licence Agreement. The hostel undertook risk assessments and provided a support plan.

The author of this review is unable to say whether or not Joe was dependent on drugs and alcohol, the records are unclear with regard to dependency. This in itself is a matter of concern because it would affect the way that Joe was treated medically and holistically. It would affect his need and ability to access services. There is mention in the records supplied of periods of sobriety/abstinence. There is also a mention from the hostel support plan covering the period from June 2023 that Joe "*has no interest in managing his substance misuse*". Whether this was informed by choice, or whether Joe had no ability to manage the substance misuse because of his complex symptoms of schizophrenia and his dual diagnosis is not recorded. The ambiguity in the records doesn't seem to have been recognised.

Joe's family believe that his substance misuse was a way of dealing with the devastating effects of his mental ill-health and that the substance misuse was helpful in blunting the full effects of the psychotic symptoms. Given this, and the author of this review accepts the family comments, Joe would have had no interest in given up his use of drugs and alcohol without an improvement in his mental health. The two issues needed to be tackled in tandem.

Given Joe's residence at the hostel, that the hostel was for people with support needs and that he had a support worker; the hostel could and, this review believes, should have provided a stronger role in coordinating support for him.

Following Joe's death, the local authority undertook its own review and reached similar conclusions to this review. The hostel could have worked more effectively with Joe, in particular with regard to the three paragraphs below and they have set out an improvement plan for the hostel. An update on this is provided later in this review. (see also recommendation 5)

The hostel Risk Assessment and Support Plan for the period June to September 2023 have been provided to this review. In the view of the author both documents could be more helpful. The support plan is negatively slanted, talking of Joe's plans to pay off arrears, "*unfortunately he doesn't stick to them", "J resents his relatives for not funding his chaotic lifestyle", "budgetary control is poor", "unrealistic expectations" "unwilling to work on issues that caused him to lose his last two flats"* (in regard to moving to a private rent). There is however some positive encouragement with regard to music. Switching to a strengths-based approach to agreeing support plans and including the voice of the resident in the plans may well be helpful in supporting residents. It could also have set out clearer ambitions for Joe that he owned. The hostel have since revised their assessment processes. Knowing how creative and talented Joe was the negative assessments that don't contain Joe's voice and ambitions are sad to read.

With regard to the risk assessment completed only a month before Joe died, his risk is classified as "*Medium*" and the is risk to himself. The writer of the risk assessment identified that Joe was at risk of overdose due to the frequency and amount of drug and alcohol use. This is said with awareness of hindsight bias, but the risk was clearly "*high*" given his death so soon after. This should also have considered the comment from Joe's recovery worker when he moved into the hostel, that the drug users already there might compromise Joe's ability to be safe and drug free.

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Photographs supplied to this review from both Joe's mother and the internal assurance review from Camden Council show that Joe was living in very poor conditions. Joe's mother also supplied photographs from the time that Joe moved into the hostel, there was a stark change in the condition of his accommodation from the time he moved in through to his death. Following their own review, the hostel have agreed to review their risk assessment process and to include the potential for self-neglect within the assessment. Self-neglect is a general term used to describe a vulnerable adult living in a way that puts his or her health, safety, or well-being at risk Examples of self-neglect are:

- Lack of self-care to an extent that it threatens personal health and safety
- Neglecting to care for one's personal hygiene, health or surroundings
- Inability to avoid harm as a result of self-neglect
- Failure to seek help or access services to meet health and social care needs
- Inability or unwillingness to manage one's personal affairs

If the potential self-neglect is identified it can trigger a referral for a Safeguarding Enquiry and a Multi-Agency Meeting. Some of the factors identified in the support plan, e.g. "*failing to seek help*" and an "*inability or unwillingness to manage one's personal affairs*" combined with the poor state of Joe's accommodation could have led to a referral for self-neglect. Joe's family also identified that he had lost weight and that he looked unwell. A combination of environmental and personal factors might well have suggested self-neglect[7].

No recommendation is made with regard to self-neglect by this review because the Local Authority have agreed to make the need for referral explicit in their hostel policies if self-neglect is suspected.

A further observation on both the support plan and risk assessment is that Joe's voice is lacking from both. The observations read as though they are about him, not agreed with him. The hostel have already taken action with regard to this and have revised their documentation to ensure that the voice of their residents is clear in assessments.

Again, no recommendation is made in this review with regard to ensuring that the voice of hostel residents is explicitly included in support plans and risk assessments this as it is covered by recommendation 5.

During his time at Holmes Road Hostel Joe worked with the Camden Drug Service and was said in the North London Mental Health Partnership Patient Safety Incident Review report to have variable engagement with the service, but a "*good rapport with staff*". In early 2023 the national service, Change Grow Live, was awarded the contract for the area covering the hostel. Although hostel staff were aware of this Joe was not formally referred. This was an oversight and a missed opportunity. The experience of this reviewer is that Change Grow Live have a good reputation

[7] https://www.camden.gov.uk/documents/20142/0/Multi-Agency+Self-Neglect+Toolkit+2020+%281%29.pdf/47b4f4ef-eff5-09f9-8aac-f603a1c1ac40?t=1615993974005

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and may well have been able to engage effectively with Joe[8]. All residents who use drugs are now referred automatically to Change Grow Live.

The hostel support plan comments that Joe was made aware of the potential to work with Change Grow Live. For their part Change Grow Live, it is said in the Patient Safety Incident Review, were unaware of Joe. A formal referral to Change Grow Live should have been made, Joe might have chosen not to work with Change Grow Live, but the attempt should have been made. Information provided to this review was that Change Grow Live operated a "*drop-in*" facility in the hostel and Joe might have been persuaded by staff to see them. Joe might have been amenable to this if he had been asked in the right way, at the right time. There is no record of whether or not this was attempted.

ToR 5. Should/could Joe have had a lead worker, and what difference might this have made? Could the risk to Joe have been held by a multi-agency partnership?

As referred to there were opportunities to discuss Joe's support needs through a Care Act Assessment but this was not taken.

The Patient Safety Incident Review report confirms that Joe was allocated a North Camden Rehabilitation and Recovery Team Care Coordinator for the period February 2021 to April 2021. This is in line with the policy that North Camden Rehabilitation and Recovery Team have that a coordinator is assigned to assess the needs of the individual for a limited period of time, usually 8 to 12 weeks. The Patient Safety Incident Review accepts that the rationale for having a Care Coordinator for a limited period of time is not set out in the North Camden Rehabilitation and Recovery Team operational policy, nor was it adequately explained to Joe or to his family. The Patient Safety Incident Review confirms that at the end of an assessment period the outcome should be clearly documented and communicated to the patient and to their support network. The Camden SAPB will wish to satisfy itself that this is being done. (see recommendation 5)

With regard to whether Joe should have had a lead worker and the difference this might have made a finding from this review is that the hostel could have undertaken this role more effectively than it did through Joe's hostel support worker. As mentioned earlier the Licence Agreement set out the expectations of the pathway to be followed through the four stages of "*assessment*" to "*move through*". Clear planning with Joe in a way that involved him and used his strengths and abilities may well have been effective if he could have been more effectively engaged.

Joe's mother gave information to this review that whilst her son was in Brent, that he had a Care Coordinator. The account she gave was that this role was effective in supporting Joe and that she was able to work with the Care Coordinator in doing this. Camden doesn't offer the same model, and it is for Camden to determine how support is offered. What seems to have been effective in Brent was the personal relationship and replicating this in Camden via whatever model is offered should be equally effective as long as the assessments and relationships are good.

[8] https://www.changegrowlive.org/

ToR 6 Was there an agreed understanding of JFB's vulnerabilities and areas of risk? If so, who held this risk and how was it managed?

From the information supplied there was no single understanding of Joe's vulnerabilities and areas of risk. The hostel in collaboration with the Rehabilitation and Recovery Team were in the best position to collaborate to agree these with Joe and his family but this opportunity was not taken. A Care Act Assessment would also have been helpful in identifying Joe's vulnerabilities and risk if this had been undertaken in 2021.

The Patient Safety Incident Review accepts (their outcome and finding 2) that their Red, Amber, Green system was not referenced with Joe's notes and, further, that no actions for guidance for assessing risk were specified. This was an omission.

Revised risk assessment guidance for hostels in Camden has been updated and supplied to this review. Recommendation 5 covering both hostels and the PSIR outcomes is relevant and no specific recommendation on risk is made by this review.

ToR 7 Had capacity assessments been undertaken, if so were these effective and used appropriately?

Mental Capacity Assessments are undertaken when there is doubt that someone can make their own decisions. Typically, they are undertaken with regard to decisions about treatment when there is doubt about whether someone is able to make wise and informed choices. Capacity Assessments should always be situation and time specific. The Mental Capacity Act 2005[9] provides the legislative framework for this. Social Care Institute for Excellence provides information on when capacity assessments should be undertaken[10]. An overriding principle is that someone should be assumed to have capacity unless there is reason to doubt it.

There is no evidence that any Mental Capacity Assessments were undertaken during the timeline of this review. In terms of whether Mental Capacity Assessments should have been undertaken, the author of this review has seen no occasion where it might have been appropriate to do so. Joe was largely compliant with his medication and treatment. Joe's family have made the point to this review that they assisted with reminding him of his appointments and that they played a large part in him receiving his medication on, or near, time. The point is, however, that Joe was not resistant to taking his medication, albeit he needed support to do so.

[9] https://www.legislation.gov.uk/ukpga/2005/9/contents

[10] https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance/

There is plenty of evidence that the use of alcohol can affect mental capacity[11]. However, this again relates to specific decision making where the long-term effects of alcohol can influence executive functions. Long-term use of anti-psychotic medication could add to this.

Mental Capacity Assessments by themselves will not stop someone taking drugs and alcohol. Use of the Mental Health Act might in some circumstances; but where Joe was managing to look after himself, to a degree, and he was often working for a few hours a week, it is unlikely that the Mental Health Act would have been used.

There are no simple solutions to working with people who misuse drugs and alcohol. The reality is that, if someone has capacity, there is little that anyone can do apart from forming the best relationship that can be achieved and working with them towards harm reduction/abstinence. The Mental Health Act can be applied under some circumstances and, occasionally the Inherent Jurisdiction of the High Court[12]. However, such instances are rarely appropriate for those who misuse alcohol; can care for themselves, at least to a degree, and are working. Those working in this field will be familiar with the concept of "Legal Literacy", this is an understanding of the various approaches and legislation to obtain the best outcome for the person involved [13]. If a multi-agency meeting had been called, most likely under the self-neglect protocols as self-neglect did seem to be present, the range of legal options could then have been considered. It is however, extremely unlikely that the use of either the Mental Health Act or Inherent Jurisdiction would have been considered to be appropriate for Joe.

In the absence of a capacity assessment, and as said, there was no overriding reason for undertaking one, a multi-agency meeting under the self-neglect protocols would have helped with planning and support for Joe.

ToR 8 Was the dual diagnosis policy/protocol followed and used?

The Patient Safety Incident Review found that there was limited knowledge of the Co-occurring mental health and drug and alcohol misuse policy across the North London Mental Health Partnership and that the hostel were unaware of it. This is a significant omission. The policy was entirely appropriate to Joe's needs and should be far more effectively promoted. Such policies are multi-agency documents, they explain how work can be undertaken to support mental ill-health and substance misuse and are highly relevant to the problems that Joe lived with. All relevant agencies should be aware of the policy. (*Recommendation 1)*

[11] https://www.ias.org.uk/2021/12/01/how-can-we-use-legal-powers-to-safeguard-vulnerable-dependent-drinkers/

[12] https://www.39essex.com/sites/default/files/Mental-Capacity-Guidance-Note-Inherent-Jurisdiction-October-2022.pdf

[13] https://www.researchinpractice.org.uk/adults/news-views/2022/november/the-importance-of-legal-literacy-in-adult-social-care/

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ToR 9 How effectively were Joe's family included in his support and treatment?

The Patient Safety Incident Review accepts that Joe's mother could have been more formally supported by the offer of a Carer's Assessment[14]. This review concurs with, that but goes further.

Records show that there were times when Joe didn't want information shared with his family. This is understood and acknowledged and needed to be managed. However, he was in regular contact with his family, all of whom supported him and there was potential to include them in his support network. He may or may not have been accepting of this.

Where an individual has capacity, family and friends can only be included in any plans with consent. This review was not given a clear record of whether Joe's refusal to give consent to the involvement of his family was regularly tested and whether it was consistent. Joe's family did want to be involved in his care, they knew him well, loved him and wanted to help him. Without the access to full records this review cannot say whether attempts were made to persuade Joe to agree that his family should be included. A recommendation is made that agencies should assure themselves, and the Camden SAPB, that they have procedures and guidance in place to involve family and friends in the care of an individual where it is appropriate and agreed. The procedures, whilst encouraging involvement from family and friends where possible, should cover the issue of consent from the individual to the inclusion of others. Guidance should be clear that the decision lies with the individual concerned as long as they have capacity. (Recommendation 4)

ToR 10 Can any circumstances/actions be identified that might have averted Joe's death?

This review has identified some omissions, has made some recommendations and suggested some changes to practice. It is, of course, impossible to say whether, had practices been different, that Joe's death would have been averted. The purpose of a safeguarding adult review is to identify improvements to practice. Every circumstance is different, but the aim of a review is to learn and to improve outcomes for others.

A comment on the North London Mental Health Partnership Serious Incident Review

The author of this review was provided with a draft copy of The North London Mental Health Partnership Serious Incident Review at the very beginning of September 2024 and it was completed and agreed at the end of September 2024. The review was commissioned on the 13th August 2023 and the deadline for completion, stated on the review itself was the 19th December 2023. The framework and supporting documents are set out here (https://www.england.nhs.uk/long-read/patient-safety-incident-response-framework/).

[14] https://www.carersuk.org/help-and-advice/practical-support/carer-s-assessment/

The purpose of the review is to gain learning and to enhance patient safety. Patient Incident Response Standards are published (https://www.england.nhs.uk/long-read/patient-safety-incident-response-standards/) and include timescales stating that the review should be complete in no more than six months. "*14.3. Depending on discussions with those involved, learning responses are completed within one to three months and/or no longer than six months"*. Taking over a year to produce a report is poor and negates the opportunity to gain, and implement, quick learning. A recommendation from this review is that the North London Mental Health Partnership and Camden SAPB should monitor the performance with regard to the production of PSIRs across their borough. (Recommendation 7)

8.Holmes Road Hostel today

Since Joe's death significant changes have been made at Holmes Road Hostel and other hostels in the Borough. In 2024 a new senior manager assumed responsibility and has addressed many of the identified shortcomings. This demonstrates good leadership. They are aware of this review including its recommendations and referred directly to it in their discussions with the author of this review about the changes to the hostel.

The work undertaken recently provides some assurance of improvements. Recommendation 5 ensures that the Camden SAPB will continue to oversee and monitor these improvements over the coming months to ensure that changes are embedded.

The following documents have been revised and submitted to this review:

Drug and Alcohol Policy- Reviewed July 2024. This clarifies the approach that there is "zero tolerance" to dealing on the premises but that harm reduction will be used to assist those who use drugs.

Complaints Policy for Residents- Reviewed July 2024

Supervision Policy (for staff)– Reviewed July 2024

Risk Management Policy- Reviewed July 2024

Guidance on room cleaning and a subsequent escalation process. Reviewed in July 2024. The author of this SAR has suggested that the document should also be linked to the Borough Self-Neglect Protocols, this should be monitored under recommendation 5.

A revised Safeguarding Policy is in train and is yet to be finally agreed, again this should be monitored under recommendation 5.

Hostel staff have all undertaken mandatory training in relevant areas. As is common across the care and support sector staff it is unusual in these types of settings to hold professional qualifications An example is that of trauma-informed practice with trauma-informed

champions in each hostel. This follows research from Homeless Link [15] that the vast majority of homeless people have experienced trauma at some point in their lives.

Revisions have also been made to the way that support plans and risk assessments are undertaken. The author of this review was shown an example of a "passport". This is a document which each resident completes, with assistance if necessary. It sets out their plans and aspirations in their own words and is a key part of the support plan.

Anecdotal evidence given to this review is that Holmes Road hostel is in a geographical "hot spot" for drug use. The explanation is that Kings Cross was an area of significant drug usage. Since Kings Cross has been redeveloped it has pushed drug use away from the centre of London and that Kentish Town has borne the brunt of this. As said this is anecdotal and the author of this review has seen no studies with regard to this. A recommendation is that the police, public health and Change Grow Live consider this information and the implications for the hostel. (Recommendation 3)

Whilst this review accepts and agrees that appropriate action has been taken to strengthen the policies and procedures for the hostel, a recommendation is made to the Department of Health and Social Care that Holmes Road and other hostels are inspected by the regulator to ensure that there are consistent standards across the sector. (Recommendation 2)

In the process of undertaking research for this review the author found it difficult to find out what services and support are offered by Holmes Road Hostel. A "Google" search will show the architectural merits of the hostel, but not the services and support offered. The families and friends of residents at Holmes Road Hostel are also likely to seek out information on the internet and it would be helpful if this could be found more easily. An example is that housing and support are offered by the hostel. "Care" services aren't, albeit the hostel has links to other agencies in the area that can offer care. (Recommendation 6)

[15] https://homeless.org.uk/knowledge-hub/trauma-informed-care-and-psychologically-informed-environments/

9.Review Recommendations and Rationale

1. 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 SAPB should confirm rollout to staff and contractors within three months of the agreement of this review.

2. 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.

3. Anecdotal evidence provided to this review is that Holmes Road Hostel is in a "hot spot" for drug use, this is said to be particularly so since Kings Cross has been developed. If true, this is concerning and makes it all the more difficult for the hostel staff to maintain their aim of harm reduction for their residents.

   A recommendation(Recommendation 3) is made that a meeting is held to include hostel staff, the police, Change Grow Live and Public Health to pool knowledge as to what is known about drug use in the environs of the hostel. The outcome should be to provide local intelligence that will inform the approach that all relevant agencies will take towards supporting the intended outcome of harm reduction.

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4 Relevant constituent agencies of the Camden SAPB 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.

A recommendation (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.

5 *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 13th 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 three months after the agreement of this review and again a year after agreement to confirm that the recommendations are complete and embedded.

6. This review found it difficult to identify what support a resident can expect from Holmes Road hostel. Likewise, Joe's parents said that they did not know what their son could expect from staff and visiting services. Relevant information is set out in the Licence Agreement but more could be done to ensure the right information is shared and understood by all relevant parties including family members.

A recommendation is made (Recommendation 6) that Camden Council should ensure that the offer of what a resident can expect from this hostel, and others in the Borough, are well publicised and accessible. The contents should cover both the housing and the

support arrangements and should include the likely pathway that a resident would follow, the conditions of the licence agreement and the services that are available to support residents.

7.The Patient Safety Incident Review was significantly delayed. The aim of a Patient Safety Incident Review is to gain timely learning and to ensure that it is implemented. The rollout of learning may be delayed if timescales are not met. Families are also likely to be concerned/distressed about delay.

A recommendation (Recommendation 7) is made that the North London Mental Health Partnership, as a constituent agency of the Camden SAPB, should monitor its adherence to the timescales for the production of Patient Safety Incident Reviews biannually. until the North London Mental Health Partnership and the Camden SAPB are satisfied that PSIRs are completed in a timely way to ensure that learning can be gained and rolled out promptly. The North London Mental Health Partnership have acknowledged the delay and are committed to improving timescales.

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A note from the Safeguarding Adults Review Author

To Joe's family, it has been a privilege to work with you over the last year.

I'm sorry that it has been under the circumstances that it has.

Your love and care for Joe has been apparent at all times. The most important part of a Safeguarding Adults Review is to bring about change and to improve safeguarding for others. I'm confident that the seven recommendations will make a difference.

With very best wishes

Alan Critchley

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