# SERIOUS CASE REVIEW

**STAFF BRIEFING SHEET IN RESPECT OF ‘ROBERT’**

(To be read in conjunction with the case briefing sheet)

# INTRODUCTION

In 2013, North Yorkshire Safeguarding Adults Board published a Serious Case Review into the death of ‘Robert’.

‘Robert ’, a homeless man in his mid-40s, died in North Yorkshire in January 2012 as a result of an accidental intoxication by morphine. There was concern that a vulnerable adult in receipt of health or social care had an unexpected death or died in unusual circumstances. As a Serious Case Review, it was unusual in that it focused on a very short period of the man’s life and that his involvement took place over the extended Christmas and New Year holiday period.

The [*Executive Summary*](http://www.nypartnerships.org.uk/CHttpHandler.ashx?id=21369&amp;p=0) outlines the circumstances surrounding ‘Robert’s ‘ death which spanned a short period between 21 December 2011 and 6 January 2012 and involved contact with a number of statutory agencies in the Harrogate area, none of whom had previously had contact with him.

There were a number of lessons to be learned for all the agencies involved with Robert, in particular the review identified that there was a need for greater understanding and information sharing across agencies on both homelessness legislation and its interaction with community care and the duty to take vulnerability into account in relation to homelessness.

The review recommended actions or learning points for the agencies involved and for the Safeguarding Adults Board. Individual agency recommendations have now been implemented.

The recommendations in the report were accepted fully by the Board as a means to further professionals’ understanding, support wider knowledge sharing and improve services for homeless people in this complex and unique area of adult social care.

***LESSONS TO BE LEARNED (taken from the Executive Summary)***

* 1. *There are a number of lessons to be learned for all agencies involved with Robert. There is a need for greater understanding and information sharing across agencies on both homelessness legislation and its interaction with community care, and the duty to take vulnerability into account in relation to homelessness.*
  2. *There was also a lack of understanding about the extent to which Robert’s health needs warranted acute admission to hospital. Although primary care services were clear that this was not the case, assumptions were made based on incomplete information, heightened by Robert’s own anxieties about his health. For example the*

*out of hours housing service made assumptions about the level of health care required which was outside of their remit to decide.*

* 1. *There was no agreement reached as to who should have taken overall responsibility for meeting Robert’s needs. The HHP staff who were most in contact with him made significant efforts to engage statutory agencies. Primary care services responded positively to address his health needs and support the project’s efforts to find accommodation. However the response by housing and care agencies was very focused on eligibility for service, and there was no evidence of a joint approach to meeting needs.*
  2. *There was only one direct contact between Robert and HBC which was the phone conversation between him and housing options staff on 21 December. A number of miscommunications occurred particularly in relation to the state of Robert’s health and whether he needed hospital admission. No offer of assessment whether by telephone or face to face was made by the County Council’s emergency duty team.*
  3. *The arrangements for out of hours homelessness provision which had only recently been put in place by HBC were lacking in ensuring that management back up was formally available to front line staff. Additionally as the changeover was so close to the Christmas holiday period there was not enough time to check how the contract was working and iron out any early teething problems.*
  4. *Handover and communication between out of hours and normal hours staff in NYCC and HBC over the holiday period was not robust and out of hours recording systems were insufficient. There was no direct contact between the County and Borough Council’s respective out of hours services, and it was left to the HHP to try to make the connections.*
  5. *Finally it is very regrettable that once Robert was reported as missing on 2 January by the Homelessness Project, it was not until 6 January that his body was found. Assumptions were made by the hotel staff that Robert had left as only two nights had been paid for, and this was not verified by checking his room.*

# RECOMMENDATIONS AND ACTIONS TAKEN

**THEME 1: Assessment and service responses under legislation and guidance**

**Recommendation 1**: That there should be review and re-issue of multi-agency policies and procedures in relation to partnership working to prevent homelessness of vulnerable adults to all relevant agencies.

**Response:** Procedures for housing authorities and adult social care have been reviewed and will be reissued, resulting in simplification and greater emphasis on the need for information sharing out-of hours and for social care follow up to emergency homeless placements.

**Recommendation 2:** That Harrogate Borough Council, North Yorkshire County Council, Harrogate Homelessness Project, the Spa Surgery, Harrogate and North Yorkshire Police, should review their involvement and report their action plans to the Safeguarding Adults Board.

**Response:** This was done by May 2013 and the Board was satisfied that the actions were completed and that practice regarding out of hours responses had been improved, particularly the way that the social care and housing authorities work together to respond to homeless people who need an emergency response.

**Lessons learned** included;

* Ensuring that the North Yorkshire County Council emergency duty team has an up to date knowledge of eligibility criteria, thresholds for assessment, safeguarding procedures and services available for adults.
* Reviewing out of hours cover arrangements to inform the Christmas and New Year period 2012, to ensure that cover over extended holiday periods was sufficiently robust. The out-of- hours cover contract for the housing authority has been renewed and mystery shopping exercises are organised to test the robustness of these arrangements.
* Strengthening working relationships between the housing authority and local homeless project.
* Increasing awareness of the needs of street homeless people amongst health services.
* Improving call handling with the police and the housing authority.
* Additional joint training on rough sleeper related issues for housing, health and social care staff.

# Theme Two: Training and Staff Development

**Recommendation 3:** That Harrogate Borough Council and North Yorkshire County Council should arrange joint training and development for housing and social care staff with voluntary sector providers to ensure greater knowledge and understanding of respective roles in relation to homelessness and community support, vulnerability and best practice in meeting the needs of rough sleepers.

**Response:** This has been partially achieved through the joint launch and ongoing rollout of the ‘No Second Night Out’ initiative (see below)

**Recommendation 4 & 5** : That the good practice evidenced by the joint work between the Harrogate Homeless Project and the GP surgery in supporting Robert should be used as a case study in raising awareness of homelessness needs in other primary care settings. Promote the good practice regarding opiate prescribing

for new patients adopted by the Spa Surgery as a result of this review, with all North Yorkshire GP practices.

**Response:** These actions have been taken forward by the Clinical Commissioning Groups, NHS England and the Commissioning Support Unit.

# Theme Three: Out of Hours Services

**Recommendation 6:** That North Yorkshire County Council should ensure that knowledge of eligibility criteria; thresholds for assessment and services available to the emergency duty team should be updated and maintained through workforce development and performance management.

**Response:** This was achieved by North Yorkshire County Council through completion of the Emergency Duty Team action plan. Work will continue as a result of the reconfiguration of EDT structure from April 2014 and the establishment of the EDT stakeholders group (see below)

**Recommendation 7:** Joint protocols should be established between North Yorkshire County Council, Harrogate Borough Council and the other District Councils within North Yorkshire out of hours services to strengthen awareness and joint working in relation to homelessness and safeguarding vulnerable adults.

**Recommendations 1, 3 and 7** - are interlinked and were taken forward by a sub group of the County Homelessness Group (CHG) with responsibilities agreed for District Councils, Health and Adult Services, and No Second Night Out partners. The key areas that have been taken forward are

* + **Implementation of the ‘No Second Night Out’ Action Plan** – developed to tackle single person homelessness within the sub region (York and North Yorkshire). A launch event took place in October 2013 to underline the partnership working across North Yorkshire and York for these very vulnerable people. NYCC Health and Adult Services has approved the No Second Night Out principles and has set in motion a process to achieve formal sign up.
  + **Clarify referral pathways to ensure that rough sleepers can access health and social care; and review procedures for a joined up assessment process.** This work has been taken forward by County Homelessness Group in partnership with NYCC Health and Adult Services, and will be informed by the improved communication processes that have been put in place between the county out-of-hours services and by the good practice that is already in place.
  + **Improved communication and awareness of the out-of-hours services and responses that are provided for single homeless people.** An Emergency Duty Team Stakeholders Group has been established which includes representation from the County Homelessness Group which will ensure continued awareness and opportunity for resolution of any operational

issues. NYCC has introduced revised operational arrangements for EDT which includes closer connections to the daytime services and workforce development plans including a commitment to regular refresher training for EDT staff.

**Recommendation 7:** That North Yorkshire County Council, Harrogate Borough Council and the other District Councils within North Yorkshire should review their out of hours cover arrangements to ensure that cover over extended holiday periods, such as Christmas and New Year is sufficiently robust. This review should include record keeping, communication, and strengthening arrangements for access to senior managers for decision making where required.

**Response:** As required this was undertaken in time to inform the arrangements for cover over the Christmas and New Year period 2012.

**Recommendation 8:** That where out of hours homelessness services are contracted to an external organisation, robust contract specification and monitoring should be in place to ensure agreed standards in relation to meeting the needs of vulnerable adults at risk of homelessness are maintained.

**Response:** This was a single agency action and achieved by Harrogate Borough Council.

**Theme Four: North Yorkshire Safeguarding Adults Board Recommendation 9:** That the executive summary of the overview report of the

Serious Case Review should be made public within three months of its approval by the Board

**Response:** This was achieved and published in January 2013.

**Recommendation 10:** That the overview report of the Serious Case Review should be shared with family members and with staff directly affected prior to the report being made public.

**Response:** This was achieved.

**Recommendation 11:** That North Yorkshire Safeguarding Adults Board should monitor the implementation of the individual agency action plans on a quarterly basis and ensure that all actions are implemented within twelve months of the approval of the action plans by the Board.

**Response:** This was achieved and signed off by the Board on 26 July 2013.

**Recommendation 12:** That North Yorkshire Safeguarding Adults Board should review the multi-agency safeguarding policy and procedures in the light of this review, with particular reference to definitions and to triggers for safeguarding.

**Response:** These actions have been incorporated into the strategic plan for the Board for 2013 to 2016.

**Recommendation 13:** That the lessons learned from the detailed review of the circumstances of Robert’s death are used both to improve multiagency working through implementing the action plans, but also to raise awareness, understanding and skills in meeting the needs of rough sleepers who may be some of the most vulnerable and hard to reach people that agencies are trying to support.

**Response:** These actions have been achieved by delivery of the overall action plan and by any on-going actions.

# SERIOUS CASE REVIEW

**CASE BRIEFING SHEET IN RESPECT OF ROBERT**

*This case briefing is based on a Serious Case Review report from North Yorkshire Safeguarding Adults Board to assist learning in both statutory and voluntary organisations across adults services, particularly (but not exclusively) housing organisations, voluntary organisations supporting homeless people, and adult social care.*

*The* [*Executive Summary*](http://www.nypartnerships.org.uk/CHttpHandler.ashx?id=21369&amp;p=0) *of the serious case review is an important reference tool to use alongside this case briefing document, it is recommended anyone who is using the case briefing as a learning tool read and digest the Executive Summary in advance of using this.*

*Following this Serious Case Review, SCIE has produced the following documents related to adult safeguarding and housing.*

# SCIE Guide 53

* + Adult safeguarding for housing staff: Guidance for frontline housing staff and contractors
  + Adult safeguarding for housing staff: Guidance for housing managers
  + Adult safeguarding for housing staff: Guidance for local authority social care staff

*The documents are available via the following link:* [*http://www.scie.org.uk/publications/guides/guide53/*](http://www.scie.org.uk/publications/guides/guide53/)

*Additional information in the form of the actions taken as a result of the serious case review is located in the staff briefing section of this document.*

*It is strongly recommended that this case briefing is used in conjunction with these documents.*

# PART 1

**Robert, a homeless man in his mid-40s came into contact with Springboard, a day service project for homeless people, in Harrogate on 21 December 2011, requesting support. He informed the project he had been living in a tent on the outskirts of Wetherby, a nearby town, for the previous six months and that he could no longer manage this due to worsening pain in his arms and legs, which were as a consequence of a road traffic accident seven years ago. He stated he wished to remain living in the Harrogate area and that he had been to the job centre to move his Disabled Living Allowance claim to Harrogate.**

* + What is your assessment of the situation and what concerns and potential risks are there for Robert?
  + What support/services would you offer Robert
  + What agencies would you involve?

Notes:

*Robert was referred to the local GP surgery as Robert identified he required a prescription for pain killing medication, the actual GP appointment did not take place at this time.*

*He was provided with overnight accommodation through the Shelter to Assist Rough Sleepers (STARS) scheme.*

*Springboard supported Robert to contact Harrogate Borough Council (HBC) housing advice to request a homelessness assessment; this was arranged for the following day. There was some debate about the location of the tent Robert had been sleeping in and whether this was in the Harrogate district or Leeds district boundary.*

# Would you have done anything differently?

**PART 2**

**Robert was not seen again at the project until 26 December. From 26 to 30 December he stayed overnight at the STARS project and also used Springboard during the day. A project worker offered to support Robert to go for the homelessness assessment as this had still not taken place, he declined the offer stating he was waiting for further information regarding his benefits, it was agreed that he would meet the Springboard project worker on 2 January at Springboard to then go for the assessment. During this period he was supported to attend the GP surgery and he was prescribed morphine for pain relief, and the GP made a referral to the hospital using the ‘Choose and Book’ system.**

**On the 29 December, in discussion with Robert, the project staff became worried about Roberts increasing health concerns and physical needs, added to which the current arrangement for attending Springboard during the day would not be available over the weekend/bank holiday period.**

* + What is your assessment of the situation and what concerns and potential risks are there for Robert now?
  + What support/services would you offer Robert?
  + What agencies would you involve? Do you require any additional information at this stage to inform your conversations with other agencies?

*Notes:*

*The STARS project leader contacted the HBC out of hour’s service (on 29 December) requesting emergency accommodation for Robert due to the medical needs he was presenting and physical needs beyond what the STARS service could provide, and also stated that there were particular concerns for Robert over the*

*forthcoming weekend/bank holiday as there would be nowhere for Robert to go during the day.*

*After a number of phone calls the request for emergency accommodation was declined based upon – the (out of hours) warden believed the hospital had a duty of care; Robert’s benefits were from an address in Grimsby; for the last 6 months Robert’s had not had a fixed address in the Harrogate Borough area; no suitable accommodation was available in the (emergency) hostel due to the rooms being upstairs which Robert was unable to access. Therefore STARS agreed to accommodate Robert on a camp bed on the ground floor. At this point the warden also recorded that she had been informed that Robert was due to attend the hospital the following day and that STARS would contact the hospital and raise their concerns.*

# Would you have done anything different at this stage?

**PART 3**

**29 December - Robert slept overnight at STARS as planned. On 30 December, the STARS project leader agreed to follow up with the GP their concerns. It was agreed Robert would leave his morphine medication in a locked box at STARS as Robert was concerned about having it in his possession when out and about in the community. Robert attended a further GP appointment later in the day on the 30 December. At Roberts request the GP rang the STARS project leader and also rang the out of hours housing service and spoke to an Officer in this service. This was now a different organisation responsible for handling homelessness applications, to the one on the 29 December, due to it being a weekend and bank holiday. The GP re-enforced the view that STARS was not suitable for Robert due to Robert requiring somewhere to rest during the day.**

**At this point the Officer declined this request and this information was shared with the STARS project Officer.**

* + What would you do now and who would you involve?

*Notes:*

*The Project Officer sought further advice and the Homeless Project Manager*

*contacted North Yorkshire County Council’s emergency duty team (EDT) explaining the situation regarding Robert and requesting the possibility of admission into emergency residential accommodation or support from the rapid response team, and also enquired about the possibility of some day care provision due to the extended bank holiday. The Project Manager enquired as to whether Robert’s situation fell within the threshold for a safeguarding referral as a vulnerable adult. The EDT response was that they could not offer any assistance regarding a housing issue, that Robert’s age would preclude him from accessing residential provision and that the circumstances did not fulfil the criteria for a safeguarding referral. (Note - the SCIE guidance provides some very helpful advice regarding actions to take in the event of a referral not being accepted – Guidance for Housing Managers, pg 11).*

* + What learning is there here for out of hour’s teams, housing / social care etc. how do you ensure you receive sufficient information to decline a referral at this point?

# Further efforts were made by the homelessness project to secure accommodation for Robert from the out of hours housing officer, including an attempt to secure B&B for Robert, however this was without success. The STARS Project Manager advised the out of hours housing officer that their project would fund B&B accommodation for Robert over the weekend until the Springboard day service was open again on the 2 January. This meant Robert would have accommodation over the weekend during the day and that he would have somewhere to store and access his morphine medication. A hotel was found and Robert helped settle into the hotel. It was agreed Robert would attend STARS for his evening meal which Robert did on the 31 December. On the 1 December Robert did not attend for his evening meal, the STARS project leader telephone Robert who replied to the call stating he had been resting all day and would attend Springboard on the 2 January and also stay at STARS on the night of January 2 as planned.

**On 2 January the STARS project leader noticed Robert did not attend. Over the next few hours and on the 3, 4 and 5 January several attempts were made by STARS staff to contact Robert, by checking hospital A&E dept., ringing the hotel, contacting the GP and including contacting the police on the 3 January. On 6 January Robert was found dead in his room at the hotel by the hotel duty manager, his door was closed but not locked, there was a do not disturb sign on the door.**

Final points for consideration (use as applicable to each individual organisation):

* + At what points in this case do you think information could have been acted upon differently?
  + As an organisation receiving information: what questions do you need to ensure you ask to ensure you have as clear a picture as possible of the situation being described?
  + As an organisation providing an out of hours services: what methods of sharing information do you have internally and externally with other partners responsible for supporting and responding to the needs of vulnerable people?
  + As an organisation assessing an individual for services against a set of eligibility criteria (for example, homelessness/adult social care): How do you think your staff would have responded in this situation, what is the learning for you and your organisation?