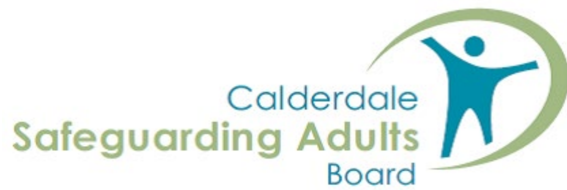

Burnt Bridges?

A Thematic Review of the deaths of five men on the streets of Halifax during Winter 2018/19

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Glossary

Adverse Childhood Experiences – these are stressful or traumatic events that children and young people can be exposed to. ACEs range from experiences that directly harm a child, such as physical, verbal or sexual abuse, and physical or emotional neglect, to those that affect the environments in which children grow up, such as parental separation, domestic violence, mental illness, alcohol abuse, drug use or imprisonment.

Analgesics – Pain relieving drug

Anticoagulants - medicines that help prevent blood clots

Attention Deficit Hyperactivity Disorder (ADHD) – brain disorder of ongoing patterns of inattention and/or hyperactivity-impulsivity that interferes with functioning or development.

Bacteraemia - the presence of bacteria in the blood.

Benzodiazepine – sedatives which slow down the body's functions and are used for both sleeping problems and anxiety

Bilateral Pneumonia – type of pneumonia that impacts on both lungs

Bi-Polar – mental health disorder that is characterised by extreme mood swings; these can range from extreme highs (mania) to extreme lows (depression).

Body Mass Index - The body mass index (BMI) is a measure that uses your height and weight to work out if your weight is healthy.

Buprenorphine /Subutex- opioid medication that is used to treat opioid addiction e.g. Heroin addiction.

Cellulitis - bacterial infection of the deeper layers of skin and the underlying tissue

Centile Chart - charts used to measure the pattern of growth of children.

Chronic Obstructive Pulmonary Disease - name for a group of lung conditions that cause breathing difficulties.

Claustrophobia - irrational fear of confined spaces

Clavicle Fracture - partial or complete break in the collar bone

Deep Vein Thrombosis - occurs when a blood clot forms in one or more of the deep veins in your body, usually in your legs

Depressive Disorder - mood disorder that causes a persistent feeling of sadness and loss of interest

Dual Diagnosis - condition of suffering from a mental illness and a comorbid substance abuse problem.

Dyslexia - A learning difficulty which affects skills involved in reading, spelling and writing

Emaciated – somebody who is abnormally / extremely thin or weak, especially because of illness or a lack of food.

Epilim - an anticonvulsant medication used to treat epilepsy in adults and children

Gangrene - a loss of blood supply causes body tissue to die. It can affect any part of the body but typically starts in the toes, feet, fingers and hands.

Group A Streptococcal - bacterium which can colonise in the throat, skin and anogenital tract. It causes a diverse range of skin, soft tissue and respiratory tract infections

Haematuria - the presence of blood in urine.

Haemoptysis - the coughing up of blood

Hepatitis B - A serious infection of the liver caused by hepatitis B virus

Hepatology – medical clinic for patients with a wide variety of liver diseases

Hindsight Bias / Outcome Bias – this is a perception of past events as having been more predictable than they actually were

Hyperlipidaemia - an abnormally high concentration of fats or lipids in the blood.

Hypoglycaemia - low blood glucose/ sugar

Hypoxia - decreased level of oxygen in all or part of the body, such as the brain.

Marfan Syndrome - A genetic disorder that affects connective tissues

Meningitis - infection of the protective membranes that surround the brain and spinal cord (meninges).

Methadone – opioid prescription drug used for both pain relief and also as a substitute for heroin in the treatment of heroin addiction.

Metoclopramide - used mostly for stomach and esophageal problems such as acid reflux but can also be used to treat migraine headaches.

Mirtazapine – antidepressant medication used to treat depression.

Motor Neurone Disease - rare condition that progressively damages parts of the nervous system which leads to muscle weakness.

Myotonic Dystrophy - long-term genetic disorder that affects muscle function. Symptoms include gradually worsening muscle loss and weakness. Muscles often contract and are unable to relax.

Naloxone - a drug that can temporarily reverse opioid overdose e.g. Heroin overdose.

Necrotising Fasciitis - serious bacterial infection that results in the death of the body's soft tissue

Non-Molestation Order – injunction to stop harassment from a partner or ex-partner

Olanzapine - antipsychotic drug used to treat mental health problems such as schizophrenia and bipolar disorder.

Ophthalmology – medical clinic for patients that need diagnosis and treatment of eye disorders

Pneumonia - swelling (inflammation) of the tissue in one or both lungs.

Pregabalin - anti-epileptic drug to treat seizures in adults and diabetic nerve pain

Promethazine – antihistamine used to treat allergy symptoms such as itching, runny nose, sneezing, itchy or watery eyes, hives, and itchy skin rashes

Psychoactive Drugs - a chemical substance that changes brain function and results in alterations in perception, mood, consciousness, cognition, or behavior.

Puerperal Sepsis - the condition of developing bacterial infection in women after childbirth or during breastfeeding.

Pulmonary Emboli - A condition in which a blood vessel in the lung(s) gets blocked by a blood clot.

Schizophrenia - A mental disorder characterised by delusions, hallucinations, disorganised speech and behaviour

Self-Neglect - behavioral condition in which an individual neglects to attend to their basic needs, such as personal hygiene, appropriate clothing, feeding, or tending appropriately to any medical conditions they have.

Sepsis - An infection of the blood stream which starts to damage the body's own tissues and organs. This can also be called **Septicaemia.**

Septic Arterial Embolism - bacterial infection that originates in the heart valves which can result in a small blood clot, which may travel to other parts of the body

Septic Arthritis - Inflammation of a joint due to bacterial infection.

Spontaneous Pneumothorax - A collapsed lung that occurs when air enters the space around lungs.

Staphylococcus Aureus Bacteraemia - a bacterium that is commonly found on human skin and lining of the nose without causing any harm. However, it can cause infection, particularly if there is an opportunity for the bacteria to enter the body.

Street Based Lives – this term has been used in this review to encompass all 5, who were involved in begging, street drinking, street-based drug use; as well as a range of housing and support needs.

Streptococcal Toxic Shock Syndrome – also known as **Toxic Shock Syndrome**, is a life-threatening illness caused by bacterial toxins. Symptoms may include fever, rash, skin peeling, and low blood pressure.

Tuberculosis - A contagious infection caused by bacteria that mainly affects the lungs but also can affect any other organ.

Warfarin - blood thinning medication used to treat and prevent blood clots that might result in heart attack, stroke, or death

Zopiclone - sleeping tablet used by adults who are suffering from insomnia.

1. Context

1.1. This report is a thematic review into the circumstances of the deaths of five men over a four-month period during winter 2018/19, who all lived street-based lifestyles in Halifax, three of whom died in the same week.

1.2. 'Burnt Bridges' was chosen as the title of this report as it was an idiom that was striking in the way in which it was used on numerous occasions by workers in both the practitioner meetings and in individual interviews, throughout the course of this review. It is an expression often used to describe how someone might intentionally set out to destroy their opportunities or reputation, and, in the case of the subjects of this review more specifically where someone has behaved offensively or not complied with rules, particularly in relation to their perceived ability to maintain a home.

1.3. Vision 2024 is Calderdale Council's vision for the future of the borough as it approaches its 50th year. It is based around three core themes that envision the council's services as distinctive, kind and resilient, and talented and enterprising.

1.4. Key aims of Vision 2024 include:

- The ability for someone to "realise your potential whoever you are, whether your voice has been heard or unheard in the past"
- That Calderdale is a "place defined by our innate kindness and resilience, by how our people care for each other, are able to recover from setbacks and are full of hope"
- That Calderdale is a "place to live a larger life"

This ethos underpins Calderdale's response to these deaths.

1.5. Historically, Halifax has not been the kind of town where someone might expect to see people homeless or begging, their tents and mattresses yards from Sainsbury's, but in common with other parts of the country, Halifax has seen a marked increase in its street population over recent years.

1.6. It is of concern to Calderdale Council that no system of alert was in place to monitor what led to the deaths of those living amongst the street-based population, to which this review makes reference, and that no one agency appeared to be aware of all the deaths, or with whom to share that information. Initial recognition of the significance of these deaths arose because of reports of a spate of drug-related deaths made by the drug and alcohol service, and subsequently the gravity of the situation emerged through informal discussions between Calderdale's public health team and the police.

1.7. This review looks both at the local systems and organisations, to better understand the complexities of 'street deaths' and what we can do to develop robust and effective

responses to meet the needs of this user group, using the resilient and kind workforce we have, to develop creative and imaginative solutions.

1.8. Whilst recognising that stopping people getting to the stage where living a street-based life is their only option is ultimately the key to preventing street deaths (such early stage prevention should be a national long-term goal, and is largely beyond the scope of this review), it is important to note that by the time the subjects of this review were in their twenties or thirties all had experience of long-established multiple disadvantage, and had faced some or all of the following:

- Living in a deprived area
- Poverty
- Poor education
- Unemployment
- Ill health
- Unhealthy family situations
- Adverse childhood experiences
- Complex trauma, either as a child or as an adult
- Loneliness and isolation

1.9. Addressing these root causes of multiple disadvantages would go some considerable way to improving the life-chances of those living a street-based life, just as effective early intervention for children and families is crucial for giving everyone, regardless of background, the opportunity of living a fulfilling life.

1.10. The complexities and challenges of 'dual diagnosis', whilst not a dominant theme in the cases reviewed, is a recurring issue in day to day work with similar cases in Calderdale, and is the condition of suffering from a mental illness and a comorbid drug or alcohol problem. The World Health Organization defines the term as "the co-occurrence in the same individual of a psychoactive substance use disorder and another psychiatric disorder", whereas the UK National Institute for Health and Care Excellence (NICE) refers to "young people and adults with *severe* mental illness who misuse substances". Whilst there is considerable debate surrounding the appropriateness of using a single category for a heterogeneous group of individuals with complex needs, it is clear that diagnosing a primary psychiatric illness in substance users is challenging, as drug use itself may induce psychiatric symptoms, thus making it necessary to differentiate between substance induced and pre-existing mental illness.

1.11. Nationally analysis is being undertaken to determine whether the variations over time in deaths of homeless people relate to weather, or to other factors such as the availability and purity of opiates, which may lead to unexpected drug poisonings. The opening of temporary homeless shelters and services in winter may have a protective effect. In the cases outlined in this review, the temperatures during the week in which most of the deaths occurred was between -1 and 10 degrees during that week.

2. Methodology

2.1. Terms of Reference

2.1.1. The Care Act 2014 provides a legal framework to protect adults at risk of abuse or neglect. Roles, responsibilities and accountability are set out and include guidance on the principles which should underpin all work in adult safeguarding. Under the Act, Safeguarding Adults Boards (SABs) are responsible for Safeguarding Adults Reviews (SARs), but the five subjects of this review did not meet the criteria for a SAR, because it was not known or suspected whether the individuals involved were abused or neglected. It was, however, decided that the Calderdale Safeguarding Adult Board (SAB) would undertake a Thematic Review following the Care Act Section 44.4 of the Act
"A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs)"

2.1.2. It was agreed that this review would not set a precedent for undertaking reviews of deaths of people who have lived street-based lives.

2.1.3. The Terms of Reference for this thematic review outline the lines of enquiry, the methodology and how the Calderdale SAB will determine whether the review has been completed satisfactorily. In addition, those terms outline the tasks needed to be undertaken by the Calderdale SAB SAR Panel and the SAB SAR Subgroup.

2.1.4. This review focuses on events that took place between July 16th, 2018 and January 16th, 2019 which is the six months prior to the tragic deaths of these men. It was agreed by the SAB SAR Subgroup to allow six months of chronology for each person. The rationale for this was that this would enable consideration of the life of each of the men in detail, without it being overbearing for agencies required to complete all five chronologies.

2.2. Purpose of the Thematic Review

- To establish the facts pertaining to the deaths.

- Establish whether there are lessons to be learnt from the circumstances of the cases about the way in which local professionals and agencies (or any other person involved in the care of an adult) work together to safeguard adults.
- Review the effectiveness of local procedures and guidance (both multi-agency and those of individual organisations).
- Inform and improve local interagency practice and commissioning arrangements.
- Improve the multi-agency response to people who live street-based lives by acting on learning and developing best practice.
- Bring together and analyse the findings of reports from other areas to make recommendations for future action.
- Make use of relevant research and case evidence to inform the findings.
- Understand what can be done differently as a system to reduce the risk of deaths occurring in the future.

2.3. Specific areas to focus on and key areas to be analysed

- What local policies and procedures are in place to work with people who live street-based lives.
- Whether policies and procedures were followed and the extent to which these were appropriate or had a positive effect on the lives of these men.
- Whether services are in place to support people who experience significant or traumatic life events.
- How the vulnerability of people who live street-based lives influences services, professionals and the general public's attitudes and whether their vulnerabilities are recognised and acted upon.
- How effectively agencies worked together, shared information and responded in a coordinated way at key points.
- How risks were identified, assessed, managed and responded to (including timeliness).
- The lessons for service delivery around engagement and accessibility of appointments, services, and the use of communications technology.
- What, if anything, prevented action being taken earlier, and what can be done to overcome this.
- Identification of gaps in services and resources.

2.4 Chair and Author of the SAR

1.1.1. Julia Caldwell, Calderdale Safeguarding Children & Adults Partnership Manager, is the Chairperson for this SAR, and has not been involved in the delivery of identified services, nor any line management responsibilities for any service or individual mentioned in the report. Julia has been involved as an independent overseer for Safeguarding Adults Reviews, Serious Case Reviews, Learning Lessons Reviews and Local Learning Reviews for over five years.

1.1.2. Niamh Cullen is the Public Health Manager for Alcohol and Drugs for Calderdale Council. Niamh has over 30 years' experience working with this client group in a variety of settings and roles, providing the knowledge, skills and experience to undertake the role of lead reviewer in this Thematic Review. Niamh worked in collaboration with the SAR panel members, the SAB Independent Chair, Ged McManus, and drawing upon the knowledge of experts from National Agencies.

2.5 Quality Assurance

2.5.1 The SAR will be quality-assured through a multiagency SAR Panel, the SAR Subgroup and the Independent Chair of the Safeguarding Adults Board.

2.5.2 Local Authority Legal Services will check that the report has been undertaken appropriately and with consideration given to any parallel process and that it is fit for publication.

2.5.3 In addition, the SAB will seek independent scrutiny from experts in the field prior to making decisions about recommendations.

2.5.4 'Hindsight bias' and 'outcome bias' will be recognised and reduced by using analysis that examines why decisions were made and what actions were taken at the time.

2.5.5 The Calderdale Safeguarding Adults Board will approve the final draft of the SAR prior to publication.

2.6 Membership of the SAR Panel

Julia Caldwell, Chairperson, Calderdale SAB

Niamh Cullen, Lead Reviewer, Calderdale Public Health

Heidi Wilson, Strategic Housing Delivery Manager, Calderdale MBC

Adrian Waugh/Helen Madden, Police Partnership Leads, West Yorkshire Police

Lorraine Andrew/Libby Smith, Service Manager, Adults Social Care, Calderdale MBC

Emma Cox, Assistant Director of Nursing, Quality and Professions, Prevent Lead, South West Yorkshire Partnership NHS Foundation Trust

Sue Brook / Luke Turnbull, Deputy / Designated Nurse Safeguarding Adults, NHS Calderdale CCG

Cath Miller, Team Manager, Housing Options Services, Calderdale CMBC

Vicky Thersby, Head of Safeguarding, Calderdale and Huddersfield NHS Foundation Trust

Janette Pearce, Head of Service, Together Housing Association

Oliver Crosland, Community Safety Partnership Officer, Calderdale CMBC

Emily Todd, Area Director, Recovery Steps

2.7 Approach

2.7.1 The ChronoLator tool was initially used in this review to summarise events by agency and date, and to merge all agency's chronologies, thereby making it possible to produce a single chronology to review interactions between different agencies and organisations. Joint multiagency chronologies for each individual were used, together with further analysis, provided the basis for writing the terms of reference for this review and also to facilitate the learning events with front-line practitioners and managers.

2.7.2 Two separate learning events for practitioners and managers, who either worked with the men or who have experience of working with people who live street-based lives, were held.

2.7.3 The outcomes from those events included:

2.7.4 Clarification of the case records which allowed the lead reviewer to understand the interventions and to develop hypotheses

2.7.5 Shared experiences of working with the men and contribution to the information provided by agency chronologies by understanding not just 'what happened' but 'why it happened'.

2.7.6 Contributions to discussions about what improvements in policy and practice are required.

2.7.7 Responses to the specific lines of enquiry identified by the Terms of Reference.

2.7.8 Agencies providing chronologies and contributing to the Learning Events:

a) West Yorkshire Police

b) Calderdale CCG (GPs)

c) Housing Options service

d) Christians Together (Winter Shelter Provider)

e) Adults Social Care

f) Calderdale and Huddersfield NHS Foundation trust

g) South West Yorkshire Partnership NHS Foundation Trust

h) Horton Housing

i) Together Housing

j) Yorkshire Ambulance Service

k) Humankind - Calderdale Recovery Steps (Drug and Alcohol Service)

l) Customer First

m) Calderdale Smart move

n) Department for Work and Pensions

o) Probation

2.7.9 In addition, met separately with individual professionals to gain more in-depth understanding. These included:

- The Winter Shelter staff
- Community Safety Wardens
- The Rough Sleeper Navigator
- The Street Reach outreach worker

2.7.10 The review author also interviewed the manager of McDonalds and the head of security at Sainsbury's supermarket, both of whom had known two of the men who died.

2.7.11 An expert-by-experience, who knew four of the men and had lived with one of them until his death was also interviewed during the review period.

2.7.12 Several informal discussions also took place in both the Winter Shelter and the local Breakfast Club with men currently living street-based lives, giving insights into their experiences in Halifax.

2.7.13 The Coroner's Office declined to share the details of any family contacts of the subjects reviewed, and it has therefore not been possible to incorporate the views of these men's families into the review.

2.7.14 In April 2020, new (short term) funding from central government, alongside growth monies from within the Local Authority, enabled Calderdale to develop services to respond

to those living street-based lives. Key new posts include a Rough Sleeper Navigator, whose role it is to undertake a mapping of rough sleepers and their needs with a focus on engaging services to meet their needs, and to provide increased capacity within the Street Reach Team to both engage and outreach rough sleepers and support them in tenancies when secured.

2.7.15 This increase in resource coupled with the review author working for Calderdale Council has provided the additional benefit of an element of 'action learning' during the review process. Live cases that have presented with similar difficulties to those of the subjects of this review have been followed, allowing care pathways to be tested and to support the both the review learning and the development of potential system-wide solutions. The review author has also been able to observe case meetings during the review period.

2.7.16 The Winter Shelter has been open during the review period, providing the review author with easy access to those living street-based lives in Calderdale to both sense-check and provide continuous feedback.

2.7.17 The review also involved an extensive review of the research and literature relating to the emerging themes, and information has additionally been gathered from regional and national forums and national organisations that are exemplars of good practice in this area.

2.7.18 It is important to acknowledge that both managers and frontline workers interviewed during the review were candid and conscious that the system was not currently effective in responding to the challenges presented by this user group.

2.8 Strategy for implementation of lessons learnt

2.8.1 The Board and its partners have several mechanisms to ensure satisfactory dissemination of the lessons learnt from this review, and across the safeguarding partnership there is a culture of continuous learning and improvement. This must be sustained and will be tested through regular monitoring and review, and the following are some examples of how the learning from this review will be promoted and embedded in practice:

- Training and briefings to professionals
- Newsletters, briefing papers and learning lessons for front-line practitioners
- Quality assurance through audit
- Performance management of indicators which outline practice improvements
- Publication on Calderdale Safeguarding Adult Board website

- Publication on the National Library of Safeguarding Adults Reviews
- Challenge events for front line practitioners to ensure the learning has been embedded.

2.9 Language and Terminology

2.9.1 Though homelessness is traditionally associated with rough sleeping, it is now accepted to be broader than that. Someone who has a roof over their head can still be homeless. The term now covers a spectrum of living situations notable by the absence of safety, security, and stability, including:

- people residing in temporary accommodation: night or winter shelters, hostels, B&Bs, women's refuges, and private or social housing
- 'statutory homeless': people who local authorities have a legal duty to secure a home for
- people sleeping rough: people who sleep (or bed down) in the open air, or in places not designed for human occupancy
- the 'hidden homeless': people dealing with their situation informally (staying with family and friends, 'couch-surfing' or 'squatting')

2.9.2 The subjects of this review were not all rough sleeping or seeking accommodation but were all living aspects of a street-based lifestyle, including begging, street drinking, street-based drug use. People leading street-based lives have a range of housing and support needs and are often vulnerable or contribute to the vulnerability of others. They are not always rough sleeping, although street activity can follow a period of rough sleeping. Leading a street-based life can also increase the risk of street homelessness for people who are in accommodation, especially for those who have substance misuse needs.

2.9.3 The Rough Sleepers Strategy (MHCLG, 2018) acknowledges that the relationship between rough sleeping and street-based lifestyles is complex. Addressing the needs of this group is therefore challenging and service responses may not be as fully developed as for other homelessness cohorts.

2.9.4 Whilst much of the literature referenced during this review used the terms 'rough sleepers' and 'homeless' to describe this client group, for the purpose of this review we understand those terms to encompass those living street-based lives.

3 The Legal context

3.4 The Homelessness Reduction Act (HRA)

3.4.1 This came into force in April 2018. The HRA places new legal duties on councils around homelessness and represents a significant change in how councils in England work with

single homeless people and with other local agencies to prevent homelessness and rough sleeping.

3.4.2 The key changes include:

- **Improving advice and information about homelessness and homelessness prevention to local people.** This includes meeting the specialist needs of groups such as care leavers, people leaving hospital or prison, ex-armed forces personnel, victims of domestic abuse and people with mental health problems.
- **Extension of the period 'threatened with homelessness' to 56 days.** Increasing the time councils have to carry out homelessness prevention work
- **Extension of prevention and relief of homelessness** assistance to all eligible applicants, including those not in priority need, or are intentionally homeless or who may lack a local connection to the area. Councils are expected to take 'reasonable steps' to help people secure accommodation for at least six months – which can be in a hostel or supported housing.
- **Assessing cases and agreeing a 'personal housing plan'** which reflects an applicant's full range of housing and support needs and sets out actions for them and for the council which will prevent or relieve their homelessness.
- **The duty to refer.** Since October 2018, certain public authorities, including prisons, hospital A&E departments and Jobcentre Plus have had a legal duty to refer individuals who have given their consent who they think may be homeless or threatened with homelessness within 56 days.

3.4.3 Historically it has been difficult for single homeless people to be accepted as a priority need, the Homeless Reduction Act now expects that local authorities work with individuals for longer, (56 days) in order to try prevent and/or relieve their homelessness before a priority need decision is made. For Local Authorities there are however concerns of increases in demand, the availability of suitable accommodation and the pressure new administrative demands place on frontline services (LGA 2019).

3.5 The Care Act (2014)

3.5.1 The Care Act (2014) created a single law for adult care and support that replaced various pieces of outdated and complex legislation and also brought adult safeguarding within the legislative framework. The Act sets out local authorities' duties in relation to assessing people's needs and their eligibility for publicly funded care.

3.5.2 The Act requires Councils with adult social care responsibilities to have a Safeguarding Adults Board (SAB) and it sets out a clear framework for how local authorities and other parts of the system should protect adults with care and support needs (as defined by the Act) who are at risk of abuse or neglect.

3.5.3 In the case of a death, if there is a safeguarding concern and if it is considered that abuse or neglect may have contributed to the death of a person deemed to have had care and support needs, the case is referred to a SAB for consideration. If the criteria are met,

including concerns about the quality of joint working between local agencies, a Safeguarding Adults Review (SAR) is carried out. The SAR seeks to learn lessons across the system to improve practice.

3.6 Mental Capacity Act (2005)

3.6.1 The Mental Capacity Act (MCA) has been in force since 2007 and applies to England and Wales. Its main purpose is to promote and safeguard decision-making within a legal framework by:

- Empowering people to make decisions for themselves wherever possible and protecting people who lack capacity by providing a flexible framework that places individuals at the heart of the decision-making process.
- Allowing people to plan for a time in the future when they might lack mental capacity.

3.6.2 The MCA is underpinned by five key principles:

- Presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
- Individuals should be supported to make their own decisions - a person must be given all practicable help before anyone treats them as not being able to make their own decisions.
- Unwise decisions - people have the right to make decisions that others might regard as unwise or eccentric.
- Best interests - anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.
- Less restrictive options - someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the person's rights and freedoms of action, or whether there is a need to decide to act at all. Any intervention should be weighed with due consideration given to the circumstances of the case.

3.6.3 Guidance commissioned by the Safeguarding Adults Board within the London Homeless Health Programme (2017) highlights that rough sleepers experience a range of risks which make them more vulnerable to harm and abuse. They also have significantly increased risk of organic and functional mental illness, substance use, acquired brain injury, autistic spectrum conditions, learning difficulties and some communicable diseases. Any of these conditions can contribute to behaviours which result in self-neglect. However, rough sleepers may refuse to accept help which would reduce significant risk to them, for example by accessing medical care or being removed from immediate danger.

3.6.4 The Rough Sleeping Strategy

3.6.5 The current national Rough Sleeping Strategy was published by Ministry of Housing, Communities and Local Government (MHCLG) in August 2018. The strategy confirms the

Government's commitment to end rough sleeping in England by 2027, with a vision based around the themes of *Prevent*, *Intervene* and *Recover*.

3.6.6 The strategy strongly promotes the principle of joint commissioning and service delivery at local and national levels. This includes local partnerships between housing and health services around hospital discharge arrangements and with housing, probation and community rehabilitation companies around work with ex-offenders. The aim is also that services will offer person-centred support which recognises an individual's needs and strengths, promotes individual choice and creates appropriate environments for helping to safeguard vulnerable people.

3.6.7 The strategy contains several specific commitments, including:

- *Somewhere Safe to Stay* pilots. These new services will rapidly assess the needs of people at risk of rough sleeping and support them to get the right help and accommodation. They follow on from the success of *No Second Night Out* and reflect evidence of the damage that rough sleeping causes to physical and mental health.
- Funding for rough sleeping 'navigators' - new specialists who will help rough sleepers with complex or multiple needs to access the appropriate local services, get off the streets and into settled accommodation.
- Pilots to support prison leavers to find sustainable accommodation.
- Mental health and substance misuse treatment: up to £2 million in health funding to enable access to health and support services for rough sleepers.
- New training for frontline staff to ensure they have the right skills to support rough sleepers, including clients under the influence of spice, victims of modern slavery or domestic abuse.
- Ensuring the deaths or incidents of serious harm of rough sleepers are rigorously investigated, where this is appropriate. This will include Government working with Safeguarding Adult Boards to ensure that Safeguarding Adult Reviews are carried out when a rough sleeper dies or is seriously harmed as a result of abuse or neglect (whether known or suspected) and there is concern that partner agencies could have worked more effectively to protect the adult(s) concerned. Lessons learned from these reviews will inform local systems and services improvements.
- Strengthening local homelessness strategies, with an emphasis on rough sleeping.

3.6.8 The strategy highlights the vulnerability of people living street-based lives and notes the need for closer working between voluntary sector organisations, community groups and local authorities to address the immediate and longer-term support needs of this group, to enable them to move away from street-based lifestyles. This may include working with people with lived experience to engage with service users who are refusing current interventions or support offers.

4 Prevalence

4.4 Calderdale rough sleeping figures are not increasing at the same rate as other areas of the England. The last data available from the Office for National Statistics (ONS) for 2018 show Calderdale to have the lowest number of rough sleepers in West Yorkshire. *Note:* Calderdale has the smallest population area in West Yorkshire.

4.5

	2016	2017	2018
Bradford	10	15	24
Kirklees	5	8	13
Leeds	20	28	33
Wakefield	7	7	9
Calderdale	6	6	5

*Street counts, evidence-based estimates informed by a spotlight street count of rough sleeping by LA.

4.6 It is important to note the relative lack of robustness of this data, given it is taken from a spot check at a single point in time. It should also be noted that it is considerably more difficult to undertake a spot check in a Local Authority which is rural or urban/rural and covers a broad geographical area. Finally, the data is based upon a definition of homelessness that only counts those sleeping on the street. These figures should therefore be regarded as less than perfect.

4.7 The ONS figures also show that 49 homeless people died in Yorkshire and the Humber during 2018, an increase of almost 60% in five years. Of those deaths, 40 were based on identified records, but, since the ONS describes its modeling method as providing a 'robust but conservative estimate', the real numbers may be higher.

4.8 New research from St Mungo's, entitled *Knocked back: Failing to support people sleeping rough with drug and alcohol problems is costing lives* (2020) examined the growing number of people sleeping rough who are living with, and dying of, preventable drug and alcohol problems. The research finds that drug and alcohol-related causes are the biggest killer of people sleeping rough or are in emergency accommodation, accounting for 380 out of 726 deaths in 2018. Deaths caused by drug poisoning have increased dramatically – by 55% in just one year (2017 - 2018). The report also estimated that 12,000 people sleeping rough, or at risk of doing so, missed out on life-saving drug and alcohol treatment in 2018/19. Of the five cases reviewed here, three were drug users not currently engaged in treatment.

4.9 Calderdale does not have a perceptible growing problem with people sleeping rough, but as this review has revealed one of the most significant findings is that these men had multiple and complex needs (MCN) or multiple disadvantage.

4.10 MCN is when a person experiences a combination of homelessness, addiction, re-offending behavior or mental ill-health at the same time. People facing this complex set of challenges are also sometimes victims of domestic abuse, are likely to have poor physical health, may be sex-working and may be in debt. This is discussed in more depth elsewhere in this report.

4.11 Understanding this brings into question the housing and public disorder lens through which homelessness and substance use problems have been traditionally viewed and challenges the lack of public responsibility for the conditions that leads to these problems. It also brings to the fore a key debate in the field of substance use - the validity of harm reduction not just as a mechanism to engage people who use drugs with treatment, but as a legitimate goal in itself.

4.12 We have some insight into the prevalence of MCN in Calderdale, having been one of the areas to benefit from The Big Lottery's West Yorkshire Finding Independence project (WY-FI). Since 2014, WY-FI has supported people in Calderdale who are experiencing entrenched, multiple needs in at least three of the following HARM areas:

- Homelessness
- Addiction to drugs or alcohol
- Reoffending
- Mental ill-health

4.13 They have also supported service users by using multiple needs navigators and specialist workers who have built trusting relationships over time and who are service neutral. Each service user receives person-centered support to achieve their hopes and aspirations. Workers have had low caseloads and the flexibility to provide input as it is required. The project comes to an end this year.

4.14 During the life of the project WY-FI has worked with 150 individuals (beneficiaries) in Calderdale, 55 of these women and six from a BAME background. Data from the project shown in the table below to demonstrate the multiple problems individuals presented with in Calderdale.

Calderdale Starting Harm Needs

HARM Need	Number	Percentage
Homelessness	109	74%
Addiction	140	95%
Reoffending	102	69%

Mental Health	142	97%

Frequency of Number of Needs

The table below shows the frequency and proportion of the number of needs of the Calderdale beneficiaries. 95% of Calderdale beneficiaries have three or four of the HARM needs. The remaining seven have at least one occurrence of Addiction and Mental Health needs, four have both.

Number of Needs	Count	Percentage
Four	67	44.7%
Three	76	50.7%
Two	6	4.0%
One	1	0.7%
Total	**150**	**100%**

5 Case Studies

This section will offer information on what we know about the lives of the five men, and details of the circumstances leading up to their deaths.

5.4 Peter

Context

5.4.1 On October 21st, 2018 West Yorkshire Police received a call from a member of the public who found the remains of a person near to the old railway lines, and officers and an ambulance were despatched. A wallet with £65 in cash was found with the body identifying Peter, together with a sleeping bag, fleece, a pair of glasses, a flask, and a Tupperware box.

5.4.2 Peter does not fit the profile of the other four individuals in this thematic review, who whilst all having individual narratives, have several themes in common with each other which are not all present in this case.

Family

5.4.3 In 2005 Peter and his partner self-referred to the Calderdale Learning Disability Team. They had a four-year-old child and were planning another and sought general support and help with parenting skills. Whilst they were willing to engage with the team, they were adamantly against engagement with Children's Services, but no detail of why is recorded. Engagement with the Learning Disability Team ended after parenting advice was given.

5.4.4 In a police statement taken from Peter's mother following his death in October 2018, she reported last seeing her son five or six years ago before he moved away with his partner. She believed they had subsequently separated three years later. She told police that he suffered from Myotonic Dystrophy, may have had a heart condition and that about

a month previously she had received a call from a Housing Officer from Customer First on her son's mobile phone. The caller asked if Peter could stay with her and, presuming that he could be accommodated elsewhere, she had declined, as she was at that time caring for her twelve-year-old grandson.

Mental Health

5.4.5 Peter's poor physical and mental health were inextricably linked. He self-reported loneliness, isolation and hopelessness to professionals during most contacts with them and was consistently described as in low mood and vulnerable by social workers and neighbours in records going back as far as 2005.

5.4.6 In 2002 his GP had communicated in a letter to a colleague that it was suspected that Peter may have low academic ability. Whilst it is recognised that low IQ is one of the presenting symptoms of Myotonic Dystrophy, Peter had not yet been formally diagnosed. In 2005 Peter was assessed as not having a learning disability which met the criteria at the time of the assessment, but some disability and difficulty was noted. There is also a reference of him being referred to psychology and mental health services in February 2008, but no further information exists regarding the outcome.

5.4.7 Peter reported having a 'low mood' to his GP again in August 2015 and no medication or therapeutic intervention was prescribed. In a social work visit later in 2015 he seemed depressed again but told the social worker that he had never been given anti-depressants and did not think that they would work. At that meeting he said he felt he had no life and had given up and that his physical condition was getting him down, but he requested help getting his life in order, especially his finances. It was suggested he have a home visit from his GP.

5.4.8 In the same month Peter's neighbour made a referral to Support at Home - a community social work practice team. His neighbour described him to the social worker as weighing 4 stones, not having changed his clothes or bathed for over a year, often not bothering to eat, living and sleeping in a chair, urinating in a jug and often saying that he wanted to die. At this time (2015) Peter was also in debt and being pursued by bailiffs. The neighbour was provided with the phone numbers for Shelter and for Christians Against Poverty, who could help with his debt and the imminent threat of seizure of his possessions by bailiffs. A referral was accepted by the Support at Home team and a case allocated. After the social worker visit, Peter was recorded as independently mobile but walking very slowly and being very thin. It was also recorded that his accommodation was a mess. The social worker contacted Peter's GP to request a home visit and recorded no further action for the social work team.

5.4.9 In August 2016 Peter was referred again to the community social work practice team by Pennine Housing (now known as Together Housing). They were concerned that he had been diagnosed with Myotonic Dystrophy, suffered from depression, and was struggling

with rent arrears. Peter was now living alone in a two-bedroom property so was also paying the Spare Room Subsidy ('Bedroom Tax') but was unwilling to move. They felt he had mental capacity to make this decision but was struggling with his mental wellbeing.

5.4.10 An unannounced home visit to Peter by a social worker in September 2016 found him still feeling low. Peter, fearing that his health problems were going to get considerably worse and that he would eventually require a wheelchair, explained that due to muscle wastage and the lack of strength and dexterity in his hands, he was not be able to use a standard wheelchair alone and that a motorised one would be 'expensive'. He again expressed feelings of isolation. The social worker noted that his flat was in a state of untidiness and significant uncleanliness and gave Peter her contact details, explaining that if he wished, he could contact her to arrange another visit.

5.4.11 During a further unannounced home visit in October 2016, a friend of Peter's answered the door. Peter declined to be seen but the social worker explained that if he wished to get in touch she would respond. Peter made no further contact, and, having no concerns about his mental capacity to make this decision, the case was closed on October 20th, 2016.

Physical Health

5.4.12 Peter had a long history of health problems and interventions. He was prescribed Metoclopramide in 2000 when presenting with epigastric pain that had lasted over 18 months, and he was concerned about his low weight and raised this several times with different health professionals. His BMI (Body Mass Index) was recorded in hospital in 2004 as 15.4, which is extremely low, and his GP described him as 'emaciated' with no muscle bulk in 2005. He was referred to a dietician in 2002 and again in 2006 but failed to attend either appointment. Neither missed appointment was followed up.

5.4.13 Peter suffered a Spontaneous Pneumothorax in July 2004 and Haemoptysis in November 2004. This followed an earlier lung function test in November 2003 which was recorded as 'poor', and his history of 'tiredness and breathlessness' was also noted.

5.4.14 He received a diagnosis of Marfan Syndrome in June 2002. He however failed to attend further tests to confirm the diagnosis, which was in 2005 re-evaluated as Myotonic Dystrophy. Peter's mother had been previously tested and found not to have the condition, but both his sister and his nephew did.

5.4.15 Myotonic Dystrophy is a long-term genetic disorder that affects muscle function. Symptoms include gradually worsening muscle loss and weakness. Muscles often contract and are unable to relax. Other symptoms may include cataracts, intellectual disability (defined as having an IQ under 70), poor pulmonary function and heart conduction problems.

5.4.16 After diagnosis, Peter was placed under the care of the Genetics Department at the Leeds Teaching Hospitals NHS Trust, and attended appointments between 2006 and 2010 where he underwent nerve conduction studies (Electromyography) in connection with his diagnosis. He was also referred to the Ophthalmology department in 2006 but failed to attend the appointment.

5.4.17 There is a record of a telephone conversation with a district nurse in 2015 but no record of why the nurse was visiting or any outcome of that visit. During the review CHFT confirmed that this was for a blood test only and that he had not been taken on to the community nursing caseload. This was ordered by the GP and information of the no access visit passed back to the GP by the District Nurse.

5.4.18 A Myotonic Dystrophy Alert card was found in Peter's wallet when his body was found.

Substance Misuse

5.4.19 Peter was not on any medication at the time of his death. Whilst it is evident that he had a chronic illness which impacted on his physical health in a number of ways, including his low mood and the 'multiple musculoskeletal aches and pains' he reported to his GP, he did not misuse prescribed medication, but, during a home visit a social worker noticed that he had cannabis in his possession, which he said he smoked around twice a day.

Criminal Justice

5.4.20 There are only two police records relating to Peter; a 1993 caution for shoplifting at Woolworths in Halifax and a domestic abuse incident at his address in Todmorden in 2001, for which no other details are known.

Homelessness

5.4.21 Peter's GP record indicates that he had been in stable housing for 16 years from 2002 until just a month before his death. During this period, he resided at only two addresses. The first, was where he lived continuously until 2009, after which he moved into his final address on the same street. He lived at this property for nine years, until evicted in September 2018.

5.4.22 A Suspended Possession court order was made against Peter in 2013 for a debt of £896.38, and though during the following years he was in breach of the order several times, the debt since 2016 had been slowly reducing with a combination of housing benefit, enforced deductions and additional payments made by Peter. He was also adversely affected by the 'bedroom tax', and had his housing benefit reduced, but he had managed to pay the difference himself.

5.4.23 In January 2018 the Calderdale Council Tax department received notification via the National Fraud Initiative data matching exercise that someone else had been living with Peter since April 2017. A letter was sent to Peter on January 9th 2018 to establish the facts,

and he was advised that if no response was received within two weeks that his award of housing benefit and his council tax single occupant rebate would be cancelled back to April 2017. On September 20th2018, Customer First recorded that Peter could not read or write, when trying to find him accommodation.

5.4.24 On February 4th, 2018, Peter's housing benefit was stopped and the debt at that point was £241.97. Peter's claim was cancelled retrospectively to April 3rd, 2017, leaving him with a housing benefit overpayment of £4,000. Despite repeated attempts to contact and discuss the overpayment Peter did not engage or make contact, and the Council Tax department, receiving no response from him, cancelled the single person discount on his council tax bill. There is no record of any further direct contact from Peter with the Council Tax department regarding his situation after this date.

5.4.25 Further attempts to contact Peter were made in connection with his housing benefit over-payment during the following six-month period, but he failed to engage and did not answer his phone or respond to door knocks, nor to information that was left. An interview prior to eviction was set for June 8th, 2018, by which time the debt was £2095.37, to which Peter did not attend.

5.4.26 Peter's eviction was set by the courts for September 19th, 2018. He was at the property for the eviction and the neighbourhood housing officer discussed his situation with him and referred him to the Housing Options team at Calderdale Council.

5.4.27 On September 20th, 2018, Peter called the housing office to discuss clearing his belongings from the property. On the afternoon of the same day, police called the neighbourhood officer expressing concern for him after finding him out in the rain with nowhere to go. Peter was given the details for Housing Options again, although he had already booked an appointment for September 25th, 2018.

5.4.28 On the September 24th, 2018 a Customer First advisor contacted the Community Social Work Practice (CSWP) team informing them of Peter's eviction, as she was concerned about his health and felt he needed help. Peter had been signposted to Smartmove to get a sleeping bag. Customer First arranged an appointment with Peter for Wednesday 26th September at 10:20am. CSWP team records do not confirm whether he attended, but this may be due to General Data Protection Regulation (GDPR) compliance requirements, since names are not taken if not required.

5.4.29 Street Reach (a rough sleepers' outreach service) were alerted about Peter but were unable to locate him. When his body was found it was not in an area easily located or known to be frequented by rough sleepers.

Benefits and Income

5.4.30 GP records indicate that Peter was in full time work at a recycling plant in June 2002 for two months until August of that year. The record shows that he struggled to work due

to his tiredness and breathlessness, which had persisted for 18 months. Despite his diagnosis of Myotonic Dystrophy and the effect this was having on his physical health, he was recorded by DWP as being fit for light work and was receiving Jobseekers Allowance in 2009 and 2010. Records do not indicate whether Peter was working or claiming benefits between 2002 and 2009, although it is known that Peter's GP issued a 'not fit for work' note to him due to his Myotonic Dystrophy in 2010.

5.4.31 There is no record of Peter being registered with DWP for Universal Credit or entered onto the DWP Labour Market System.

Analysis

5.4.32 It is clear from the GP records that Peter had a progressive illness that was having a major impact on his health and wellbeing. Self-neglect is noted in numerous records. The last time the Peter saw his GP in August 2018, he reported 'not being bothered about eating, self-care or going out'.

5.4.33 Although there was concern that Peter may have had low IQ or an undiagnosed learning disability there is no information to either support or dispute that this was the case, until Customer First recorded his inability to read or write post eviction.

5.4.34 Records show that Peter on several occasions disclosed feelings of isolation and loneliness to both medical and social work professionals, but that no interventions or referrals relating to this were recorded.

5.4.35 The GP clinical record available to view on the electronic system is sparse and the recorded communication between other services which appear to have been involved (including the District Nursing Service, Health Visiting Service, Psychology & Counselling service) is minimal.

5.4.36 It was only when Peter attended Customer First in September 2018 as homeless, post eviction, that we learn more of his needs:

- that he had difficulty walking for any distance
- that he was not on any medication, or under a consultant and had no on-going appointments for his health condition
- that he had not tried to resolve his housing issues or find a new home as he did not know how to approach the task (his ex-partner had always dealt with such matters)
- that he could not read or write or email to enable on-going contact

5.4.37 It is of concern that there was no record of Peter's health needs held by his social housing provider, which, if recorded and shared, may have prevented the eviction.

5.4.38 The fact that Peter had consistently held a tenancy for 17 years and then had died within a month of being made homeless suggests that he lacked the resources to survive without accommodation.

5.4.39 The sparse information available and the crisis that occurred on the date of eviction indicate that services may have failed to work together to support this vulnerable individual. Further information would need to be obtained to assess whether this was indeed a factor.

5.5 Jason

Context

5.5.1 On January 13th, 2019 Jason was taken to Calderdale Accident and Emergency Department by ambulance where he described having had an anxiety attack and complained of chest pains radiating to his arm. He was hyperventilating at triage and stated that he had been unwell for the previous three to four days. Jason was admitted to a ward after a period of assessment. He was diagnosed with bilateral pneumonia and possible septicaemia. He died the following day.

Family

5.5.2 Jason was a pre-term baby delivered to a diabetic mother who had not received ante-natal care. He was a large baby who suffered hypoxia and hypoglycaemia at birth and required incubation.

5.5.3 Following discharge, Jason 'failed to thrive', dropping from the 95th centile to the 3rd, and was readmitted to hospital. As a child, Jason displayed behavioural problems at school and when he was nine years old was seen by a social worker for family therapy.

5.5.4 Jason disclosed in 2008 that his sister was a 'working girl', and that it was her who gave him heroin for the first time, when he was 12 years old. Jason described his mother as being aware of this but being 'unable to do anything about it'. At age 13 Jason was referred for anger management sessions, and he told his GP in 2008 that he did not attend school as a child and that his mother had little control over him. Clinical records indicate that he punched a boxing bag and required sutures in 2001, aged 18.

5.5.5 Jason described himself as having undiagnosed Attention Deficit Hyperactivity Disorder (ADHD) and Dyslexia.

5.5.6 He was first registered with a GP in Halifax in 2006, aged 23, when he moved from Luton to live with his father in Halifax. His mother had died two years previously.

5.5.7 Jason told his probation officer that his parents separated when he was 12 years old, which had had a profound effect on him, and that his older stepsister had a criminal record and had introduced him to crack cocaine. He had whilst he was on remand been dependant on his mother, until her death, and he had struggled coming to terms with this. He blamed his father, who died in 2017, for his offending, stating that he was not supportive and did not provide him with accommodation.

5.5.8 Jason was single with no children; his last serious relationship having ended in 2003. His sister was recorded as next of kin.

Mental Health

5.5.9 Jason struggled with poor mental health. He told his GP in 2013 that he had felt depressed since his mother had died young, nine years previously. He described having suicidal thoughts every morning but had no plans to act on this, and that he had poor appetite and wanted to sleep all the time.

5.5.10 He was diagnosed with depression in April 2015 and given a 'not fit to work' doctor's note. He was prescribed Mirtazapine for low mood between January 2015 and July 2018.

5.5.11 In January 2018 he again reported to his GP little interest or pleasure in doing things, worrying and feeling hopeless. A PHQ-9 (Patient Health Questionnaire) score was conducted and the GP recorded that both this and the GAD-7 (Generalised Anxiety Disorder Questionnaire) score had deteriorated since last undertaken.

5.5.12 Warning markers on police systems flagged Jason for self-harm, mental ill health, crack cocaine, heroin and alcohol misuse. Additional police records stated that Jason suffered from depression and schizophrenia (GP and SWYFPT records indicate no formal diagnosis of Schizophrenia) but that he had not been prescribed any medication, and that an incident of self-harm by hanging took place in 2005. The Probation Service also recorded that he suffered with anxiety and depression.

Physical Health

5.5.13 Jason was diagnosed Hepatitis-C positive in August 2017, Hepatitis C is a virus that can infect the liver. If left untreated, it can cause serious and potentially life-threatening damage to the liver over many years. Jason never kept his hepatology appointments.

5.5.14 On July 1st, 2018, Jason attended a GP appointment for a 'not fit to work' note and for repeat depression medication. He also requested food supplements but was not given them. He was described as 'unkempt' at this consultation and advised to contact the drug treatment service and to request a hepatology review.

5.5.15 On the August 16th, 2018 Jason was 18 minutes late for a 9.20am GP appointment. He was not seen and was advised to try and secure an emergency appointment by phone later in the day. He did not have a phone. Jason returned to the surgery at 10am to book an appointment for later in the week and explained that he was homeless and had slept at a friend's house some distance away, which was why he was late. After Jason left the surgery, the receptionist followed him to give him an appointment for the following day, but he did not hear her calling after him. Reception staff were advised to give Jason an appointment if he came back, but he never returned to the practice.

5.5.16 Calderdale and Huddersfield Foundation Trust (CHFT) undertook an investigation, as Jason's death was unexpected. It was found that there had been a delay in recognising his sepsis and in treatment in the Accident and Emergency department. The evidence presented to the investigation demonstrated no clear discrimination because he was a

drug user, staff were clinically treating the presenting symptoms of severe withdrawal, which overshadowed the signs of sepsis.

Substance Misuse

5.5.17 Jason had been addicted to both heroin and crack cocaine since his early teens, using heroin daily and spending £40 a day. In 2006 when he moved to Halifax, he reported to his GP that his alcohol consumption was over 100 units a week.

5.5.18 Between 2008 and 2015, Jason was prescribed substitute opioid prescriptions (Methadone or Buprenorphine), both during custodial sentences and whilst in the community, and there is a record of him being issued with Naloxone in June 2017. His last episode of treatment was on prison release in December 2017 and he last attended the local drug treatment service on January 26th, 2018.

5.5.19 Despite being long known to treatment services, his engagement was chaotic. He frequently dropped off his prescription and continued to provide positive drug tests. Interventions were primarily criminal justice focused.

Criminal Justice

5.5.20 Jason's first recorded involvement with the criminal justice system was on March 21st, 1996, when he was cautioned for being carried in a vehicle taken without consent. By the time of his death, he had 61 Police National Computer (PNC) records, and in 2004, at Luton Crown Court, he had received a three-year sentence for robbery. The remainder of his offences were related to shoplifting, criminal damage, non-compliance with court orders, begging, possessing heroin, and drunk and disorderly behaviour. These lesser infractions resulted either in community orders or in short periods of imprisonment and records indicate that Jason usually failed to comply with his sentence requirements in respect of drug treatment.

5.5.21 Jason had been supervised by the National Probation Service since 2004 and was also supervised by West Yorkshire Community Rehabilitation Company (CRC) on three occasions.

Assaults

- May 2007: Accident & Emergency attendance due to assault (multiple injuries including fracture)

- September 2013: Stab wound to neck – attended Bradford Accident & Emergency

- April 2014: Accident & Emergency attendance due to an assault to the face with keys, resulting in a broken tooth and black eye. Jason returned to hospital the same night due to a further assault after he had been kicked in head.

Homelessness

5.5.22 When Jason was last released from prison in December 2017 he had nowhere to go - his father, who he used to stay with, having died just before Jason's imprisonment. He approached a local supported housing project that works with offenders and was accepted into their recovery-focused supported housing. Within three weeks Jason received his first written warning for using heroin. He also struggled to comply with house rules that included providing negative drugs tests.

5.5.23 Jason was finally evicted from supported accommodation on February 15th, 2018. The supported housing provider stated that he was encouraged to stay and try to complete the programme, but that he had decided that he wanted to continue to use heroin and was not ready to stop.

5.5.24 Over the next year, local agencies who work directly on the streets, outreach workers, the police and community safety wardens all became aware of Jason because of his town centre begging. Community safety wardens took Jason to Customer First and to the Winter Shelter. Jason reported that he was rough sleeping, and this was reported to the outreach Service to enable them to verify him as a rough sleeper, so that he could access support and accommodation. Between August 2018 and January 2019, despite several attempts, the outreach team had been unable to find Jason to verify him. Jason spent two short periods in the Winter Shelter; the last being in December 2018, when he was evicted for aggressive behaviour.

Benefits and income

5.5.25 Jason claimed Universal Credit from December 13th, 2017 and was placed in the 'all work-related requirements' group. In March 2018, He accepted his claimant commitment to attend and take part in appointments with a 'work coach' when required. In October of that year he was notified by the benefits journal system to attend an appointment later that month. He did not attend and was asked via the journal to give his reasons. He did not respond and his claim to Universal Credit was subsequently closed on January 13th, 2019. Subsequently, Jason told his Probation Officer that he was without money and that he had resorted to acquisitive crime to fund his addiction and was using food banks to feed himself.

Analysis

5.5.26 Jason spent many years in regular contact with both the probation and drug treatment services, yet nothing seemed to change for him. There is no evidence of any therapeutic engagement with his key workers.

5.5.27 His records in the drug treatment service indicate no record of his struggles with his mental health, though this may have been due to his lack of communication. Despite his history of reporting depression and low mood he did not appear to have been signposted or referred to specialist support.

5.5.28 Jason had neither a phone nor access to a computer. This impacted on his ability to make appointments or to seek information, as is demonstrated in his lack of contact with DWP, which resulted in his Universal Credit claim being closed, and in his difficulty in making GP appointments, though when he was late for his GP appointment in August 2018 and was initially turned away, the General Practice considered the difficulties he faced without a home address or phone and the receptionist tried to call him back in an attempt to respond to his needs.

5.5.29 It also seems that the process to verify Jason as a rough sleeper, and therefore enable support in accessing housing, was delayed due to difficulties finding him, despite reports of his location from several agencies.

5.5.30 Jason is last recorded as being issued with Naloxone in June 2017. There is no record of it having been issued to him after that date, despite his release from prison in December 2017 when he would have been vulnerable to overdose. The Naloxone should have been available from the local drug and alcohol service.

5.6 Lenny

Context

5.6.1 Lenny was found dead in January 2019 outside a retail outlet in Halifax. He was suspected of having overdosed.

Family

5.6.2 Very little has been learnt from agency records, but there are some references to significant relationships. His father appeared to have provided him with support over several years, on occasion providing accommodation on Lenny's discharge from prison. There are also references to Lenny having worked with his father in 2004 and in 2007, and to his father's death. An uncle, who Lenny described as being like a father to him, died in July 2018 of Motor Neurone Disease.

5.6.3 Lenny's relationship with his wife and children included long periods of separation and incidents of domestic abuse, which included an injunction being in place until 2017. In July 2018, records suggested that he was living at his wife's address, which was his final known address. The couple had three children, now aged seven, nine and ten. There are also references to his "partner", but it is unclear in the records whether reference is being made to his wife or to another relationship.

Mental Health

5.6.4 Lenny had a history of mental health problems. A diagnosis of Depressive Disorder was recorded on GP records in 2000 and again in 2007, and he had been detained under section 136 of the Mental Health Act in 2014. Police records stated that he was Bi-Polar and had a history of self-harm and depression, but this is not supported by a clinical

diagnosis, no significant mental health risk was identified by the Specialist Drug Treatment service.

5.6.5 There are three records of Lenny being seen by the South West Yorkshire Foundation Partnership Trust (SWYFPT) Mental Health Liaison Team in A&E, two being on two consecutive days, in July 2018. On all occasions he was signposted to Substance Misuse Services and his GP. On the 23rd July 2018 he consented to an assessment by the mental health liaison team who felt that his engagement was an attempt to obtain further prescribed pain relief and signposted him Substance Misuse Services and his GP.

5.6.6 In 2017 an appointment was offered (in writing) by Improving Access to Psychological Therapies (IAPT), but Lenny did not respond (if he received the letter).

5.6.7 Lenny self-reported ADHD as a child to his GP.

Physical Health

5.6.8 Lenny had a range of physical health issues. He reported that his leg had been crushed in a motorbike accident in the past and that he had sciatic nerve damage from a stabbing injury when 16 years old.

5.6.9 There are records of bi-lateral lower limb fractures after base jumping from North Bridge in 2014, a clavicle fracture caused by a fall in 2016 and further record of a fractured sternum.

5.6.10 In 2016, a BISI (Brain Injury Screening Index) undertaken at HMP Leeds concluded that he had mild Traumatic Brain Injury.

5.6.11 GP records show presentations for chronic pain, chest infections and possible epilepsy. Although prescribed Epilim, he was never seen by a neurologist. NICE guidance (2004) states that the diagnosis of epilepsy in adults should be established by a specialist medical practitioner with training and expertise in epilepsy and that where it is not possible to make a definite diagnosis of epilepsy and if the diagnosis cannot be clearly established, further investigations and/or referral to a tertiary epilepsy specialist should be undertaken.

Substance Misuse

5.6.12 Lenny's dependence on opiates was recorded first in 2002 when he was 24 years old. There was some reduction in substance use during custodial sentences but for most of the last 16 years of his life he was accessing substance misuse treatment either via his GP or through specialist services. He consistently used illicit drugs alongside prescribed substitutes and there were also periods of alcohol abuse. He had a history of overdosing but there is little evidence of engagement with the specialist treatment services. He was recorded as being challenging towards clinicians and they had him marked as having a history of domestic abuse. His attendance rate in drug treatment was 40%.

5.6.13 In July 2018 Lenny reported to the local drug treatment service that following a dispute he was unable to access prescriptions from his partner's house and was told he would not be able to restart treatment until he returned the prescriptions. He rang the service a fortnight later and was told that they were following the 'lost prescription policy'. Lenny did not represent until mid-November 2018, by which time his case had been closed. He had to start the process again and was screened but told he needed to attend a Choices group (a one-off information and motivational group) before a full assessment. He did attend the group but was too intoxicated to participate.

5.6.14 Whilst Lenny is recorded as being offered and refusing Naloxone in 2017, there is no other evidence of explicit harm reduction interventions.

Assaults

5.6.15 Lenny was the victim of several assaults. He disclosed he was stabbed in the leg at the age of 16. In 2015 he was admitted to A&E after being assaulted with a baseball bat and hammer. He had been hit across his knees and head and was vomiting.

5.6.16 In May 2016, he disclosed a traumatic event whilst in prison to his drug treatment worker but gave no detail. There is a separate referral to a Sexual Assault Referral Centre (SARC) in November 2017 in which a serious sexual assault by a male, alleged to have taken place two days previously by a known assailant, was recorded.

5.6.17 In October 2018 he attended A&E with a head injury after being assaulted with a bottle by his partner.

Criminal Justice

5.6.18 Lenny had 57 Police National Computer (PNC) records, his first being for theft in 1992. His offending appears to have been largely acquisitive crime relating to drugs use. His GP records refer to several short custodial sentences.

5.6.19 Lenny had a Community Order with electronic monitoring at the time of his death, but there was no Community Rehabilitation Company (CRC) or National Probation Service (NPS) involvement.

Domestic Abuse

5.6.20 Records show that Lenny's relationships with both his wife and more latterly his partner were volatile.

5.6.21 A non-molestation order was in place from August 2013 preventing Lenny from residing at the family home, but by January 2014 it appears that the couple had resumed their relationship. In July 2014, following a police callout because of his erratic behaviour, a breach of the order was discovered, and he was arrested. In 2014 a GP record stated that he had argued with his wife who had locked him out of the family home and that he had been unable to get his medication.

5.6.22 In April 2015 an incident at the family home where he was still living with his wife and children was recorded. It is also recorded that his wife spent two months in a refuge around this time. A Multi Agency Risk Assessment Conference (MARAC) referral was made at this time.

5.6.23 In July 2018, a neighbour reported a fight occurring at the family home address. All parties were drunk and no prosecution or any further action was taken. Referrals were subsequently made by the Safeguarding Unit clerk to Early Intervention and to Children's Health.

5.6.24 In October 2018, Lenny attended the police station to report that he had been again assaulted by his partner. He had returned home to find her drunk and she had hit him on the head and in the face with a whisky bottle, causing cuts to his nose and the loss of two teeth. A domestic abuse assault crime was recorded and a Domestic Abuse, Stalking and Honour (DASH) risk assessment was completed on November 15th, 2018. The risk level was recorded as "Standard". Referrals were again made to Early Intervention and to Children's Health in December 2018.

Housing and Homelessness

5.6.25 Lenny was never recorded as being of no fixed abode in his GP records although he did move often, his longest recorded period at one address being 26 months. There were however several addresses that he returned to over the years, which are thought to be those of his relatives or partner.

5.6.26 He is only recorded as having had his own tenancy once, commencing in May 2016 following discharge from prison. He last used this address in July 2018. After this and until the time of his death he used his partner's mother's home address.

5.6.27 He was known as a street beggar in Halifax town centre. The No Second Night Out Service (NSNO) spoke to him several times. He told them he was rough sleeping but would not confirm his location, so they were unable to verify his rough sleeping status that would trigger access to accommodation.

5.6.28 Lenny had accessed the Cold Weather Shelter in the days before his death but was evicted due to drug use on the premises.

Benefits and Income

5.6.29 Lenny referred to undertaking casual work and whilst there was no claim registered to Universal Credit, he did have an active Employment Support Allowance claim at the time of his death.

Analysis

5.6.30 Lenny had a history of drug overdoses and it is known that he was admitted to A&E following a heroin overdose in October 2018. It is also recorded that he was offered

Naloxone in 2017, but that he refused. There is no record of him being offered it again, nor is there any record of harm reduction interventions when he was without a prescription, either at appointments or when he dropped into the service.

5.6.31 Regarding the impact that adherence to the 'lost prescription policy' had on Lenny, it is worth noting that the Lost Prescriptions Policy states that:

*"All new Service Users into treatment should be advised that there is a **no replacement policy** for both lost prescriptions and medication"*

Applying this policy rigidly may have precipitated Lenny's fall out of treatment.

5.6.32 Whilst Lenny had been the victim of several violent assaults, including at least one rape, there is no evidence of any support being offered or referrals made to specialist support services.

5.6.33 Lenny's engagement with services was focused upon his drug use and offending behaviour. Whilst he had accessed mental health support when in crisis, he does not appear to have received any treatment beyond this. He was known to have lost both his father and a significant uncle in recent years and there had been several overdose admissions to A&E, all of which he denied were intentional.

5.6.34 There is no evidence of any agency having attempted to contact Lenny by phone or through outreach work.

5.7 Pat

Context

5.7.1 On January 15th, 2019 at 15:00 an ambulance was called to a tent located near to the Sainsbury's supermarket in Halifax. The tent was occupied by two men, one of whom was Pat. He had been unwell for a while and his friend and fellow occupant had reported that Pat had been getting worse over the past four or five days. Pat was found to have Deep Vein Thrombosis (DVT) in his right groin. His friend had been concerned about him as he had not been eating and had been becoming more lethargic, so had called 999.

5.7.2 On examination Pat was drowsy and weak, complaining of aches and pains all over, and was pale and clammy. His clothes were bloodstained from blood loss, and he reported that he had been bleeding for the past four days. He was taken to Calderdale Royal Hospital.

5.7.3 Pat died in hospital within a month from Staphylococcus Aureus Bacteraemia, a groin abscess, Septic Arterial Embolism and Deep Vein Thrombosis of the lower limb.

Family

5.7.4 Pat was born in York and records show him as cohabitating there in 2006. There is evidence of him having maintained his relationship with both his father and mother as an adult. Pat's father shared the condition asthma with Pat and is recorded as provided him with inhalers on at least one occasion, whilst his mother is recorded as having been his 'protective factor'.

Mental Health

5.7.5 There is a family history of depression recorded.

5.7.6 In 1996 it was recorded by a GP that Pat had a 'history' of overdose, although there is no record of when these events took place and whether they were accidental or intentional.

5.7.7 Pat reported having a 'low mood' at several consultations over several years, including at his last consultation with a GP in June 2017, but he reported that he had no feelings of suicide or self-harm. Sertraline was prescribed in April and June 2017. Police records also show that in 2018 he was suffering from depression and anxiety but was not medicated for either.

Physical Health

5.7.8 Pat had suffered from asthma since childhood which required medication throughout his life. There were several consultations for chest infections and the Police National Computer had a warning marker for asthma.

5.7.9 The last record of a prescription being provided for asthma inhalers was at his last GP contact on 7th July 2017. At this consultation Pat was informed that inhalers would no longer be prescribed unless he attended an asthma review. Pat did not attend practice again. In July 2018 the practice were unable to contact him and removed him from its list.

5.7.10 Pat had a low BMI recorded consistently since 2005. His low weight - 20kgs underweight - was recognised as an issue during consultations at different practices. He received advice about diet and periodically dietary supplements were also prescribed. He was seen by the Dietetics Service in March 2017 and blood tests did not indicate an underlying medical cause.

5.7.11 Pat was vaccinated against Pneumonia and Hepatitis B, last accepted an influenza vaccination in 2015 and he was diagnosed Hepatitis C positive in June 2018.

5.7.12 On the 15th January 2019 he was admitted to hospital with a gradual deterioration of a groin abscess and necrotic foot. He was diagnosed with Infective endocarditis.

5.7.13 Larry, who had shared the tent with Pat, recounted when interviewed that he was very fond of Pat and had known him for several years. He also said that the only thing that really made Pat happy was drugs, and that he was a heavy drug user.

5.7.14 Larry described them both living in the tent near Sainsbury's during the Christmas period of 2018. He recounted that they were inundated with food, alcohol and money. He said that they had three Christmas dinners and described waking up to find cards containing £20 notes - on one day alone accruing £600.

5.7.15 He also recounted that two years previously Pat had an infected blister on his heel (which eventually healed). He thought that this was the source of Pat's gangrene, and suspected infection in the bone. In the days before his admission to hospital, Pat "missed" whilst trying to inject into his groin, during what Larry described as a drugs binge and he also said that Pat had begun to sleep more and more. When Pat began to have no interest in crack cocaine, Larry became concerned and called for an ambulance.

Substance Misuse

5.7.16 Pat had been dependent on heroin since he was 22 years old. He had told workers that he had always used substances, even when working. Records confirm a history of use of heroin, crack cocaine and cannabis.

5.7.17 There was a long period of engagement with substance misuse services over a period of 12 years from 2005. For much of this time Pat was prescribed methadone, either via the GP shared care scheme at his local General Practice or in the specialist drug service. GP records indicate good engagement when seeing the GP under this scheme.

5.7.18 In his last 12 months alive his attendance rate at the drug treatment service was 100%. Pat attended 11 appointments in all, his engagement was positive, and it was noted that he was actively seeking support to be referred to hospital for his Hepatitis C.

5.7.19 During this time the drug treatment service documented concerns about his unexplained weight loss, breathing problems and his homelessness. He was encouraged to contact his GP and homelessness support services.

5.7.20 Other than a record of Naloxone being offered to Pat in 2017, there is no record of any harm reduction interventions (proactive approaches to reducing the damage done by alcohol, drugs, rather than focusing on abstinence for example, needle exchange)whilst he was residing in a tent.

Criminal Justice

5.7.21 Pat first became known to West Yorkshire Police in 1993, aged 20 years old, when he was cautioned for possession of heroin. He had significant further contact with the police over the next twenty-five years, primarily in connection to his drug use - his offending history was not significant. For the supply of heroin, he was in 2001 sentenced to a 100-

hour Community Service Order and received a two-year Probation Order. His last offence was in 2017 when he was fined for travelling on a train without paying.

Assaults

5.7.22 GP records record that Pat was assaulted with a hammer in December 2008 by drug dealers who entered his home in the belief that he had given information to police. This was not reported to the police and Pat did not seek medical attention.

5.7.23 In April 2017 records show Pat sustained a fractured right cheek bone.

Homelessness

5.7.24 Pat's GP records indicated that he lived at several addresses, though his last registered address, recorded in March 2018, had also been recorded on previous occasions. From 2015 that address alternated with five others, suggesting long stretches of sofa surfing. A period of no fixed abode was also recorded within the same period.

5.7.25 Since late 2017, Pat was known to be rough sleeping in a tent near Sainsbury's in Halifax.

5.7.26 During November and December 2018, No Second Night Out (NSNO) outreach workers made several attempts to engage with Pat at the tent, but he consistently refused to open the tent or agree to support. However, at this time Pat was engaging with community safety wardens, who were helping him access support in securing accommodation with Customer First.

Benefits and Income

5.7.27 Pat referred to working casually several times during his contacts with professionals. In the last months of his life, while living in the tent, he secured a job at Halifax's McDonalds. This appeared to have a very positive impact on him, and he managed to maintain employment despite his chaotic lifestyle and living circumstances.

5.7.28 Records show that in January 2018 he claimed Universal Credit (UC) and that in October 2018 that he had started working at McDonalds in Halifax. He received regular monthly UC payments and no sanctions were applied during life of claim.

Analysis

5.7.29 Pat was well liked by all the professionals that he had engagement with. He was compliant in treatment, always attending appointments. He managed his UC claim with DWP, never receiving a sanction, and made the transition into work whilst maintaining his benefits. This could be perceived as 'Disguised compliance' where Pat intentionally gives the appearance of co-operating with agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention.

5.7.30 His health was however deteriorating. He was living in a tent during winter and he was chaotically consuming illicit drugs in addition to prescribed medication. He does not appear to have been challenged by professionals about the difference between what he said and what he did.

5.7.31 Pat was encouraged and signposted to services by his drug treatment key worker in relation to his health and housing needs, but he does not appear to have been referred or assisted beyond this.

5.7.32 Whilst it would have been best had he attended his asthma reviews it is unfortunate that his medication was stopped for not doing so. Asthma was a lifelong concern for Pat, and he raised it regularly with his drug treatment workers. During his last year alive there were concerns that he was suffering from chronic obstructive pulmonary disease, and during this time, his family were providing him with asthma inhalers.

5.7.33 It is of concern, given his living circumstance, that there is no record of Pat being offered Naloxone since 2017 or of any other explicit harm reduction interventions, such as the provision of clean injecting equipment.

5.8 Zeb

Context

5.8.1 At 11.45am on January 16th, 2019, Zeb was found dead in the canal at Brook Foot, in Brighouse, by a dog walker. His remains were recovered from the canal and a sudden death report was submitted. A search of his home address was subsequently conducted which was described as in a poor state of repair, with no electricity and with signs of drug use.

Family

5.8.2 Zeb's father is recorded as having died aged 50 from a brain tumour, and in 2009 Zeb told his GP his mother was in her sixties and living in France.

5.8.3 In 1998 records show that Zeb had been married for four years, that the relationship had broken down following a stillbirth, and that Zeb had been physically aggressive towards his wife and to his mother-in-law.

5.8.4 Between 2009 and 2012 records indicate regular contact between Zeb, his mother and sister. Over the years his sister had repeatedly attempted to support him, but his challenging behaviour inevitably led to this breaking down.

5.8.5 In May 2016, Zeb was recorded as stating he was 'living alone' with 'no close family', when assessed by the drug treatment service.

Mental Health

5.8.6 He also had a long history of treatment for his mental health. His first admission was informal in 1994 following a three-year history of auditory hallucinations and longstanding amphetamine misuse.

5.8.7 In 1998 he was diagnosed as having schizophrenia, and in 1999 he had a further informal admission and was discharged with antipsychotic medication alongside benzodiazepine and opiate-based medications.

5.8.8 His GP records indicate a chronic relapsing psychotic disorder variously diagnosed as amphetamine related psychosis, schizophrenia, paranoid schizophrenia and schizoaffective disorder (mixed type), complicated by drug use, particularly amphetamines.

5.8.9 Although frequently admitted informally to hospital in the early stages of his mental illness, Zeb was detained under a Mental Health Section many times over the coming years. Between 2007 and 2012 he had been detained seven times.

5.8.10 In 2006 he was referred to Halifax Assertive Outreach Team (AOT). In the same year an overdose was recorded, although Zeb denied it had been intentional. He was also recorded as being a 'suicide risk' in January 2014 in a psychiatry update to his GP.

5.8.11 A discharge letter in August 2010 summarised that Zeb's presentation to Mental Health Services was usually as a result of a crisis and that contact between crises was inconsistent. Zeb was under the care of a specialist drug dual diagnosis nurse in Calderdale between 1997 and 2007 but was eventually discharged due to poor engagement.

5.8.12 In November 2015 both the police and ambulance services were called to Zeb's address. He was found to be smashing up his room and was recorded as hallucinating. He was assessed at hospital as being psychotic. In March 2016, he was found wandering, mumbling and staggering and taken to A&E. During triage he denied any drug use and self-discharged, not waiting to be seen by a doctor.

5.8.13 Zeb had several warning markers on police databases for violence and for mental health issues, including schizophrenia, psychosis, claustrophobia and for self-harm (because of attempted hanging) in 2005.

5.8.14 Between August and November 2016 there was a brief stable period, where his CPN recorded his mental health as 'improved'. He was described as 'rational' and 'focussed on recovery' with an improvement in his appearance recorded. The consultant who knew Zeb from previous consultations considered him to be doing well, considering his previous erratic engagement. At this time there is a record that his local pharmacy on June 3rd, 2016 informed his GP that Zeb had failed to collect his prescribed medication for several weeks.

5.8.15 In March 2017 staff in the drug treatment service observed Zeb engaging in dialogue with himself and were concerned about further evidence of self-neglect, including weight loss and being dirty and unkempt. They wrote to his GP.

5.8.16 Zeb is recorded as having had a Mental Health Medication Review by his GP on October 15th, 2018. The record refers to a mental health personal health plan but there is no detailed description of this in the GP record. A medication review was also completed at around this time.

5.8.17 On January 15th, 2019 Zeb presented to the Community Mental Health Team in the morning requesting to be seen by a practitioner as a matter of urgency. As the practitioner he wanted to see was at another clinic, an appointment was made for 4.30pm the same day, but he did not attend.

Physical Health

5.8.18 Zeb presented an overall picture of physical illnesses caused or complicated by injecting drug use, assaults, and accidents or self-neglect. He attended the Accident & Emergency department on twelve occasions in 2017, the penultimate year of life. This significantly contrasted with the single GP consultation he attended during the same period. The Practice did however continue to prescribe, as Zeb was reviewed by the local pharmacist and the drug treatment service.

5.8.19 Zeb was diagnosed with Hepatitis C in 2009, but his mental health problems proved a significant obstacle to treatment. He also suffered multiple Deep Vein Thromboses (DVT) and pulmonary emboli (PE) between 1996 and 2009, and again in 2016 and 2017, caused by his injecting into his groin. He underwent treatment with Warfarin but suffered long-term pain related to this condition.

5.8.20 Zeb was prescribed five main classes of medication during last 3 years:

- Psychoactive drugs for his mental health problems comprising an antipsychotic (olanzapine), a mood stabiliser and antidepressants
- Medication comprising Methadone and Buprenorphine to address his drug dependency
- Zopiclone and Promethazine for the symptomatic relief of insomnia and anxiety. These drugs are known to have particularly high abuse potential with associated risk of overdose.
- Anticoagulants to prevent further deep vein thrombosis and pulmonary emboli
- Analgesics (Codeine and Tramadol) for pain. When Zeb started buying illicit Pregabalin, his GP in March 2016 opted to provide a regular prescription for Gabapentin, but this was withdrawn three weeks later following advice from the drug treatment service that there was both an overdose and diversion risk.

5.8.21 At the time of his death his GP was prescribing all his mental health drugs. Prescriptions were issued weekly due to risk of overdose and concern of abuse or diversion to the street.

5.8.22 Patients in receipt of antipsychotics are routinely monitored for side effects (this applies to olanzapine) with regular blood pressure and blood tests for hyperlipidaemia and blood glucose (sugar) levels, but there is no record of blood pressure recordings or blood tests having been undertaken in Zeb's GP record.

5.8.23 There is recorded evidence of self-neglect and physical injuries relating to his drug use, including two operations to remove needles from his legs, a fractured ankle complicated by injection-related abscesses on his feet and abscesses his in legs.

5.8.24 In an eight-month period between 2010 to 2011, records indicate that Zeb lost six stone in weight, had multiple chest infections and on two occasions acute kidney injury, thought to be secondary to dehydration.

Substance Misuse

5.8.25 Zeb had a long history of substance misuse. Benzodiazepine and opiate prescriptions are recorded in 1989 and amphetamine use in 1994, at his first inpatient admission.

5.8.26 He is recorded as having been in drug treatment since 2004, excepting two short periods between July 2012 and January 2014. His drug use included heroin, crack, and amphetamines, alongside illicitly obtained benzodiazepines and gabapentin. He was also in receipt of prescriptions for Subutex and Methadone.

5.8.27 He was difficult to engage with, often missing his prescription pick-ups and requiring treatment to be restarted. His appointment attendance rate in the last twelve months of his life was 47%, but ad-hoc attendance was common. Much of the keyworker engagement with him was focused on managing risk. There is little evidence of intervention, although it seems he did often pop in for appointment-time checking or for cups of tea.

5.8.28 The drug treatment service did communicate observations and concerns to Zeb's community psychiatric nurse. In August 2017 the service marked him as 'vulnerable', meaning he would be offered an appointment as soon as he presented, and would be seen without an appointment and a prescription for methadone reinstated if required.

5.8.29 Zeb overdosed twice in 2017 and was admitted to A&E and treated with Naloxone. He was last issued with Naloxone on August 30th, 2017.

5.8.30 He last attended the drug treatment service on December 7th, 2018, where he was prescribed 30ml methadone and requested gabapentin for nerve pain. No illicit drug use was reported, but he refused a blood test. He was given a two-week prescription and told that he must undertake a urine toxicology screening at his next appointment. He never returned.

5.8.31 When he last saw his GP for his medication review on October 15th, 2018, he reported that he was drinking 7-9 units of alcohol a day.

Criminal Justice

5.8.32 Zeb first became known to West Yorkshire Police in 1990 when, at the age of 21, he was convicted of shoplifting.

5.8.33 Police records show that Zeb had accumulated 55 crime offender records, 46 custody records and seven crime victim records. He was also arrested twice in 2007 under Section 136 of the Mental Health Act.

5.8.34 His offences were predominantly shoplifting and public order offences, with some convictions for possession of drugs (amphetamine and cocaine) and other miscellaneous offences including burglary and fraud.

5.8.35 Between May 2004 and December 2013 Zeb provided police with twelve positive drug tests, predominantly for cocaine.

5.8.36 He was last seen by the police in Halifax on January 8th, 2019.

5.8.37 A number of the sightings reported during the review period suggest that Zeb may have been in the act of purchasing drugs, but this was not definitively established. His contacts with police during this time were primarily because of his engagement in street begging.

5.8.38 During the last six months of his life Zeb was referred to the Anti-Social Behaviour Panel following several incidents that had been reported to the police in relation to begging and abusive behaviour in Halifax town centre. A file was being compiled at the time of his death containing multiple reports of aggressive begging.

Domestic Abuse

5.8.39 Zeb is recorded on five domestic incident reports between 2004 and 2011, but as this fell outside of the report time frame no further detail is available as to whether he was a victim or perpetrator or both.

Assaults

5.8.40 Zeb was victim to several assaults, the most serious of which occurred in 2015 when he sustained serious and life-threatening injuries to his head, nose and face, resulting in a titanium plate being placed in his skull. Before this the only other injury noted was a human bite to a finger in 2014.

5.8.41 In March 2016, he was admitted with a haematuria after an assault to the genitalia with an iron bar.

5.8.42 He saw his GP in August 2016 with a shoulder injury resulting from having been hit by a bus. There were also three attendances at A&E during 2017, at which injuries that would have been consistent with assault were recorded.

Housing and Homelessness

5.8.43 After being released from a low security hospital in 2009, it became difficult to rehouse Zeb in Halifax. Due to rent arrears and his chaotic lifestyle, several housing agencies in Halifax declined to offer accommodation.

5.8.44 Despite this, a private tenancy was secured in the Liversidge area in November 2009. His psychiatrist and the Dewsbury Outreach Team supported his transition into the community. This period of housing provided a degree of stability for three years. The tenancy was managed well, and a care coordinator was allocated. Zeb at this time is recorded as accepting support from several services, including advice on managing his finances.

5.8.45 In January 2012 his landlady reported deterioration in his mental health. Zeb was not allowed back to his home due to damage to the boiler and copper piping, where there was evidence that he had tampered with the gas supply.

5.8.46 Following an inpatient hospital admission in October 2012, he returned to Halifax where support by a housing worker enabled him to again regain a degree of stability, through help with appointments, finances and medication compliance. The housing worker maintained regular contact with mental health services to provide updates and the care coordinator had given the housing worker a crisis contact phone number. Zeb resided there until August 2015.

5.8.47 Between 2015 and 2018 Zeb lived at several addresses in Halifax, his final change of address being in August 2018.

5.8.48 In July 2018, he approached Customer First accompanied by a psychiatric nurse and alleged that on July 25th, 2018 his landlord had hit him over the head, taken his cash card and was continually abusive to him. The police were not informed. Advice was given about reporting the matter to the police, and Customer First offered to speak to his landlord, but Zeb declined the offer.

Benefits and Income

5.8.49 Zeb left school aged 15 and was employed in a series of manual jobs, although he told his GP in 2009 that he had not worked 'for many years'.

5.8.50 The drug treatment service recorded that he was in receipt of Personal Independence Payment (PIP) in May 2017.

Analysis

5.8.51 Despite shared concerns about Zeb being communicated between the Community Psychiatric Nurse, his GP and the drug treatment service, there is no record of a professional meeting or any joint working between the agencies in contact with him.

5.8.52 Whilst Zeb had difficulty keeping appointments, he did contact services when he either perceived that his needs were likely to be met or when he was nearby or simply wanted a cup of tea. These occurrences could have seen as an opportunity to engage with him.

5.8.53 It is considered good practise to monitor patients on antipsychotics for side effects (this particularly applies to olanzapine) with regular blood pressure and blood tests for hyperlipidaemia and glucose levels. There is however no evidence of blood pressure recordings or blood tests having taken place in the GP record. It is the responsibility of the prescriber of olanzapine to check if monitoring is undertaken, and the lack of records indicated that it was not. Whilst it is unlikely to have contributed to his death, if left untreated, diabetes can cause weight loss.

5.8.54 Zeb was especially vulnerable to exploitation since all his Halifax addresses were in areas known to be low rent, high crime areas where drug users congregated. His chaotic lifestyle and vulnerabilities would have put him at risk of 'cuckooing', a practice where a person's home is taken over and used to facilitate the dealing, storing or consumption of drugs, for sex work or simply as a place to live.

5.8.55 Zeb responded well to housing support in 2009 and again in 2015, and these were his most stable periods as it appears that during these periods he also was responding well to practical support with appointments, finances and medication. It is unclear why no agency referred him for tenancy sustainment support in more recent years.

5.8.56 Despite Zeb's history of overdose there is no record of him being offered Naloxone after August 2017.

6 Themes & Recommendations

Each of these themes requires multi-agency task groups with senior level membership (who have the authority to make decisions) to develop detailed single and multi-agency actions to address the broad recommendations. Co-production is essential in addressing recommendations and actions.

6.4 Multiple and complex needs

6.4.1 Multiple and complex needs (MCN) are persistent, problematic and interrelated health and social care needs which impact on an individual's life and their ability to function in society. They are likely to include repeated homelessness, mental, psychological and physical health problems, drug and alcohol dependency, and offending

behaviour. People with MCN are more likely to experience violence and abuse, including domestic violence, live in poverty and have experienced trauma in childhood or throughout their lives. They often have ineffective contact with services, partly because most public services are designed to deal with one problem at a time and to support people with single, severe conditions. Lacking effective support from services, people with MCN may end up in a downward spiral of mental ill health, homelessness, drug and alcohol problems and crime.

6.4.2 It has become clear during this review process that the overarching theme is one of multiple and complex needs. Zeb, Pat, Lenny and Jason all experienced problems with substance misuse, offending behaviour, homelessness and physical and mental poor health. Peter too experienced poor mental and physical health, was suspected of having a learning disability, was lonely, isolated and experienced homelessness just before his death. All these men additionally had difficulty engaging in support and were not able to access and utilise services effectively.

6.4.3 To consider these men as struggling with multiple and complex needs will enable us to:

- Learn from the raft of evidence that will enable us to develop a system that better responds to those needs
- Better support the workforce who are confronted with these complicated and difficult cases, by providing pathways and solutions and appropriate supervisory support
- Ensure that we reduce the unproductive use of high cost health services (A&E) by this user group

6.4.4 While relatively small in number, this group imposes disproportionate costs on government and society. Current commissioning processes for services relevant to this group typically do not consider how having simultaneous needs can potentially exclude them from help when they need it the most.

6.4.5 When people with multiple and complex needs try to fit into multiple disjointed services, they often experience increased negative outcomes and become more unwell through exclusion. Services themselves can also experience service disruption when they are not designed to cope with the behaviours associated with trauma. In this way those most in need in our community are being overlooked precisely because their needs are so great.

6.4.6 To put the issue into a national context, the Making Every Adult Matter (MEAM) coalition estimate that 85% of people with the most complex needs experienced some form of trauma in childhood. For women, this frequently continues into adulthood, when they experience domestic abuse and violence. It is also estimated that 58,000 people in

England face problems of homelessness, substance misuse and offending in any one year. Within this group, a majority will also have experienced mental health problems (Lankelly Chase 2015).

6.4.7 People experiencing MCN are more likely to access emergency, rather than planned services, going to accident and emergency rather than to their local GP. They are also likely to be known to everyone, but often are served by no one, as they are perceived to be 'hard to reach' or someone else's responsibility. This has been apparent in the lives of all the men in this review, where no single agency took a proactive lead role in co-ordinating or following up their care, and that all apart from Peter regularly visited the A&E department.

6.4.8 The Fulfilling Lives programme is a National Lottery Community Fund initiative, investing £112 million over eight years (2014–2022) to support people who are experiencing multiple disadvantage. The programme has funded a West Yorkshire partnership called West Yorkshire Finding Independence (WY-FI) to test new ways of ensuring individuals receive joined up and person-centred services.

6.4.9 During the project there have been over 250 referrals into the WY-FI team in Calderdale and of those 143 were accepted on to Caseload. The remaining 120 did not make it on to the project for several reasons. 55 could not be contacted, 45 were deemed to have sub-threshold needs and the remaining 20 either disengaged almost straight away or moved out of the area. 111 were identified as having three or four of the HARM (Homelessness, Addiction, Re-offending and Mental Health) measures.

6.4.10 At a West Yorkshire level, the history and demographics of the WY-FI beneficiaries reinforce the finding that the overarching theme in the lives of the men who are subjects of the review is their multiple disadvantage, in that:

- Most people are aged 35 to 44 when they start the project (the average is 38 years old).
- 99% of people aged 45 to 54 experienced a substance misuse issue.
- Disabilities are prevalent within the WY-FI cohort. Only 21% of beneficiaries have confirmed that they do not have a disability.

6.4.11 WY-FI can draw specific links between some health issues, such as long-term physical health problems, diagnosed mental health problems and drug taking, and multiple needs - indicating that there is a higher prevalence of these issues in the WY-FI population than among the general homeless population.

6.4.12 Only one of the subjects of the review, Zeb, was known to WY-FI services. He had been first seen in late 2015 and taken onto caseload in May 2016. Despite many attempts to engage with him the only contacts were made by chance in the street. His case appears to have been closed in September 2016. There is no record of any WY-FI contact for any of the other.

6.4.13 It is unclear why Zeb's case was closed, though he was identified quite early on in the project, which over its life has learned the benefits of persistence and patience with this user group, so it is possible that he would have benefitted from remaining on caseload. It seems that the other men were either not referred or declined the support of WY-FI.

6.4.14 It has taken some time for WY-FI to become established in Calderdale. Some partners have been harder to bring on board in terms of referrals and attendance at WY-FI locality meetings, particularly the mental health service and community rehabilitation company (probation). Agencies are now beginning to see the benefit of the project, and not simply viewing it as another meeting to attend but realising how it supports partnership working. Mental health clinicians are now attending to request WY-FI support for patients that they would traditionally close for non-engagement.

6.4.15 Whilst National Lottery funding for WYFI ended in May 2020. In Calderdale our system change approach to the WYFI exit is to embed key learning into our local system.

6.4.16 Sheffield Hallam University's 2018 independent evaluation shows that the future of multiple needs support should include the key elements of the WY-FI model.

Multiple and complex needs Recommendations

- ***Develop a shared understanding across Calderdale of the cohort of people who have Multiple and Complex needs who experience the greatest inequalities.***
- ***Review commissioning arrangements by health and social care to ensure the needs of the client group are fully embedded in commissioned services.***
- ***Explore how the needs of people who experience multiple complex needs can be best met by all agencies in a joined up, multi-agency way.***
- ***Support the workforce to enable it to be sufficiently skilled, competent and resilient to effectively engage with this cohort of people and support their needs.***
- ***The lessons from national Multiple and Complex Need initiatives, particularly locally the WYFI experience should be embedded in new service models and interagency working***

6.5 Access to and engagement in healthcare and other services

6.5.1 This review has highlighted several sub themes that may have impacted upon these men's ability to access and effectively engage in support services

Culture, attitude and professional curiosity

6.5.2 "People with multiple disadvantage are likely to live in poverty and experience stigma, discrimination, isolation and loneliness. They tend to be known to everyone, but often are

served by no one as they are perceived to be 'hard to reach' or 'not my responsibility.' This can make services seem unhelpful and uncaring to someone experiencing multiple disadvantage who is seeking help". MEAM (2018)

6.5.3 Attitudes and language play a significant part in how we approach the support of people with complex needs. If we label this group as 'beggars or ''rough sleepers', we limit our understanding, and risk looking at the problem only through the lens of housing or enforcement services, rather than taking a broader health and social care view.

6.5.4 Four out of five of the men whose lives form the case studies for this review had been repeat victims of assault, some of which were very serious, and yet there appears to have been little or no police involvement or referrals made to victim support services. In the practitioners' workshop one of the themes that emerged was that those assaults were often either perpetrated by individuals known to the victim or by their drug dealers and that there was fear of being viewed as a 'snitch'. In both 2016 and 2017 Lenny disclosed both a traumatic event whilst in prison and a sexual assault to his drug treatment worker, but there is no evidence of referral to a specialist support service.

6.5.5 When working with people living street-based lifestyles there is also the danger that high levels of risk can become normalised. One example of this is Pat living in a tent outside Sainsbury's during the depth of winter, in poor health, injecting into his groin.

6.5.6 The term 'burning bridges' was used several times by practitioners in the practitioners' workshop. This is not to suggest that service users were thought deserving of their circumstances, but rather, was used describe the reality that many of this group had exhausted their options with private housing landlords, had accrued arrears with social landlords and in some cases were banned from areas of the borough, making housing them challenging.

6.5.7 At both the practitioner and manager workshops held for this review, participants voiced concern about the stretched and inadequate resources within which they operate. They discussed how a combination of this and of dealing with vulnerable people, who can be difficult and sometimes aggressive, could lead to 'burn out'. It is very difficult for staff when the only intervention they have to offer a vulnerable person is to simply give them a sleeping bag on a cold night. There is a clear need for staff supervision and support in this respect, and this was stressed in both workshops.

6.5.8 Staffing issues were also raised in the practitioners' workshop, where mental health service staff talked of 400 referrals in the previous two months, and of how they felt under pressure, particularly when working with individuals with a combination of mental health and substance misuse problems. The drug treatment service described workers carrying caseloads of 80, challenging their ability to outreach cases. All of the individuals who are the focus of this review had a clinical appointment of 15 minutes every three months, and

they also typically had appointments with their keyworker, but the case studies indicate that they often tended to miss these appointments but keep their clinical appointments. The drug treatment service nonetheless made endeavours to allow them to visit outside appointment times, to enable them to have "sight" of the patient, as is described in Zeb's case.

6.5.9 Local social housing providers take on high-risk customers who are at risk of their tenancies failing because of their chaotic lifestyles. They have a team of 12 to support these customers, yet they have had 3,500 referrals since April 2019. They talked of feeling under pressure to take on individuals who have often not quite met the criteria for other support services and felt strongly that they are left managing problems that go beyond their duty as a social landlord.

6.5.10 In the Martineau (2019) appraisal of Safeguarding Adults Reviews, concern is expressed about what is termed a lack of 'professional' or 'concerned' curiosity amongst professionals. This is also evident in the findings of this review, where there is a striking absence of the service user's 'story' being recorded. This is particularly evident amongst those in long-term drug treatment, where the engagement seems merely transactional in the sense that the service user attends appointments to receive a prescription. Beyond this there seems to be very little knowledge of their situation, and of how they arrived in their predicament. The managers' workshop highlighted a 'lack of professional curiosity in asking about childhood adversity and trauma' which could and should inform interventions.

6.5.11 Pat had 100% attendance at his appointments, yet he was chaotically using high levels of illicit drugs on top of his prescription and there were concerns about his health. None of this appears to have been addressed during his appointments.

6.5.12 In Peter's case, no one demonstrated concern by following up on referrals made on his behalf or facilitated communication between housing and health agencies, which may have prevented his eviction, or triggered a safeguarding alert.

6.5.13 Engagement with Jason and Lenny is reduced to a transactional arrangement simply for the issuing of prescriptions.

6.5.14 In all cases there were file notes across agencies recording a decline in the appearance of these men, but no onward referrals, follow up or outreach took place. It seems that 'signposting' is used by practitioners to suggest to service users that they contact their GP or visit housing services themselves. The third sector workers who had the most face to face contact with service users described feeling that they had been left "holding the baby" and were not supported by other agencies, and they expressed concern around the lack of clarity surrounding the thresholds of adult health and social care services.

6.5.15 There is also evidence to suggest that attitudes towards people with substance misuse problems might influence the way the services engage with habitual drug users, particularly with respect to their access to health services.

6.5.16 Pat, who had suffered asthma all his life, was informed at his last GP consultation in July 2018 that inhalers would no longer be prescribed unless he attended an asthma review, despite requiring a prescription of antibiotics for a chest infection.

6.5.17 In Jason's case there was a delay in recognising and treating sepsis in the Accident and Emergency department. Whilst an investigation following his death demonstrated no discrimination on the grounds that he was a drug user, clinicians were focused upon treating the presenting symptoms of withdrawal which overshadowed the signs of sepsis, thereby causing a delay in the correct treatment being provided.

6.5.18 These examples may highlight a lack of understanding of the life circumstances that these men were living and service delivery models that are not shaped to respond to their needs.

6.5.19 During the course of the review several workers from outside the traditional agencies who engaged with this client group were interviewed. They included the community safety wardens who cover Halifax town centre, the security guard at Sainsbury's and the manager of McDonald's - both in Halifax. Those individuals demonstrated striking levels of concern and of professional curiosity, particularly so in the case of Pat.

- They were able to recount more of his history than any of the other agencies
- They had positive things to say of his character, beyond his identity as a drug user.
- They expressed on-going concern about his health, with a community safety warden taking him to Boots to buy ointment for his feet out of concern that his sore feet were being worsened by the cold weather.
- The community safety wardens stayed in regular contact with him until his hospital admission. They also took him to Customer First for advice on his housing situation.
- McDonald's gave Pat a job, where he worked for 16 hours a week until just before his last hospital admission.
- Following his hospital admission, a community safety warden visited Pat and met with his mother.
- The manager of McDonald's attended his funeral.
- Both the Sainsbury's security guard and the community safety wardens were concerned that the man Pat was sharing the tent with was aggressive and may have been bullying him.

- A local café owner supported Zeb by allowing him to call his mother on their phone. It is recorded that the café owner was also keeping the 'professionals' updated.

6.5.20 These episodes demonstrate the important role that the wider community can play in supporting work with this client group, and of the potential benefits of involving them in both training and communication networks.

Access Barriers

6.5.21 Managers and practitioners have highlighted the difficulties of navigating a complex and changing support systems, and these factors may also play a part.

6.5.22 Experience of discrimination and stigma, and previous negative experiences of interventions may also impact on access and engagement.

6.5.23 There are many well documented barriers that made it difficult for the subjects of this review to effectively access health and social care services, including tangible barriers such as transport and other costs, opening and waiting times.

Literacy

6.5.24 In Peter's case, despite contact with health and housing services over many years, it was only a week before his death that it was recorded that he could not read or write. Literacy is not mentioned in any of the other cases, so it is not known if this was an issue for any of the other men.

6.5.25 Following Peters death, the social housing provider have reviewed the communications they send to those that could have 'hidden' vulnerabilities. They have used a mental health charity to help reword their correspondence to all their customers to enable more engagement, and over the last year they have reported greater success with hard-to-reach clients in consequence.

Access to digital resources

6.5.26 All the men involved in this review had either inconsistent or no access to mobile phones or computers for email contact. This made communicating with support services challenging, and their records in each case noted this. This was particularly notable regarding contact with GPs and with the DWP. If claimants do not access their Jobseeker's journal online or if they lose their passwords, they are at risk of sanctions and of losing their benefits. Jason, however, was the only case reviewed who had been sanctioned because he was unable to access his DWP journal.

Appointments

6.5.27 In both the managers' and practitioners' workshops the inability of these men to keep appointments was raised by several agencies. Practitioners reported in the course of this review that it was often the case that each of those men in the case study might not turn up for a month but then could present every day, and that there was a consistent problem

with timekeeping. Both Lenny and Zeb often turned up on the right day but at the wrong time.

6.5.28 The availability of resources impacted upon the ability of services to be flexible. Adult Social Care social workers felt they did not have the time. Customer First also talked of other duties being allocated to workers because of reduced staff numbers that then impacted on their ability to respond to customers attending the service in an unplanned way.

6.5.29 Where services can be flexible, they are. The drug treatment service encourages their service users to drop in, in order that they have "sight" of them, and the Street Reach outreach service offers open access drop-in sessions.

6.5.30 Both the managers' and practitioners' workshops stressed the importance of being flexible and mindful of factors that may impact on attendance - for example the weather, and stressed the importance of being able to offer a homeless drug user an immediate and tangible service; one provider stating that they needed to "bring the service to where the punters are rather then expecting them to jump through all these hoops…"

6.5.31 Agencies also fed back that non-engagement patterns are not often shared between agencies.

Motivation

6.5.32 A common theme in these cases is a perception that the review subjects lacked the motivation to make the necessary changes to their lives, and this is particularly apparent in the drug treatment services. There seemed to be an acceptance amongst professionals that the gap between the street-based lifestyles lived and the achievement of any significant stability in their drug use is huge and probably unachievable.

6.5.33 In Jason's case his probation officer noted that his "engagement was very poor, and it was very difficult to encourage, motivate and work with him due to the level of engagement that he displayed. During the times I did have contact with him he was always polite and pleasant although he displayed little ability and willingness to change".

6.5.34 Jason, Lenny, Pat and Zeb were known to drug treatment services for, many years. Jason's engagement was chaotic, frequently dropping off his prescription and continuing to provide positive drug tests. Interventions were primarily criminal justice rather than health focused.

6.5.35 Zeb and Lenny were also described as difficult to engage with, using illicit drugs and alcohol alongside prescribed substitutes and had a history of overdosing but there is little evidence of any structured intervention.

6.5.36 For all four men who had engaged in drug treatment there was little evidence of effective care planning and where there were plans in place they had not been reviewed

for some time. Homeless Link (2019) suggests a co-produced holistic care plan with this group improves outcomes.

6.5.37 During interview, Larry who had shared the tent with Pat (and is now in accommodation) was asked what had changed for him. He explained that it had been the two years of persistence of his outreach worker, and that she was plain-speaking, honest and had stuck with him. He acknowledged how difficult he had been to engage with, saying he usually resented workers, and found it very difficult to conform.

6.5.38 There is little evidence of advocacy on behalf of these men, particularly in relation to referrals to housing and health services, but there is evidence of too much reliance on 'signposting' - expecting the men to contact services themselves, and minimal follow up of referrals where they are made.

6.5.39 Whilst this review was made aware of the Council's Vulnerable Adults panel, the Hospital Avoidance Team (HAT) and the Clover Leaf independent advocacy service, this user group do not feature as an area of consideration in any of these.

Policies

6.5.40 There is evidence that rigid enforcement of policy impacted negatively on these men.

6.5.41 The drug treatment service's rigid 'lost prescription policy' meant in Lenny's case that he dropped out of treatment as he was unable to return the prescriptions. The review has found his explanation for this to be corroborated. Lenny did attempt to re-engage twice but was unable to meet the requirements of the service and did not access treatment again before his death.

6.5.42 For a rough sleeper to access housing and support, national policy requires that they are 'verified'. This means that outreach workers must witness people about to bed down (by sitting on or in or standing next to their bedding) or actually bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments) or in buildings or other places not designed for providing refuge. In Jason's case it seems the process to verify him as a rough sleeper was delayed due to difficulties finding him, despite reports of his location from several agencies.

6.5.43 Housing Options and Street Reach have since reviewed their process of verification of rough sleepers. Identified areas are visited numerous times by both Street Reach and other agencies such as community safety wardens and they are utilising CCTV and placing emphasis on the "likelihood" of someone sleeping rough in these areas to find them as soon as is possible

6.5.44 In Peter's case the inflexibility of the eviction process made it impossible to reverse, despite concerns of his vulnerability, as noted by both Customer Service and the police within the days following the eviction.

The impact of Trauma

6.5.45 Understanding the impact of trauma helps to reframe our understanding of this group's vulnerabilities and often challenging behaviours.

6.5.46 In this context trauma refers to experiences or events that are out of the ordinary. Trauma might therefore be variously described as shocking, terrifying or devastating to the trauma survivor and the suffering of trauma often results in feelings of terror, fear, shame, helplessness or powerlessness.

6.5.47 Goodman et al, 1991 (cited in Feantsa, 2017) describe two types of trauma:

- Type 1, which occurs at a particular time and place, and is short-lived, such as serious accident, sudden loss of parent or a single sexual assault.
- Type 2, which refers to events which are typically chronic, begin in early childhood and occur within a family or social environment. It is usually repetitive and prolonged and involves direct or indirect (witnessing) harm or neglect by caregivers or other entrusted adults in an environment where escape is impossible.

6.5.48 Maguire et al (2009) describe many homeless people as having experience of both Type 1 and Type 2 trauma. This is called 'compound' or 'complex' trauma.

6.5.49 Whilst this review received limited information on the life stories of the men involved, there is evidence of both Type 1 and Type 2 trauma in these men's lives.

6.5.50 Recent research conducted by Stubbs et al (2019) and cited in the Lancet tells us that half of all homeless people may have suffered a traumatic brain injury (TBI) at some point in their lives, which may be either a consequence or even the cause of their homelessness. Traumatic brain injury is sudden damage caused by a blow or jolt to the head. In some cases, it can potentially cause long-term damage to the brain, and may lead to neurological and psychiatric disorders. The research found that a quarter of homeless people had suffered a moderate to severe injury, which is ten times that of the general population. The study also found that TBI was consistently associated with poorer self-reported physical and mental health, higher suicide risk, memory concerns, increased health service use, and criminal justice system involvement.

6.5.51 For four of the five men reviewed in this report there is evidence of serious violent assaults involving blows to the head with weapons including bottles and baseball bats. In Zeb's case his injuries were so traumatic his treatment required a titanium plate to be placed in his skull. Lenny was victim of sexual assault. There were however no recorded specialist interventions for TBI in the records made available to the review.

6.5.52 There are also indications of Type 2 trauma. In Jason's case, he disclosed that his sister gave him heroin for the first time when he was 12 years old, describing his mother as being aware but 'unable to do anything about it'. He also appears to have lost both of his parents

prematurely. Peter was adamantly against involvement of children's services due to a previous, presumably unsatisfactory, experience, and described his own family as chaotic. His father also died prematurely. In Lenny's records there are references to him suffering the bereavement of both his father and an uncle. Zeb's father is recorded as having suddenly died aged 50, whilst his marriage broke down following the stillbirth of their child.

6.5.53 Feantsa (2017) cite Goodman et al (1991) who suggest that homelessness itself can be considered a trauma in multiple ways, because "like other traumas, becoming homeless frequently renders people unable to control their daily lives"

6.5.54 Living a street-based lifestyle can be such an overwhelming additional stress in the life of a person that it may erode their coping mechanisms. We are told that trauma and in particular complex trauma overwhelms a person's resources for coping and impacts upon the person's sense of safety, ability to self-regulate, sense of self, perception of control and interpersonal relationships, and that this has a significant impact on help-seeking and engagement.

6.5.55 Homeless Link (2017) suggests that reflective practise is helpful to both practitioners and service users when working with traumatised clients. Reflective practise considers what causes might be underlying the situation and encourages support workers to review their interventions, consult with others to aid this reflection, and test new approaches. This can lead to improved outcomes for the service user, and in the practitioner taking greater responsibility for their role in the relationship and develops greater confidence in their ability to solve problems.

6.5.56 Practitioners who work in a reactive way are more likely to resort to rules-based responses in the face of challenging behaviour or disengagement (e.g. by issuing a warning, closing a case, or using phrases such as hard to reach and 'burned their bridges'). Such responses triggered disengagement from drug treatment and GP services for Phil, Jason and for Lenny.

6.5.57 Creating psychologically informed environments (PIEs) is seen as the latest good practice when supporting individuals who are experiencing complex trauma, and there is a wave of enthusiasm within the homelessness sector to adopt its principles. A Psychologically Informed Environment (PIE) "... is one that takes into account the psychological makeup – the thinking, emotions, personalities and past experience - of its participants in the way that it operates." (Johnson 2012)

6.5.58 Westminster City Council (2015) has developed a PIE toolkit and describes a PIE as having five key elements:

- Relationships
- Staff support and training

- The physical environment and social spaces
- A psychological framework
- Evidence generating practice

6.5.59 The approach focuses strongly on relationship-building to promote recovery and can be used by outreach and day centre staff as well as hostel and shelter workers.

6.5.60 Experts in this area also talk of 'retraumatisation', where a conscious or unconscious reminder of past trauma results in a re-experiencing of the initial trauma event. It can be triggered by a situation, an attitude or expression, or by certain environments that replicate the dynamics (for example a loss of power, control or safety) of the original trauma.

6.5.61 Zgoda et al (2016) noted that systems that operate in isolation, with fragmentation of authority and lack of accountability, or that lack resources adequate to provide necessary services can retraumatise service users and also negatively impact the system's employees.

6.5.62 Some departments of Calderdale Council, including Customer First, have undertaken Trauma Informed Care (TIC) training, an approach that advocates an organisational structure and treatment framework that involves understanding, recognising and responding to both physical and psychological trauma. Customer First has also undertaken Strengths Based Practice training during the review period and found it very useful.

Access to health care

6.5.63 Homelessness can be both a cause and a symptom of extreme health inequalities and inequity. This is illustrated by:

- Mortality rates being eight to twelve times higher than the general population
- A mean age of death of 44 for men and 42 for women, compared to 76 and 81 respectively in the general population. The average age of death of the men reviewed in this report was 43 (the youngest 36, and the oldest 51).
- Co-morbidity (having more than one long -term condition) being not uncommon amongst people who have experienced homelessness and rough sleeping for a significant period
- The homeless reporting much poorer health than the general population (MHCLG 2019)

6.5.64 Office of National Statistics figures tell us that at least 726 homeless people died in England and Wales during 2018 (the latest available figures), a 22% increase on the previous year and the largest rise since records began in 2013.

6.5.65 The following are the most commonly associated conditions for homeless people:

- drug and alcohol dependence and the associated adverse effects
- mental ill-health and personality disorder
- physical trauma
- infections, including hepatitis B & C, HIV, and other sexually transmitted infections
- inflammatory skin conditions
- skin infestations
- respiratory illness, including asthma. John W. and Law K. (2011)

6.5.66 Living a street-based lifestyle will inevitably exacerbate existing poor health. It is well documented that rough sleepers have more health needs than the general population and this is borne out in the stories of the subjects of this review.

6.5.67 In terms of their physical health, all four of men whose stories are outlined in this report and who used drugs were Hepatitis C positive. Peter additionally suffered with chronic pain, having Myotonic Dystrophy, Pat suffered with chronic asthma and Lenny was suspected of having epilepsy. Zeb, Peter and Pat were all of low weight and all, but Peter had suffered significant physical trauma, which left them with chronic pain.

6.5.68 The men that used drugs all received treatment for overdoses and injecting-related health issues such as deep vein thrombosis.

6.5.69 All men presented to their GPs with depression and anxiety, with clinicians recording a range of diagnoses, from 'low mood' to depressive disorder. Both Jason and Zeb were recorded as being suicidal at times. Lenny and Zeb had both been detained under the Mental Health Act and Zeb was diagnosed with amphetamine-related psychosis and paranoid schizophrenia.

6.5.70 This combination of poor mental health and substance misuse is known as dual diagnosis. Dual diagnosis is one of the biggest challenges facing mental health and substance use services, as mental health services may exclude people if their problem is perceived to be substance related, due to the requirement for a period of sobriety to enable a full mental health assessment to be undertaken. Conversely, substance use services struggle to effectively engage substance users with poor mental health.

6.5.71 Public Heath Wales (2008) report into the barriers to accessing healthcare, as reported by rough sleepers, summarised that health is not seen as a priority and that not seeking help for health needs should be seen as a form of self-harm. Difficulties in communicating health needs, poor engagement and communication skills and a lack of understanding of the system compound this.

6.5.72 Experience of stigma, previous experience of discrimination from health professionals, fear and denial of ill-health, fear of officials and clinical settings, embarrassment and low self-esteem are also barriers to accessing healthcare.

6.5.73 There is evidence of a lack of formal referrals and a reliance on ‘signposting’ these men to other services in the assumption that they would self-refer. An example being that in Lenny’s case there are three records of him being seen by the SWYPFT (South West Yorkshire Partnership Foundation Trust) team at A&E, two being on consecutive days. On the 23rd July 2018 he consented to an assessment by the mental health liaison team who felt that his engagement was an attempt to obtain further prescribed pain relief and signposted him Substance Misuse Services and his GP. In Jason’s case, despite a history of reporting depression and low mood, he did not appear to have been signposted or referred to any specialist support.

6.5.74 The drug treatment service also relied on the men referring themselves to GP services, housing support and hepatology.

6.5.75 Records show that Peter disclosed feelings of isolation and loneliness to both medical and social work professionals, but no interventions or referrals relating to this were recorded.

6.5.76 There is also evidence of poor communication and a lack of follow-up between professionals. Despite GP records highlighting both Jason and Lenny’s struggles with their mental health, their drug treatment records show no record of assessed mental health risk.

6.5.77 National estimates show that the homeless population consumes about four times more acute hospital services than the general population. Rough sleepers access A&E seven times more and are much more likely to be admitted to hospital as emergencies, which costs four times more than an elective inpatient admission. They also present with more co-morbidity – one in five who had contact with hospitals had three or more diseases resulting in greater secondary care (hospital) usage and costs.

6.5.78 In both the managers’ and practitioners’ workshops it was unanimously recognised that A&E was often the only point of referral for the subjects of this review when they presented with health needs. Both practitioners and managers acknowledged that hospital discharge is a challenge and that these men were often left hospital without the support that they needed. They highlighted that this user group often became tired of waiting and left before being seen by a doctor, and it was suggested that this may have been due to drug withdrawal and the need to seek drugs or alcohol. Hospital staff indicated that they felt that there were so many services that it was difficult to keep abreast of change.

6.5.79 NICE (2017) guidance suggests that intravenous drug use is a specific risk factor for sepsis. Jason and Pat both attended Calderdale’s Accident and Emergency department shortly before their deaths from sepsis.

6.5.80 The UK Drug Policy Commission in their paper addressing stigma and drug use heard numerous examples of insensitive and inhumane treatment by healthcare staff. They acknowledge that drug users may at times seek to abuse the system to obtain drugs from clinicians, and that this appears to have led to a belief among some staff that everyone with a history of opiate dependence attending A&E departments is only there to obtain drugs (UKDPC 2010).

6.5.81 Aldridge (2019) highlights that most people experiencing homelessness have been admitted to hospital in acute health crisis and that their health needs represent a system failure to intervene early to prevent serious harm. Safeguarding Adults Reviews into the deaths of people who are homeless have highlighted poor hospital discharge practices, including people being discharged back onto the street. Martineau et al (2019) argue that discharging a patient without them having somewhere safe to stay is a clear safeguarding issue, and this review during workshops was made aware of a case where an ambulance arrived at the Council's Halifax Customer First premises at the end of the day with a discharged patient with no housing for him to go to.

6.5.82 Since the Government introduced the 'duty to refer' as part of the Homelessness Reduction Act, (2018), hospital staff are legally obliged to ask if someone is homeless. They are then obliged to refer someone to the local housing authority for future support before they are discharged. Whilst this is a positive move, asking someone if they have somewhere safe to go when they leave hospital is challenging when the answer is 'no', and no viable solution is not immediately available.

6.5.83 The current local hospital discharge policy (currently under review) states that although patient choice is extremely important, patients who have been assessed as not requiring continuing inpatient care do not have the right to indefinitely occupy a hospital bed, and that the housing situation of patients should be identified on admission and wherever possible to ensure that patients are not discharged to inappropriate places or become homeless as a result of their stay in hospital. The policy suggests that the Discharge Co-ordinator will give guidance on housing issues for patients and that Out of hours arrangements are provided by the Local authority emergency duty team.

6.5.84 The policy also suggests that referrals for multi-professional assessment are made at the earliest opportunity to enable effective liaison between health, social services and the local housing department and thereby ensure acute facilities are not used inappropriately.

6.5.85 During this review Housing Options staff commented that even when they alerted the hospital that they were involved with a patient and wanted feedback relating to treatment and discharge plans, that often did not happen.

6.5.86 Community mental health services described describe dual diagnosis patients as very difficult to engage and almost impossible to assess when intoxicated. There is no designated post for dual diagnosis in Calderdale.

6.5.87 The drug treatment service staff highlighted challenges in care co-ordination and discharge from hospital for their patients, having had experience of patients self-discharging after having started a detoxification regime and leaving with no medication.

6.5.88 Managers and practitioners felt that the absence of an alcohol care liaison team in Calderdale Royal hospital is a gap in Calderdale. They told us that teams in hospitals in Wakefield, Bradford and Barnsley have improved both discharge planning and communication between hospital and community services.

6.5.89 Learning Disability was also discussed in the workshops. There were some concerns raised in relation to whether an individual had a learning disability or a learning difficulty. At Calderdale Royal Hospital there is a learning disability matron who provides a service to patients with a learning disability and if referred to her with no formal diagnosis and there are concerns that the person has a learning disability as opposed to a learning difficulty she can assess the individual and refer on for appropriate screening to a specialist team in SYWPFT. The hospital acknowledges that often in cases presenting with mental health and substance misuse problems there can appear to have a learning disability but often it is a learning difficulty in which case the Matron will review and offer advice. Calderdale adult social care told us that without a formal diagnosis help cannot be offered.

6.5.90 Despite a recognised high level of need for oral health care amongst both the homeless and drug using populations, none of the men whose cases have been reviewed were registered with a dentist.

Accident and Emergency (A&E)

6.5.91 In both Jason's and Pat's deaths, sepsis was a factor. There has been a small cluster of four Invasive Group A streptococcal (iGAS) infections among injecting drug users in Calderdale in recent months. Two cases were homeless. Such iGAS infections are acute and are frequently life-threatening, with consequences ranging from bacteraemia, cellulitis, pneumonia, meningitis, puerperal sepsis and septic arthritis, to, less commonly, necrotising fasciitis and Streptococcal Toxic Shock Syndrome.

6.5.92 There is a high intensity user group meeting held regularly at Calderdale Royal hospital, which is attended by police, social workers and community nurses. Whilst two of the five subjects of the review appeared be regular attenders at A&E, their cases do not appear to have been discussed at these meetings as they may not have met the criteria. Since this review was commissioned, both Housing Options and the Street Reach team are now invited to the group, but reported that because of confidentiality requirements, relevant information prior to the meeting is not provided in a way that non-NHS staff can

utilise (e.g. hospital numbers rather than names), leaving external agencies unprepared for the meetings.

General Practice

6.5.93 In all the cases reviewed all men were registered with a GP, and the motivation for this may have been a reliance on letters from the GP stating that they were unfit for work, in order to retain their benefits. However, there is also evidence that their engagement with GP services were not maximised.

6.5.94 Both Jason and Pat stopped attending their GP in the months before their deaths, Jason in August 2018 when he was turned away for being late for a GP appointment and Pat when he was told that his asthma medication would be stopped if he did not attend for an asthma review.

6.5.95 There is evidence in the review that some referrals were not followed up, that in some cases the subjects were 'signposted' rather than formally referred to other health services, and that there was little understanding of the challenges of managing appointments and communication when rough sleeping, often with no access to a phone.

6.5.96 There are examples of good practice and good communication. In Zeb's case his GP worked closely with mental health and drug treatment services and in another case a GP demonstrated good practice in offering flexibility around appointments because the person was homeless and did not have a phone. This good practice has been shared with all general practices through the CCG 'Safeguarding' newsletter.

6.5.97 In Peter's case, more than one professional suspected that he had a learning difficulty, yet there does not appear to have been any attempt to assess this. This is a common issue within the rough sleeping and multiple and complex needs population.

6.5.98 During this review several agencies expressed the need for a community nurse to work alongside outreach workers. There are several existing local models and The Queen's Nursing Institute's Homeless Health Programme, which is a national professional network for nurses working in this field, offers a raft of guidance and protocols.

6.5.99 Primary Care Networks (PCNs) are a key part of the NHS Long Term Plan, with general practices being a part of a network, typically covering 30,000-50,000 patients. Calderdale has five PCNs. The networks will provide the structure and funding for services to be developed locally in response to the needs of the patients they serve. The networks will have expanded neighbourhood teams which will comprise a range of staff including GPs, clinical pharmacists, district nurses, community geriatricians, dementia workers and allied health professionals such as physiotherapists and podiatrists and chiropodists, working in collaboration with social care and the voluntary sector. The Central PCN which covers Halifax town centre is already considering how to deliver wound care to this patient group in a community setting.

Access to healthcare and other services recommendations

- ***Services should work flexibly to be accessible and able to meet the needs of service users with multiple complex needs: recognising that there is often a short window of opportunity to engage a person with multi-complex needs and the need to respond quickly in order to build trust and understanding.***

Key areas in this work stream will be:

- ***Prevent people who have multiple and complex needs becoming disengaged from services and where they do to encourage rapid re-engagement and a develop culture of never giving up. Consider a multi-agency team to ensure individuals have a named care coordinator who can help maximise engagement.***

- ***The High Intensity User Group to ensure that non health partners can effectively engage to support people with Multiple Complex Needs***

- ***Opportunities for Primary Care to in-reach / out-reach with services such as the Gathering Place and drug and alcohol treatment services***

- ***Develop opportunities for services and pathways for rapid access to Mental Health and Dual Diagnosis services***

- ***Explore how to develop rapid access to services for diagnosis and support with intellectual disability***

- ***Review harm reduction services for drug and alcohol users and ensure that people who are not ready to change their substance use behaviour receive support to meet their health, social care and housing needs.***

- ***Review hospital discharge policies for the homeless / people with MCNs to ensure their housing support and ongoing substance use treatment needs are considered.***

- ***In order to maximise access and engagement, agencies to consider reasonable adaptions to appointment arrangements, communication and policies for this group of people.***

- ***The Clinical Commissioning Group (CCG) to consider how the co-ordination of healthcare commissioning for homeless people can be strengthened, to ensure it works closely with partner agencies and ensure services are joined up, reviewed and monitored as part of the commissioning cycle***

- ***Local GPs and practice staff would benefit from training in relation to treating this patient group to develop understanding of the trauma they have experienced, how they live, the complexity of their health needs and how fragile the nature of their engagement with health services can be.***

6.6 Homeless Strategy /Access to suitable and sustainable accommodation

6.6.1 The provision of housing alone is not the solution to the difficulties of those living with multiple and complex needs face and homelessness is a consequence of numerous factors already covered in the report. All the men in this review had previously been housed but for various reasons were unable to maintain a tenancy.

6.6.2 Martineau et al (2019) elaborate the concern expressed by some SARs around the insufficient provision of accommodation suitable for those with a history of mental illness or alcohol dependency and that there is insufficient housing-related support available. They reported services being commissioned for 'low level' support when there is a pressing need for more specialist and intensive support. Another finding was that stakeholders felt that individual tenancy support is not long enough, as it is often limited to only the first six weeks.

6.6.3 Both the managers' and practitioners' workshops highlighted several issues for Calderdale relating to accommodation:

- Calderdale does not have a direct access hostel for single homeless people, and hostel placements are therefore sought from out of the area. Since local authorities prioritise their own residents, these are often full, resulting in those that are deemed to be non-priority being sent out of area, even though it is common for such service users to want to stay in Halifax.
- Horton Housing have two 'crash pads', in Halifax and Brighouse, for emergency direct access accommodation, but as with the hostels, Brighouse is often refused if the Halifax one is not available.
- Universal credit, including the rent component, is often paid directly to the service user. This often leads to rent not being paid. The housing benefit element can be paid directly to the landlord but to do this often requires professional support to set up. A participant in the Practitioners' workshop stated that when landlords receive rent directly from a claimant any sanctions may mean their payments fluctuate.
- Professionals felt that the practice of landlords requiring upfront bonds, a week's rent as a deposit and the prospective tenant to organise the connection of gas and electricity is simply too high a bar for many service users, particularly those with drug and alcohol problems or learning disabilities.
- Many service users have accrued thousands of pounds in rent arrears with social landlords.

- Physically finding hard to reach service users and then engaging with them and holding them long enough to complete a housing referral was identified as a specific problem.
- Many service users lack basic life skills and need additional support.
- It was noted that many of this service user group had a history of eviction and arrears from local housing associations, and, for similar reasons, had 'burned their bridges' with many of Halifax's private landlords.
- The available private properties tend to be clustered in deprived areas of the borough, are often in poor repair or are in areas of known drug use and are therefore known to drug dealers.
- Chaotic drug use was unanimously cited as a barrier to housing by agencies attending the review workshops. Even the low threshold Winter Shelter that opens to provide shelter over the winter period has struggled to manage active drug users, evicting many for either using or dealing on the premises. Both Lenny and Jason used the winter shelter but were evicted for breaking drug-related rules.

6.6.4 Lenny and Jason were both reported to be sleeping rough but were never verified by outreach workers, and neither seems to have been able to actively sustain seeking of accommodation. Peter and Pat never received any housing support, despite their obvious vulnerabilities, and there is no record of them being either offered or declining such support. Zeb had received housing-related support twice, in 2009 and again in 2015, and both periods of support coincided with periods of stability for him. His housing worker is described as supporting him with his keeping of appointments, his management of his finances and in complying with his medication regimes. Zeb did not have any housing support in place at the time of his death.

6.6.5 Accommodation is difficult to maintain for active drug users due to restrictive policies, fear and lack of knowledge about the law.

6.6.6 The main articles of legislation requiring consideration by providers of housing to drug users are Section 8 of the Misuse of Drugs Act (1971) and Section 1 of the Anti-social Behaviour Act (2003).

6.6.7 The former came dramatically to the attention of homelessness services in 2000 following the imprisonment of two members of staff from the Wintercomfort Centre in Cambridge, for 'knowingly permitting or suffering' the supply of drugs on site. This case almost certainly led to restrictions in access to housing for homeless drug users. However, it also prompted the need to clarify legal obligations and the principles of good practice in housing and support services.

6.6.8 The Misuse of Drugs Act (MDA) 1971: Section 8, places legal obligations on occupiers, workers, managers, and directors ('concerned in the management') of premises to act

when specified drug activities are taking place. The obligations apply in specific circumstances stated in the Act, where persons knowingly permit or suffer:

- production or attempted production of a controlled drug
- supply, attempting to supply or offering to supply a controlled drug to another
- preparation of opium for smoking and the smoking of cannabis, cannabis resin or prepared opium.

6.6.9 It should be noted that the Act does not place any legal obligations on organisations to stop the use of any substances other than cannabis or opium on their premises. Permitting the use of other substances such as heroin or cocaine, including through injection on premises is therefore not illegal. Nor does the Act require the exclusion of service users in possession of controlled substances or those who have used substances (including cannabis) elsewhere. However, the Anti-Social Behaviour Act (2003): Section 1, provides the police with powers to close and seal premises where there is reasonable evidence that a property is associated with the production, use or supply of Class A drugs, and that the property is associated with disorder or serious nuisance.

6.6.10 Homeless Link (2019) provides guidance and training for homelessness accommodation providers to develop their ability to work with drug users, and they suggest it is important that an organisation has the following in place:

- Clear entry criteria
- A comprehensive assessment – to determine the type of drugs being used, and the frequency, history of use and type of administration (i.e. smoking, injecting, vaping, snorting)
- Risk assessments – based on the tolerance levels of the service and its setup, other clients, staff and the individual themselves
- Regular key-working sessions
- Correct and legal policies and procedures – to ensure that people that use drugs, as well as other clients and staff, are safe and supported appropriately, and that services operate within the law
- Good joint working arrangements
- An effective relationship with the police to enable safe working practices and joint ownership and support to be offered to people who use drugs

6.6.11 Housing Options staff highlighted the lack of complimentary services to support the work of tenancy related support. They talked about Street Reach Tenancy Sustainment

having to clean up after clients and needing to repeatedly deal with hygiene issues in order to prevent eviction. For them, such issues were primarily care, not tenancy, related.

6.6.12 This year's (2020-21) Winter Shelter project received 54 residents in the first three months. 19 were dependent on alcohol, heroin or crack, and a further 15 described themselves as recreational substance users. Of the 19 drug-dependant users, six had co-morbid mental health problems and had a community psychiatric nurse allocated to them and four had been evicted from the shelter. It is important to understand that the Winter Shelter operates with low levels of staff, relying heavily on volunteers, many of whom are inexperienced and so the focus of their work is primarily the safety of everyone in the building.

6.6.13 In the 2018/19 financial year, 65% of the households in receipt of homelessness prevention or relief duty by Calderdale Council comprised single people and 43% were single males. 55% of all households owed a duty were comprised of people under the age of 35. There is clearly a shortage of affordable accommodation for single people in Calderdale.

6.6.14 Zeb was especially vulnerable to exploitation since all his Halifax addresses were in areas known to be low-rent, high crime areas where drug users congregated. His chaotic lifestyle and vulnerabilities put him at risk of 'cuckooing', a practice where a person's home is taken over and used to facilitate the dealing, storing or consumption of drugs, for sex work or simply as a place to live.

Current Housing Developments

6.6.15 During the last year, Calderdale Council has rapidly developed a strengthened multi – agency response to this group. A full time Rough Sleeper Navigator has been recruited whose role is to coordinate support for individuals, review pathways and encourage joint working. He coordinates a well-attended monthly Task and Target multi-agency meeting. Funding was also secured to appoint an additional Navigator and tenancy sustainment officers to be based within the Street Reach team managed by Horton Housing.

6.6.16 Funding for these posts has been largely centrally allocated and time limited external, and as they are short term, it will be important to seek alternative funding sources if these posts are to be sustained long term.

6.6.17 The frontline service at Customer First have received training to enable them to deal with complex issues, and a dedicated prevention officer focuses on early intervention, ensuring people can remain in their homes or access alternative long-term accommodation, rather than accessing temporary accommodation.

6.6.18 The Winter Shelter opened on October 1st, 2019 for a six-month period.

6.6.19 These developments are both having positive impact on individuals and improving partnership working. Calderdale's most prolific rough sleeper last year, who lived in the tent with Pat, has been worked with intensively. It has taken 18 months to get him into accommodation, due to his complex needs and his suspicion of services, but sustained engagement has also provided an opportunity to test and develop pathways.

Access to suitable accommodation Recommendations:

A review of the Calderdale homeless strategy is scheduled for 2021. Due to the complex needs of this population this strategy must have multi-agency input and engagement. The findings of this SAR should influence this strategy. The governance of this strategy should be overseen by a Partnership Board.

All agencies to recognise that support to gain and sustain a tenancy is not the sole responsibility of one agency. It requires a multi-agency response including housing, health and care.

To explore ways to provide intensive and long-term support to those people who struggle to overcome the barriers in maintaining a tenancy. This should include:

- ***Addressing accommodation barriers for active drug and alcohol users even if they are not ready to change their drug or alcohol use, learning from good practice in other areas of the country.***
- ***Maximise opportunities to support people to have the rent component of Universal Credit to be paid directly to landlord.***
- ***Whilst acknowledging that much central funding is short term and piecemeal funding for homeless support services, solutions should be sought to secure longer-term funding of posts and services to provide stability to homeless support services.***
- ***That when applying for the anticipated capital funding to develop more direct access accommodation available through the Rough Sleepers Initiative, Calderdale should consider the learning from this review. Accommodation should be developed on PIE (psychologically Informed Environment) principles.***
- ***Options for funding the response to rough sleeping is considered urgently by Calderdale MBC as funding streams end in 2021.***

6.7 How do we prevent such deaths?

Leadership

6.7.1 The support of both Calderdale's Council's corporate leadership team and Adult Safeguarding Board to undertake this review demonstrates their respective commitment

to addressing the pressing issues of people living a street-based life, who may also be rough sleeping and have multiple and complex needs.

6.7.2 There is, however, no accountability framework to support system level assurance on delivery and accountability for mutually agreed outcomes relating to this group.

6.7.3 An NHS Long Term Plan objective is to improve the health outcomes of rough sleepers and provides opportunities to engage with health leaders.

6.7.4 The Government's National Rough Sleeping Strategy acknowledges that rough sleeping is not just about housing, and as such, the strategy encompasses input from the Department of Health and Social Care, the Home Office (including Police and Crime Commissioners), the Department of Media, Culture, and Sport as well as from local communities and local government, showing the need for a cross-government approach and for shared responsibility for the agenda. It is an approach that should be replicated at local authority level.

6.7.5 Calderdale Council is required to produce a strategy for tackling and preventing homelessness and plans to do so in the 2020/21 financial year when revising the current Homelessness Strategy , the Housing Options team have developed the Rough Sleeping Action Plan 2019–2021, which recommends actions relating to health, and in particular, to mental health providing opportunities to involve wider stakeholders.

6.7.6 In addition to the human cost of rough sleeping, there is clear evidence of high total system costs, and therefore an opportunity for whole system efficiencies exists by holistically tackling the issue. In 2015, a report produced by Lankelly Chase estimated the costs of rough sleeping to the public purse as being between £14,300 and £21,200 per person per year - three to four times the cost to public services of an average adult. The longer a person is rough sleeping, the higher the cost. For the NHS the cost is particularly high. In a recent Calderdale case, a man in his fifties with an alcohol problem living a street-based lifestyle was in the 2016-2018 period calculated by West Yorkshire Finding Independence (WY-FI) using the standard costings in the Troubled Families Database was estimated to have cost public services £107,274, NHS costs being £90,156 of this.

6.7.7 He has since been referred to Adult Social Care Services for a Care Act assessment with a view to securing a placement where he can safely consume alcohol and receive care, such a placement costs around 50% of the of the incurred hospital services and provides long-term safety and stability.

6.7.8 This man was in institutional care as a child and suffered further abuse in his placement giving us some insight into the trauma and restraumatisation this man experienced. Housing staff interviewed during this review felt that the presenting housing need was often the result of long and complex traumatic personal histories. This case also

highlights where the system uses resources reacting to the consequences of not providing the right interventions earlier in the life course.

Public Health

6.7.9 There is clear health inequality when comparing homeless people to the rest of the population, they are approximately:

- 50 times more likely to have Hepatitis C
- 34 times more likely to have Tuberculosis
- 20 times more likely to die from illicit drug use
- 9 times more likely to commit suicide
- 8 times more likely to have epilepsy
- 4 times more likely to have a mental health problem

Inter-agency Communication

6.7.10 Homeless Link (2018) described how different perceptions or interpretations of risk between agencies can lead to inappropriate referrals being made or can exclude clients from accessing some services, and that sharing information concerning risks needs to take place at the same time as the sharing of other information, to establish a more overall assessment. Information on levels of engagement and support needs were also vital components. Homeless Link suggest that not all of the clients had given consent or had had an informed discussion with their case worker about how their information would be shared, yet nearly all wanted their information to be shared so it would help better co-ordinate their support and minimise or avoid duplication.

6.7.11 Effective information sharing can be a challenge in all organisations, and the cases reviewed here have highlighted how failures in information sharing have contributed to disjointed case management. This has been an issue between the drug treatment service and the RAID Mental Health Liaison Team at Calderdale A&E. Drug treatment keyworkers were not aware that their patients had attended A&E requiring mental health support from the RAID team. In Peter's case, the health visiting service at the time did not use the same electronic record as his GP, and in consequence the outcomes of any visits were not known by the GP. At the time of this review the mental health service (SWYFPT) similarly did not use the same electronic record as a patient's GP, resulting in mental health care plans not being easily available to the GP, but this is currently being addressed.

6.7.12 Computer systems within the Local Authority are also not always linked. The Housing system and the Social care's CIS system were not cross referenced. In Peter's case, if they had been, the referral regarding his vulnerability made in 2016 would have been discovered and may have forestalled his eviction.

6.7.13 Concerns about confidentiality and data-sharing between organisations, particularly when liaising with NHS providers, was discussed in the practitioner workshop, this resulted in some agencies (third sector) not feeling able to contribute fully to multi-agency care planning.

6.7.14 The use of flags and alerts was discussed in the Managers' workshop. In Lenny's case, the only flag or alert that all agencies were aware of was when he was flagged as a domestic abuse perpetrator. Lenny was however both a victim and a perpetrator of domestic abuse.

6.7.15 There is currently no formal system of setting flags or alerts where an individual with multiple and complex needs who is also rough sleeping has disengaged from services or is not being seen at their habitual sites. Elsewhere however, there are examples of multi-agency databases recording information about people sleeping rough and the wider street population.

6.7.16 Most agencies used some internal system of flags or alerts, but in the main these were described as relating to staff safety (for example no lone working or no female workers) as opposed to client vulnerability, and this information was not systematically shared across organisations.

6.7.17 Those organisations or agencies using flags, particularly Housing and the Probation Service, stressed the importance of understanding the purpose of flags and ensuring that they are reviewed regularly.

6.7.18 Another commonly voiced concern amongst frontline workers spoken to during the review was around the issue of consent. Consent is required to refer into adult social care services, and workers described many of this service user group as not consenting because of fear of statutory service involvement, or because they were often intoxicated or difficult to locate to confirm consent.

6.7.19 Concern about breaching The General Data Protection Regulations (GDPR) was mentioned several times, but GDPR allows organisations to share 'special' information (the GDPR term for sensitive information) about clients without their consent in some limited circumstances.

6.7.20 Information-sharing affects the comprehensiveness, timeliness and effectiveness of needs and risk assessments and of support plans, impacting on swift and appropriate referrals and their follow up. There are examples of this in the review case stories, where referrals had been made but not followed up. For example, Peter was referred to Psychology Services, but no record is available as to whether this in fact resulted in Peter ever being seen.

6.7.21 The idea of an 'assessment passport' was raised in the staff workshops as a way of ensuring that assessments travelled with the service user to prevent them having to retell their stories to numerous agencies, and an online portal was suggested as a means of facilitating this.

6.7.22 All the cases reviewed had multiple and complex needs requiring the input of numerous agencies. This requires co-ordination. In such cases a lead co-ordinator should be identified and given responsibility for oversight.

6.7.23 Better communication between organisations may result in better use of existing resources. For example, the development of pathways between the drug treatment service and the hospital, could both improve outcomes and maximise resources through the use of Calderdale's community detoxification house for patients discharged following an admission to hospital where the episode of care additionally required a short hospital detox, but patients remain in need of respite and support.

6.7.24 Whilst only one of the subjects of the review had a dual diagnosis of mental illness and substance misuse, the absence of a dual diagnosis service was highlighted as a common area of concern by both the review workshops and by many of the people spoken to across a variety of agencies during the review.

Safeguarding

6.7.25 There is some evidence of reluctance amongst statutory bodies to see the situation of rough sleepers who self-neglect as a safeguarding matter. We know that when workers are engaging with people living street-based lifestyles over many years that there is the danger that the high levels of risk that characterise this client group can become normalised amongst the workforce.

6.7.26 Third sector workers who had the most face-to-face contact with service users described feeling that they had been left "holding the baby" and were not supported by other agencies. They expressed a lack of clarity surrounding the thresholds of adult health and social care services engagement and felt that there were negative attitudes towards rough sleepers, which they felt was perceived by some as a lifestyle choice.

6.7.27 Possible missed opportunities with those men who form the case studies may have arisen because key agency workers (outreach workers, drug treatment key workers and winter shelter staff) did not understand their role in raising a safeguarding concern.

6.7.28 During the review period a consistent effort has been made to make safeguarding referrals by the Rough sleeper Navigator, he reports a lack of feedback on referrals he has made to Adult Services and Wellbeing, excessive waits (over 12 months) for care act assessments where clients had consented and attendance by statutory services at meetings about clients of concern had been poor.

6.7.29 Housing and Street Reach staff felt they needed prompt and effective feedback from Safeguarding Referrals. They felt they needed to understand the "rules" and timescales allowed for assessment and that this needed to be transparent. Where agencies still had concerns, they felt were not being addressed, they felt unaware of the processes of review, challenge or escalation.

6.7.30 It is important to note here that by review completion work has been undertaken to address these issues and it is significantly improving.

6.7.31 Martineau et al (2019) reported that eight of the 14 SARs forming part of their review recorded self-neglect as a factor. These SARs articulated concern among practitioners about the relationship between addiction and self-neglect. In one SAR, three referrals for self-neglect did not give rise to a section 42 CA enquiry. In another, the SAR author found that practitioners did not understand that self-neglect could trigger such an enquiry.

6.7.32 Calderdale Safeguarding Adults Board has a Multi–Agency Self–Neglect Policy and toolkit, revised in June 2018. Key agencies and frontline workers (outreach workers, drug treatment key workers and winter shelter staff) were however either unaware of this policy or not confident that it related to this user group.

6.7.33 Three SARs used Making Safeguarding Personal as an evaluative measure in relation to agency activity. There is no evidence that this initiative had been implemented in practice amongst local agencies working directly with those living street-based lifestyles.

6.7.34 The lack of 'professional curiosity' highlighted in this review (particularly so in substance misuse services) was echoed in the SARs in the Martineau review, many of which expressed concern about what is described as a lack of 'professional' or 'concerned' curiosity among professionals. This ranged from simply lack of interest in the homeless person's 'story', to a failure to see patterns in the person's record that might have triggered a safeguarding alert.

6.7.35 Practitioners interviewed during this review speculated that curiosity may be inhibited by a fear that they do not have the capacity to take ownership of such cases when operating within overstretched Adult Social Care resources.

6.7.36 Difficulties with engagement, the normalising of risk and many practitioner attitudes evidenced in this review were also common themes in the Martineau review. There was also evidence to suggest that practitioner attitudes about people with substance misuse problems might negatively influence safeguarding responses.

6.7.37 Martineau also highlighted concern about the use of the Mental Capacity Act 2005 (MCA) by practitioners in relation to this client group. They reported that practitioners lacked confidence in applying the MCA, particularly where the person's capacity may be fluctuating due to their substance misuse.

6.7.38 In the cases of the men reviewed in this report, there was clear evidence of self-neglect and the taking of decisions considered unwise by others, yet there is little evidence of use of the MCA during the last six months of their lives. This was discussed at the Practitioners' workshop, conducted as part of this review. Several agencies fed back that the MCA was rarely used with this group as they needed to be sober to undertake an assessment, and that they rarely were.

6.7.39 Homeless Link's (2017) briefing 'Taking Action' following the death of a rough sleeper in 2017 highlighted the potential for Care Act and Mental Capacity Act provisions to protect individuals at risk and provides examples of effective prevention measures.

Harm reduction

6.7.40 Other than the men being able to access substitute opiate prescriptions, there is no evidence of explicit harm reduction interventions, particularly given the men's living circumstances.

6.7.41 Harm reduction models appear to meet with more success with this patient group than striving for abstinence, though it needs to be borne in mind that the goals of such models are more limited than those which aim for complete abstinence.

6.7.42 Naloxone is an antidote to counteract an opiate-related (e.g. heroin, fentanyl or methadone) overdose. Naloxone temporarily reverses the effects of such an overdose, which gains vital time before paramedics arrive. Whilst Jason, Zeb, Pat and Lenny all had a history of overdose, it appears none of them had been offered Naloxone since 2017.

6.7.43 As a consequence of this review the drug treatment service are developing a 'peer-to-peer naloxone' project, which involves training a team of people who have experience of drug issues in how to administer the medicine, who take naloxone out on to the streets to give to opiate users, meaning people do not have to rely on access to treatment services to receive the medicine.

6.7.44 They have also designed a mortality risk assessment that they will pilot in Calderdale. The aim of the pilot is to use national and local data and best practice to identify, via a flagging system, service users who are at risk of mortality through overdose. This work is intended primarily to support identification and risk management on an individual client basis but will also be of use to the broader system by highlighting prevalence and risk factors.

6.7.45 Calderdale's current remodelling of substance misuse treatment provision will improve service delivery for this group. It is planned to have on-site dispensing of medication for the more chaotic and complex clients, which removes the need for restrictive appointment times and ensures that this user group are seen daily by specialists. Opportunities are being explored with partners to secure secondments into the service of a community psychiatric nurse, a social worker, and a primary care nurse. The remodelling

will release resource to work with partner agencies to systematically attempt to outreach those who have dropped out of treatment but continue to be present on the streets, in order to re-engage.

Prevention Recommendations:

- ***The Calderdale Public Health Team consider rough sleepers and those living a street-based life as a priority group in addressing health inequalities and develop a specific JSNA (joint strategic needs assessment) profile to inform service development and commissioning.***

- ***Develop a system to identify and support those people who are at significant risk of developing multiple complex needs which ensures that when an individual's mental and physical health, social and housing needs are deteriorating, that these are recognised and that a coordinated, multi-agency response prevents further decline. The CSAB should consider the development of a process be it multi-agency hub or panel to support those who chronically disengage from services. Such a system should also consider child to adult transition.***

- ***The costs (and therefore the efficiencies) would be spread across the various agencies involved and collective decisions will therefore be needed to realise the benefits, it is recommended that the Homelessness Strategy 2021 should be shared and jointly developed and owned by health, housing, social care and the voluntary sector. This strategy should develop an accountability framework which identifies a Board that will monitor and be accountable for this work.***

- ***Safeguarding processes for this user group are reviewed and that pathways and communication systems are refreshed and shared with all key agencies in order to maximise the potential to safeguard this user group.***

- ***Safeguarding policies and procedures should be reviewed to ensure that this user group are able to access safeguarding services. A multi-agency training package is developed by the CSAB to improve practitioners understanding about eligibility criteria, identification of safeguarding needs, the expected safeguarding response (including promoting use of the self-neglect toolkit), trauma informed practice, professional curiosity and disguised compliance, information sharing arrangements and the application of the Mental Capacity Act for this user group.***

7 References

"Knocked back: Failing to support people sleeping rough with drug and alcohol problems is costing lives", 2020

"Psychologically Informed Services for Homeless People – Good Practice Guide", 2012, Department of Communities and Local Government, Robin Johnson, co-author

Addressing the Health Needs of the Homeless. British Journal of Community Nursing 16(3): 134-139, John W. and Law K. (2011).

Anti-social Behaviour Act, 2003

Getting Serious about Stigma: The Problem with Stigmatising Drug Users, UK Drug Policy Commission (UKDPC), 2010

Great Britain. Homelessness Reduction Act, 2017

Hard Edges: Mapping Severe and Multiple Disadvantage in England, Glen Bramley, Suzanne Fitzpatrick, Jenny Edwards, David Ford, Sarah Johnsen, Filip Sosenko and David Watkins, 2015

Healthy London Partnership, Safeguarding Adults Who Sleep Rough in London, 2018

Homeless Link - Reflective Practice in Homelessness Services - An Introduction, 2017

Homeless Link, Reflective Practice in Homelessness Services: An Introduction, 2017

Homeless Link: Safeguarding Adults at Risk 2 Safeguarding Vulnerable Adults: Guidance for Frontline Staff

Homeless Link: Working with People Who Use Drugs v2, Produced by Innovation and Good Practice, 2019

Homeless Link: Working with People Who Use Drugs, Guidance for Homelessness Accommodation Services, 2019

Homelessness and Complex Trauma: A Review of the Literature. University of Southampton Maguire, N.J., Johnson, R., Vostanis, P., Keats, H. and Remington, R.E., 2009

Homelessness as Psychological Trauma: Broadening perspectives. Goodman, Lisa A.; Saxe, Leonard; Harvey, Mary: American Psychologist, vol 46 (11), Nov 1991, 1219-1225.

Homelessness: A Barometer of Social Justice, The Lancet, Rob Aldridge, Open Access, 2019

HUMANKIND: How to Manage lost prescriptions and Medication Emma Haigh 01/05/2019

LGA Survey, 2019

London Homeless Health Programme, 2017

MEAM, 2018

Misuse of Drugs Act, 1971

NICE Guidance, 2004

Office of National Statistics Deaths, 2018

Preventing Retraumatization: A Macro Social Work Approach to Trauma-Informed Practices & Policies, Karen Zgoda, Pat Shelly, Shelley Hitzel, 2016

Psychologically Informed Environments - No One Left Out: Solutions Ltd, for Westminster City Council, 2015

Recognising the Link Between Trauma and Homelessness, European Federation of National Organisations Working with the Homeless, Feantsa, 2017

Rough Sleepers' Health and Healthcare: John Bradley, NHS Public Health Wales, 2008

Rough Sleeping in England: Autumn 2018. Annual statistical release about the number of people sleeping rough in local authorities across England, Office for National Statistics (ONS), 2019.

Rough sleeping in London (CHAIN reports) Greater London Authority (GLA), 2015

Safeguarding, Homelessness and Rough Sleeping: An Analysis of Safeguarding Adults Reviews, Martineau, 2019

Sepsis: Recognition, Diagnosis and Early Management, NICE guideline [NG51], 2017

Sheffield Hallam University, Centre for Regional and Economic Social Research: The evaluation of West Yorkshire Finding Independence project, Richard Crisp, Del Roy Fletcher, Sadie Parr, Ian Wilson, 2018

The Care Act, 2014

The complexity and challenge of 'dual diagnosis'

The Homelessness Reduction Act (HRA), 2017

The Mental Capacity Act (MCA), 2005

The Rough Sleepers Strategy, 2018

Traumatic Brain Injury in Homeless and Marginally Housed Individuals: A Systematic Review and Meta-analysis, Jacob L Stubbs, BKin Prof Allen E Thornton, PhD, Jessica M Sevick, BEng, Noah D Silverberg, PhD, Alasdair M Barr, PhD, Prof William G Honer, MD et al. Open Access, 2019