Learning & Themes from Homeless Mortality Reviews in 2022

Explanatory Notes

The purpose of this document, is to highlight the learning and themes that have been noted, following the reviews into the sad deaths of people in Oxfordshire, who were either without accommodation, or were living in temporary accommodation, at the time of their death.

Contents

Summary Table	This shows a summary of the person's story, the cause of their death and the learning from the review.	2-11
Themes	Shown in a list in relation to the individuals and in a table for organisations	12-15
Case Studies	2 Case Studies showing good practice that led to positive outcomes for the individuals concerned.	16-17

<table>
<tr><th>Initials</th><th>Concerns</th><th>Cause of Death</th><th>Learning</th></tr>
<tr><td>AA</td><td>History of involvement with mental Health Services in various settings, but while they presented with low mood, suicidal ideation, hearing voices etc, they did not appear to have a formal diagnosis.
AA informed the Drug & Alcohol Service that ‘the Dr’ had diagnosed PTSD & Psychosis, but they were due to be re-assessed.
Support agencies unable to get an understanding of their mental health needs.
Was evicted on several occasions due to their behaviour.
8 Agencies involved.</td><td>1a) Hypoxic brain injury following cardiac arrest

1b) Multidrug toxicity (ethanol, heroin, cocaine, amitriptyline)</td><td>It is felt that having a Co-ordinator/Lead Professional with some oversight would be helpful, to highlight gaps with someone’s overall support across agencies – Make Every Adult Matter (MEAM) could help with this.
More flexibility required throughout the system when working with clients living such lifestyles – staff need to be supported to make changes to better suit the people they are working with.
Availability of a shared database could allow multiple agencies access to relevant information to improve outcomes for people with no home.
There should be provision for people who are struggling with their behaviour/managing their emotions, when they present as a risk within the accommodation, they are in. Some sort of respite/ emergency bed.</td></tr>
</table>

Initials	Concerns	Cause of Death	Learning
AB	• Incomplete picture of their mental health diagnosis • Safeguarding triage took over 6 weeks • Concerns from professionals were around their mental health, addictions and fear that they were being coerced into selling drugs. They were also refusing medical help. The referral was closed after speaking with AB who confirmed they weren't being abused. • Barrier to finding suitable accommodation due to disagreements over local connection. • Suffered from Epilepsy and was not able to manage their medication properly • 10 Agencies involved	1a) Alcoholic Ketoacidosis 2) Fatty Liver Disease	• It is felt that having a Co-ordinator/Lead Professional with some oversight would be helpful, to highlight gaps with someone's overall support across agencies – MEAM could help with this. • There was a lack of professional curiosity and there didn't appear to be a full understanding of the concerns of other professionals working closely with complex clients. • Consideration to be given as to what constitutes a care & support need under Section 42 and how it impacts on a person's ability to protect themselves. • Agencies need to work together, to support each other with a view to the 'person' getting the right support and to assist the agency who is working with them • Assistance needed for clients who require medication but are not always capable of managing it for themselves. • Access to services for someone with dual diagnosis

Initials	Concerns	Cause of Death	Learning
AC	• Brain Injury • Epilepsy and was unable to manage their medication properly • Victim of Domestic Abuse • 8 ED Admissions leading to them being advised to contact the Drug & Alcohol Service (although history shows they don't engage). 1 Referral to Alcohol care Team. • Delay in Safeguarding triage due to AC being in Temporary accommodation in a neighbouring authority. It was unclear who had responsibility. • Safeguarding referral closed because AC advised they were no longer in the relationship and their care needs didn't impact on their ability to keep themself safe. Was consideration given to their brain injury, epilepsy, self-neglect or mental capacity? • Mental Health Services had a plan to support AC, but AC didn't engage. Perhaps this could have been pursued more? • Waiting for someone to be 'sober' or 'clean' before being able to engage with them to move forward.	Multiple Organ Failure Aspiration Epileptic seizure	• Lack of single Co-ordinator/ Lead Professional with some oversight – MEAM • Professional curiosity and a full understanding of concerns of other professionals working closely with complex clients • Assistance needed for clients who require medication but are not always capable of managing it for themselves. • More flexibility required throughout the system when working with clients living such lifestyles – staff need to be supported to make changes to better suit the people they are working with. • Staff need to be able to/have capacity to offer 'assertive outreach' to meet with clients at the point in the day, or week that they may be 'at their best', although maybe not completely 'sober' or 'clean'. They also need to be able to and be supported to keep trying.

Initials	Concerns	Cause of Death	Learning
	• Rules excluding people, without consideration into why someone doesn't fit their criteria, or if the rules are causing additional issues, or blocks (*e.g., AC had an offer of a placement in a rehab, but lost the place due to a relapse over the Christmas & New Year period. There didn't appear to be any consideration of why this happened and yet this time of year is probably the most emotional and difficult time for many people, but more so for those who struggle to manage their emotions*). • When AC was placed in a neighbouring authority and moved away from most of the services trying to support them. There didn't appear to be a co-ordinated plan to support them through this transition, or a lead person for agencies to contact to plan support or manage risk. • 11 Agencies Involved		• For people with this level of complex difficulties, there should be a meaningful risk assessment and support plan that is shared with all the agencies working with them. This would create focus and reduce any duplication of work. • Adult safeguarding team is stretched & they require staff to assist with volume of calls and enable further investigation into each referral. • Availability of a shared database could allow multiple agencies access to relevant information to improve outcomes for people with no home. • Access to services for someone with dual diagnosis

Initials	Concerns	Cause of Death	Learning
AD	• Long-term Coercive relationship • Unrealistic expectations of housing options, benefit system and support • Shared mistrust of services/organisations. • Frequent refusal of accommodation offers, choosing to sleep rough as the alternative. • Safeguarding referrals made due to Domestic Abuse, but couple assessed as being in a co-dependant relationship and that AD was not showing signs of fear or distress – both referrals closed. • Support agencies felt they would benefit from more input from statutory agencies and that they had to build up evidence before re-referring. • No Multi-agency meeting held to have discussions about how to best support the couple, between statutory and third sector agencies. • Care Act Assessment was requested and the couple refused the assessment. They were deemed to have capacity to refuse the assessment. Unsure if there was an assessment around their capacity to refuse	07/06/2023 - Metastatic Carcinoma of the Chest Wall	• Lack of single Co-ordinator/Lead Professional with some oversight – MEAM • Professional curiosity and a full understanding of concerns of other professionals working closely with complex clients • Consideration to be given as to what constitutes a care & support need under Section 42 and how it impacts on a person's ability to protect themselves. • Agency referring to Adult Safeguarding were unsure what to do or where to get help regarding their concerns for welfare • Agencies need to escalate if they feel unsupported. • Agencies could learn from this case about determining the difference between an 'unconventional' relationship (as the couple viewed it) & how they were assessed by Social Care and a coercive relationship, as seen by other agencies.

Initials	Concerns	Cause of Death	Learning
	accommodation, benefits and access healthcare? • The Care Act Assessment could have been pursued under Section 11 of the Care Act, part 2 (although this would go back to consideration about their capacity and belief of the abuse) • 6 Agencies involved		• Multi-agency approach to ensure that the options available to the couple are discussed and then put to them, to assist them with managing their expectations.
AE	• History of failed tenancies • Delay in moving them from homeless services to settled accommodation • Poor health since 2020 – no background information to this. • AE's health deteriorated rapidly in the 6 weeks prior to their death. During which time they were diagnosed with pancreatic cancer. • 4 Agencies involved	1a) Ischaemic stroke and metastatic pancreatic cancer 2) COPD	• People in Homeless Services should receive some level of priority for 'move-on'. • For those where move-on to general needs accommodation is not appropriate, there should be routes in place for the alternatives. • Better Co-ordination of housing options with all relevant agencies, to agree a plan. (i.e., general needs, care homes, extra care homes, housing first etc) • Head scan missed – was this a missed opportunity?

Initials	Concerns	Cause of Death	Learning
AF	• Had an on/off relationship with someone who had accommodation. AF would sometimes be able to stay there. This led to an unstable housing situation. • AF was reluctant to stay in the homeless services, quoting reasons such as noise, affordability and bank problems. • They chose to leave the last accommodation in March 2021. • In January 2021 AF advised a support worker that they had a Learning difficulty (but they couldn't say what it was), depression, anxiety, arthritis and they believed they had diabetes due to their alcohol use. • Support worker attempted to get clarity from the GP around AF's Learning difficulty. After delay in responding, GP returns call & advised AF has a mild learning difficulty & mental health issues. They were not able to confirm any details due to AF's non-attendance. AF was last in surgery towards the end of 2019.	1a) Obesity Cardiomyopathy 2) Steatohepatitis	• Lack of single Co-ordinator/Lead Professional with some oversight – MEAM • Availability of a shared database could allow multiple agencies access to relevant information to improve outcomes for people with no home. • AF had no stable accommodation, which made following up on missed appointments & discussions about his alcohol use difficult. • Missed appointments not followed up in a timely way. • When AF did attend the GP surgery, there appeared to be a lack of connectivity with previous medical history. They would have seen that the GP had wanted blood tests done. (Making Every Contact Count). • No Multi-agency approach to jointly review AF's options & share the risk.

Initials	Concerns	Cause of Death	Learning
	• AF missed 3 appointments with the GP over a 3 month period and when they did attend for their COVID Vaccine, there did not appear to be any follow-up from the previously missed appointments. • AF attended the emergency department twice. Both times due to pain while urinating and blood in urine. On the second visit, it was noted that AF had been homeless for 3 weeks and the plan was to prescribe antibiotics & arrange for the embedded housing worker to review their options. AF absconded. A referral was made to the Adult Safeguarding Team (ASG). • 2 Referrals were made to ASG Team. One in March 21 due to feeling suicidal – AF was signposted to their GP and referral closed. The 2nd was from the Hospital due to them being homeless. The referral closed. • Only formal involvement with mental health service was in 2015, when Criminal Justice and Liaison Service carried out a Court Diversion Report (offence unknown) – they state AF had a good insight to depression and understood that alcohol was a depressant. They recommended AF access		• While AF was refusing to address their drinking, yet believed they had diabetes due to their drinking, had anyone considered a Mental Capacity Act Assessment? • In circumstances where the hospitals are aware that someone is homeless, or will be homeless when they are discharged, or if they abscond – clear referral routes should be in place to access statutory housing services, or other appropriate housing support, along with escalation routes. • Access to services for someone with dual diagnosis

Initials	Concerns	Cause of Death	Learning
	the Drug & Alcohol Support Service, but AF was not interested. • 4 Agencies involved		
AG	• In 2014 AG was assaulted, leading to them being in a coma. When they came out of the coma, they were unable to walk and feed themself for over a year. They were left with a permanent brain injury and problems with memory. • AG misused alcohol and class A drugs • AG was in a volatile relationship & both parties would breech tenancy agreements and bans to stay with each other. Sometimes AG would sleep rough with their partner if they couldn't stay together. • English was not AG's first language. • Probation requested Adult Social Care do a 'Capacity Assessment' – they recommended using translation services and to get the GP to assess AG's mental capacity. There is no information on this being followed up. • Support workers helped AG to apply for settled status. • During this process (2 months) they had no recourse to public funds.	07/06/23 - The precise medical cause of death has yet to be established	• Lack of single Co-ordinator/Lead Professional with some oversight – MEAM • Access to services for someone with dual diagnosis • Availability of a shared database could allow multiple agencies access to relevant information to improve outcomes for people with no home. • There should be a multi-agency approach to people in homeless services with a brain injury. This should lead to joined up planning around assessments, understanding how best to support them, look at what would be suitable settled accommodation and agree actions. • Staff need access to good quality translation services

Initials	Concerns	Cause of Death	Learning
	• There was a Hearing held by Home Office, as they were considering AG for deportation. • Released from a short stay in prison, with no plans regarding housing. Street Outreach team saw them in town 2 days after the Hearing. • Care Act Assessment carried out by Mental Health specialist in street services team. They recommended that AG have access to memory aids. • In April 2022 the COVID emergency accommodation was closed due to Government funding ending. Support workers attempted to work with AG to investigate their housing options, as they had received their settled status. • As AG was still engaging with the Drug & Alcohol Service, they attended their offices, but AG didn't follow up with any offers of assistance. • AG was 'sofa surfing' at the time of their death. • 7 Agencies Involved		• There were several times that reports state that AG 'did not follow up on offers of…..' Considering they had a brain injury, a language barrier & used drugs and alcohol, Staff should be able to actively follow-up with clients where there is such a history, to effect any change. • No Recourse to Public Funds (NRPF) could there have been better follow-up when trying to sort benefits etc, so this was sorted sooner. • Lack of curiosity around the MCA assessment. Was the assessment followed up? This may have led to them being housed. • Discharge to street from prison with no co-ordination.

Themes

For the individuals who have died:

- History of Trauma
- Complex issues with Mental Health & difficulties with a formal diagnosis
- History of Drugs/Alcohol misuse
- Struggle to engage with support being offered/the way support is offered
- History of offending
- Acquired Brain Injury
- Inability to manage medication (either due to poor memory or substance misuse)
- Poor physical health (often linked to substance misuse)
- Difficulties regulating their emotions

Issue	Impact	Solution
Lack of single co-ordinator, taking ownership of case management across organisations. Someone who could spot and act on data triggers (e.g., 8 ED presentations)	Missed opportunities - not making every contact count. Efforts not joined up - information missing	Consistent MEAM approach – Oxfordshire are looking to appoint a MEAM Co-ordinator who will have this role for a specified cohort. Much will be learned from this approach. Support is required from Director level, to encourage everyone to engage in this, for the best outcomes.
Lack of a shared risk management process.	Third sector holding too much risk Difficulty in getting concerns heard within statutory agencies	Shared risk management process driven by the By Names List (BNL) database. This is currently being developed with funding raised by MDT. Director-led conversations around sharing risk - give permission to work collaboratively/differently.
Lack of framework for when risks start to escalate in times of crisis and need an immediate response (as MARM would not be suitable in these situations.)	Spiralling risk and ultimately, untimely deaths	
Lack of awareness of risk – e.g., people not taking their medication, people moving out of area (away from support network)	Opportunities missed - risks spiral, person becomes more unwell	Training, shadowing and joint working. This needs to be a change within the system. An agreement across services such as Health, Mental Health, Adult Social Care, Housing Teams & Homeless Service Providers
Lack of curiosity and perseverance – e.g., potential brain injuries, language barriers, LD, autism, mental capacity…	Delays in assessments. Assessments not followed up so true picture not known.	Training, shadowing and joint working. This needs to be a change within the system. An agreement across services such as Health,

Issue	Impact	Solution
		Mental Health, Adult Social Care, Housing Teams & Homeless Service Providers
People not able to manage their medication and third sector not able to administer it.	People become more unwell – this could save lives	Review of commissioning specifications
Lack of flexibility in service models (within supported housing services, support) – people expected to fit resources, rather than services designed/flexing to meet the individual needs of complex cases	Inequalities in access to all services. People waiting for suitable bedspaces	Creative, persistent, flexible outreach. Housing providers able to accept a border cohort of people – this might need change to commissioning requirements.
Lack of Housing options to move people out of Homeless Services and into more suitable, settled accommodation (suitable supported housing, Rehab, Detox, Care Homes, etc)	People's specialist needs not being fully met. Including palliative/end of life care. Older people (55+) living in Homeless services. Someone ready for their own tenancy might deteriorate after a period, if not seeing an end to their situation.	Priority to be given to those ready for move-on to General Housing Register. Discussions in place with MDT and Care Home organisations to see if they will work with people who might still be drinking. Focus to be given to joined up working to move people out of the services as soon as possible when people are ready, or their support neds require more specialist provision. This needs to be director -led by all organisations with access to specialist provision and housing.
Lack of access to services for people who have substance use issues	Spiralling risk and ultimately untimely deaths	Change of mind-set and culture. This needs to be Director-led.

Issue	Impact	Solution
		Shape services to meet actual need - flexible, elastic boundaries and approach. This is an action for Commissioners, Directors and Management. Find a way to engage - see case studies below.
Underlying trauma not addressed, only surface symptoms at point of crisis	Patterns of coping mechanisms/behaviour repeat under stress	True psychological approach embedded in all services

SAB

Case Study 1 from OOHCT:

- Homeless young woman, 20 weeks pregnant
- Trauma, ongoing sexual and domestic abuse
- Heavy daily use of heroin, crack and alcohol, injecting into neck and groin – abscess, DVT
- Mental health crisis, not engaging meaningfully with any support offered or maternity appointments.
- Several serious incidents of domestic violence towards her during pregnancy, continued sex working
- Series of violent assaults on others and wanted by police.

What made the difference?

- Flexible, intensive support and attempts to engage
- Sustained and intensive joint work with Children's Social Care, Turning Point, Homeless Oxfordshire, Police, Probation, OOHCT psychologist, Hospital, Mental Health
- Thorough consideration of all legal frameworks – Protection vs Promotion of rights and autonomy
- Relationship-based practice
- Careful preparation with hospital staff for admission
- Sustained advocacy by Out of Hospital Care Team social worker and psychologist to prevent a move to an unsuitable or unsafe environment

Outcome

- Baby born in hospital without complications
- Approx. 2 months clean from all substances
- Regular contact
- Engaging in training and looking to join a college course
- Reconnected with family
- Accepted for own flat with Housing First
- Reducing methadone
- Continues to engage in psychology

SAB

Case Study 2 from OOHCT:
▶ Evicted from complex needs hostel twice ▶ Learning disability, trauma, mental health ▶ Use of heroin, crack, alcohol ▶ Living in tent in inaccessible field ▶ Multiple attempts to end life – detained under Mental Health Act and discharged to tent
What made the difference?
▶ Sustained efforts to support and advocate by OOHCT and Outreach ▶ Intervening in crisis – preventing needing to sleep rough ▶ Use of specific housing legislation to challenge district council and advocate for client ▶ Continuing efforts to advocate for community LD and MH support Recognition of what the behaviour is communicating
Outcome
▶ Now living in temp accommodation, not tent ▶ No incidents of violence, antisocial behaviour or mental health crises since moving in ▶ Re-connected with family ▶ Gained confidence – paying off own arrears ▶ Aiming for Housing First ▶ Small outreach package agreed – reduction in cost to local authority by preventing/delaying the need for more intensive support