Independent review into the death of an individual sleeping rough - C

May 2018

Contents

1. The Report Author

1.1 Neelam Sunder has worked across the West Midlands and nationally in the homelessness sector for 14 years. She has experience of both managing a frontline homeless service within the criminal justice sector and as a key strategic lead for homelessness across the region.

1.2 Neelam has expert knowledge in tackling rough sleeping, having supported the roll out of a number of national multi-million pound initiatives including the Places of Change Programme, No Second Night Out Initiative, Help for Single Homeless Fund, Homelessness Change Programme and Fulfilling Lives Supporting People with Multiple Needs Programme.

1.3 Neelam has worked extensively across the region with both voluntary and statutory sector services, influencing strategy development and service improvement alongside systems and culture change through the facilitation of collaborative approaches to prevent and tackle single homelessness and rough sleeping resulting in the delivery of coordinated cross-sector interventions.

2. Introduction

2.1 Worcester City Council commissioned this independent review following the death of a gentleman who for the purposes of this report will be referred to as C.

2.2 C was found deceased in a tent in Worcester in July 2016. This review will primarily explore known contacts and interactions between C and services in Worcestershire in the 12 months leading up to his death.

2.3 The aim of this review is to enable lessons to be learned, identify any missed opportunities for intervention and to prevent avoidable deaths of people sleeping rough in the future. The intention of the review is to identify opportunities for learning and service improvement; to improve outcomes for people sleeping rough. This review aims to learn from the incident rather than investigate it and does not seek to apportion blame.

2.4 This review offers an opportunity for Worcester City Council and local partners to work together to ensure that lessons learned are applied to future cases and recommended improvement actions are implemented to improve system approaches for individuals who sleep rough.

2.5 This review will use guidance set out in Homeless Link's briefing, 'Taking action following the death of someone sleeping rough'[1] to review the circumstances surrounding C's death. The briefing published in June 2017 recommends that the death of a person who is homeless should always result in a review taking place, even if this review is not a Safeguarding Adults Review.

[1] Homeless Link (2017) Taking action following the death of someone sleeping rough: https://www.homeless.org.uk/sites/default/files/site-attachments/Taking%20action%20after%20someone%20dies%20June2017.pdf

3. Safeguarding Adults Review

3.1 It is understood that a referral was made to Worcestershire County Council's Adult Safeguarding Team by a member of the public in November 2016 to undertake a Safeguarding Adults Review (SAR).

3.2 This referral was passed onto Worcestershire Safeguarding Adults Board (WSAB).

3.3 During November and December 2016 WSAB undertook a SAR scoping exercise with services in Worcestershire.

3.4 Information was collated from agencies thought to be involved with C's case to determine:

- Which agencies were involved with C.
- What involvement agencies had with C.
- Whether agencies had undertaken any formal internal investigations and/or identified any learning.
- Whether any issues had been identified by agencies that may require further investigation.
- Whether agencies were of the view that any form of multi agency review should be undertaken.

3.5 This information was considered by WSAB's Case Review Sub Group and a decision in December 2016 was made by WSAB not to commission a SAR, as C *"was deemed to, at his own choice, only have had very limited involvement with services in Worcestershire"* and *"that he had actually spent very little time in Worcestershire prior to his death."* WSAB stated that they did not believe there had been lost opportunities for multi agency working.

3.6 Questions were raised by local partners regarding the decision made by WSAB. In July 2017 the rationale behind the decision not to undertake a SAR was explained by WSAB to partners and the initial decision was upheld by them.

3.7 This review does not intend to explore whether or not the criteria for a SAR was met, nor does it seek to act as a substitute for a SAR.

3.8 This review sets out to examine known service interactions with C and to use this information to propose recommendations for improved practice.

4. Scope

4.1 This review will broadly consider three main questions as recommended in Homeless Link's briefing 'Taking action following the death of someone sleeping rough':

- What went wrong?
- What can we learn?
- What can we do differently?

4.2 As per the review brief prepared by Worcester City Council in December 2017, the scope of this review is as follows:

- To undertake interviews with key staff within agencies (voluntary and statutory) that were known to have contact with, and that interacted with C in the 12 months prior to his death.

- To examine known service interactions with C within the review period.

- To review and analyse service logs/case notes/case files where available, detailing work undertaken by agencies relating to C.

- To consider any earlier information outside the review period that is available to establish background information.

- To limit the review to examining service interactions within the county of Worcestershire.

- To refer to the Homeless Link briefing 'Taking action following the death of someone sleeping rough' and other best practice guidance as appropriate.

- To produce a report that includes:
    - A detailed outline of key service interactions with C.
    - Recommendations for improved service and system approaches for people sleeping rough, with recommended actions for the future and timescales.

4.3 The scope of this review **does not** include:

- An examination of any police investigation following the discovery of C's body.

- An assessment of the investigation undertaken by the Coroner's office, Coroner's Inquest and any deliberations made by the Coroner.

- Consideration of whether the criteria for a SAR was met or whether a SAR should have been undertaken by WSAB.

- A review of any agency's policies and procedural documents.

- Analysis of any procurement processes and decisions to commission and/or de-commission homelessness services.

5. Methodology

5.1 This report is largely based on information available during the undertaking of this time limited review and gathered from agencies that had contact with C between 20th May 2013 and 16th March 2016.

5.2 Due to C's very limited known contact with services in Worcestershire in the 12 months leading up to his death, it was decided that semi-structured interviews would be conducted with staff from agencies that were known to have contact with C in the 12 months leading up to his death, as well as those that had contact with C outside of this review period.

5.3 Information provided by agencies who interacted with C outside of the review period is included in this report to provide a better understanding of the circumstances surrounding C's interaction with services in Worcestershire and for background purposes.

5.4 Interviews with agencies that were known to have had contact with C were undertaken to establish:

- How C was known to agencies.
- What they knew about C and how he came to rough sleeping in Worcester.
- Who in the organisation worked/supported/had contact with him.
- When contact was first made.
- What service interaction/contact took place in the 12 months leading up to his death.
- Whether agencies were aware of other services C may have been in contact with.
- What learning can be taken from this incident.
- What could be done to prevent deaths of people sleeping rough in the future.

5.5 Service logs, case notes and case files were requested from agencies that had contact with C and were received from three services.

5.6 Four organisations shared their individual responses to the SAR scoping exercise with the report author.

5.7 Meetings were also held with additional agencies to confirm whether any contact had taken place prior to C's death, and to understand any involvement with this case. All information provided to Worcester City Council for the purposes of this review was passed onto the report author and considered as part of the review.

5.8 Further information was requested from voluntary and statutory sector organisations, including health services to ascertain whether they had any involvement with C.

5.9 Information gathered during interviews and meetings with agencies, and from available service logs, case notes and case files was reviewed to build a chronology outlining known service interactions with C.

5.10 Relevant local documents were also referred to; to provide context.

6. Methodology Limitations

6.1 Worcester City Council has no statutory or legal basis for undertaking this review. Therefore, the findings and recommendations contained in this report are based on the willingness of partners to engage with the review process and share information with the report author.

6.2 The availability of case notes and case files relating to C's interaction with services across Worcestershire was limited to whether agencies had access to the relevant information/records during the review period and whether they were able to share this information for the purposes of this review. In some instances, case files were not available and information that staff could recall had to be considered.

6.3 There have been significant changes to service provision since C's death. This has resulted in services closing that had supported C (e.g. county outreach service) and staff no longer working within agencies that had contact with and/or supported C. Therefore, in some instances it was not possible to interview staff that had directly worked with C.

7. Case Summary

7.1 On the 5th July 2016 staff at Worcestershire County Cricket Club in Worcester were alerted by a member of the public to a strong odour coming from a nearby tent. The tent was located in some shrubbery, by a footpath running alongside the River Severn. Staff from the club made their way to the tent and found a decomposing body within it.

7.2 The police were called and initial enquiries indicated that the body was that of C. Due to the level of decomposition, DNA analysis was required to formally identify C. The police deemed C's death as non-suspicious.

7.3 A Coroner's Inquest in October 2016 confirmed that the body discovered on the 5th July 2016 was that of C, and that he had died in the tent in which he was found some time before that date. C's remains had decomposed to such a level that the Coroner was unable to determine an exact date of death, medical cause of death or how C's death had occurred. Therefore, the Coroner recorded an open verdict.

7.4 C was born on the 11th June 1942 in St Vincent and the Grenadines in the Caribbean. It is understood that C worked in the Merchant Navy and moved to the UK circa 1960 when he was 18 years old.

7.5 C had lived a transient life since 1966 and moved around the UK on a regular basis. C indicated that he did not *"like settling"*. C lived a solitary life and reported that he was not in contact with his family.

7.6 Housing benefit records for Worcestershire indicate that a new claim was logged on 23rd August 2004 for C. There was no information recorded at this time to establish where this claim related to. On 13th January 2005 housing benefit records show that C was staying at Berwick Hotel. Berwick Hotel is thought to have been a B&B on Lowesmoor in Worcester that is no

longer in operation. Housing benefit records from 26th January 2005 show that on 24th January 2005 C notified the contact centre that he was moving out of the property. Notes associated with this contact suggested he was possibly moving to Gloucester.

7.7 There were no further service records located for C until May 2013.

7.8 C first presented at Maggs Day Centre on 20th May 2013. He had arrived in Worcester on that day having abandoned a shared property which he was privately renting in Birmingham, because he *"has had enough"*. C possessed a 52 week tenancy for this property that had been signed on 31st July 2012.

7.9 Prior to 31st July 2012, C was accommodated at Rugby House in Birmingham for seven to eight weeks. Rugby House is thought to be B&B accommodation on Slade Road and possibly used by Birmingham City Council as temporary accommodation.

7.10 It is understood that C's main source of income was his state pension that was paid into a post office account and housing benefit was paid directly to the landlord.

7.11 C was registered with a GP in Birmingham and reported overall good physical health. C did indicate that he had sprained a ligament in his left knee; this did not impact on his mobility but did cause pain from time to time. C had no known diagnosed mental health issues.

7.12 Information obtained during this review indicated that C had not presented at health services in Worcestershire.

7.13 It is possible that C had a history of alcohol misuse. Case files examined suggest that C had disclosed that he had given up alcohol and *"doesn't drink now."* A reference for C written by a support worker states that he *"does not present with any substance misuse issues although from speaking to him there may have been previous alcohol problems."*

7.14 C had an offending history but was not known to West Mercia Police prior to 5th July 2016.

7.15 There was no record of C approaching Worcester City Council to make a homelessness application.

7.16 There were no known StreetLink referrals relating to C.

7.17 C's last known contact with services in Worcestershire occurred on 16th March 2016.

7.18 C's body was found on 5th July 2016. It is unclear what happened to C between 16th March 2016 and 5th July 2016.

8. Overview of Key Service Interactions

8.1 An outline of service interactions drawn from information collated during the period of this review illustrates that C had limited contact with services in Worcestershire between May

2013 and March 2016.

8.2 C's involvement with services took place over short periods of time and there were significant gaps ranging from four to eleven months between May 2013 and March 2016 when C appeared to not be in contact with any services in the area.

8.3 C's known interactions with services in Worcestershire can be described as occurring over five distinct time periods:

- Between 20th May 2013 and 14th June 2013.
- Between 8th January 2014 and 22nd February 2014.
- On 8th July 2014.
- Between 13th April 2015 and 19th April 2015.
- On 16th March 2016.

8.4 C's known key interactions with services can be summarised as:

- C attended Maggs Day Centre a total of 12 times between 20th May 2013 and 16th March 2016.
- C was supported by Worcestershire Homeless Intervention Team to access accommodation between 8th January 2014 and 31st January 2014.
- C resided at YMCA Worcestershire for a total of 23 days between 31st January 2014 and 22nd February 2014.

9. Chronology of Service Interactions

9.1 The chronology of known interactions between C and services in Worcestershire starts on 20th May 2013 when C first presented at Maggs Day Centre and ends with the discovery of C's remains on 5th July 2016.

- **May - June 2013**

9.2 **20th May 2013** C first attended Maggs Day Centre (MDC) on this date. He reported that he had arrived in Worcester on that day having abandoned a shared property which he was privately renting in Birmingham. C was recorded as being of no fixed abode (NFA). C had a free lunch at MDC.

9.3 **21st May 2013** C attended MDC and had breakfast and lunch that had been paid for in advance.

9.4 **22nd May 2013** C attended MDC in the afternoon and had lunch there which had been paid for in advance.

9.5 **23rd May 2013** C went into MDC during the morning but did not eat any breakfast. He had lunch in the afternoon that had been paid for in advance. With C in attendance, a support worker at MDC completed a Link Up Initial Referral Form for support from Worcestershire Homeless Intervention Team (WHIT). The completed form records that C had arrived in Worcester on Monday 20th May 2013 and had been rough sleeping for the past 3 nights. Prior to this C had been living in private rented accommodation in Birmingham since July 2012, and before this was accommodated at Rugby House in Birmingham. C signed the Initial Referral Form as well as Confidentiality and Information Sharing Forms giving permission for contact to be made with Rugby House and WHIT.

9.6 **24th May 2013** C attended MDC in the morning and had a free meal. A referral for C was made to WHIT and submitted by MDC via the Link Up system.

No records were available to ascertain the outcome of this referral.

9.7 **27th May 2013** C attended MDC in the afternoon and had a free lunch.

9.8 **28th May 2013** C attended MDC in the morning but did not eat. This was the last known contact for this period.

9.9 **14th June 2013** A Service Departure Form was completed by a support worker at MDC in C's absence. This form records that C had moved on and no longer required support from MDC. The form stated that C had returned to previous accommodation not in the area. C's case was closed.

- **January - February 2014**

9.10 **8th January 2014** Following a gap of 7 months, C presented at the Night Assessment Centre (NAC) which was located at YMCA Worcestershire (YMCA) and delivered by WHIT. C was accommodated in the NAC until 12th January 2014. During this time C was supported by a WHIT support worker to find move-on accommodation.

9.11 **13th January 2014** C was supported by WHIT to move into shared private rented accommodation located on Lowesmoor in Worcester. Housing benefit was paid directly to the landlord. C resided in this property until 31st January 2014.

9.12 **28th January 2014** Following a referral by WHIT, a support worker at the YMCA conducted an interview with C for accommodation. The Needs Assessment Form completed with C during the interview shows that C had been residing in Handsworth, Birmingham and had come back to Worcester in the last few weeks. He was currently accommodated in a shared property that WHIT had facilitated for him but a clash with other residents had led C to want to move out. C provided the YMCA with two forms of ID including a birth certificate and housing benefit letter. The housing benefit letter had notes written over it by C that were difficult to follow discussing religion, brainwashing, and disjointed random subjects. The support worker undertaking the needs assessment noted that he had concerns around C's behaviour and that C had demonstrated racist viewpoints during the assessment. The support worker also recorded that

he had safeguarding concerns because C had stated that he *"will leave [the] property [he is currently residing in] to live in a tent if not accepted here."*

9.13 **30th January 2014** A reference for C was received by the YMCA from a support worker at WHIT. The reference states that *"C wants to leave the shared house where he is currently living due to an issue with another member of the household……I am unsure if this is a race issue or just a clash of personalities…..at the current time I feel C may benefit from a more supported environment which may help determine whether there are any deeper lying issues which have not previously been addressed."* A reference was also received on this date from MDC confirming that C was known to them.

9.14 **31st January 2014** C moved into the YMCA and was supported by WHIT with the move. Records indicate that the YMCA supported C to make a housing benefit claim. It is understood that housing benefit was paid directly to the landlord for the duration of C's stay at the YMCA.

9.15 **5th February 2014** C signed his License Agreement for the YMCA.

9.16 **6th February 2014** An Initial Support Plan was completed with C that confirmed his benefits were in place. C was provided with details to enable him to register with a GP. Handwritten notes on the Support Plan Checklist document for this date indicate that C had been supported to register with Home Choice Plus. C was also reminded not to bring cannabis on site.

Other than the handwritten notes there were no further records within the YMCA case file or on local authority systems to confirm that a Home Choice Plus application had been registered or received.

9.17 **10th February 2014** C was issued a written warning for racist behaviour towards a staff member on 9th February 2014. C refused to sign the warning letter unless the YMCA issued it for different reasons that he stated were written on the back of the letter. The notes he wrote were confusing and incoherent.

9.18 **11th February 2014** C signed a copy of the warning he received the day before.

9.19 **19th February 2014** A follow up Support Plan was completed with C. He disclosed that he had a sprained ligament in his knee and *"could do with a doctor to get help when it starts to hurt."* C had not registered with a GP as discussed in his previous support session on 6th February 2014 and the support worker therefore offered further help and advice to enable C to do this.

9.20 **20th February 2014** C was issued a written warning for smoking cannabis on site and trying to mask the smell by spraying deodorant on 19th February 2014. C was moved to a different room within the YMCA. The reason for this is unknown.

9.21 **21st February 2014** C signed a copy of the warning he received the day before.

9.22 **22nd February 2014** C moved out of the YMCA. It is not known whether C abandoned or was evicted.

It is not known where C went after his departure from the YMCA.

- **July 2014**

9.23 **8th July 2014** C attended MDC in the afternoon and had lunch there. This attendance was 13 months after his last attendance at MDC on 28th May 2013, and just over 4 months after leaving the YMCA. This presentation was the only known contact that C had with MDC in 2014.

There was no information available to ascertain where C was staying immediately before or after his attendance.

- **April 2015**

9.24 **13th April 2015** Following a gap of 9 months, C attended MDC and had a free meal.

9.25 **16th April 2015** C attended MDC in the morning but did not have breakfast. He had lunch which was paid for with a voucher.

9.26 **19th April 2015** Again, C attended MDC in the morning but did not have breakfast. He had lunch which was paid for with a voucher. C was recorded as being NFA.

There was no further information available to determine where C had been for the 9 months prior to his presentation or after.

- **March 2016**

9.27 **16th March 2016** Following another long gap (just under 11 months), the MDC service register showed that C attended MDC but did not eat. C was recorded as being NFA. The support worker on duty remembers that C was in the day centre talking to other service users. He also spoke to the support worker about some issues that he had with fellow residents when accommodated in the past. The support worker recalls suggesting that C speak to WHIT as they had previously supported C to access accommodation and would possibly have more knowledge about what had happened. Two members of the WHIT team were at the day centre undertaking a drop in and they were told that C would like to talk to them. C went outside to smoke and whilst outside had a chat with a support worker from WHIT. C did not come back into the day centre and was not seen again.

St Paul's Hostel who delivered WHIT indicated that they were not aware of any interaction between C and a WHIT support worker on 16th March 2016. No additional service records were obtained during the undertaking of this review to determine any further service interactions.

- **July 2016**

9.28 **5th July 2016** Staff at Worcestershire County Cricket Club in Worcester were alerted by a member of the public to a strong odour coming from a nearby tent. Club staff went to investigate and found C deceased in the tent.

10. Analysis of Service Interactions

- **C's engagement with services up to 16th March 2016**

10.1 C intermittently engaged with support services in Worcestershire, which was most probably symptomatic of living a transient life. This made it difficult for services to identify when C was in the county. During the 12 months leading up to his death there were four known service interactions.

10.2 Overall, C's known interactions with services in Worcestershire suggest that he stayed in the area for short periods of time before moving on.

10.3 Information obtained and examined during this review illustrates that C had travelled from Birmingham immediately before his first presentation at MDC on 20th May 2013, and that he returned to Birmingham sometime after 28th May 2013, and then presented for a second time in January 2014. It was not possible to establish where C went after his departure from the YMCA in February 2014. It is also not known where in the country C travelled from or to, immediately before and after his known service interactions in July 2014, April 2015 and March 2016.

10.4 The maximum length of consecutive interactions with services in Worcestershire was just over six weeks between January and February 2014. There was one period in April 2015 when there were three presentations over seven days and two periods in July 2014 and March 2016 when known service interactions occurred on one day only. This limited and intermittent engagement with services in the area impacted on the support that could be provided to C.

10.5 During C's first presentation in May 2013 appropriate steps were taken by MDC to engage with C. There was little opportunity to progress the referral made to WHIT as C returned to Birmingham shortly after the referral was submitted.

10.6 During his second presentation between January and February 2014, C was supported by WHIT and accommodated in the NAC, a private property and the YMCA. During this period both WHIT and the YMCA took positive action to ensure that C did not return to rough sleeping when the private property that C had initially been placed in was not working out for him.

10.7 C's stay in the YMCA lasted a total of twenty three days. Whilst support planning sessions had started to take place during this time, it was thought that a longer stay may have resulted in the identification of any underlying support needs that C could have been supported with to prevent him from returning to rough sleeping.

10.8 It did not appear from the information examined that any follow up had been attempted by any service after C had left the YMCA in February 2014. It is possible that this was a missed opportunity to ascertain whether C was still in the area and rough sleeping immediately after

leaving the YMCA. If this was the case, it is possible that attempts could have been made to support him further by services in the county.

- **C's presenting needs**

10.9 The three homeless support services that had supported C during his presentations in Worcester were aware through their engagement with him that there had been periods when C had slept rough in Worcester. Services responded to this information by attempting to address C's accommodation needs.

10.10 The report author acknowledges that when C was in the area for a relatively significant amount of time services worked to try and ensure he was accommodated and not rough sleeping. However, from the information examined it does seem that the accommodation options considered were limited to those within homelessness services or those that they had access to. The report author feels that this was a missed opportunity. For example, given that C was in his seventies, alternative options such as sheltered accommodation could have been considered.

10.11 Services were aware that C had struggled to sustain shared accommodation prior to arriving in Worcester. However, there was no information to suggest that consideration had been given to the reasons why C had been unable to maintain his previous shared tenancy. This missed opportunity may have resulted in the identification of underlying issues that may have been addressed or alternative accommodation sought that would better meet his needs, instead of being placed into shared private accommodation again.

10.12 It is important when undertaking support work that consideration is given to an individual's wider needs and any possible underlying issues when deciding upon a course of action. There is some evidence to suggest C's wider needs were considered when he was referred to supported accommodation. It was recognised that C may benefit from a supported environment to ascertain whether there were any underlying issues. A comprehensive needs assessment was completed with C. During this assessment the support worker noted concern around C's behaviour and identified that C may require support to access preventative mental health services. However, this was not picked up in the limited (two) support sessions that C had. It is possible that had C stayed in supported accommodation for a longer period, information gained from his needs assessment along with his continuing presenting behaviours may have alerted support workers to the possibility of associated underlying issues that could have started to be addressed.

10.13 It is well known that mental ill health is prevalent in individuals experiencing homelessness. Improved access to mental health services can be facilitated through improved staff awareness and knowledge. Research conducted by Homeless Link found that approximately 70% of people accessing homelessness services have mental ill health and that there is a complex link between mental ill health and long term rough sleeping[2]. It is possible that C's transient nature and presenting behaviours may have indicated undiagnosed or undisclosed mental ill health and the reason for why C found it difficult to settle. Focussing on

[2] Homeless Link (2011) Homelessness, mental health and wellbeing guide: https://www.homeless.org.uk/sites/default/files/site-attachments/Mental_Health_Guide.pdf

staff awareness and skills in supporting individuals with possible mental ill health is an area requiring further exploration that could improve the support provided to service users.

- **Cross authority working**

10.14 During C's interaction with services there were two separate occasions when C was known to have signed Information Sharing Forms giving permission for information to be shared between agencies. One consent form specifically gave consent for contact to be made with Rugby House in Birmingham. There were no records to indicate that any service in Worcestershire had taken steps to contact Rugby House or any other service and/or the local authority in Birmingham; a potentially missed opportunity. Had for example, this been followed up, it is possible that key information could have been gained about C's time in Birmingham or elsewhere in the country, why he found it difficult to maintain shared accommodation, any known safeguarding concerns and underlying issues that he may have needed support with.

- **Period between 16th March 2016 and 5th July 2016**

10.15 From the information obtained during this review it was not possible to establish why C returned to Worcester in March 2016 and exactly when he returned to rough sleeping during this period.

10.16 The report author was unable to determine what happened to C in the time between his last known contact on 16th March 2016 and being found deceased on 5th July 2016. It was not possible to ascertain whether C died on the same day as his last known contact, or a few weeks after this date, or whether he left Worcester sometime during this period and returned prior to his death; all probable scenarios in the absence of any further information.

10.17 Prior to C's last service interaction, he was not known to have been seen by any service in the area for just under 11 months. Agencies who had previously been in contact with C were aware that he did not engage with services regularly in the area and that he frequently travelled around the country. In the time that services had known C it was not unusual for him to present on one day and then return after a significant amount of time had passed, therefore C was not thought to be missing following his last known service interaction.

10.18 C's last known contact occurred during the transition stage of WHIT's contract ending and the new Single and Childless Couples Homeless Prevention Support Service (HoPES) commencing.

10.19 Originally, the WHIT service was due to end on 31st March 2016 and HoPES was expected to start on 1st April 2016. At short notice, HoPES was asked to commence their service from the 21st March 2016. The outgoing service was no longer receiving new referrals or involved in the running of No Second Night Out and StreetLink referrals from this date. This cessation in service was earlier than expected and presented a challenge for the new provider in the absence of a planned and robust handover.

10.20 Local services reported that this period of service transition resulted in uncertainty amongst providers about what services were available for rough sleepers. In addition, during the undertaking of this review it was evident that it was not clear to some agencies that HoPES was

not a direct replacement of the previous county outreach service. There appears to have been and still is some confusion amongst organisations specifically about the level of outreach that HoPES is commissioned to deliver. The report author believes that it would be beneficial to provide local organisations with information clarifying the 'service offer' for individuals that rough sleep and is aware that steps are being taken to address this.

10.21 The report author found that there were differing accounts about the location of the tent in which C's remains were found. Some colleagues seemed to think that the tent was hidden in shrubbery/brambles and not easily visible, whilst others believed that the tent was located in a well known rough sleeper hotspot and would have been visible to passers-by. During the service transition period there was no handover of any intelligence relating to individuals who were known to rough sleep or rough sleeper locations. It is possible that this was another missed opportunity. Had a planned handover taken place and intelligence shared, this may have resulted in C being found sooner.

10.22 From service commencement, HoPES began receiving and responding to StreetLink referrals. There was no information to indicate that any referrals had been made or received in relation to C during this period.

- **Information recording systems**

10.23 Examination of service logs, case notes and case files detailing contact and support provided to C showed that there were some problems with information recording systems during the time that C was presenting at services in the area.

10.24 The report author found that the availability and quality of information relating to C's interaction with services in Worcestershire varied across agencies.

10.25 The Link Up system was a countywide database that was used by services at the time that C was accessing services in Worcester in 2013 and 2014. When the facility was closed, information detailing C's interaction with services prior to October 2014 was limited to whether agencies had saved information from the Link Up system before it was closed.

10.26 There was little consistency in what information was retained by individual services from the Link Up system. This was partly due to the information they were able to access, which was dependent on the licence that they held for the system, as well as internal decisions that were made about which service users' details would be saved i.e. current and/or closed cases.

10.27 Along with support information; the ability to track an individual's pathway, who has reported as NFA and which services have interacted with an individual has been lost. Currently much of the information sharing between agencies tends to only happen when a referral is made from one service to another, potentially resulting in missed opportunities for wider service involvement and positive outcomes for individuals experiencing homelessness.

10.28 During the undertaking of this review, services reported that some of the work carried out by staff to support those at risk of homelessness occurs via email. As staff leave or IT systems are upgraded this information can be lost and there is little clarity on how this information should be recorded and retained.

10.29 This review identified a significant issue with the quality of record keeping relating to C's contact with services across both statutory and voluntary sector agencies. Some records lacked content and clarity, and others could not be located which made it difficult to interpret key details about C's interaction with services.

10.30 Robust record management is important not just for the purposes of a review such as this one; but to facilitate effective support planning, ensure that services can keep track of the work that they have undertaken and to improve outcomes for individuals. Information recording systems within both statutory and voluntary sector agencies and information sharing across the county are two issues that require further exploration based on the information examined during this review.

11. Conclusion

This review of known service interactions found that C intermittently engaged with support services in Worcestershire. The frequency of C's interactions with services suggest that he presented in Worcester for short periods of time before moving on. During the 12 months leading up to his death there were four known service interactions. C's transient nature and limited service interactions presented challenges and impacted on the support that could be provided to C. The report author's examination of C's interaction with services in Worcestershire has identified some key areas where lessons can be learned and action that can be taken to improve service and system approaches for people sleeping rough and to prevent future deaths.

12. Recommendations

- **Improvement Area: Staff skills and knowledge**

1) Undertake a skills audit of frontline staff who work with individuals that rough sleep to identify staff that require training/refresher training in areas including:
    - Mental Health Awareness
    - Mental Capacity Act and Assessing Mental Capacity
    - Self-Neglect Awareness and Reporting
    - Information Sharing between services in Worcestershire and outside of the county

- **Improvement Area: Cross authority working**

2) Develop and implement a protocol for working with individuals that are transient. This protocol should include an 'alert' system for services to indicate when an individual that is known to be transient presents in the area and is at possible risk of rough sleeping; and procedures that outline how to report safeguarding concerns in local authority

areas outside of Worcestershire as well as obtaining information and alerts relating to safeguarding concerns that have been raised outside of the area.

- **Improvement Area: Identification of individuals sleeping rough and rough sleeper locations, and clarification of services**

3) Identify a local reporting mechanism (including out of hours) that can be used by members of the public to report the location of tents, squats, other places not designed for habitation, sleeping bags and any other items related to rough sleeping.
4) Launch a targeted publicity campaign to:
    - Publicise StreetLink and encourage members of the public to use it to refer individuals that are rough sleeping.
    - Inform members of the public of what to do if they come across any tents, squats, other places not designed for habitation or sleeping bags.
    - Encourage service users to notify services if they are concerned about an individual that they believe may be missing.
    - Clarify what services are available to support individuals that rough sleep.

- **Improvement Area: Ensuring the safety of individuals who rough sleep in tents, squats, other places not designed for habitation and on the streets**

The report author is aware that CCP currently undertake some outreach in response to rough sleeper referrals and in partnership with Swanswell, and that Maggs Day Centre has recently been successful in securing funding to deliver some further outreach provision. It is recommended that:

5) Consideration is given to introducing regular welfare checks on individuals sleeping rough. Partnerships with West Mercia Police, Hereford and Worcester Fire and Rescue Service and voluntary agencies should be explored.

- **Improvement Area: Service transition procedures**

6) Develop service transition guidelines to inform future decommissioning and commissioning of homelessness services. It is recommended that any guidance produced considers:
    - A mobilisation period of at least 3 months from the end of the standstill period.
    - A period of 'overlap' between an existing service ending and a new service commencing.
    - Robust procedures for handover to any new provider(s) so that individuals experiencing or at risk of homelessness can be effectively supported.

- **Improvement Area: Information recording systems**

7) Undertake an audit of a sample of case files for individuals who are currently rough sleeping or who have a history of rough sleeping and have accessed/are currently accessing multiple services across the county. The audit findings should be used to

inform the development of a record keeping, information retention and document storage policy/polices (conforming to the new General Data Protection Regulation) to be agreed and implemented by services in the area.

- **Improvement Area: Undertaking reviews following the death of an individual sleeping rough**

The report author is aware that Worcester City Council have committed to ensuring that any future death of a person who is rough sleeping will always result in a review taking place. It is recommended that:

8) Worcester City Council commit to launching any future reviews as soon as possible following the death of an individual to minimise any loss of information.
9) A procedural document be developed and agreed with partner agencies outlining the processes that will be followed in the undertaking of a review following the death of a rough sleeper.

- **Implementation of recommendations**

10) It is recommended that a multi-agency task and finish group be set up to translate recommendations 1 to 9 into an achievable action plan, which is reviewed regularly.

13.Proposed Timescales for Recommendations

Timescale	Recommendations
Immediately	8
Within 3 months	5, 9 & 10
Within 6 months	2, 3 ,4 & 6
Within 9 months	7
Within 12 months	1