Healthwatch Worcestershire
Civic Centre
Queen Elizabeth Drive
Pershore
WR10 1PT
Tel: 01386 550 264
info@healthwatchworcestershire.co.uk
www.healthwatchworcestershire.co.uk

B Brickley
Board Manager
Worcestershire Adult Safeguarding Board
County Hall
Spetchley Road
Worcester
WR5 2NP

22 July 2019

Dear Bridget

Ref: Terms of Reference for the Thematic Review of Rough Sleeper Deaths
I am writing on behalf of the Board of Healthwatch Worcestershire to thank you for attending the Public Board meeting on 10 July and briefing the Board on the forthcoming thematic review of 'Rough Sleeper Deaths'. The Board noted that the terms of reference for the thematic review have not been finalised and welcomed your invitation for Healthwatch Worcestershire to contribute to, and comment on them before they are finalised.

The Board understands that the Worcestershire Adult Safeguarding Board [WASB] Case Review Sub-group intends that the thematic review will focus on the 4 deaths of rough sleepers that have occurred in Worcestershire since the death of Cardon Banfield, 2 of which you told us met the criteria for a Safeguarding Adult Review [SAR] whilst the other 2 did not. And, that the death of Cardon Banfield would not be included as it had not met the criteria for a SAR, although the thematic review would consider the independent report on Cardon Banfield's death which was commissioned and published by Worcester City Council following the decision of the WASB Independent Chair in relation to a SAR.
By way of context, and as you are aware following public representations about Cardon Banfield's death at a public meeting, Healthwatch Worcestershire has been enquiring into how the health and wellbeing of homeless people with care and support needs who are rough sleeping are safeguarded.
The statutory responsibilities of Healthwatch Worcestershire that have driven the enquires include:

- Promoting and supporting the involvement of local people in the commissioning, the provision and scrutiny of local health and social care services.
- Enabling local people to monitor the standard of provision of local health and social care services.
- Making reports and recommendations about how local health and social care services could or ought to be improved to commissioners and/or providers of those services, and people responsible for scrutinising the services.

Healthwatch Worcestershire's priority is to promote continuous improvement in the commissioning and delivery of health and social care services, and whilst looking to the future recognises that this must include a willingness to learn from past experiences by those organisations involved in commissioning and providing health and social care services for the people of Worcestershire, without apportioning blame.

Healthwatch Worcestershire's Board which, whilst aware of the deaths of rough sleepers in Malvern Hills District, was unaware of the 2 other deaths that have occurred since Cardon Banfield's death until very recently, had anticipated that it would finalise its enquiry with the consideration of a draft report with recommendations at its Public Board Meeting on 10 July last. However, as you are aware from attending that meeting the Board agreed to extend the enquiry to consider the provision of 'outreach services' for rough sleepers based on information set out in a briefing note [copy included for information] and to contribute to the draft terms of reference for the thematic review. Therefore, please find set out below proposals for inclusion in the terms of reference together with supporting argument.

1. The thematic review should extend to, and consider the death of Cardon Banfield [CB], because:
   - The death, which was unexplained, and therefore involved other agencies than the councils, health and the voluntary sector, potentially offers the most opportunity for learning.
     [NB Worcester City Council independent report identified the opportunity to improve partnership working across the agencies caught by the review].
   - CB was a transient rough sleeper across the West Midlands [one of the stated reasons for not undertaking a SAR], and therefore there is opportunity to consider how services to safeguard rough sleepers with care and support needs work effectively across upper tier local authority boundaries.
   - There was little evidence that CB had been in contact with either public or voluntary sector agency services immediately prior to his death [another stated reason for not holding a SAR]. The Healthwatch Worcestershire Board now understands that a new contract for services to support rough sleepers that was let in April 2016 (around the period of CB's death) by Worcester City Council and funded by Worcestershire County Council to a new 'out of area' provider significantly reduced the level of 'outreach services' for entrenched rough sleepers. That contract is still in place.
   - CB was known as an entrenched rough sleeper. The Care Act 2014 introduced 'self-neglect' as a care and support need. Although the police decided that the unexplained death of CB was not suspicious, despite the involvement of several statutory and voluntary sector organisations with responsibilities for safeguarding, the death was only referred for a SAR sometime after it had been discovered by a member of the public.
   - Worcester City's independent report into the death of CB cannot be relied upon as it specifically did not consider the following issues which the Healthwatch Worcestershire Board considers might be relevant for the future commissioning and provision of services:

    - *An examination of any police investigation following the discovery of CB'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.*
    - The effectiveness of services to identify and support access to care and support needs for rough sleepers.

- To exclude CB's death form the full thematic review on the grounds that it did not meet the criteria for a SAR would appear to be wholly inconsistent with the decision to include the 2 deaths that did not meet the same criteria, and appears to be inconsistent with the ethos and principles of safeguarding.

2. The thematic review should consider how safeguarding policies and procedures were operated by those organisations with either a statutory or contractual responsibility to safeguard rough sleepers; to include:
    - awareness of the Care Act provisions relating to self-neglect and safeguarding.
    - The decision-making process in relation to SARs, and in particular:
        - transparency of decision making and level of independent voice within the Case Review sub-group
        - the exercise of discretion in reaching a decision to undertake a SAR in circumstances where the statutory criteria are not made out
        - how the implementation of the relevant policy in the Government's Rough Sleeping Strategy 2018 would have operated in CB's case.
    - The effective operation of safeguarding arrangements across upper tier authority boundaries.

3. The thematic review should consider the public response to the deaths of rough sleepers in Malvern, and its implications for public safety, safeguarding of rough sleepers and policy/service provision.

   Healthwatch Worcestershire does have some concerns about the plethora of agencies, community groups and individuals who appear to be involved in providing basic services (eg meals, food supplies, clothing, sleeping bags, etc) for rough sleepers and the wider 'homelessness' cohort within Worcester City and elsewhere in the County, without any apparent oversight or co-ordination of these services to ensure that needs are being met appropriately. While we recognise that this area may well lie outside the remit of WASB, nevertheless these seemingly 'unregulated' but well-meaning voluntary services should perhaps be included in the thematic review because they may well have had contact of some sort with the rough sleepers who are the subject of the review and have intelligence/views to share that would contribute to the process.

4. The thematic review should consider if there is a coherent and rough sleepers' strategy in Worcestershire which has the capacity to identify and safeguard the immediate care and support needs of rough sleepers, including needs that arise because of self-neglect.

   If you wish to discuss any of the above in more detail, please contact Simon Adams or me. I look forward to receiving your response to Healthwatch Worcestershire's proposals, and to sight of the draft terms of reference in due course. In the meantime, we will continue our enquiries but will need to ensure that those do not duplicate or compromise any work undertaken in the thematic review.

   Yours sincerely

   J Taylor
   Director

Encs.

cc. A Wilson
   Director of Adult Services
   Worcestershire County Council

   Dr F Howie
   Director of Public Health
   Worcestershire County Council

   D Blake
   Managing Director
   Worcester City Council