Safeguarding Adult Review – Colleen

Systems Findings Report

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Approved by SAB: 22nd April 2026

Published: April 2026

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Introduction

A SAR referral, in respect of a 31-year-old woman, Colleen, who died within two days of being released from prison whilst residing in interim hotel accommodation, was discussed by the Camden Safeguarding Adult Board in September 2025. It was agreed that a discretionary SAR was appropriate, as outlined in Section 44(4) Care Act 2014.

Gill Taylor was commissioned as independent author. She has more than twenty years subject matter expertise in homelessness and multiple disadvantage, including senior leadership experience in both statutory and voluntary sectors.

The Reviewer would like to share her heartfelt condolences with Colleen's family and loved ones, and to thank them for their generous participation in the review.

Pen Portrait

The following text was drafted in collaboration with Colleen's family, using both their own words and summary information from conversations and written submissions they made as part of the review. They decided that the review report should be published using Colleen's real name, rather than a pseudonym, reflecting their desire to ensure a positive and unashamed legacy following Colleen's life and death.

Colleen was born and brought up in Camden as part of a large and loving family, where she was a deeply cared-for daughter, sister and aunt. She was also a devoted mother to two children, one aged fifteen and one aged three during the period under review. Colleen "loved and adored her children with all her heart, and her whole world revolved around them". Whilst in prison, Colleen's children visited her on a weekly basis. During these visits, "she focused her attention on the children, talking with them and playing with them rather than engaging with the adults who were present". Her family described these moments as deeply important to Colleen, reflecting how central her children were to her sense of identity and purpose. She was motivated to be a good and present mother, and much of her focus during the review period was on the opportunities, following release, to spend time with her children and move towards creating stability for herself, knowing this was what her children needed.

Her family describe Colleen as "innocent" and "child-like" with "a heart of gold", which they connected partly with her diagnosed ADHD, the impact of significant trauma, and her optimistic and loving personality. She spoke to her family almost every day, sharing her poetry, singing and hopes for the future. During a meeting with the Reviewer, they shared photographs, videos and writing by and of Colleen, providing a glimpse into the life of a young woman with many talents and interests, who wanted to use her experiences to benefit others.

Colleen lived with repeated experiences of homelessness, drug dependency and mental ill-health, and had been a victim of physical and sexual harm on multiple occasions during her adult life. At times she was street homeless, living in a tent in Euston, without stable support, and was known to agencies as facing high-risk harm. She had multiple stays in supported housing services, part of Camden's Homeless Pathway, during the last eight years of her life, and was in regular contact with Police, Probation and substance misuse services during this time. Colleen was convicted of several violent offences and was considered by Probation to present a high risk of harm to others. Her family, whilst acknowledging this, felt that her behaviour was not always understood through the lens of the neurodivergence, brain injury and trauma that she lived with.

In 2018, Colleen was involved in a serious road traffic accident in which she sustained a life-changing brain injury that resulted in enduring cognitive impairment. This affected her behaviour and communication skills, exacerbated her neurodivergent presentation and inhibited her mental capacity. Following six months of intensive rehabilitation, Colleen was described by her family as having been given "a second chance at life". After leaving hospital, her family reported that Colleen made significant positive changes, including periods of abstinence from substances and working constructively with Children's Social Care. The death of her father shortly afterwards, followed in 2023 by the death of one of her sisters, triggered a period of crisis and relapse from which she was unable to recover before her death. In 2023, the Court of Protection granted deputyship powers, in respect of financial affairs and property, to Irwin Mitchell LLP.

Colleen's family shared that her hopes for her life after release from prison dwindled due to the emotional toll of repeated recalls in the final months of her life. She struggled to cope with the uncertainty of this period and experienced evictions from Approved Premises, rapid recalls to prison and uncertain release dates as deeply distressing. She was particularly affected by being unable to spend the 2024 festive season with her children and wider family, having planned to buy presents and go on family walks. Her sisters expressed concern that the emotional impact of this period was not sufficiently considered by agencies when assessing risk and seeking to understand her presentation.

Methodology & SAR Process

A Terms of Reference was established and agreed by a Panel, which describes a blended methodology, adopting elements of the SAR in Rapid Time[1] and SCIE 'Learning Together[2]' approaches. This approach aimed to facilitate a collaborative and focussed Rapid Learning Review with the aim of sharing a draft report to the Coroner ahead of the inquest hearing in late February 2026.

The aim of the review is to identify systemic issues, and opportunities for practice improvement, through a rapid thematic case analysis and reflective discussions with relevant practitioners and senior managers. This report is presented for consideration by the Camden Safeguarding Adults Board with the goal of providing actionable recommendations to improving multi-agency practice and system coordination.

The review considered case information from the period 1st August 2024 to 16th January 2025, immediately after Colleen passed away. This review period was selected to explore learning opportunities related to coordinated prison discharge planning and the needs of women with complex housing, health, care and support needs.

The review adopted the following four key lines of enquiry (KLOEs), each with a series of guiding sub-elements:

1. Prison Discharge Planning
2. Application and interface between legal duties and powers
3. Provision of Suitable Accommodation
4. Decision-Making related to Entry without Consent

[1] https://www.scie.org.uk/safeguarding/adults/reviews/in-rapid-time/
[2] https://www.scie.org.uk/safeguarding/children/case-reviews/learningtogether/

London Metropolitan Police and Camden Council teams and departments engaged meaningfully in the review, sharing case information, attending 1:1 and group discussions as well as joining the Review Panel. On request, HMP Bronzefield shared their report outlining the independent review of Colleen's death conducted for the Prison and Probation Ombudsman in Spring 2025. This report provided some insight into pre-release activity that took place, although does not have a specific focus on safeguarding activity.

Staff sickness within the Camden and Islington Probation Service resulted in regrettable challenges to their participation in the review, which in turn delayed the reviews progression. This has since been remedied and this report is presented with contributions from all agencies involved in Colleen's care and support during the review period.

Relevant Literature

There is a growing body of evidence exploring the needs and experiences of people living with multiple disadvantage. Whilst this cannot be explored in detail here, evidence from research[3] and lived-experience testimony[4] concludes that people experiencing multiple disadvantage face a range of interconnected vulnerabilities that impact their health, wellbeing and exposure to risk. These vulnerabilities arise from overlapping experiences of homelessness, trauma and abuse, drug and alcohol dependency, mental ill-health and criminal justice involvement and how these are responded to by professionals. Evidence also points to the gendered dimensions of multiple disadvantage and how perceptions of vulnerability, and responses to unusual or problematic behaviour, are shaped by prevailing social attitudes about addiction, motherhood, femininity and sex work[5].

Coordinated and personalised multi-agency support that centres rapport and trust building has been identified as best practice[6]. One impact of complex trauma and multiple disadvantage, that can create further barriers to positive outcomes, is behaviour that challenges professionals. This can range from issues with maintaining contact and building relationships to serious acts of self-harm, aggression and violence and requires flexible support and trauma-informed practice beyond standard operating models and service thresholds. Evidence from research and practice identifies professional curiosity, persistence, creativity and the prioritisation of psychological safety; long-term relational support, positive risk-taking and a strong understanding of the personal and environmental factors that activate and escalate distress. This is challenging for services managing high levels of demand, competing priorities and unwieldy statutory duties, but with supportive leadership and robust organisational support, mechanisms can be established to enable creative and person-centred practice on the individual's own terms.

The presence of this stigma has been highlighted as a factor in professional decision-making about homeless adults with care and support needs, as part of national analyses of Safeguarding Adult Reviews where homelessness is a feature[7], and in in research about mental health[8] and drug and

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[3] University of Sheffield (2022) The Fulfilling Lives programme: supporting people experiencing multiple disadvantage A summary of programme achievements, evaluation findings, learning and resources. Available at: https://www.tnlcommunityfund.org.uk/media/insights/documents/Summary-of-programme-achievements-evaluation-findings-learning-and-resources-2022.pdf?mtime=20221128143121&focal=none

[4] Taylor, G., Clint, G., and Price, C. (2022) 'Seen but not heard: why challenging your assumptions about homelessness is a matter of life and death' in Preston-Shoot, M. and Cooper, A. (eds), in *Adult Safeguarding and Homelessness: Understanding Good Practice,* pp. 40-58. London; Jessica Kingsley Publishing

[5] https://lankellychase.org.uk/wp-content/uploads/2020/02/Gender-Matters-full-report-Feb-2020.pdf

[6] https://assets.publishing.service.gov.uk/media/642af3507de82b000c31350c/Changing_Futures_Evaluation_-_Frontline_support_models_REA.pdf

[7] Martineau, S. J., Cornes, M., Manthorpe, J., Ornelas, B., & Fuller, J. (2019). Safeguarding, homelessness and rough sleeping: Ali analysis of Safeguarding Adults Reviews. NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London. https://doi.org/10.18742/pub01-006

[8] Eylem, O., de Wit, L., van Straten, A. *et al* (2020) Stigma for common mental disorders in racial minorities and majorities a systematic review and meta-analysis. *BMC Public Health* 20, 879. https://doi.org/10.1186/s12889-020-08964-3 and Kapadia, D. (2023). Stigma, mental illness & ethnicity: Time to centre racism and structural stigma. *Sociology of Health & Illness*, 45(4), 1–17. https://doi.org/10.1111/1467-9566.13615

alcohol dependency[9]. Pervasive negative attitudes about drug use and sex work mean that women who experience multiple disadvantage are more likely to experience child removal, less likely to have their experiences of sexual and domestic violence recognised as causal factors to behaviour, and more likely to experience barriers in the pursuit of diagnoses related to trauma and neurodivergence. In short, the evidence suggests that women living with multiple disadvantage face overlapping barriers to accessing and engaging with support services and are more likely to have their behaviour understood through the lens of risk, rather than through vulnerability.

This evidence from practice is supported by the London Assembly's *Breaking the Cycle* report of May 2025[10], which highlights that women leaving prison face acute housing insecurity driven by scarce safe accommodation, fragmented support, and inconsistent practice across agencies. Speaking to the gendered dimensions of need it recognised that around 60% of women released from prison are survivors of domestic abuse, and specific groups—including disabled women—face additional barriers and, at times, discrimination. The closure of London's only women's prison has further detached women from local support networks, while the shortage of gender-informed, women-only supported housing exacerbates risks of homelessness and repeat criminalisation. The report concludes that although the challenges around resettlement for women leaving prison are complex and deeply entwined with the ongoing housing emergency, individual local authorities can adopt gender-specific, trauma-informed housing pathways, ringfencing supported units, coordinating pre-release planning, and early access to wraparound support.

Emerging research[11] in the UK presents a stark and life-limiting reality for mothers experiencing child removal. Research from the University of Birmingham and the University of Edinburgh, working with the charity Pause, suggests that mothers who have had children repeatedly taken from their care are 14 times more likely to die prematurely. When viewed alongside national data about the deaths of women who experience homelessness, where the average age at death for women is just 43 years old[12], the intersection of women's homelessness and child removal becomes a key public health concern.

Best practice can be challenging to achieve and sustain due to the conditionality of legal rights and entitlements, short-term funding models, rigid eligibility criterion of key services and overwhelming demand for highly stretched local housing, social care and mental health services. Local efforts to respond to the needs of people with multiple disadvantage occur within this context and whilst there are clear areas for practice development, influencing national law and policy is also a key area of opportunity. In Camden, significant efforts have already been made to develop evidence-based approaches to multiple disadvantage, shaped by the boroughs commitment to homelessness system transformation[13], co-production and trauma-informed practice and this review seeks to establish opportunities to strengthen and build on these foundations as part of the implementation of the boroughs Homelessness and Rough Sleeping Strategy 2025-30[14].

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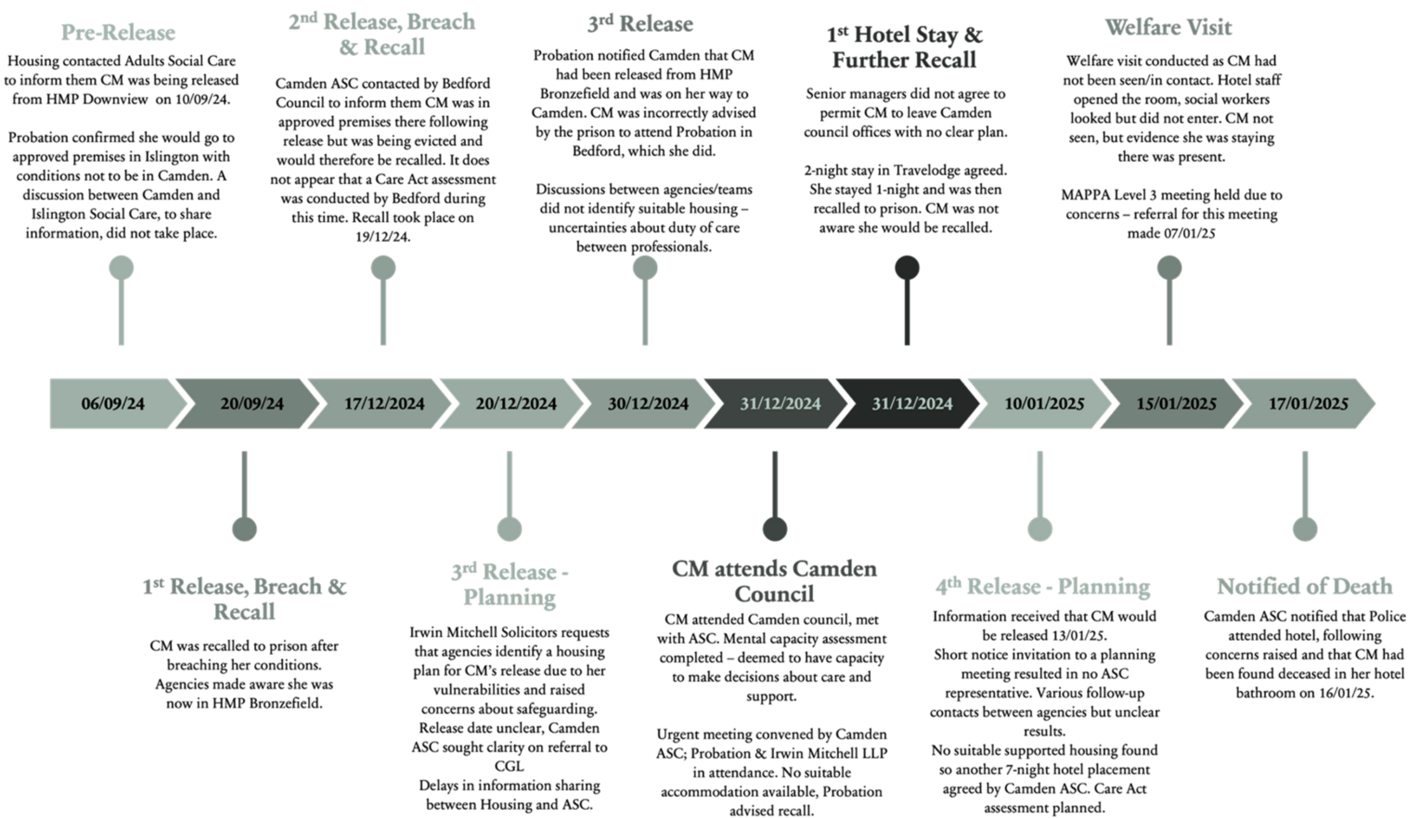
[9] Lloyd, C. (2010). Sinning and Sinned Against: The Stigmatisation of Problem Drug Users. London: UK Drug Policy Commission. Available at: http://www.ukdpc.org.uk/resources/Stigma_Expert_Commentary_final2.pdf and Page S, Fedorowicz S, McCormack F, Whitehead S. (2024) Women, Addictions, Mental Health, Dishonesty, and Crime Stigma: Solutions to Reduce the Social Harms of Stigma. *International Journal of Environmental Research and Public Health*. 2024; 21(1):63. https://doi.org/10.3390/ijerph21010063
[10] https://www.london.gov.uk/sites/default/files/2025-05/Housing%20Committee%20report%20-%20Women%20leaving%20Prison%20FINAL.pdf
[11] Early maternal death following child removal—A short report using observational data
[12] Deaths of homeless people in England and Wales: 2021 registrations
[13] https://camden.moderngov.co.uk/documents/s113245/3.1%20Appendix%20A%20-%20Homelessness%20System%20Transformation.pdf
[14] https://www.camden.gov.uk/documents/d/guest/homelessness-and-rough-sleeping-strategy-2025-to-2030

Case Analysis

Summary Activity

The following diagram provides a summary chronology of significant practice episodes during the review period September 2024 to January 2025.

Although not presented here, detailed chronologies and reflections of individual agency activity, as well as information about Colleen's personal experience and family concerns, have been considered in detail by the reviewer to inform the case analysis and system findings that follow.



System Finding 1: Inconsistent Multi-Agency Coordination in Prison Release Planning

In December 2023, Colleen was given a 12-month custodial sentence, which was following in the months after by two additional custodial sentences. The Probation Service reflected that the overlapping nature of these sentences created uncertainties around her release dates. This uncertainty is evident in the way that agencies worked together during the review period.

It is clear, from the documentation and reflections shared as part of the review, that the appropriate agencies were involved in communication and planning around Colleen's housing, care and support during the review period. In general, it is also evident that attempts were made by agencies to work together in respect of Colleen's housing, care and support. Individual practitioners across all agencies made efforts to share information, bring professionals together and to highlight their concerns and decisions in respect of Colleen's housing, care and support.

During the review period there were a handful of professionals' meetings where Colleen was discussed, two that were specifically called by/for professionals involved in her care and two others where Colleen was discussed as part of a multi-case discussion. Due to uncertainties around her release dates, the two individual meetings were called on the day, and as such full attendance from relevant agencies was not possible. There are discrepancies between notes and the recollections of those involved in these discussions and there was no single plan created from these meetings to mitigate risk or set out how Colleen's needs would be met. There were undoubtedly uncertainties about whether Colleen would return to Camden at each of the prison releases and if so, when. However, given the complexity of her situation, her history in the borough and her supervision by the Camden and Islington Probation Service, multi-agency professionals' meetings could have been better utilised, and risks escalated more proactively when these discussions could not identify adequate mitigation.

Some coordination between Housing and Adults Social Care was evident, information was shared and some liaison is documented in respect of arrangements for accommodation and sharing of statutory decisions in respect of housing. However, information shared by Housing (by email) about the extent of Colleen's history and known needs had not been read by the duty social workers who met with Colleen on December 31st, and there is no information to suggest planning activity was undertaken in the period beforehand, when it was known she would be released back to Camden. Uncertainties about the legal duty to provide Colleen accommodation, following the decision by the Housing department in September 2024 that she did not have the capacity to make a homeless application, would have been more effectively explored and resolved outside of email communication. There were missed opportunities to facilitate a joint meeting between the two departments at an earlier stage, to ensure a clear position was established and then communicated with external agencies.

It is good practice that Camden have established an 'Ex-offender and Complex Needs Referrals Coordinator' role within the Pathway Team of the Homelessness Service. This role coordinates referrals into the boroughs supported housing projects for adults who have a history of criminal justice involvement and is specifically designed to work with people who are subject to Integrated Offender Management (IOM) or Multi Agency Public Protection Arrangements (MAPPA). Case information suggests that during the review period the role holder acted proactively and responsively in respect of Colleen's housing, including liaising with agencies involved, requesting and sharing relevant information and attending the Integrated Offender Manager Panel (Nov 2024) where Colleen's case was discussed. The role clearly provides meaningful system coordination around the needs of people being discharged from prison, although because Colleen was determined not to have the capacity to make a homeless application, the input of this role in decisions about her was limited to the earlier part of the review period. This review indicates there might be value in expanding the remit of this role, on a case-by-case basis, to provide ongoing support, advice and system coordination for adults leaving prison who are at risk of homelessness, even if their need for housing won't be met under Housing Act duties.

The independent investigation carried out on behalf of the Prison and Probation Ombudsman (PPO) considers activity by prison and probation staff in respect pre-release planning and post-release supervision. As such, it does not reflect on adult safeguarding duties or activities specifically, and nor is it within the purview of a Safeguarding Adult Review to consider adult safeguarding activity that took place whilst an adult with care and support needs was residing in prison or Approved Premises. Nonetheless, effective multi-agency prison discharge planning is both an opportunity for adult safeguarding and an informal safeguarding activity itself - identifying needs and their relationship to risks to self and others, enabling access to community support and engaging multi-agency

coordination around housing, health and care. The Probation Service was responsible for convening the coordination of information sharing and planning activity ahead of Colleen's discharge from prison and in so doing, to escalate concerns about unmitigated risks in the community. It is evident from the information shared by Probation and the transcripts collated in the PPO report, that the Community Offender Manager did initiate discussions between agencies, make referrals and share relevant information. However, this coordination was only partial and not always accurate; specific conditions around Colleen's release were not well communicated and confusion around discharge dates between HMP Bronzefield and Camden and Islington Probation service resulted in confused planning activity between agencies. The Probation Service felt that the referral to MAPPA Level 3 in January 2025 was appropriate, stating that this meeting is about managing risk and not about housing issues. However, it was documented from September 2024 onwards that Approved Premises were unsuitable, that Commissioned Rehabilitation Services were not wanted by Colleen and that there were significant issues in securing alternative accommodation. Given that the risks Colleen presented to self and others were considered to be high, and therefore the likelihood of reoffending similarly so without appropriate accommodation, it is the view of the SAR author that risk concerns related to her accommodation on release should have been escalated earlier.

There was insufficient consideration of Colleen's care and support needs whilst she was residing in prison and when released to Approved Premises; no Care Act assessment appears to have been completed whilst she was residing in Bedford (in neither HMP Bronzefield or in the Approved Premises that Colleen was released to there) or in Islington. In the PPO report it is stated that a referral to Camden Adults Social Care was made in mid-December 2024, but no date was given for this and there is no record of it in the Council's records. It also appears that a request for a Care Act assessment was made to the prison by the Probation Service on 19th December 2024, but this was not actioned in time for Colleen's release later that month. Camden Adults Social Care reflected that the absence of a Care Act assessment resulted in assumptions being made about Colleen based on her presentation at the Council offices on 31st December 2024, and on background information from more than a year before. Whilst conducting a Care Act assessment is the responsibility of the local authority in which the person resides, Camden Adult Social Care reflected that they could have pursued this more robustly when contact was made by Bedford in September 2024 and later when they were made aware that Colleen was being released back to Camden.

Overall, whilst there were some examples of effective information sharing and of multi-agency meetings taking place, this was neither consistent, timely or robustly recorded, resulting in differences of opinion between agencies about legal duties, the actions to be taken and the extent that risk concerns were heard, explored and addressed. There were significant missed opportunities to coordinate the efforts of agencies around a single plan, to escalate concerns when it became clear that suitable accommodation would be a challenge to secure and to ensure the transfer of information between teams, departments and organisations in a timely and accurate way. Ultimately, multi-agency activity during the review period was fragmented and administrative rather than coordinated, professionally curious and person-centred, which significantly limited the likelihood that Colleen's releases from prison would be successful and safe.

Recommendation 1: Establish a focussed **Prison Discharge Protocol** to meet the needs of adults with care and support needs, especially those at risk of homelessness on release.

- Within 9 months of SAB approval, Camden SAB will implement a multi-agency Prison Discharge Protocol for adults with care and support needs, with clearly defined roles, a clear escalation pathway, meeting structures and timeframes.

- The protocol should be developed in collaboration with the boroughs Homelessness Co-Producers
- The protocol should be widely promoted with and by key partners
- A brief assurance report will be shared with the Camden Safeguarding Adult Board after the first year of implementation describing the protocols utilisation, outcomes for adults and any system coordination benefits or challenges.

It may be useful to draw on the MHCLG research Prison Release Protocol Guidance[15] and MOPAC Women's Prison Release Practice Briefing[16] which provide cross-sector insights and practical checklists for local partnerships seeking to strengthen their support for women leaving prison.

In recognition of the urgency of implementing this learning, the reviewer understands that work on this recommendation has already been initiated by Camden Council.

System Finding 2: **Assessment and Management of Risk was Fragmented and Unduly Optimistic**

The Care Act and its accompanying statutory guidance is clear that effective adult safeguarding is preventative, person-centred and observant. Agencies are expected to implement timely information sharing and robust risk management processes in order to prevent concerns escalating towards crisis, where intervention under safeguarding adult procedures is required.

Agencies involved in planning for Colleen's release from prison, securing her accommodation and identifying her needs and vulnerabilities did share risk information with each other. This was both verbal and in writing, with emails, professional discussions, alert mechanisms and risk assessment tools employed. At least one formal safeguarding concern was raised with Camden Adult Social Care during the review period (by Irwin Mitchell LLP) and the Adult Social Care Safeguarding Team recognised informal safeguarding concerns as being raised, beyond this, by professionals and family members. Further analysis about the application of duties and powers under Section 42 of the Care Act (2014) is explored in the next section of this report.

All agencies involved in the review had a clear understanding of the importance of effective information sharing around risk and vulnerability. However, there were significant missed opportunities to go beyond information sharing, to develop a single risk assessment and management plan, that took assertive action to prevent harm.

Irwin Mitchell LLP shared a comprehensive risk screening tool with the Probation Service and Camden Council on several occasions during the review period. A representative from Irwin Mitchell LLP reflected, in his statement to the Coroner and shared as part of the review, that on only one occasion did another professional ask about information contained in the screening tool; it is unclear from the case records if the tool was considered or explored by agencies, or if so, how it informed decision-making. Given that at this time, it had not been possible for Probation or Camden Council staff to conduct a robust risk assessment themselves, because Colleen was still in custody or residing

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[15] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814964/Prison_Release_Protocol_research_report_FINAL.pdf

[16] https://static1.squarespace.com/static/5f452b14193e515746f79fcf/t/6499d9b0c4108077361f10a5/1687804338436/SHI+%26+MOPAC+Womens+Prison+Release+Practice+Briefing+June+2023+.pdf

in another local authority, this document provided important insights into her vulnerabilities and the risks to self and others, that were not made full use of.

Information shared between agencies about Colleen's discharge dates and locations focussed on the risk of homelessness upon release, rather than on the effects of that homelessness on her safety and wellbeing. It is not clear from the information provided if agencies understood *why* hotel accommodation was unsuitable, and therefore what was needed to mitigate the risk of the absence of supervision in such settings. Had they done so and given the Housing Department's substantial experience and provision of specialist supported accommodation for adults with highly complex needs, it would have been reasonable for a discussion to have taken place about an interim accommodation arrangement in one of the 24-hour staffed accommodation services within this provision. It is acknowledged that Colleen had multiple unsuccessful placements in such 'Pathway' provision, and it seems clear that her needs exceeded the support available from these services in the long term – nonetheless, given the primary risk concern about hotel accommodation was the lack of supervision, this may have provided a safer interim housing option than a hotel. It would also certainly have meant that, in the event her death could not be prevented, she would have been found the next morning during daily welfare checks that are standard activity in this type of accommodation.

Information shared by and available to the network of agencies describes a significant brain injury, ADHD and substance misuse disorder, alongside an extended history of trauma, victimisation and aggression. Agencies understood that hotel accommodation alone, could therefore not provide the level of supervision and welfare support that she needed. It was therefore unduly optimistic to assume these arrangements would be safe for any period of time and not to explore additional interim support to mitigate these risks until a comprehensive care and support needs assessment could be completed.

Further, decisions to recall Colleen to prison appeared to be about the absence of suitable housing and system coordination issues, and little consideration appears to have been given to the adult safeguarding implications of these decisions. Decisions were made not to share information with Colleen about her final recall to prison on January 1st 2025, and it does not appear that consideration was given to the impact this might have on Colleen's trust in local agencies, nor her vulnerability and exposure to risk going forward. This demonstrates a lack of consideration of Making Safeguarding Personal guidance in respect of being person-led and outcome-focussed[17] when exploring safeguarding concerns. Further, it indicates a failure to apply professional curiosity in respect of understanding the factors that influenced Colleen's vulnerabilities and behaviours. Here, there could have been benefits to involving an advocate, either formal or informal, to communicate Colleen's wishes and experiences as part of discussions about her. Albeit that it would have been difficult to arrange one at such short notice, ensuring vulnerable adults are able to fully communicate their needs and wishes is a responsibility of the local authority when making decisions about their care.

In relation to Colleen's penultimate release from prison on 30th December, there is evidence of good practice in the escalation of risk concerns between practitioners and senior managers in Camden Adult Social Care. Following an initial meeting between Colleen and a social worker at the Council's offices, concerns about risk were escalated to the relevant Head of Service and Director who made the decision that, whilst unsuitable, on the balance of risk it was inappropriate for Colleen to leave the Council's offices that evening without accommodation in place. Therefore a 2-night stay in a hotel

[17] 14.15, Safeguarding, Care and Support Statutory Guidance https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

was booked. In making this decision, those involved were not aware of the conditions prohibiting Colleen from residing in this area, despite communicating the location of the hotel accommodation with the Probation Service who were aware of these conditions. Staff absences in the Probation Service during this time seems have to resulted in gaps in the information available to staff who were covering.

Information sharing about Colleen's final release from prison in January was confused, with most agencies, including The Probation Service, believing that Colleen would be recalled for 28 days on 1st January 2025 when this was not the case. Information from the prison that she would be released after only 12 days was shared very late. Once informed, Adult Social Care called an urgent professionals meeting on Friday 10th January ahead of her release on Monday 13th. However, this meeting again focussed on suitable housing as the risk, rather than on the additional support that could be implemented to manage these risks until suitable housing could be found.

Data protection law and confidentiality duties rightly prohibit council officers from having universal access to information about local residents. However, there was no mechanism in place to alert social workers meeting Colleen for the first time in December 2024 and January 2025 to information held by other council departments about her needs, vulnerabilities and risks. Although information had been shared by email, the social workers meeting Colleen that day report not being aware of this and as such did not have enough information to make informed decisions. This could have been remedied by improved preparation for her appointment, which although occurring at short notice came after months of ongoing discussion between teams and agencies. The reviewer understands that Camden Council is currently implementing a system to connect resident records across the authority, alerting staff that an individual is known to other teams and departments and seek information and input accordingly.

Recommendation 2a: Connected to Recommendation 1, Camden Adult Safeguarding and Homelessness Teams to **develop appropriate protocols for assessing and managing risk** related to adults with care and support needs leaving prison at risk of homelessness.

- Within nine months of this review being approved, Camden Council will introduce a Multi-Agency Risk Management Plan (process and template documents) for adults requiring multi-agency support to reduce risk, which will clearly identify known risks and protective factors, agencies involved, interim risk management actions and escalation pathways.
- Any document templates should mandate an exploration of abuse and neglect (including self-neglect) risks as well as those associated with homelessness and recidivism.
- Importantly, the template should capture any factors that limit and/or strengthen the individual's ability to protect themselves
- Utilisation and outcomes to be monitored and assurance provided to CSAB as part of the report identified in Recommendation 1.

Recommendation 2b: Using appropriate escalation mechanisms, the Independent Chair of the Camden Adult Safeguarding Board **to highlight the gaps and learning identified as part of this review to relevant national bodies and central government departments**. In particular, it is recommended the Chair escalate the safeguarding risks affecting especially vulnerable female prisoners, when short-term sentencing prohibits timely assessment of need and effective multi-agency release planning.

System Finding 3: **Gaps in Legal Literacy around Mental Capacity and Missed Opportunities to Apply Statutory Guidance around Safeguarding**

Agency summaries and practitioner reflections point to the challenge, in practice, of navigating the complex interface between legal duties and powers involved in meeting the needs of homeless adults with care and support needs. For Colleen, this largely centred around uncertainties about mental capacity and the duty to provide accommodation. The review concludes that overall, although practitioners and agencies acted in accordance with legal duties, misunderstandings and tensions between agencies caused delays and shifted the focus away from securing a positive outcome for Colleen.

One of the most impactful uncertainties around the application of legal duties related to deputyship arrangements and Colleen's mental capacity. Most notably, there were uncertainties about whether Irwin Mitchell LLP were responsible for, or had authority to, make decisions about her housing. Whilst they clarified their role, on several occasions, as one of Court of Protection appointed deputyship for best interest decision-making around property and financial affairs and *not* personal welfare, this uncertainty recurred throughout the review period. Further, the differences between best interest deputyship arrangements and responsibility to meet an individual's needs do not seem to have been clearly understood. A deputy has narrowly defined responsibilities outlined by the Mental Capacity Act and regulated by the Public Guardian and these responsibilities do not supersede the statutory obligations of local authorities and others around housing, care and support. In this respect, the deputy is only responsible for making best-interest decisions about financial or property-related agreements and choices they may need or want to make. Chronologies and agency records indicate gaps in the legal literacy around the Mental Capacity Act (2005)[18] in respect of deputyship and best-interest decision-making, which is a learning opportunity for all agencies working with adults with care and support needs.

Further, although it was good practice that social workers conducted a brief assessment of Colleen's mental capacity to make decisions about her day to day care and support when she attended their Pancras Square office on 31st December 2024, this does not appear to have considered the fluctuating nature and impact of her needs (brain injury and substance use disorder) in different circumstances and times in the day. Practice guidance suggests that longitudinal assessments can be useful, as can assessments conducted in the genuine circumstances in which a particular decision is to be made. Whichever approach is taken, it follows that establishing any fluctuation in Colleen's mental capacity would not have been achievable in a brief single interaction. Given what was known about her brain injury, substance use dependency and life history, the conclusion that Colleen had mental capacity to make and execute decisions about her care and support was unduly optimistic and not reflective of the full information available. Although the presumption of capacity without a full assessment is legally required[19], had it been recorded that fluctuating capacity could not be fully assessed at that time it would have amplified the need to implement additional support whilst she resided in the hotel, such as welfare visits and calls. Assessing fluctuating capacity can be complex and the Mental Capacity Act Code of Guidance pays limited attention to how to assess and determine the appropriate steps for safeguarding when fluctuating capacity or executive functioning issues are identified. This creates uncertainties in practice, which some Safeguarding Adult Boards have addressed by developing localised guidance[20]. The Camden Safeguarding Adults Board website does

[18] https://www.legislation.gov.uk/ukpga/2005/9/section/4
[19] Section 12, Mental Capacity Act (2005)
[20] For example Solihull SAB https://www.safeguardingsolihull.org.uk/ssab/wp-content/uploads/sites/2/2024/08/Executive-Functioning-and-Mental-Capacity-Guide-Compressed.pdf

not provide resources or information about fluctuating capacity and executive functioning, nor is it possible to identify online if there is a multi-agency training offer around mental capacity in the borough. The development of such would provide both an opportunity for practice improvement and enhanced system coordination in Camden.

The Council's Housing Department made a decision, citing relevant case law[21] that Colleen did not have capacity to enter into a tenancy and therefore was not eligible for homelessness assistance under Housing Act (1996). Once made, this decision satisfies the stipulation, under Sec 23 of the Care Act (2014), that "a local authority may not meet needs under sections 18 to 20 by doing anything which it or another local authority is required to do under (a) the Housing Act 1996…" It follows that the legal duty to provide accommodation for Colleen lay with the Adult Social Care department of the local authority area where she was resident. Information shared by Camden Adult Social Care states that they were fully aware of and accepted this duty, evident in their decision to provide interim hotel accommodation whilst a full assessment was undertaken. However, other agencies describe discussions where their impression was that this duty was rejected and time was spent trying to mitigate the implications of this perceived decision. This is a learning point for Adult Social Care going forward, in respect of clearly communicating, in writing if necessary, when a duty is held or not.

Camden Adult Social Care made good use of the legal power afforded to local authorities, by Section 19(3) of the Care Act (2014), to meet urgent, but as yet unassessed, need for care and support. They utilised this power to arrange accommodation for Colleen on two occasions, in December (2 nights accommodation in a hotel) and January (one week accommodation in a hotel). They accepted, at the time, that these arrangements were unsuitable and therefore temporary, making the decision that on the balance of risk, hotel accommodation was safer than rough sleeping. They did not know, at the time of making the decision, that conditions were in place that prevented Colleen from being placed in accommodation in Camden upon her release from prison. Those involved in the review reflected that had this information been shared hotel accommodation would have been arranged elsewhere. Despite this, the decision to provide interim emergency accommodation was an appropriate use of legal powers and took consideration of the target duties around prevention and wellbeing.

Safeguarding concerns were raised by agencies and acknowledged by Adult Social Care at several points during the review period. Camden Adults Social Care concluded that the concerns raised did not meet the threshold to instigate an enquiry under Sec42 of the care Act (2014) because "*the risks identified were understood to relate primarily to system coordination, release planning, housing responsibility and capacity disputes, rather than suspected abuse or neglect*". Whilst the information provided as part of the review corroborates this reflection to some extent, it does not appear that self-neglect was considered, or indeed the risk of abuse and exploitation from unknown others in the community, who Colleen was known to be vulnerable to.

The Care and Support Statutory guidance creates an intentionally low threshold for safeguarding concerns and encourages local authorities to initiate a Section 42 enquiry if it believes it is proportionate to do so. In respect of self-neglect, a decision about whether a response is required under safeguarding should be made on a case-by-case basis and will "depend on the adult's ability to protect themselves by controlling their own behaviour." Given the concerns about Colleen's safety, arising from both the system coordination issues noted and the mental capacity, cognitive functioning and addiction concerns raised, an informal enquiry may have been able to convene the network of professionals with a greater emphasis on reducing risk, employing Making Safeguarding Personal

[21] see R (MT) v Oxford CC [2015] EWHC 795 and WB v W District Council [2018] EWCA Civ 928

principles to bring Colleen's wishes, concerns and plans into the room rather than only those professionals felt were the priority.

Recommendation 3a: Camden Safeguarding Adults Board to make improvements to the information, training and guidance available to partner agencies and the public on key areas of legal and practice literacy, with a focus on the specific issues for adults with multiple disadvantage.

- By March 2027, the SAB will design (commission where relevant), publish and promote multi-agency training and guidance on:
    - deputyship arrangements
    - fluctuating capacity & executive functioning[22]
    - interface between the Housing and Care Acts

- The Board should ensure that **resources and training offers are easily accessible online** as well as regularly promoted through relevant email communication with partner agencies. This should include consideration of a discrete website for the Board and a review of existing communication mechanisms between partners.
- The Board should seek assurance, perhaps through an annual highlight report, about the **uptake of adult safeguarding training** by key partners, including relevant voluntary sector organisations.

Recommendation 3b: As part of existing practice improvement activity, the Camden Safeguarding Adult Board should **review and update the current Multi-Agency Self-Neglect Toolkit** and accompanying resources, to ensure it reflects best practice about the influencing factors, behaviours and remedies for self-neglect in adults experiencing multiple disadvantage.

Systems Finding 4: Gaps in Suitable Accommodation for Women Experiencing Multiple Disadvantage

Foregrounding this review, and the circumstances of Colleen's final months, are the deepening challenges facing individuals who need to seek homelessness assistance from a local authority. Equally, the context of a growing national housing emergency and significant pressure on specialist accommodation was clearly a factor in the challenges professionals faced in securing suitable accommodation for Colleen. The specific challenges of securing specialist accommodation for the growing population of adults with care and support needs related to multiple exclusion homelessness and/or multiple disadvantage are well documented and beyond the control of individual local authorities in many respects.

A significant gap in available accommodation for this group of adults is acknowledged in The National Plan to End Homelessness[23] and the findings of the Second National Analysis of Safeguarding Adult Reviews[24]. All those engaged in the review reflected this issue as growing and urgent locally, often at the heart of professional tensions and, being largely market driven, not always within the control of the local authority. Agencies reflected that even securing fairly straightforward temporary

[22] CSAPB may want to consider the video resources created by Manchester City Council's Entrenched Rough Sleeper Social Work Team, available here: https://youtu.be/yoy1aDqMmbk
[23] https://www.gov.uk/government/publications/a-national-plan-to-end-homelessness/a-national-plan-to-end-homelessness#pillar-3--preventing-crisis
[24] https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023-executive

accommodation placements is a growing challenge, with requirements for highly specialist provision requiring time to source and secure that is rarely available in the urgent circumstances of homelessness.

Colleen had been placed in at least 7 different supported housing services in the borough over the previous five years and was unable to manage and sustain her own tenancy. These placements were unsuccessful largely due to Colleen being unable to meet license agreement conditions around behaviour and substance use. Whilst it appears reasonable that the Housing service concluded that her needs could not be met by the accommodation available in the boroughs Homeless Pathway, with additional input from social care these options might have provided more robust support and risk management whilst a long-term alternative was explored. There is no information to suggest that this was considered and learning from this review indicates that enabling more individualised, collaborative and creative planning between Adult Social Care and Housing would be beneficial for meeting the needs of this group of adults.

Camden is a borough known for innovation in homelessness, having been the first to establish the homelessness pathway approach and having developed pioneering integrated service provision for homeless adults leaving hospital. The subject matter expertise is available locally to develop an approach to commissioning and/or developing specialist accommodation for adults with care and support needs that cannot be met in traditional social care settings, like residential care homes. With the right strategic direction, a joint commissioning approach between Housing and Adults Social Care and confident mark shaping activity, the borough has an opportunity to establish a model for a type of provision for which there is growing demand locally and nationally.

Recommendation 4: Conduct a **strategic review of rough sleeping and homelessness support for women with care and support needs**, with a focus on the ability of existing supported accommodation services to meet the needs of women like Colleen.

- By June 2027, complete a needs and gaps analysis about women's homelessness in Camden and the provision of accommodation and support to meet need.
- By September 2027, based on the findings of the above analysis, Camden Housing and Adult Social Care to meet to discuss any identified gaps and agree appropriate remedial action, which may include developing a joint business case for the commissioning or reconfiguration of specialist supported housing for women experiencing multiple disadvantage who have care and support needs. The SAB should seek assurance about the outcome of this discussion and any subsequent commissioning or system coordination activity to be taken forward.

Systems Finding 5: **Uncertainties about Powers of Entry related to Welfare Concerns**

As part of the review, Colleen's family shared the significant impact of not being able to view their loved one's body because. They feel deeply distressed knowing that Colleen lay deceased for up to three days before being found, including on the day of a visit to the hotel by Camden Council social workers.

Concerns were raised by family and by Irwin Mitchell LLP that Colleen had not been in touch with anyone since the evening of 13th January and assistance was requested from Camden Adults Social Care. With direction from the relevant Head of Service, two social workers undertook a visit to the

hotel and requested that the hotel manager provide access to Colleen's room. They stated that they stood in the doorway of the room, and upon seeing Colleen's possessions inside were satisfied that she was staying there and left without entering. Had they entered the room at this time, they would likely have found that Colleen had passed away.

As part of the review, practitioners from all agencies reflected that they were not confident about which agencies and individuals have the power to enter a room or property on the basis of a welfare concern, complicated further when the property is a hotel room and not someone's home. Agencies were not clear about the powers afforded to hotel proprietors. Adult Social Care were clear that the Care Act (2014) does not create a legal power of entry in respect of safeguarding concerns, and it was on this basis that social workers made the decision not to enter the hotel room. Police confirmed that they have the power to enter a property when a concern about someone's welfare is raised with them, which they employed on 15th January when the Probation Service contacted them to request assistance. It was during this visit that Colleen was found.

Social workers and managers in Adult Social Care reflected on the gap between legal powers and ethical duties in respect entering a home without consent when there are safeguarding concerns. All involved were clear that unfettered power to enter people's homes could over-reach ethical duties but reflected that not having an explicit power of entry in respect of safeguarding inhibited confident action to protect an individual, leaving individual social workers feeling exposed and uncertain about what to prioritise. This was one such incident in their view, and Senior Managers reflected that whilst more experienced social workers may have felt more confident to enter the room, managerial support that was more visible and proactive may have given them the confidence to prioritise Colleen's welfare above concerns about the legal basis for their decision to enter her room. Irrespective of the uncertainties between legal and ethical duties here, social workers involved could have done more to satisfy themselves of Colleen's welfare and to make good employ of the legal powers afforded to other agencies in this respect.

The review identifies learning for agencies around employing multi-agency coordination to make best use of legal powers to take action when an adult with care and support needs, living with known risks, is missing or concerns have been raised about their welfare. In Colleen's case, the known risks of harm to self when staying in unsupervised hotel accommodation, alongside the unusual loss of contact with family and professionals were clear grounds for seeking entry. It would therefore have been reasonable and proportionate for the social workers involved to have requested an urgent welfare check by Police, which could have been conducted as a joint visit and, had she been present and well, created an opportunity to check-in with Colleen about her wellbeing and safety.

Further, given the increasing need for local authorities to place people in hotel and other nightly paid accommodation, as licensees rather than tenants or owner-occupiers, it is important that housing and social care staff are legally literate about the powers of entry in all settings where people are placed. Making appropriate and proportionate use of the power of entry afforded to hotel proprietors, to enhance welfare and risk mitigation measures for vulnerable adults, would be a positive step in establishing safer emergency/interim housing and support where this is needed.

Recommendation 5: Camden Safeguarding Adults Board to **take action to improve legal literacy** and practice confidence around powers of entry.

- By July 2026, the Board should create a **7-minute briefing** highlighting learning from this review in respect of powers of entry and responding to welfare and safeguarding concerns about adults with care and support needs
- CSAB to seek **assurance about dissemination** of the 7-minute briefing amongst frontline teams in Housing and Social Care by autumn 2026.
- Frontline social work teams should receive a verbal briefing to accompany the note, giving them opportunities to test scenarios and explore any management oversight of practice, with attendance recorded.

In recognition of the urgency of implementing this learning, the reviewer understands that Camden's Principal Social Worker is producing guidance for staff about responding to welfare concerns. This guidance should reflect learning from this review to ensure that social workers know who to speak to if they are unsure about what action to take, and how to escalate concerns when an adult with care and support needs is uncontactable.

Systems Finding 6: **Missed Opportunities to Listen to and Engage with Family**

Professionals involved in Colleen's care missed several opportunities to engage with family members meaningfully, to listen to their concerns and to invite them to play a role in planning. Her family reflected that they felt ignored and were disappointed that no one from Camden Council made contact with them to share condolences following Colleen's death, despite having the contact details of her mother and sisters. Agencies involved in the review were willing to accept that stigma and unconscious bias about the nature and quality of family relationships enjoyed by adults experiencing homelessness and substance dependency may have influenced decisions not to reach out to family, or not to listen meaningfully to their concerns.

Colleen's family played a significant role in her life, providing daily support to her as well as contacting agencies throughout her time in custody. It is unclear from case records and agency reflections if Colleen had given her consent for agencies to share information with her family, but this should not have prohibited agencies from reaching out to them to invite their input or to understand more about the risks related to her being in Camden, some of which directly affected them. They reflected that they were not asked to share information with statutory agencies about known risks or needs and expressed that "all we wanted was to work with them".

The Think Family approach emphasises that safeguarding and promoting the welfare of adults and children is a shared responsibility and that practitioners should consider the needs, strengths, and perspectives of the wider family network, not just the individual at the centre of professional attention. This includes recognising that effective safeguarding requires early involvement, joined-up communication, and proactive consideration of the family's role in understanding risk, supporting wellbeing and sharing relevant information. Making Safeguarding Personal (MSP)[25] guidance promotes a similar person-centred, outcomes-focused approach that extends to communication with carers, families and advocates, ensuring they are informed, involved and treated with dignity and respect. MSP guidance emphasises the importance of accessible communication, personalised engagement, and supporting people to improve or resolve their circumstances, including through family reconnection and engagement. For Colleen this was particularly relevant because her two children were in special guardianship arrangements with a family member and she was motivated by

[25] https://www.local.gov.uk/our-support/partners-care-and-health/care-and-health-improvement/safeguarding-resources/making-safeguarding-personal

her relationship with them. Further, practitioners may have been better placed to understand the complexity and nuance of Colleen's presenting behaviours, and to mitigate risk concerns, if Colleen's relatives had been invited to be part of the network of support. Whilst securing Colleen's consent would have been required for professionals to share information, there was nothing preventing them from engaging professional curiosity to listen to, acknowledge and document information shared by family members about Colleen.

Similarly, the absence of timely, compassionate communication with Colleen's family following her death stands in contrast to the central principles of Making Safeguarding Personal (MSP) and does not align with 'duty of candour[26]' expectations and general commitments to transparency and openness in social care practice. Whilst it would not have changed the circumstances, by not reaching out to share condolences Camden Council missed the opportunity to demonstrate a compassionate and open safeguarding culture and left bereaved family feeling that the situation was being 'covered up'.

Lastly, as part of the review Colleen's family shared their intentions to approach Ministers about gaps in the care for vulnerable prisoners. They have spent significant time thinking about how learning from this review, and their experience as the loved ones of Colleen, might benefit others. Their ideas and efforts are worthy of recognition and consideration.

Recommendation 6a: The Independent Chair of the Camden Adult Safeguarding Board to offer to **meet with Colleen's family**, to formally share their condolences and to listen, and where appropriate lend support to, their intentions to approach Ministers about improvements to the care for vulnerable prisoners[27].

SAR Joe (2025)[28] also highlighted missed opportunities to meaningfully include family members as part of the network of support around adults with care and support needs experiencing homelessness. This review concluded with a recommendation that the borough develop guidance to ensure that family/friends are meaningfully involved in the care and treatment of their loved ones. A draft document 'Working with Families' has been developed and as such, this review concludes without unnecessarily duplicating that recommendation.

Recommendation 6b: Camden Adult Social Care should offer Colleen's family, as well as relevant local family and carers networks, the **opportunity to consult** on the 'Working with Families' guidance document before it is finalised for publication.

System Finding 7: **Unclear application of trauma-informed care principles**

It is uncontested that Colleen lived with the effects of trauma, including from acquired brain injury, bereavements and child removal, street homelessness experiences and instances of violence and abuse across her lifespan. Agency responses indicate that approaches to challenging behaviour, vulnerability and risk were not explicitly or always trauma-informed. For example, behaviour deemed

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[26] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20

[27] In March 2026, the independent Chair of Camden Safeguarding Adult Board and the SAR Author met with Colleen's family. As part of this meeting, the Chair agreed to meet with the family at 4-6 month intervals following approval of the review to ensure that they were kept up to date on progress on the review's recommendations and had an opportunity to feed in as appropriate.

[28] https://www.camden.gov.uk/documents/d/guest/sar-report-joe-2025

as anti-social or aggressive doesn't appear to have been considered as potentially connected to prior experiences of trauma and harm, which may have been helpful when considering the risk she posed to self and others in the community and at her hotel accommodation. Colleen's family reflected that her communication could often be perceived as aggressive when that wasn't her intention, pointing to the volume she spoke at and her use of body language and exaggerated gestures.

Although Colleen's behaviour could be aggressive and unpredictable, it is difficult to identify from case records how this was considered in connection to feelings of mistrust, prior harmful experiences or concerns about being once again recalled to prison. This may have inhibited agencies understanding of the root causes of behaviour and limited their insight into Colleen's decisions to reject offers of support, to accept hotel accommodation in a place where she experienced and perpetrated previous harm and to why previous accommodation placements had failed.

The nature of contact with agencies during the review period, being both reactive and urgent, prevented fully trauma-informed and person-centred assessments to be conducted with Colleen. However, it would have nonetheless been good practice for the impact of the recent releases and recalls to prison to have been considered in relation to her emotional wellbeing, vulnerability and behaviour.

Camden Council and its partners have been at the forefront of developing trauma-informed practice when working with people experiencing homelessness and multiple disadvantage. The Camden and Islington Trauma-Informed Network has developed a range of resources and opportunities for practice sharing over the last five years, that are publicly available[29]. The network is open to all practitioners working across the two boroughs, although it was unknown to the social workers who engaged in the review process, which indicates an opportunity to promote the network and its resources to the wider workforce and partnership.

It is encouraging that in the recently published Homelessness and Rough Sleeping Strategy 2025-30, the Council committed to; "Partners across housing, health, social care, prison, probation, police, employment, benefit services, refugee and asylum seeker services working closely together to provide proactive, trauma-informed, person-centred support to a person or family as a whole, rather than addressing isolated needs." This commitment recognises the impact of stigma, rigid service thresholds and the need for trust and improved system coordination, and recognises that there is work to do to achieve these aims. This review identifies that applying trauma-informed principles is important even when there has not yet been the time to build relationships and rapport, and that consideration of the impact of trauma is especially important for women living with complex care and support needs whose behaviour may not immediately indicate vulnerability.

Recommendation 7: Camden's Safeguarding Adults Board to seek assurance about how trauma-informed principles and ways of working are being promoted and applied in Camden.

- By September 2026, relevant officers to make a **presentation to the Camden Safeguarding Adult Board** about the boroughs approach to trauma-informed principles, identifying relevant strategies and plans, outlining opportunities for training and practice development and highlighting challenges for practical delivery.

[29] https://padlet.com/beverleylatania/camden-and-islington-trauma-informed-network-f1mwvfbhajrkfeuh

- The Board to consider developing **a guidance note** about the impact of trauma on behaviour and how this might challenge attempts to identify and respond to abuse and neglect, including self-neglect.
- CSAPB to disseminate information about the **Camden and Islington Trauma-Informed Network**[30], to maximise opportunities for peer learning and practice sharing.

Changes Since Colleen's Death

Since Colleen's death Camden Council have been proactive in identifying learning and opportunities for practice improvement, including the commissioning of this discretionary review. The early drafting of Prison Release Guidance and Welfare Visit Guidance documents is positive, although it is recommended that time is taken to finalise and implement these when the findings and learning from this review have been approved by the CASPB and can be fully taken into consideration.

The reviewer is also aware of a number of digital system improvements which will connect information about Camden residents held by council departments. It is recommended that these system advancements are tested in respect of their usefulness in adult safeguarding and working with adults experiencing multiple disadvantage.

The reviewer has also been made aware of a programme of practice improvement activity around self-neglect, which will explicitly include learning from this review. This programme, led by CSAB, has already started and will continue throughout 2026/27.

Finally, the reviewer is aware that in light of Colleen's death, Social Care Institute for Excellence guidance about gaining access to adults at risk of abuse and neglect [31]has been widely shared and promoted amongst adult social work teams.

Conclusion

Colleen's death highlights the profound vulnerabilities experienced by women living with multiple disadvantage and the critical importance of coordinated, trauma-informed, legally-literate multi-agency practice.

Across the review period, professionals were asked to navigate a complex landscape of risks, statutory duties and housing pressures, under unwieldy time pressures resulting from short notice prison discharge dates. Nonetheless, this review identifies that efforts were unduly fragmented, reactive, and constrained by gaps in information-sharing, risk coordination, legal literacy, suitable accommodation options and the meaningful inclusion of Colleen and her family. Collectively, these system barriers limited the ability of agencies to intervene effectively at moments when coordinated, proactive safeguarding activity could have reduced risk and prioritised Colleen's wellbeing.

Colleen's experiences also highlight the wider context in which safeguarding and homelessness systems operate: a national housing emergency, limited specialist accommodation for women with complex needs, and growing pressures on criminal justice, health and social care services. Within this context, Camden's commitment to trauma-informed and multi-agency system transformation provides a strong foundation from which to embed learning from this review and strengthen local responses. The learning emerging from this review should therefore be viewed not only as an

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[30] https://www.shp.org.uk/news/our-story-so-far-camden-islingtons-trauma-informed-network-principles-and-learning
[31] https://www.scie.org.uk/safeguarding/adults/practice/gaining-access/

opportunity to address discrete practice gaps, but as an invitation to embed deeper cultural and structural change—ensuring that adults with multiple disadvantage are met with curiosity, empathy, and coordinated support that recognises both their vulnerabilities and their strengths.

A central message from Colleen's family is their desire to have been listened to, engaged with and respected. Their insight, love and commitment to Colleen were invaluable protective factors, and their exclusion represents a missed opportunity to understand her risks and needs more fully. Ensuring that the local system is better able to hear, understand and respond to individuals and families facing similar challenges will be an important step forward.