REGULATION 29: RESPONSE TO PREVENTION OF FUTURE DEATHS REPORT

RELATING TO THE INQUEST TOUCHING THE DEATH OF IGOR KACPER SZALAPSKI (DATE OF DEATH 30.04.23)

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1. Introduction

1.1 This Report is drafted on behalf DePaul UK by their instructed solicitors, rradar of Platform, Suite 4B, New Station St, Leeds LS1 4JB the contents of which have been approved by ███ ███ (Chief executive officer) - DePaul UK). The Report is signed and dated by ███ ███ as authorised by the Board of Trustees of DePaul.

1.2 This Report is made in response to the Prevention of Future Deaths Report ("PFD") dated 13 November 2023 which was issued following the Inquest into the death of IGOR KACPER SZALAPSKI ('Mr Szalapski') who sadly died on 30 April 2023 whilst staying as an accommodation client at the London Youth Hub ("the LYH"), Holly Park, Islington.

1.3 This Report is drafted in accordance with Regulation 29 and the Chief Coroner's Guidance No. 5 'Reports to Prevent Future Deaths', specifically paragraphs 44 and 45.

1.4 The Inquest took place on 1 November 2023, the Coroner concluded that Mr Szalapski died by suicide.

1.5 DePaul was not afforded Interested Party (IP) Status prior to or during the Inquest. To the date of writing this Report, DePaul are not an IP, despite a PFD Report being made against them.

1.6 Both DePaul and rradar solicitors made numerous attempts to ascertain whether DePaul were IP's and request what information was required. These requests were not responded to prior to the Inquest. Depaul did not have the benefit of any opportunity to review the Inquest Bundle and despite repeated requests, the Coroner's Office did not confirm what information was required from them in advance of the hearing. This subsequently led to criticism in the PFD. It is disappointing that DePaul did not have the opportunity to provide information and address His Majesty's Coroner's concerns directly as they would have been able to with the benefit of having had sight of the Inquest Bundle and confirmation as to what information was being requested from them, had they been granted IP status.

1.7 rradar solicitors have instructed a third- party transcription company to provide a transcript of the recording of Inquest provided by the Coroner's Office. This document is appended to the Report in compliance with the Chief Coroner's Guidance No.4 Recordings.

2. **Background**

2.1 The LYH is a 26-bed accommodation service for 18- to 24-year-olds currently sleeping rough, and those at imminent risk of rough sleeping in London.

2.2 The Hub is lead-managed by Depaul UK with support Workers from New Horizon Youth Centre assisting guests to move on from the Hub into suitable accommodation. It is supported by the Greater London Authority. Partner agencies and statutory services refer young people into the project.

2.3 The LYH provides emergency accommodation. The aim is for most young people to stay for to up 56 days, during which time they will receive personalised, holistic support from the delivery partners Depaul UK and New Horizon Youth Centre. Some young people may stay for shorter periods (such as those for whom there are clear and immediately available accommodation options) and others longer (such as where immigration status is unclear, and a legal intervention is required). Whilst staying at the Youth Hub, young people are provided with essential items such as toiletries, food and travel support. 24-hour staff on- site assist with referrals to specialist organisations, for example substance use or health organisations.

2.4 DePaul UK is not regulated by the Care Quality Commission (CQC). DePaul is a registered Charity and is therefore regulated by the Charity Commission. The London Youth Hub as a project delivered by Depaul UK is not regulated by the CQC either.

2.5 Mr Szalapski was 18 years old and had been referred to the service by the Hounslow Street Outreach Team on 24 January 2023. He moved into the service on the 25 January 2023.

3. **The PFD Report**

3.1 In the PFD report, there are several inaccuracies which are addressed by DePaul as follows:

3.1.1 At page 2 of the PFD His Majesty's Coroner states;

"*I heard evidence at inquest that Depaul conducted an internal investigation into Igor's death. The fact of the report was not disclosed to my office in advance of the inquest as it should have been, and I did not see it until it was mentioned in evidence at the inquest.*"

DePaul had provided information to the police regarding the Internal Investigation Report. This is detailed in the MG11 of [redacted] as "*NMH/5 – Internal Investigation Report from Depaul*". There was ongoing correspondence between the police and DePaul

regarding service of this document and therefore the police were well aware of it's existence and that it was intended by DePaul to serve this as part of their investigation. DePaul would have expected that this information be sent to the Coroner. In [redacted] [redacted] email to [redacted] dated 9 August 2023 at 15:03, DePaul confirmed they would serve the log and internal investigation requested by the police but that *"Due to the nature of these documents they need further redaction but will be with you no later than 25th August."* Representations were subsequently made to the police that because of the nature of their DPA request, it would be beneficial if the Coroner requested the documents as it would then not need to be redacted in terms of the third party information it contained. The Coroner should therefore have been aware of its existence, which is contrary to the statements made at the Inquest. Further DePaul and rradar solicitors attempted on numerous occasions (including 12.10.23, 13.10.23, 16.10.23, 20.10.23), to contact the Coroner's office to clarify the position both regarding Interested Persons Status, and to request confirmation as to what information and/ or documentation was required prior to attending the Inquest. These requests were not responded to.

It is therefore factually incorrect that His Majesty's Coroner stated, "*You didn't offer this, you didn't mention it existed… you do not volunteer all of the material that you have in relation to that, and, and, and frankly one way of looking at it is that you're trying to hide your investigation."* DePaul did mention the investigation report at length in communications with the police, confirmed they were happy to provide this subject to redaction or any DPA requirements, alternatively would be happy to assist should a request come from the Coroner. DePaul are of the view that they went above and beyond what may be considered reasonable in requesting information regarding what was required, this was heard in the evidence of Nicola Harwood at 01:00:00 of the recording where she stated "*I was initially contacted 2 - 3 weeks ago with the request for a statement, and I asked for clarity about what that statement should cover and what additional records that should cover*."

3.1.2 DePaul is not regulated by the CQC. DePaul are therefore confused as to why the PFD Report has been shared with the CQC. DePaul are in fact a registered charity and in accordance with their regulatory obligations, have kept the Charity Commission updated throughout this matter, including sharing the PFD Report. This report and associated action plan will also be shared with the Charity Commission.

3.1.3 DePaul UK is not a registered provider of care with the CQC – this is because they do not provide personal care or nursing care in any of their services across England. The Youth Hub operates out of a building (280 Holly Park) that is owned by West London Mission. West London Mission are registered with the CQC, and had delivered a substance misuse service called 'The Haven' from the building until September 2021. Depaul UK began operating homelessness provision in November 2022 from that building. Haven and DePaul are in no way connected. The only connection between West London Mission and Depaul UK is that of landlord / tenant.

3.1.4 An error was made early on in the investigation by the police, who believed that Mr Szalapski lived at 'the Haven' and that the service was still operational. This reference entered the Inquest via the initial police reports which were in fact incorrect. [redacted] confirmed some confusion at the Inquest as per the transcript.

3.1.5 At every point in the process DePaul have declared both verbally and in writing that Depaul UK and the LYH is not a registered care service or CQC registered, however the mistake was promulgated throughout the correspondence for the inquest- including being referenced in the families own statement.

3.1.6 DePaul clearly stated;

i. verbally to the police

ii. via email (12 October 2023) to the Coroner's Office, and verbally by [redacted] to the Coroner's Office in a telephone conversation.

iii. in DePaul's written statement; and

iv. in the verbal evidence from the Director of Services at the inquest, that DePaul UK and the London Youth Hub are not CQC registered, going as far as to ask via email, to the Coroner's Office, to remove every reference to CQC for the avoidance of all doubt.

3.1.7 Despite all of the above attempts to correctly inform, there has been continued confusion from the police and the Coroner's Office that the service was a substance misuse centre, known as 'the Haven'. As clarified to both parties, that was a previous organisation that ceased in 2021 and had no involvement with Depaul UK.

3.2 Matters of Concern ("the Matters")

His Majesty's Coroner raised the following Matters:

3.2.1 Concern 1:

On 28 March 2023, Igor refused to get out of the shower. Hostel staff took various actions, including calling the crisis team. The crisis team decided that Igor did not need daily visits, but told staff to call back if there was any change or further concern.

1. *On 14 April 2023, staff found Igor outside, drowsy and incoherent, cold and wet, but did not re-contact the crisis team.*

<u>Response</u>

DePaul accept that there is no record on their client management system of the Mental Health Crisis Team having been contacted by DePaul following the recorded incident on 14 April 2023. HM Coroner's above statement does not represent the full facts. The Crisis Team had been contacted and subsequently visited Igor on the 29 March 2023 in response to an Incident Safeguarding and Near Miss report (ISN) on 28 March 2023. Staff had been alerted to Mr Szalapski flooding the bathroom during a very long shower (2 hours) in an effort to kill himself through electrocution. At this point the Crisis Team response (as recorded on the ISN) was:

"Crisis Team met with IS 29.03.2023

They have concluded that the above events are due to excessive drug use, his lack of medication may have impacted him, but predominately his drug use. IS stated to the Crisis Team he plans on continuing to take amphetamines and cannabis. He does not want any support. Crisis do not feel they need to come daily to see IS. They had advised we contact them again if we are concerned for IS mental health".

In any case, on 14 April 2023 contact was made by [redacted] the Manager at LYH with Mr Szalapski's GP in order that they could discuss his medication and confirm when this was last prescribed. It was agreed between [redacted] and the GP that the GP would call back on 15 April 2023. The ISN record evidences this under the 'actions taken' section following the incident and states as follows:

"[redacted] *spoke with the Doctors surgery*

IS was issued a months' worth of Duloxetine and Quetiapine on the 28.03.2023.

IS has used up all this medication in around 17 days.
The doctor is calling Saffron tomorrow to discuss his medication and what we can do moving forward."

DePaul submit that they had contacted the medical professionals (the GP) and previously the Crisis Team it was for them to make the relevant safeguarding referrals if in their medical opinion, this was required. DePaul spoke to numerous professionals on numerous occasions, referred him to the Crisis Team who referenced his drug problems, DePaul referred him to drug agencies and he would not engage with these. DePaul referred him to safeguarding and also to the GP. Safeguarding referrals were also made to Islington and to Hounslow. As DePaul were not a Care provider, they were limited in what they could do to progress any intervention with such organisations.

"It was heard during the Inquest that ██████ of the Hanley Primary Care Centre had in fact called Saffron Allan, Service Manager at 11.02 on the 15th April 2023 (a Saturday). The GP gave a detailed statement regarding their conversation. It was heard in evidence that Saffron gave a full history and reiterated to the GP that LYH was not an appropriate place for Mr Szalapski and ██████ advised DePaul to contact the crisis service, police, social services and A and E for assessment.
DePaul have since reviewed their internal communications and confirm that an email trail between the Manager and the Youth Hub Team at 18.04 at 11.36 states as follows:

"*Following on from a conversation with I.S GP we have been advised in the event of an episode re-occurring to call the Police and request a Section 136 under the Mental Health Act.*

The GP has stopped all medication for I.S due to him mis-managing his meds and misusing various substances and alcohol.

Please remember this is the only course of action to be taken in the event of another psychotic episode. There are no other routes or remedies.

Meanwhile he is attending Court 20.04.2023 and we are discussing his housing with Hounslow Council as a more suitable and permanent arrangement for him."

The above suggests ██████ may only have advised DePaul to contact other services if a further event took place. The GP's advice post- dates the advice of the Crisis Team and therefore it is reasonable to assume that this later advice should take priority. In any case, if DePaul had been granted IP status this matter could have been investigated further and the witness cross examined as rradar would expect the GP to make such referrals himself if he had such safeguarding concerns, rather than put the responsibility on another organisation.

On In-form (DePaul's client management system) a call was recorded as taking place at 10.30 am on 15 April 2023 as follows;

"GP called ████ - Manager Saturday a.m to discuss and review IS's case. The doctor said that due to his high mental health needs, IS should be living in higher needs accommodation. He also said that if IS becomes a danger to himself or/and others we should call the police as they can act and detain under the Mental Health Act Section 136. Another option is to call Crisis mental health team, depending on the situation. Regarding his medication, the doctor said that IS wouldn't be prescribed new medication for the foreseeable future as he used 28 days worth of medication in 14 days and also because he has declined substance misuse support which was offered to him after we learned he is taking methamphetamine, crystal meths and other substances."

On 17 April 2023, DePaul emailed Hounslow Substance Use Service which outlined the incident, the steps taken with the GP and asked for an update on moving him on and the concerns around his safety. This is outlined in DePaul's Incident safeguarding or near miss report (DePaul's internal incident management reporting system). This was in response to the Substance Use team stating on 14 April that there was no immediate availability for alternative accommodation. DePaul continue to struggle, much like many other organisations, to find such higher needs accommodation even though as with Mr Szalapski, the local

authority with a duty towards him had accepted their responsibility, nothing suitable was available.

DePaul have since the date of the Inquest, located email correspondence from Saffron Allen. On 18 April 2023 at 11:36, she sent correspondence to colleagues at DePaul stating:

"Following on from a conversation with I.S GP we have been advised in the event of an episode re-occurring to call the Police and request a Section 136 under the Mental Health Act.

The GP has stopped all medication for I.S due to him mis-managing his meds and misusing various substances and alcohol.

Please remember this is the only course of action to be taken in the event of another psychotic episode. There are no other routes or remedies."

This suggests that DePaul employees did as advised by the medical professionals dealing with Mr Szalapski and also questions the decision for a PFD to be made on this issue.

Meanwhile he is attending Court 20.04.2023 and we are discussing his housing with Hounslow Council as a more suitable and permanent arrangement for him.

There is no evidence on In-format that the Crisis team were updated of the 14 April incident, however other steps were taken as detailed above. Nevertheless, DePaul accept that as per their safeguarding policy (in the section on self-harm and suicide);
"*Staff must support clients to access suitable professional support to help keep them safe... In most instances this would involve a referral to other agencies or health professionals to provide additional support and management strategies to the individual and/or the team*."

In the absence of a record on In-form relating to referrals post the 14 April 2023 ISN, along with the staff who were present at the time leaving employment with DePaul, they cannot confirm such safeguarding referrals were made.

DePaul are reviewing how actions relating to ISNs is captured in In-form to ensure that ISN actions and comments are quantifiable and monitorable.

3.2.2 Concern 2:

"Igor was a vulnerable young man, recently homeless, but the last time that any member of staff had a meaningful conversation with him was on 20 April 2023, ten days before he died."

Response:

Staff from DePaul had regular contact with Mr Szalapski. According to In-form – which does not capture every interaction he had with staff, there were over 112 recorded contacts with him during his time at the service The client contact record on 20 April 2023 refers to a discussion with him about the court case in relation to an injunction his family had taken out against him. On 21 April 2023, staff met with him to discuss his housing options his drug use, the reasons for staff checking on him (he reported he felt 'babied' at the Youth Hub in response to increased checks on him), and his relationships with other clients at the service. These were relayed at the Inquest in the evidence of [redacted], as more "Structured Support" interactions rather than check- ins. However, the Coroner has interpreted them as the only conversations that were held with Mr Szalapski in the run up to his death. This is incorrect as both Depaul staff and staff from other agencies had regular conversations with Mr Szalapski and spoke warmly about him. In addition, New Horizons (DePaul's delivery partner) also worked closely with Mr Szalapski recording referrals to a number of agencies as follows:

'29/03/2023

- Contact to Phoenix Futures to request substance misuse support for IS. IS declined to engage with them.

04/04/2023

- Hounslow Housing Options to alert them of IS case.

06/04/2023

- Hounslow again. Duty to Refer was made.
- St Mungo’s to note previous chasing from Saffron at Depaul. Asked for transfer to Staging Post to be agreed.

13/04/2023

- Phone assessment between IS and Hounslow to identify options. Hounslow due to follow up.

21/04/2023

- Followed up with St Mungos to request Staging Post transfer again 24/04/2023
- IS attended further assessment with Hounslow and New Horizon. Hounslow due to make referral to St Mungo’s.

26/04/2023

- St Mungo’s carried out zoom assessment with IS.

28/04/2023

- AG followed up with St Mungo’s – said it was likely IS would be accepted into one of their projects, needed to confirm with a manager and would respond to New Horizon by 2nd May.’

The Operations Director ([redacted]) at New Horizon confirmed that the above records are all sourced from New Horizon’s In-Form system and one note regarding the Phoenix referral, was obtained from their email system.

In addition, there are daily records for most days between the 14 April 2023 incident and his death on 30 April 2023, where staff recorded seeing him or checking in with him. This includes references to him being seen with other clients in the communal spaces, but also refers to him making complaints about ‘feeling babied’, having no money, and his poor physical or mental health.

There are no further ISNs or updated risk assessments after the 14 April 2023 incident regarding any of these exchanges, and there are no other records of escalations or reports to external agencies other than the GP and the substance misuse team detailed above, which is what is expected.

However, it is important to note the nature and context of the service in relation to support. The LYH model was born out of the emergency hotel initiative during the pandemic. The purpose of the service is to provide emergency housing for up to 56

days, during which time the clients will 'receive personalised, holistic support from the delivery partners Depaul UK and New Horizon Youth Centre'. It is not supported accommodation and therefore does not specify the frequency of support sessions to clients, recognising the short-term nature of their stay, and the focus of the provision on moving them on to longer term accommodation. There is the expectation however of general, broader support in place for clients from partner agencies and statutory services.

During the transition from emergency hotel provision, as the client's needs (higher risk referrals than expected) and length of stay have evolved, DePaul recognise that regular structured support sessions were beneficial for clients and staff – rather than more informal support- based interactions.

The LYH now has structured sessions in place.

3.2.3 Concern 3:

"The Depaul executive director of services recognised at inquest that there should have been more staff conversation with Igor throughout his time at the London Youth Hub."

Response:

[redacted] (Executive Director of Services) was called to the Inquest to give evidence. She did not directly work with the Mr Szalapski or the staff team, and therefore the information given in her statement and testimony was based on what was recorded on In-form.

It is recognised that the quality of record keeping at the LYH was not of the standard expected – an example being the conversation between the GP and the Manager on 15 April 2023, that was heard at the inquest, varied in how it was recorded by both parties. This, however does cast doubt on which is the accurate version of events. In addition, the staff model was based on the model used across the emergency covid hotel provision where Agency Security staff worked alongside single cover support provision. The staff at the hub at the time of Igor's death were either new or temporary staff following an extremely challenging period of staff recruitment across the voluntary sector. Induction, training and support for the staff team was not as detailed as it should have been, with reliance on temporary staff in the absence of recruited permanent staff. Temporary staff do not have access to In-form, and do not

always attend or engage with DePaul's full training offer (due to the temporary nature of roles). This means it is difficult to conclude whether the In- form records reflect the team's full interactions with Mr Szalapski.

Following the incident, staff and management did share their interactions with Mr Szalapski, with [redacted] (ED of Services). They spoke clearly with warmth about him and shared details of their conversations. It is [redacted] view that there were regular conversations with him, but this was not always recorded on In-form. As the Executive Director of Services, [redacted] could only go from the formal reports on In- form. Had the team directly working with him been called to give evidence too, she is confident they would more accurately paint a picture of the relationship staff had with him and be able to detail the conversations that took place.

3.2.4 Concern 4:

"She also acknowledged that greater attempts should have been made by staff to engage with partner agencies regarding Igor's care and welfare."

Response:

In-form shows that during his stay at the Youth Hub, contacts were made with;

• EASL for a mental health assessment (24.02.2023)

• Islington Housing Benefit (throughout stay)

• Crisis Mental Health Team (28.03.2023 – who informed DePaul that Mr Szalapski, was receiving support from the community mental health team)

• Consultant Psychiatrist (28.03.2023 and 30.03.2023 reiterating more suitable accommodation should be found for IS)

• GP's at Hanley Road Surgery as per the statements at Inquest (throughout his stay)

• Islington Safeguarding team (28.03.2023)

• Better Lives substance Use service (this was refused by Mr Szalapski on 30.03.2023)

• Hounslow Substance Misuse team, regarding accommodation options (later deemed to be too high risk for options 17.04.2023).

• New Horizons – DePaul's partner in the delivery of the London Youth Hub focused on his housing move on. DePaul's records show that they referred him to as per the above paragraph 3.2.2;

• LB Hounslow, highlighting 'a significant deterioration in his mental health and behaviour' (06.04.2023)

• Staging Post/St Mungo's (Emergency accommodation transfer request) as above (06.04.2023)

They also shared that referrals for long-term accommodation were explored with Cooperative Housing and Aves Housing, but neither could be progressed due to the risk around IS' support needs increasing.

However, whilst referrals were made, and risks shared, it is clear that more could have been done professionally to disagree with or challenge the external advice regarding his housing situation and wider support needs. In addition, all agencies working with him should have been informed when there was a change in his mental health.

3.2.5 Concern 5:

"Igor was only 18 years old and his father did visit him, but the hostel did not have any contact details for his family."

Response:

DePaul request next of kin details for all our clients, when they move into their services however it is not a condition or requirement of accommodation and given the family relationship history of many of their clients, it is unsurprising that they choose not to provide this information.

DePaul's Data Protection policy outlines it may be necessary to share information with other agencies and organisations – this is related to safeguarding concerns – and they are clear with clients about this.

Where clients have visitors, they record their time and date of visit, and their name but do not record their contact details. This in line with data protection procedures.

When a serious incident occurs, and next of kin do need to be notified, they share relevant information that they may hold with the police and the police are required to contact the next of kin. In this case, the police agreed to notify the family. This was confirmed by the police at the Inquest.

3.2.6 Concern 6:

"I heard evidence at inquest that Depaul conducted an internal investigation into Igor's death. The fact of the report was not disclosed to my office in advance of the inquest

as it should have been, and I did not see it until it was mentioned in evidence at the inquest. However, I have read the report since. It went into some detail and identified that, when Igor was found at 6.25pm, no staff member had undertaken a welfare check of him since half past midnight, whereas there should have been at least one per shift. I was told at inquest that staff were disciplined about this after Igor's death."

<u>Response:</u>

DePaul UK are committed to sharing information to enable wider understanding and learning. Both DePaul and DePaul's legal advisers (rradar) were proactive in asking the Coroner's Office for clarity on what to share and to what extent, on a number of occasions and received no response from the Coroner's Office. Without a doubt DePaul would have shared whatever was required. To summarise DePaul's communications;

i. On 11 October DePaul received a request for a statement for the Coroner's Office, stating "The coroner requires reports from staff dealing with Mr Szalapski's stay at the Haven and details any treatment that he had there". In response to this request, [redacted] spoke on the phone with the officer asking for clarity on the parameters of the statement, and what evidence we should provide as part of this. [redacted] explained the volume of client records they hold, and the clarity they needed in line with data protection. Advice was to email with request.

ii. On 12 October, [redacted] emailed the Coroner's Office following up on the conversation above, asking; *"What information do you need in the statement – your initial request below refers to any treatment he had. Is there anything else you need covering or is it solely what Depaul do at the Youth Hub, and information regarding treatments?"*

iii. On 13 October, the coroner's office responded to state *"The coroner has reviewed the file and feels she has everything required for the inquest so no need for a further report. However, she requires you to attend the inquest to give evidence".* This statement has undoubtedly added to the confusion on the part of DePaul.

iv. On 16 October, [redacted] replied to state "*Many thanks for sharing this. Do you have any details regarding the parameters of what I might be asked*

about, or indeed what evidence I may need to consider bringing?“ No response was received.

v. Whilst a statement was not required DePaul, voluntarily decided to provide one, to ensure they were as transparent and prepared as possible.

vi. They also sought legal advice from rradar on both preparation for the statement and for attending the Inquest as a witness. On 25 October 2023, rradar advised that it was unclear whether DePaul were an Interested Party or not, and they contacted the Coroner’s Office on a number of occasions as follows:

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i. Email dated Wednesday 25 October 2023 at 14:28 hrs; and

ii. Email dated Thursday 26 October 2023 at 15:13 hrs

Further to the above, rradar attempted to call the Coroner’s Office on the following dates:

iii. 25 October 2023 x 2 calls at 14:46

iv. 25 October 2023 at 14:40

v. 27 October 2023 at 13:41

All of the above 6 attempts to make contact with the Coroner’s office were unanswered and no response was provided to rradar.

Following the immediate aftermath of the incident, DePaul learned that Mr Szalapski had not been seen for 18 hours. They would have expected staff to check on him on every shift as a minimum. Furthermore, they learned a local management decision had been made to complete these checks more frequently due to his deteriorating mental health. However, staff on shift reported different understanding of this, and routine or increased checks were either not actioned or not recorded.
DePaul immediately led an internal investigation with the staff on shift at the time, and as a result of that investigation, two staff members failed their probation and are no longer employed by DePaul UK.

Whilst it is unlikely that his death could have been prevented by Depaul UK, there could have been more dignity in the way he was found, and the timing of this. He should have been seen or checked on by each shift and this did not happen.

3.2.7 Concern 7:

"At the time of Igor's death, there was no national policy on when to increase welfare checks. I was told that there is now national guidance.

Response:

As part of the investigation DePaul recognised that there was a lack of clarity on welfare checks. There was no organisational policy on this, and local management was trusted to make decisions based on their experience.

DePaul have now developed an organisational procedure on welfare checks (as part of safeguarding policy) that captures what routine checks are, and when increased checks may be put in place (including by who, for how long, and how to record this) to ensure staff and managers are clear. Through the incident and safeguarding procedures, designated safeguarding officers have been clear on parameters surrounding increased checks (i.e temporary, and with external specialist advice in place).

3.2.8 Concern 8:

"The Depaul investigation also identified that staff at the London Youth Hub had not attended self-harm and suicide awareness training. I heard that training has now increased and is mandatory. The report described the culture at the London Youth Hub as chaotic."

Response:

The clients of Depaul services are increasingly presenting on referral with higher mental health support needs than they have experienced in the past. As they see increased mental health challenges for people experiencing homelessness, coupled with limited external specialist resources available to them, they are seeking to address this. Considering this, DePaul developed training in self-harm and suicidal ideation, and to date, 186 staff have attended this training.

Following this incident, DePaul took quick action to address the concerns regarding the 'chaotic' feel of the service. This included;

- Change in management, drawing on experienced London service managers
- Change in leadership, with the service being overseen by our experienced Area Director of Housing and Support.
- Staff (permanent and agency) from other services, experienced in the application of Depaul policies and procedures working shifts at the hub, providing shadowing and buddying opportunities.
- Organisational policies and procedures implemented, rather than local procedures in place (that had related to the Covid hotels rather than supported housing).
- Thresholds to access and enter supported accommodation have increased, along with increased pressures and demand on emergency, health, social care, housing and support services across the board.

4 Measures already in place prior to Mr Szalapski's death

As an organisation providing housing and support to people experiencing homelessness, there are organisational procedures in place that relate to this case. They include;

- Organisational Safeguarding Policy
- Incident near miss and safeguarding procedure
- Support Planning Policy
- Mental Health Strategy

Operationally DePaul requires room checks and housing management security checks, which aim to ensure the health and safety of clients.

DePaul also works in close partnership with expert and specialist providers to complement the housing and support they offer. Their staff are not specialists in wider support needs, and therefore seek technical advice from these organisations on specific issues clients may face. These include – but are not exhaustive – working with local authority teams (social workers, safeguarding teams, housing teams) and with specialist Mental Health providers, substance use organisations, family support / relationship organisations.

In relation to the ISN process, fortnightly senior review of ISN's meeting has been in place for some years.

5 Action taken or to be taken, whether in response to the report or otherwise, and the timetable for it, or it must explain why no action is proposed (Regulation 29(3)).

5.2 DePaul attach as an appendix to this document, their action plan. This was finalised and put in place by DePaul on 1 December 2023. The Action Plan is monitored at a high level through the Executive Team Meeting and Services Committee at DePaul

6 Conclusion

6.2 The safety of DePaul's clients remains of the utmost importance to them. All those who knew Mr Szalapski were saddened and shocked upon learning of the event of his death.

6.3 DePaul wishes to pass on their sincere condolences to the family of Mr Szalapski. DePaul hopes this response provides the Coroner and the family with the appropriate level of assurance that as a Charity they have dealt with the concerns highlighted within the PFD report.

6.4 DePaul acknowledges that this was a tragic event and whilst rare within DePaul's services, has resulted in reflections and learning which have shown that Mr Szalapski was failed by a number of services.

6.5 The Youth Hub provided temporary emergency shelter for him – a better alternative than rough sleeping – but not supported or specialist accommodation. He had complex high needs, that the Youth Hub was not able to provide. His housing needs were raised by both New Horizon (responsible for the housing move on) and Depaul who advocated that the Youth Hub was not able to meet his needs.

6.6 However, despite acknowledging the nature of the service (26 clients, with limited staff cover, all in temporary emergency accommodation) the quality of service he received within the LYH was still not the quality he should have had. The immediate aftermath of the incident addressed this through formal HR processes with individuals, disciplinary action and a full internal investigation. However, wider learnings show that DePaul could have done more notably on;

6.6.1 Identifying smaller changes in behaviour / interactions, and seeing them as a deterioration in mental health and ensuring these were acted upon by the relevant agencies

6.6.2 Making continued escalation and referrals to housing teams, mental health teams and to safeguarding teams.

6.6.3 Ensuring staff were well inducted, trained, managed and supported to provide effective support within the service (including the recording of those interactions on In-form).

6.7 More broadly, following this incident DePaul quickly undertook a number of HR investigations and broader service changes and improvements. Whilst this was necessary to ensure the safety and wellbeing of other clients, this meant DePaul did not in parallel complete an individual case review into the support Mr Szalapski received. DePaul will, going forwards, ensure following serious incidents, that individual case reviews continue alongside wider organisational reviews.

6.8 On process there are a number of points DePaul challenge within the PFD;

i. That Depaul UK withheld / failed to provide supporting evidence to the Coroner

ii. That Depaul UK is CQC registered and a care provider

iii. That Depaul UK should have contacted the next of kin rather than the police.

These points are addressed above.

6.9 Though DePaul have reflected following this incident and put in place the above measures and action plan, as discussed at 3.2.1, DePaul raised issues of a deterioration in mental health with the Crisis Team and were told that it was a substance use issue not a mental health issue. This is after he had expressed an intention to take his own life through electrocution in the shower. The GP refused to prescribe his medication given that he had taken 4 weeks supply in 14 days (as detailed at paragraph 3.2.1). DePaul did identify changes in behaviour and raised those concerns with the appropriate mental health services and safeguarding.

Signed:…… ……… (CEO)(for and on behalf of DePaul UK)

Dated: ………31.01.2023………………………………..