Camden Safeguarding Adults Board

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7 MINUTE BRIEFING OF

Safeguarding Adults review

A Themed Review

Colleen Madden

Context

Safeguarding Adults Reviews (SARs) are mandatory for the Camden Safeguarding Adults Board and focus on improving adult safeguarding practices by identifying factors that facilitate or hinder effective protection, aiming to remove barriers and prevent harm.

The Camden Safeguarding Adult Board discussed a SAR referral in September 2025 concerning Colleen, a 31-year-old woman who died within two days of being released from prison while staying in interim hotel accommodation. It was decided that a discretionary SAR was suitable under Section 44(4) of the Care Act 2014.

Background

Colleen was born in February 1993 and grew up in Camden with her parents and five siblings. She was diagnosed with ADHD as a child and did not attend mainstream secondary school. In adulthood, she experienced domestic and sexual violence, drug and alcohol dependency and mental ill-health.

She was first placed in homelessness Pathway accommodation in 2014 and had multiple stays in supported housing. Housing placements frequently broke down, largely around behaviours related to her drug use/dependency. Colleen died whilst in a temporary hotel placement in January 2025, two days after being released from prison.

Safeguarding Adult Review Methodology & Process

A SAR referral was made by Camden ASC in September 2025. A rapid review was commissioned, to identify learning that could be embedded quickly and shared with the Coroner ahead of the inquest hearing. The review considered information from the final 4 months of Colleen's life, from September 2024 to January 2025.

The Panel approved a hybrid approach involving case analysis, learning events, agency meetings, and family discussions, resulting in a concise Systems Learning Report. The SAR was completed before the February 2026 Coroner's inquest, with a draft shared. However, staff absences in the Probation Service delayed their involvement, leading to the inquest being adjourned.

Collen's family have been actively involved; they met with the Reviewer and submitted information by email. In March, they met with the Reviewer and the Independent Chair to discuss how they can stay informed of progress against review recommendations (Recommendation 6a)

Key lines of enquiry (KLOE) were established for this thematic review, requesting information providers to identify both good practices and areas for improvement.

- Prison Discharge Planning
- Application and interface between legal duties and powers:
- Provision of Suitable Accommodation
- Decision-Making related to Entry without Consent

Wider Learning & Recommendations

Learning Point

- 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.
- 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. 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.
- 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. 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.
- 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.

Wider Learning & Recommendations

Learning Point

- Camden Safeguarding Adults Board to take action to improve legal literacy and practice confidence around powers of entry

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

- 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.

  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.

Wider Learning

The family issued the following reflective statement:

“What happened to our sister, Colleen, was a preventable tragedy. It is our firm belief that, had the agencies involved in her care communicated effectively, shared critical information, and fulfilled their responsibilities, her death could have been avoided. There were multiple opportunities to act, and those opportunities were missed. We have come to understand that, at times, Colleen was treated as a process or administrative case rather than as the vulnerable adult she was. This lack of person-centred care had devastating consequences. Colleen was a daughter, a mother of two, and a much-loved member of our family. She deserved protection, dignity, and proper care.

We need the Board not only to reflect on the findings, but to fully acknowledge where systems and professionals failed, and to take responsibility for those failures. Accountability is critical, not just for our family, but to ensure meaningful change and to prevent this from happening to another vulnerable person.”

Do you know Camden has a Self Neglect Policy, Practice Guidance and Procedures, and how to make best use of this?

Do you fully understand the legal powers and options available to gain access to someone where there are safeguarding concerns?

How can we work more closely with partners to prevent occurrences like this?

Do you recognise the trauma that people have suffered and how does that impact on how you work with them?

What you can do to prevent reoccurrence

- **Trauma** - Use a trauma informed approach to forge relationships with individuals to gain their trust and confidence. See people in the context of their life history and the complex experiences they have had, rather than through the lens of their diagnosis or current challenges.

- **Recognising, assessing and responding to risk** – Risks should be evaluated thoroughly and tailored to individuals, taking into account recurring patterns. Addressing complex issues like homelessness, substance misuse, mental health, and self-neglect necessitates a collaborative approach among key partners. Multi-agency assessments are crucial for effective information gathering and sharing.

- **Involving family and friends** – Concerns should be shared and discussed wherever possible and appropriate, and the involvement and input of family and friends should always be considered; understanding where people are supportive factors is important, as much as understanding if they are not.

- **Safeguarding literacy** – All agencies should have an awareness of and use safeguarding pathways, including understanding thresholds. Case escalation should be used via senior managers where there is concern about risk and inadequate working together.

- **Legal awareness** - Understand the legal powers and options in complex cases of fluctuating capacity and self-neglect, involving the Court of Protection and Inherent Jurisdiction. Professionals assisting individuals without capacity must follow and beware of the Mental Capacity Act Code of Practice.