THEMATIC REVIEW: PREMATURE DEATHS

Report for Herefordshire Safeguarding Adults Board

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1. Introduction

1.1. Herefordshire County Council referred six deaths of individuals, their deaths occurring between January 2019 and August 2020. The information received from partners indicated a high level of substance abuse and physical and mental health issues. All were known to the police as victims and offenders. Concerns surrounded some of the individuals relating to self-harm, homelessness, self-neglect and suicidal ideation.

1.2. Four were accommodated at the time of their death in accommodation for single homeless people with support needs. No inquest was held with respect to the deaths of three individuals, their deaths being either expected or from natural causes. An open verdict was recorded in one case. Cause of death was given as pneumonia in one instance, liver failure in a second and as substance-related in a third.

1.3. The referral was prompted by the pattern of deaths over a two-year period. Similarities had been observed, namely individuals presenting with complex needs including substance misuse, offending, mental health, underlying physical health issues, and challenging behaviours. Herefordshire Safeguarding Adults Board (HSAB) accepted that the criteria for a discretionary safeguarding adult review (SAR) were met[1].

1.4. This report was commissioned to consider learning from the individual cases within scope of the review, with an additional focus on repetitive learning across the cases that would indicate system-wide concerns and challenges.

1.5. The focus of this report is on the issues professionals encountered in working with the six individuals. Examples of good practice have been included alongside analysis of gaps in provision and shortfalls in practice. Throughout there has been a clear commitment from practitioners, operational managers and strategic managers to appraise current service provision and to identify priorities for service improvement and enhancement.

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[1] Section 44 (4) Care Act 2014.

2. Safeguarding Adults Reviews

2.1. HSAB has a mandatory statutory duty[2] to arrange a SAR where:

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and
- There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

2.2. HSAB has discretion to commission reviews in circumstances where there is learning to be derived from how agencies worked together with respect to an adult with care and support needs, but where it is inconclusive as to whether an individual's death was the result of abuse or neglect[3]. Abuse and neglect includes self-neglect. HSAB commissioned this thematic review using that discretion.

2.3. It is important to emphasise the distinction between the mandatory and the discretionary criteria because this is not always understood. Under current law (Care Act 2014), for the mandatory criteria to be met, a SAB must have reasonable reason to believe that the adult whose case has been referred has/had care and support needs, has/had experienced abuse or neglect, including self-neglect, and there is/was reasonable cause for concern about how agencies have worked together in that case.

2.4. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future[4]. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

2.5. SARs provide a rich seam of evidence, alongside research and the voices of people with lived experience. This enables the construction of an evidence-base for positive practice. That evidence-base has been used in this report to inform the analysis.

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[2] Sections 44(1)-(3), Care Act 2014
[3] Section 44(4), Care Act 2014.
[4] Section 44(5), Care Act 2014

3. Review Process

3.1 Focus

3.1.1. HSAB commissioned this thematic review having identified a pattern of deaths amongst a cohort of adults with complex needs arising from substance use, mental health, offending and/or behaviour needs. Often these deaths seemed to be the consequence of long term lifestyle, behaviour and underlying health needs. Seeing the circumstances surrounding these deaths as a humanitarian issue, HSAB believed that there should be some form of review process to investigate the factors leading to these deaths, and learn any lessons to improve the support and services available to others with similar reliance upon drugs and alcohol, and with complex and risk taking behaviours. Thus, its purpose was to examine the events and circumstances that led to the deaths of this group of people, explore what if anything could have been done to prevent or avert this outcome, and capture learning as to what might be done to improve the effectiveness of services in Herefordshire that support people experiencing multiple and complex needs, including mainstream services.

3.1.2. The review would also consider recent and ongoing strategic initiatives focused on people with multiple physical and mental health needs, some of whom are experiencing or have experienced homelessness, and designed to address the increase in substance-related deaths. Thus, the thematic review would look at the range of existing and developing provision, including statutory services, outreach work and third sector organisations in order to gain a better overview of whether learning from the six cases regarding systemic issues was being addressed and to identify what further actions agencies can take to address any gaps.

3.1.3. A wide range of organisations were involved with some or all of the six individuals at one time or another. Representation was therefore sought from:

3.1.3.1. Organisations that work exclusively with people experiencing homelessness and/or substance misuse including local drug and alcohol services, and accommodation providers;

3.1.3.2. Organisations that provide services to the wider population, namely Herefordshire Council, West Mercia Police, Herefordshire and Worcestershire Health Care Trust, Wye Valley NHS Trust, Herefordshire and Worcestershire CCG, GP Practices, National Probation Service, Community Rehabilitation Company and West Midlands Ambulance Service.

3.1.4. The review also brought together commissioners/senior managers who have responsibility for the commissioning/management of these services. The purpose of their involvement was to identify strategic and commissioning level learning.

3.1.5. The review focused on the period from January 2018 to April 2020, during which time the deaths occurred.

3.1.6. The six individual cases are summarised below. However, rather than a traditional review that concentrates on a detailed chronology of a single case, this thematic review looks across all six cases for learning from recurring themes that indicate systemic issues to be addressed.

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3.1.7. The review has adopted a whole system focus. What enables and what obstructs best practice may reside in one or more of several domains, as captured in the diagram. Moreover, the different domains may be aligned or misaligned, meaning that part of the focus must fall on whether what might enable best practice in one domain is undermined by the components of another domain.

3.2. Methodology

3.2.1. Combined chronologies were compiled regarding the six people who died from information supplied by partner agencies. From the combined chronologies it proved possible to identify themes for further exploration.

3.2.2. The review followed a blended approach incorporating elements of traditional case review methodology and appreciative inquiry (AI), primarily through a facilitated workshop reflection event and discussions with the panel of senior leaders who supported the independent reviewers. This combined approach is rooted in action research and organisational development, and is a strengths-based, collaborative approach for creating learning change while providing assurance of a thorough investigative process. The approach was underpinned by use of the evidence base now

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available for working with people who self-neglect[5], with complex and change resistant substance misusers[6] and with people experiencing multiple exclusion homelessness[7].

3.2.3. The reflective learning event with practitioners and managers discussed learning from the six cases and the degree to which the challenges and concerns highlighted by these cases represented systemic issues in Herefordshire. The reflective learning event offered an opportunity for those involved in commissioning, in working with people with complex needs, and with adult safeguarding more generally to comment on what they believed was working effectively in Herefordshire and on where they felt that improvements were required. Contributions during the reflective learning event have been woven into the analysis that follows.

3.2.4. Interviews were also held with service users who were accessing accommodation and support provision. Their contributions have been woven into the analysis that follows.

3.2.5. Relevant policy documents have also been accessed, most especially relating to Project Brave and complex adult risk management (CARM) guidance. Reference is made to these and other initiatives in the following analysis.

3.2.6. Terms of reference were set by HSAB, namely:

3.2.6.1. To seek to understand the multi-agency responses in respect of the individuals who are the subject of this review and identify how services might be better equipped to help prevent future deaths of adults with similarly complex needs related to lifestyle, behaviours and substance use, whether or not they had eligible needs under the Care Act 2014.
3.2.6.2. To consider the impact of physical or mental impairment or illness, including dual diagnosis, on the risks experienced by adults who have substance use problems, including the service response to those issues.
3.2.6.3. To identify any other specific themes in the experience of those who are the subject of this review, such as experience of debt, family support issues, homelessness or similar, which might have an impact on learning from this thematic review overall.
3.2.6.4. To reflect on learning about any relationship between the safeguarding and assessment duties of the Care Act 2014 and safeguarding good practice such as Making Safeguarding Personal (MSP).
3.2.6.5. To consider other relevant legislation (for example, the Mental Health Act 1983 as amended and the Mental Capacity Act 2005) in relation to the experience of people with complex substance use and lifestyle issues.
3.2.6.6. To consider self-neglect as a Care Act 2014 category of abuse linked to issues around substance misuse.
3.2.6.7. To detail any learning that may be used to improve system support arrangements as well as highlighting any areas of good practice.

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[5] Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence. Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.
[6] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.
[7] Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness. A Briefing on Positive Practice. London: LGA and ADASS.

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3.3. Family Involvement

3.3.1. Where relatives could be identified from agency records, a letter was sent informing them of the thematic review and inviting their participation. Responses were received from relatives on behalf of WILL, DAWN and JOBY, all of whom shared their memories and perspectives with one of the independent reviewers. Their contributions have been woven into the analysis that follows.

3.3.2. Relatives of DAWN, JOBY, WILL and JUSTIN have given permission for their first names or nicknames to be used.

3.3.3. The names AIDEN and PASCAL are pseudonyms.

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4. Case Narratives of Six People

4.1. Initials have been used for the six individuals.

4.2. Person One: AIDEN

> AIDEN was a White British man who died at the age of 39 years. His childhood included experiencing and/or witnessing domestic, physical and alcohol abuse. He had a close relationship with his mother. Case information records he used drugs and alcohol, usage increasing in the months before his death. He had been sentenced for offences of theft and shoplifting, actual bodily harm and grievous bodily harm. A 12-month community order, including an unpaid work requirement and a restraining order, was in place at the beginning of the timeframe in scope for this review. He had police 'markers' for anxiety, depression, personality disorder and alcohol use, and had police contact as both victim and offender. He was the subject of 2 police 'Adult protection incidents'. Prior to accepting supported accommodation in a placement for single homeless people with support needs, he had spent considerable time living on the streets. AIDEN was in receipt of a local authority funded care package. Before his death he was trying to gain custody of his young son, with whom he had lost contact, following concerns about the care being provided by his son's mother. At an inquest, cause of death was recorded as substance-related.

4.3. Person Two: DAWN

> DAWN was a White British woman who died at the age of 42 years. Case information records she had alcohol dependence syndrome and depression. She had police 'markers' for self-harm, alcohol use, heroin use, suicidal ideation, and had police contact as both victim and offender. She was the subject of 4 police 'Adult protection investigations'. DAWN had a history of rough sleeping and had also spent several months in a refuge. She had recorded contact with the local authority welfare team, often associated with the provision of benefits advice. She had not been the subject of a care and support assessment. She is recorded as having experienced adverse childhood experiences, having contact with her mother whilst being brought up by her grandparents, and as struggling with the loss of contact with her child and with the death of her father, himself alcohol-dependent, with whom she did not enjoy a close relationship. She is reported as finding this more difficult when sober.

4.4. Person Three: JUSTIN

> JUSTIN was a White British man who died at the age of 45 years. He experienced the loss of mother and grandfather to cancer and was greatly affected by the death of his grandmother. Due to his lifestyle he was estranged from the rest of his family especially his brother whose property he destroyed in a drunken episode in 2016. He first experienced problems with his mental health in 1996 and had taken many overdoses and spent time as an inpatient. The last time a mental health assessment had been requested was in 2018 and he had not needed secondary care interventions at that stage. Case information records he used drugs and alcohol. He had police 'markers' for suicidal ideation, depression, epilepsy and anxiety. He also experienced heart arrhythmia, chronic obstructive pulmonary disease (COPD), oesophageal varices, stomach ulcers and liver problems. He had suffered a drug induced cardiac arrest that had required cardiopulmonary resuscitation (CPR). He had police contact

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as both victim and offender and had been the subject of an alcohol treatment requirement. He was recorded as having a long history of failed housing placements. He was referred to a project providing accommodation for single homeless people with support needs through the Housing Solutions Team. He was very vulnerable due to many physical health issues, periods of poor mental health, and substance misuse. He had become homeless when his relationship with his brother who inherited the tenancy from his grandmother broke down and he flipped between street homelessness and hostels. He was the subject of 6 police 'Vulnerable adult incidents'. JUSTIN had not been the subject of a care and support assessment. He died of natural causes and no inquest was held.

4.5. Person Four: PASCAL

PASCAL was a White British man who died at the age of 54 years. Case information records a history of physical ailments, anxiety and depression. A community order sentence for theft was in place during the timeframe in scope for this review. He had police 'markers' for drugs and heroin. He had police contact as both victim and offender. He was the subject of 3 police 'Vulnerable adult incidents'. He was homeless at the time of his death. He had recorded contact with the local authority welfare team, which is most often associated with the provision of benefits advice. PASCAL had not been the subject of a care and support assessment. Cause of death was pneumonia.

4.6. Person Five: WILL

Will Pen Picture
(This picture has been provided by Wills parents)

Will was born on 5th September 1995. In his early years his development was normal and untroubled. He developed very well in his early years in terms of his ability to speak at an early age and read. There were no issues. During Will's early childhood 3 separate foster children were welcomed into the family home. The first two of which were teenagers but presented no major issues outside what you normally expect of adolescents. The third child however was clearly troubled, Will by this time was aged 3 to 4 years. Although we have no way of proving this it is possible that the presence of this child in the household had some impact on Will. Will started in a local primary school and in the first couple of years things went along normally. However as Will got to about age 7 or 8 there started to be one or two concerns about things that were happening. Towards the end of Will's time at Primary school he was having liaison with the LA pupil support officer. Home life was generally normal and as you would expect for a child of Will's age, as was his social and wider family life. When Will then joined secondary school it was not long before things started to go downhill with his general behaviour and lack of interest in obtaining a good education. We believe the school's attitude towards Will and their actions did not help the situation but only made it worse.

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Will generally suffered with low self-esteem and lack of confidence, which again was not helped by several things that happened, including losing a circle of close friends due to the school's response to an incident. However when Will was around 13/14 the PE teacher at his school spotted a talent for Rugby in Will and nurtured this. This seemed to perk Will up and he became a key part of the school's Rugby team. As his father I then sought a local Rugby team for him to play for and he joined Ledbury, again becoming a key part of the team and enjoyed playing for them and meeting a new circle of friends. This lasted for maybe a year and a half. However, outside of school and his Rugby the friends he started to spend time with gradually became less positive characters. Eventually at about age 15 Will lost interest in Rugby and his behaviour at school also deteriorated to the point at which he was expelled and referred to a PRU.

Throughout this time, as his parents we tried to help and support Will through difficult teenage years and tried to engage the support of local services without much success. Will did not take to attendance at the PRU and was not a regular attendee. During this time we began to notice that Will was abusing certain substances (mcat and alcohol primarily) and he would often go missing for several days. This led to a real strain in the parent/child relationship. As his father I had numerous one to one conversations with Will about the direction his life was going and he would often get upset and declare that he wanted to change and wanted to succeed but could not seem to pull himself up. We used to report this to the police on each occasion but often had an indifferent response or they would track him down to a place but say as he was safe they couldn't do anything (bearing in mind he was still a juvenile at the time). Will drifted without much motivation to sort himself or do anything. Due to his natural inclination to be good at sport we encouraged him to consider attendance at Hartpury Sports College and we managed to secure a residential place for him. This started OK! However unfortunately Will's behaviour meant he was not allowed to consider residing on campus but was allowed to continue as a day student. This did not last long as Will could not commit to this.

Again Will drifted in life and had no real motivation or inspiration to pursue a job or career in any path, even though as his parents we tried many, many times to help him. Will's behaviour continued to deteriorate and he started to get into some trouble with the authorities, generally low level stuff. Eventually, Will started a relationship with a local girl and moved in with her. The relationship was quite tempestuous, however they eventually had a child together, who Will loved dearly. However, the relationship was not stable and they eventually parted. Unfortunately, the ex-partner was difficult and would flit between Will and us as grandparents being able to see his child and then not. Will found this extremely difficult and upsetting. Will had developed a dependence on alcohol and also became a regular cannabis user. He had the odd job that lasted for a while but unfortunately could not sustain this on a long term basis.

It was clear that his mental health had deteriorated and we tried to continue to support him but occasionally his behaviour was such that we was sometimes excluded from the family home, although we would continue to have contact and try to support him. Occasionally, in trying to help Will and get to the bottom of his issues he would disclose that something had happened to him to cause him to be the way he was. However, we could never get to the bottom of what that was.

At one point when Will was excluded from the family home he presented himself at the Stonebow unit, literally begging for help for his mental health. The unit phoned me as his father. I advised them that he was excluded from the family home and that he was there because he needs help. However, we woke the following morning to find out that he had been dropped off on the family drive early in the morning with a blanket and bottle of water. Fortunately, his mother's car was open so he was able to sleep in it. Will flitted in and out of the family home then and continued to abuse alcohol and cannabis, although he would go through periods where he would abstain. Eventually we tried to help William to source alternative accommodation and we eventually managed to secure a place at Pomona where we thought he might get the support and help he needed, however this was where Will unfortunately spent his last couple of months.

Underneath his problems Will was at heart a kind person. As a child he would want to give money to people he saw homeless on the street. He was very intelligent and had the potential to succeed in whatever field he may have chosen. He was extremely funny and all his friends said he would light up the room when he came in and make everyone laugh. Unfortunately, this sometimes attracted negative attention from some males who would get jealous of Will's popularity and bully him. His death was a great loss to us as his parents, his friends and most of all his daughter, who he loved dearly and who loved him.

WILL was a White British man who died at the age of 24 years. Prior to accepting accommodation for single homeless people with support needs, he had been either sofa surfing or living in the family home with his parents. Case information records anxiety and depression, dating back to his childhood. He had police 'markers' for self-harm and drugs. He had police contact as both victim and offender. He had been the subject of an alcohol treatment requirement. He had several convictions relating to alcohol misuse, including violence. He had not been the subject of a care and support assessment. He had a child, with whom he had not had contact for some time. This had a negative impact on his mental wellbeing. He received regular support from his parents. He experienced several relationship breakdowns which he reported also had a negative impact on his mental wellbeing. An open verdict was recorded at an inquest.

4.7. Person Six: JOBY

JOBY was a White British man who died at the age of 44 years. As a child, he experienced and witnessed domestic abuse. He was supported by an aunt until his

behaviour was impacting negatively on her own children. His relationship with his sister broke down because of events within the family although she stepped in as his next of kin shortly before his death. Case information records alcohol and 'related ailments', and mental and behavioural disorder, anxiety and depression. There are references to him having several children, none of whom were living with him. He had police 'markers' for diabetes, asthma, seizures, respiratory problems, pancreatitis, sleep apnoea, cirrhosis of the liver, previous strokes (TIA's), alcohol-dependence, nerve damage to his legs, suicidal ideation, drugs and a blood borne virus. He had police contact as both victim and offender. He had a long history of violent, acquisitive and drug related offending. He was the subject of 7 police Vulnerable adult or adult protection investigations. JOBY had become homeless when he was evicted from his private rented accommodation due to antisocial behaviour. When he moved into accommodation provided by a project for single homeless people with support needs, he was drinking very heavily. Despite the support on offer he continued substance misuse. He developed oesophageal thrush and became severely restricted in his mobility. JOBY was in receipt of a local authority funded care package. He had a girlfriend who was initially believed to be supportive but before his death the police were investigating whether he was being financially abused by her. His death was anticipated and the Coroner was not advised. His health had been deteriorating rapidly but he was very reluctant to have any medical intervention that involved going to hospital. He lied repeatedly about whether he had attended appointments and when his girlfriend was his carer, she also backed up him up. He was supported to have a care package put in place, was visited twice daily and had an alert alarm fitted (pendant) due to risk of falls. Shortly before his death he had an assessment for Hospice at Home which he found very upsetting.

4.8. Premature mortality is evident in all six cases. In five of the cases the individuals died before or about the average age of deaths for men (44) and women (42) who have experienced homelessness alongside mental and physical ill-health, and drug and/or alcohol misuse[8].

4.9. Drawing on the combined chronologies:

4.9.1. there is evidence of substance misuse in all six cases;
4.9.2. there is evidence of physical health concerns in all six cases;
4.9.3. four individuals had been diagnosed with Hepatitis C (AIDEN, DAWN, JUSTIN and PASCAL);
4.9.4. three individuals had experienced falls (AIDEN, JUSTIN and PASCAL) and head injury is explicitly referenced in two instances (AIDEN and JUSTIN); JUSTIN also had fits which could lead to cognitive damage;
4.9.5. concerns for mental health are referred to in all six cases;
4.9.6. adverse experiences in childhood can include abuse and neglect, domestic abuse, poverty and parental mental illness or substance misuse[9]. Adverse childhood experiences can be identified for four individuals (AIDEN, DAWN, JUSTIN and JOBY) from information supplied by the services involved;

[8] ONS Deaths of homeless people in England & Wales 2013-2017 https://www.ons.gov.uk/peoplepopulationanDawnommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2013to2017#deaths-of-homeless-people-have-increased-by-24-over-five-years

[9] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping)*. London: Public Health England.

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4.9.7. four individuals had lost contact with their own children (AIDEN, DAWN, WILL and JOBY);

4.9.8. there is evidence of domestic abuse, both as victims (DAWN and JOBY) and perpetrators (WILL and JOBY);

4.9.9. five individuals appear to have been victims of assault (AIDEN, DAWN, JUSTIN, WILL and JOBY) and two to have perpetrated violence (PASCAL and WILL);

4.9.10. in four cases individuals were able to access supported accommodation (AIDEN, JUSTIN, WILL, JOBY).

4.9.11. all six individuals appear to have committed offences.

4.10. Only two individuals were in receipt of care packages through Adult Social Care. Given the presence of substance misuse in all six cases, alongside physical and mental health concerns, one key line of enquiry explores whether or not the other individuals were referred and assessed[10] given the statutory definition of care and support needs.

4.11. Section 9 Care Act 2014 enables local authorities to assess a person who appears to have needs for care and support, regardless of the level of need. Where the authority is satisfied on the basis of a needs assessment that a person has needs for care and support, it must determine whether any of the needs meet the eligibility criteria (section 13). The eligibility criteria are set out in the Care and Support (Eligibility Criteria) Regulations 2015. An adult's needs meet the eligibility criteria if (a) the adult's needs arise from or are related to a physical or mental impairment; (b) as a result of the adult's needs the adult is unable to achieve two or more of certain specified outcomes; and (c) as a consequence there is, or there is likely to be, a significant impact on the adult's well-being. Thus, such needs may arise from physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury. The specified outcomes include being appropriately clothed, being able to maintain a habitable home environment, and being able to use facilities and services in the community. These are needs that many people experiencing multiple exclusion homelessness have and outcomes which they may not be able to achieve. If the needs are urgent, care and support can be provided before an assessment is completed (section 19(3)).[11] Besides a duty to meet eligible needs, local authorities also have a power to meet other care and support needs, again for adults ordinarily resident in their area or present and of no settled residence (section 19 (1), Annex H – Statutory Guidance[12]).

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[10] Section 9 Care Act 2014.

[11] Braye, S. and Preston-Shoot, M. (2016) Practising Social Work Law (4th ed). London: Palgrave Macmillan.

[12] Department of Health and Social Care (2018) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office.

5. The Evidence-Base for Best Practice

5.1. Reference was made earlier to research and findings from SARs[13] that enable a model of good practice to be constructed in relation to adults who self-neglect. The model comprises four domains. In line with Making Safeguarding Personal, the first domain focuses on practice with the individual. The second domain then focuses on how practitioners worked together. The third domain considers best practice in terms of how practitioners were supported by their employing organisations. The final domain summarises the contribution that Safeguarding Adults Boards can make to the development of effective practice with adults who self-neglect. The domains are summarised here.

5.2. For the purposes of this thematic review, evidence has been integrated into these domains regarding best practice drawn from research and SARs featuring homelessness and substance misuse.

5.3. It is recommended that direct practice with the adult is characterised by the following:

5.3.1. A person-centred approach that comprises proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes; work to build motivation with a focus on a person's fluctuating and conflicting hopes, fears and beliefs, and the barriers to change[14];

5.3.2. A combination of concerned and authoritative curiosity appears helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills; early and sustained intervention includes supporting people to engage with services, assertive outreach and maximising the opportunities that encounter brings[15];

5.3.3. When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage; failing to explore "choices" prevents deeper analysis;[16]

5.3.4. It is helpful to build up a picture of the person's history, and to address this "backstory"[17], which may include recognition of and work to address issues of loss

[13] Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence. Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

[14] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[15] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK. Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[16] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK.

[17] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK. NICE (2018) *People's Experience in Adult Social Care*

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and trauma in a person's life experience that can underlie refusals to engage or manifest themselves in repetitive patterns;

5.3.5. Contact should be maintained rather than the case closed so that trust can be built up;

5.3.6. Comprehensive single and multi-agency risk assessments are advised, especially in situations of service refusal and/or non-engagement, using recognised indicators to focus work on prevention and mitigation[18];

5.3.7. Where possible involvement of family and friends in assessments and care planning[19] but also, where appropriate, exploration of family dynamics, including the cared-for and care-giver relationship;

5.3.8. Thorough mental health and mental capacity assessments, which include consideration of executive capacity; assumptions should not be made about people's capacity to be in control of their own care and support[20]; all five statutory principles in the Mental Capacity Act 2005 should be accurately understood and considered together;

5.3.9. Careful preparation at the point of transition, for example hospital discharge, prison discharge, end of probation orders and placement commissioning;

5.3.10. Use of advocacy where this might assist a person to engage with assessments, service provision and treatment;

5.3.11. Thorough housing, health and social care assessments, care plans and regular reviews, comprehensive enquiries into a person's rehabilitation, resettlement and support needs[21]; taking into account the negative effect of social isolation and housing status on wellbeing[22].

5.4. It is recommended that the work of the team around the adult should comprise:

5.4.1. Inter-agency communication and collaboration, working together[23], coordinated by a lead agency and key worker in the community[24] to act as the continuity and coordinator of contact, with named people to whom referrals can be made[25]; the

Services: Improving the Experience of Care and Support for People Using Adult Social Care Services. London: National Institute for Health and Clinical Excellence.

[18] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[19] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[20] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[21] Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.

[22] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[23] Parry, I. (2014) 'Adult serious case reviews: lessons for housing providers.' *Journal of Social Welfare and Family Law*, 36 (2), 168-189. Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.

[24] Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[25] Parry, I (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

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emphasis is on integrated, whole system working, linking services to meet people's complex needs[26];

5.4.2. A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture;

5.4.3. Detailed referrals where one agency is requesting the assistance of another in order to meet a person's needs;

5.4.4. Multi-agency meetings that pool information and assessments of risk, mental health and mental capacity, agree a risk management plan, consider legal options and subsequently implement planning and review outcomes[27];

5.4.5. Use of policies and procedures for working with adults who self-neglect and/or demonstrate complex needs, with specific pathways for coordinating services to address such risks and needs as suitable accommodation on discharge from prison or hospital[28];

5.4.6. Use of the duty to enquire (section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy;

5.4.7. Evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy;

5.4.8. Clear, up-to-date[29] and thorough recording of assessments, reviews and decision-making; recording should include details of unmet needs[30].

5.5. It is recommended that the organisations around the team provide:

5.5.1. Supervision and support that promote reflection and critical analysis of the approach being taken to the case, especially when working with people who are hard to engage, resistant and sometimes hostile;

5.5.2. Access to specialist legal, mental capacity, mental health and safeguarding advice;

5.5.3. Case oversight, including comprehensive commissioning and contract monitoring of service providers;

5.5.4. Agree indicators of risk that are formulated into a risk assessment template that will guide assessments and planning;

5.5.5. Attention to workforce development[31] and workplace issues, such as staffing levels, organisational cultures and thresholds.

5.6. SABs:

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[26] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.

[27] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[28] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE.

[29] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

[30] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[31] Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.

5.6.1. Ensure that multi-agency agreements are concluded and then implemented with respect to working with high risk individuals; this will include the operation of MAPPA, MARAC, MASH[32] and other complex case or multi-agency panel arrangements, responding to anti-social behaviour, domestic abuse, offending (community safety) and vulnerability[33]; strategic agreements and leadership are necessary for the cultural and service changes required[34];

5.6.2. Develop, disseminate and audit the impact of policies and procedures regarding self-neglect;

5.6.3. Review the interface between housing/homelessness and adult social care, mental health, and adult safeguarding, and include housing in multi-agency policies and procedures[35];

5.6.4. Establish a system to review the deaths of homeless people and/or as a result of alcohol/drug misuse;

5.6.5. Work with Community Safety Partnerships, Health and Wellbeing Boards and partnership arrangements for safeguarding children and young people, to coordinate governance, namely oversight of the development and review of policies, procedures and practice;

5.6.6. Provide or arrange for the provision of workshops on practice and the management of practice with adults who self-neglect.

5.7. This model enables exploration of what facilitates good practice and where barriers to good practice reside. The thematic analysis that follows draws on information contained within the chronologies and discussions during the learning event. Where relevant, it also draws on available research. It follows the whole system framework for analysis presented above, beginning with the components of direct work with individuals and moving outwards to the legal, policy and financial context within which adult safeguarding and work with people with multiple and complex needs are situated.

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[32] Multi-Agency Public Protection Arrangements (MAPPA), Multi- Agency Risk Assessment Conferences (MARAC), Multi-Agency Safeguarding Hub (MASH)

[33] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

[34] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[35] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

6. Thematic Analysis – Direct Work with Individuals

6.1. Using the evidence-base as a framework for analysis, themes arising from the chronologies are analysed here.

6.2. Person-centred approach and responses to repeating patterns. Research has identified that staff can become inured to or normalise risk when what is being presented is repetitive[36]. Within all six chronologies there is evidence of repeating patterns of attendance at Emergency Departments and/or self-discharge and/or non-engagement or disengagement and/or non-attendance at arranged appointments. There does not appear to have been a plan to address the repeating pattern of not waiting to see a clinician and of self-discharge (AIDEN, JUSTIN, PASCAL, JOBY). Follow-up when individuals did not attend appointments or declined (drug and alcohol) support was inconsistent (AIDEN, JUSTIN, PASCAL, WILL, JOBY). Occasionally, the lack of assertive follow-up of (multiple) missed medical and key worker reviews by the substance misuse service provider was reported as being out with agency policy (JUSTIN and JOBY).

6.2.1. In response there were examples of cases being closed (DAWN, JUSTIN and WILL), resulting in needs being unmet, including for accommodation when facing the prospect of homelessness. When individuals are facing significant challenges and do not attend appointments, careful single and multi-agency consideration should be given before cases are closed. There are also instances of renewed attempts to maintain contact by offering "more of the same", namely appointments at designated times and places. This is unlikely to prove effective. AIDEN, for example, declined appointments for cognitive behavioural therapy because he felt unable to keep them. WILL was reported to experience difficulty attending appointments but outreach to assist him appears to have been limited. JUSTIN repeatedly failed to attend appointments with the substance misuse service and there is reflection in the notes that *"The local policy should have perhaps included different actions where complexities are present."*

6.2.2. There were, however, examples of wrap-around support that included outreach (PASCAL and JUSTIN), home visits (AIDEN, PASCAL, JUSTIN and DAWN) and support to attend medical reviews, outpatient appointments and other meetings (AIDEN, PASCAL, WILL). This was good practice. Thus, an outreach worker engaged with PASCAL to assist with welfare benefit applications and to appeal against DWP decisions. His offender manager, together with an outreach worker and practitioners working for the drug and alcohol misuse service, constructed a plan to address his need for accommodation. This included taking him to appointments to ensure he had money and the offer of temporary accommodation, and supplying him with a mobile phone so that he could remain in contact. Similar work was undertaken with JUSTIN to secure him accommodation.

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[36] Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence. Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

6.2.3. DAWN was seen without an appointment in an overflow clinic in order to respond to her need for healthcare. This was good practice. The importance of providing wrap-around support and outreach healthcare practitioners is clearly indicated in DAWN's case as the chronology contains several comments to the effect that she often did not attend GP, outpatient and key worker appointments when not supported to do so. She could find engagement difficult at times, perhaps because of the extent of her substance misuse and the significantly deleterious effects this had on her physical and mental health. When support was provided to enable her to keep appointments, this was good practice.

6.2.4. Advice to contact services and signposting to services as single strategies are unlikely to be effective with people who self-neglect. That was the case here with several individuals (WILL, AIDEN, PASCAL, JOBY). Assertive outreach, including proactively introducing individuals to recommended services, is more likely to be effective. Practitioners commenting on recent service developments, especially Project Brave, spoke of progress that key workers had been able to make to secure people's access to provision and to coordinate a joint holistic approach to meeting their needs and mitigating risk.

6.2.5. There are instances when chronologies explicitly question practitioner attitudes (possible unconscious bias), as in the absence of professional curiosity and making safeguarding personal. Instances include the approach to assessment by ASC (AIDEN), the police omitting to explore alleged harassment (PASCAL), and the police not attending repetitive incidents of drunkenness (DAWN). The chronology for the last of these episodes also observes inappropriate comments recorded in the police log.

6.2.6. Both DAWN's relative and JOBY's relative drew attention to what they perceived as negative attitudes towards people who misuse alcohol and other drugs. They felt that practitioners could be judgmental and "not see the person". They emphasised that practitioners and services needed "to look for the person behind the substance misuse", "to go below the surface and consider causes" in order to attempt to provide "person-specific support and individualised care." WILL's family members referred to an absence of support and to a condescending response from some practitioners when they were approach for help.

6.2.7. Lack of understanding of behaviours. At the reflection learning event some participants felt that individuals could be deterred from engaging because of the number of services involved and having to repeat their stories multiple times. It was recognised that prior experiences of involvement with services, coupled with a feeling of having been let down, could act as a deterrent, and that professional curiosity and time to build up relationships of trust were essential. Third sector agencies could be helpful in this respect.

6.2.8. However, it was evident from the chronologies that some practitioners did not consistently appear to consider why people disengage or are unable to engage with treatment, and not seeing repeated patterns of such behaviours as information to address. There appears to be a need for a better understanding of how to work with people who do not prioritise their own

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needs, in other words who self-neglect. Best practice considers the 'history' and the meaning of the pattern of events rather than seeing just a single isolated incident.

6.2.9. For example, AIDEN was very unwell, could barely walk and had little short-term memory. As was observed in his chronology, his poor health and mobility likely explained his infrequent engagement with his drug and alcohol key worker. PASCAL missed some health appointments and did not always cooperate with medical advice and recommendations. A pattern of self-neglect and his disinterest in practitioners trying to assist him continued. The chronology does not indicate whether practitioners expressed curiosity about this, or how PASCAL responded if they did. WILL's chronology observes that he had not been engaged with services other than a drug and alcohol misuse provider. It does not indicate what work was done to address this other than signposting him to agencies that could offer support for his mental health issues, namely paranoia, agitated depression, low mood and anxiety. The substance misuse service understood that JUSTIN was Hepatitis C positive. This is known to lead to fatigue and what those with the disease call "brain fog". However, this is not factored into their understanding of his pattern of poor engagement.

6.2.10. Although outreach services were available, a sense was conveyed that outpatient and substance misuse services still operated on an appointment basis and that greater flexibility was needed. Similarly, whilst support to meet people's needs and to manage risk was available, responses to "did not attend" were still not good-enough and that practitioners needed to understand what got in the way of attendance and to coordinate support to facilitate engagement.

6.2.11. Service users who shared their experiences for the purposes of this report acknowledged that changes of providers of substance misuse services, and changes of support workers, with the subsequent necessity of having to repeat their stories, made engagement more difficult. Continuity was an important part of recovery. Some acknowledged feeling ashamed about their use of drugs and/or alcohol, leading them to hide rather than disclose their dependence. It took time to build up trust and courage to disclose what had happened in their lives and the impact of such experiences.

6.2.12. Staff working with services users also emphasised the need to reflect on the language used about non-engagement or dis-engagement, when it could be that the way services were organised erected barriers. Equally, they reminded the independent reviewers of the importance of individuals feeling listened to.

6.2.13. DAWN and JOBY's relatives also focused on the theme of engagement. Drawing on their experience they questioned how accessible practitioners had proven to be. They were critical of "long waiting lists." JOBY's relative felt that he had not been prioritised because of his history of non-engagement, as a result of which he had lost motivation to address his substance misuse.

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6.2.14. Throughout this and subsequent sections of the report reference is made to the importance of wrap-around support. This was clearly acknowledged at the reflection learning event. Use of drugs and alcohol can be a coping mechanism for some individuals, to nullify the pain of adverse experiences. Attempting to take this away without support will prove counter-productive.

6.2.15. DAWN's relative spoke of the importance of "knowing the full history", drawing attention to the impact on DAWN of her father's alcohol problems and to "demons" arising from her childhood, including bereavements of adults caring for her. JOBY's relative also referred to "demons" arising from adverse experiences.

6.2.16. Indeed, one service user now engaged with accommodation, mental health and substance misuse services described their use of drugs as "my safety shield" against the impact of adverse experiences. The death of a friend had proved a turning point. Similarly, practitioners recognised that individuals with whom they were working were using drugs and/or alcohol for a reason that needed to be understood. Simply expecting individuals to be clean and/or sober before offering help was unrealistic. WILL's family members reinforced this knowledge, believing that he might have been using substances to cope with adverse experiences that he was unable to talk about.

6.3. Risk assessment. Risk assessment and risk management are crucial, with plans preferably co-designed with service users/patients and shared across partners. There were examples when risk assessments were completed. In AIDEN's case, the risk to his mother was assessed when she was visiting him as there was a restraining order in place and he had been convicted of theft from her. When AIDEN assaulted another resident (JOBY) in the accommodation where they were both residents, a risk assessment was submitted to the Adult Referral Team by the police. However, the incident was seen as a single agency issue and therefore was not shared with other services supporting the individual. There is no record of work with staff supporting residents to maintain their flats on the ongoing risk to AIDEN and JOBY.

6.3.1. Other SARs[37] have remarked that hostels and supported accommodation can be experienced as unsafe by residents who therefore prefer to return to street-based living. There were several incidents where AIDEN attacked other residents and his chronology refers to drug dealing amongst residents.

6.3.2. Risk assessments were completed on JUSTIN by the substance misuse service but these do not appear to have influenced or informed the way the service was provided to him.

6.3.3. PASCAL disliked using the night shelter and preferred to sleep in a camp. A risk assessment for PASCAL included his propensity to refuse accommodation, even in extreme weather. Risks were clearly discussed with him, for example surrounding use of needles and the danger of bleeding to death because of injecting. The chronology in one instance records that PASCAL understood the risks. However, sustained drug and alcohol misuse raises the possibility of impulse control disorder[38], which should indicate a detailed mental capacity assessment of decisional capacity and executive functioning.

[37] For example, Manchester SAB (2020) Thematic Review – Homelessness.
[38] Isle of Wight SAB (2018) SAR – Howard.

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6.3.4. DAWN's GP clearly discussed risks associated with decreasing her alcohol intake too quickly and sleeping rough. WILL's chronology records an occasion when the police openly discussed risks with him to his life, and another when suicidal ideation was risk assessed following an arrest for shoplifting. His association with drug dealers and his involvement in supplying drugs was known to the police but there is less sense of a coordinated risk management plan involving NPS and the drug and alcohol misuse service provider.

6.3.5. The police completed risk assessments when JOBY assaulted his partner, concluding that the risk was high. His partner would not file a complaint and/or denied being assaulted. It is not clear from the chronology whether undue influence or coercive and controlling behaviour was recognised as impacting on her decision-making. Nor is it clear from the chronology whether there was a risk management plan in place that would seek to safeguard her and her son. He was non-compliant with medication and advice on structured reduction of his alcohol intake, and continued to misuse alcohol and drugs.

6.3.6. There were occasions when reading the chronologies that a risk assessment and mitigation plan would have been expected. For instance, there was information that AIDEN was buying illegal drugs off the internet but this intelligence was not acted upon. He was non-compliant with medication to control his epilepsy and his physical health was deteriorating because of his injecting. Similarly, JOBY's chronology contains references to a history of alcohol withdrawal symptoms, non-compliance with advice and with medications, continued misuse of alcohol and drugs, about which he was not always honest. Yet, there is no evidence of a coordinated risk assessment and mitigation plan being updated and implemented.

6.3.7. It may be that practitioners would be assisted by having risk assessment templates from which to draw. HSAB should engage with partner agencies on the subject of risk assessment and mitigation planning, as well as exploring how practitioners and managers understand and respond to situations of self-neglect, self-harm and risks arising from persistent and at times escalating concerns regarding physical health, mental health, and substance misuse.

6.4. Mental capacity assessment. There were very few references to mental capacity assessment in the chronologies, which is perhaps surprising given that the Code of Practice[39] refers to symptoms of alcohol or drug use in the context of disorders of mind or brain. There were examples in the individual narratives of where mental capacity assessments should have been undertaken. For example, there were occasions when AIDEN was found incoherent, confused and in a state reminiscent of self-neglect. His medical diagnoses included peripheral neuropathy, encephalitis caused by drug misuse, resulting in long-term damage to his brain that meant that he had little short-term memory. That should have raised doubt about his mental capacity. However, there is no reference to assessment of his decisional capacity and executive functioning, other than one mention of an outstanding mental capacity test in the chronology for the month he died.

[39] Department of Constitutional Affairs (2007) *Mental Capacity Act 2005: Code of Practice* (London: The Stationery Office.

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6.4.1. There is only one explicit reference to mental capacity in the DAWN chronology, when she refused hospital admission in the month before she died. There is reference elsewhere to her understanding the need to keep appointments. However, from the recorded episodes it is clear that she was unable to prioritise self-care by attending appointments. She was unable to sustain reductions in her use of alcohol and drugs. She had been diagnosed with Hepatitis C, which can impair brain functioning. She had been prescribed anti-depressant medication. In that context, it is possible that her executive functioning and decision-making were impaired. The chronology also records that she had no understanding of the connection between substance misuse and low mood.

6.4.2. In May 2018 WILL's chronology references that he was assessed to have decisional capacity with respect to his use of drugs and alcohol, accommodation, and engagement with mental health services. He was given blankets and food, and signposted to services. The chronology observes that this was a missed opportunity to engage with him fully regarding his safety. WILL's family members described one such incident, seeing this as an example of "indifference" and a failure to provide "proper support."

6.4.3. In January 2019 the liaison psychiatrist in the hospital wrote to JUSTIN's GP that use of the MCA/DOLS should be considered with JUSTIN because he lacked the capacity to make decisions about his medical care. One week later he was in hospital and refusing a brain scan, yet the MCA does not appear to have been considered. Nor is it considered at any subsequent point.

6.4.4. Despite evidence of JOBY's increasing anxiety and depression, and episodes of intoxication and prolonged misuse of alcohol and drugs, with an impact on his memory and physical health, a cognitive assessment does not appear to have been completed, despite a recommendation in February 2018. No concerns have been recorded about his mental capacity, notwithstanding that in April 2018 the chronology refers to mental and behavioural disorders as a result of harmful use of alcohol and opiate-dependence syndrome. In December 2019 the chronology records that there were no indications that he lacked capacity regarding treatment decisions, at a time when he was known to be using a range of drugs together with alcohol, with impact on his physical wellbeing. Into 2020 he declined to accept treatment, partly related to his reluctance about admission to hospital, which he linked to anxiety. His declining physical health included jaundice, oedema and chronic liver disease, abdominal pain and vomiting.

6.4.5. At the reflection learning event participants were acutely conscious of the responsibility involved in assessing mental capacity, especially in situations where individuals might be assumed to be making lifestyle choices and/or where they present well verbally but where there were doubts about their executive functioning. There appeared to be some uncertainty as to which practitioner might be the ultimate decision-maker when several agencies were involved[40].

[40] This question is addressed explicitly in *SAR-MS*, published by City of London and Hackney SAB (2021).The answer depends on what the type of decision to be made, the context, and the professional expertise required.

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6.4.6. JOBY's relative recounted an experience when she took him to hospital. She believed that he was experiencing "delirium" and was "confused", his capacity fluctuating as a result of sepsis and not having eaten for a week. Her experience was that practitioners lacked an understanding of capacity. She felt that perceptions needed to change, highlighting that addiction is an illness.

6.4.7. Three questions arise that HSAB should raise with partner agencies as part of its statutory mandate to seek assurance that services across Herefordshire are working effectively in preventing abuse and neglect, including self-neglect.

6.4.8. Firstly, is there an understanding of executive capacity? Especially where there are repetitive patterns, it is essential to assess executive capacity as part of mental capacity assessment. Guidance has commented that it can be difficult to assess capacity in people with executive dysfunction. It recommends that assessment should include real world observation of a person's functioning and decision-making ability[41], with subsequent discussion to assess whether someone can use and weigh information.

6.4.9. Secondly, is sufficient recognition given to the impact of trauma and adverse childhood experiences?

6.4.10. Thirdly, is drug and/or alcohol abuse seen as a lifestyle choice and unwise decision-making or possibly invoking considerations of mental capacity and self-neglect?

6.4.11. The absence in the chronologies of explicit reference to self-neglect and to following agreed multi-agency procedures is a concern. To varying degrees all three questions were engaged when individuals were known to have experienced trauma, were revealing that they were drinking to control anxiety, were wanting to control their substance misuse but could not carry this through and/or were depressed and unable to implement their stated intentions.

6.4.12. The independent reviewers, and the representatives of the services who contributed to this thematic review, all recognise that concerns about the implementation of the Mental Capacity Act 2005 extend nationally. Any revision to the code of practice that accompanies the Act needs to address the nuances and complexities that practitioners encounter, especially those captured in the aforementioned three questions.

6.5. Domestic abuse. DAWN's chronology records domestic abuse by her partner, who allegedly also stole her bank card. A risk assessment was not completed because she did not keep appointments. As her relative pointed out, however, this may have been because of the multiple issues with which DAWN was having to cope; supportive outreach might have enabled completion of the risk assessment.

[41] NICE (2018) *Decision Making and Mental Capacity*. London: National Institute for Health and Clinical Excellence.

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6.5.1. WILL's chronology contains a record of domestic assaults on his former partner which on one occasion, because of apparently weak evidence of harassment, resulted in no further action by the police. A second incident is recorded as related to a custody dispute and resulted in a harassment warning. The chronology also observes that this episode did not result in a review of risk by his offender manager as would have been expected according to CRC public protection policy.

6.5.2. JOBY's chronology records allegations of him being assaulted by a former partner and of domestic abuse of his current partner. As children appear to have witnessed the assaults, the police made appropriate referrals to Children's Social Care. His partner repetitively withdrew complaints. The police completed risk assessments and placed warning markers on their recording system but there is no reference to the episodes being considered by a MARAC. It is not clear from the chronology how Children's Social Care or Adult Social Care responded to the notifications of risk submitted by the police.

6.6. Care and support assessment. The absence of requests for an Adult Social Care assessment for care and support in the majority of cases in the sample is noticeable. Adult Social Care assessment is an essential part of any plan that seeks to address a person's accommodation, and mental and physical health needs, as part of wrap-around support. Outreach social work is a possible helpful future development[42], alongside other practitioners, reaching out and assessing the person in their locations. Research elsewhere[43] has found that agencies can be deterred from making referrals to Adult Social Care because of potential volumes and/or that Adult Social Care is operating a higher threshold for care and support assessments than Section 9 (Care Act 2014) permits. HSAB needs to be assured that these factors are not present in Herefordshire.

6.6.1. Within the narratives of the six cases were instances of individuals who potentially had care and support needs, but were not referred for an Adult Social Care assessment of their needs and therefore did not receive an assessment.

6.6.2. AIDEN was referred to ASC for care and support assessments. On one occasion it appears that he might have declined assessment, in which case, given his presenting physical and mental health problems and substance misuse history, it is unclear why an assessment was not undertaken anyway, using the powers in section 11 Care Act 2014. The chronology also refers to a probation officer appealing against ASC decision-making and recording the assessment process as a negative experience. Once AIDEN was assessed as having care and support needs, there were then difficulties in commissioning a provider because of the risks associated with substantial substance misuse.

6.6.3. PASCAL became homeless following his mother's death. He was physically disabled, had been diagnosed with depression and anxiety, was addicted to

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[42] Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness. A Briefing on Positive Practice. London: LGA and ADASS.

[43] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14.

heroin and also alcohol-dependent. He was not referred to ASC for assessment. He was observed to be "unkempt."

6.6.4. DAWN was not referred to ASC despite evidence of physical illness, mental distress and substance misuse, and references to self-neglect. DAWN's relative questioned why this was, suggesting it was a shortcoming. Nor did WILL have an assessment of his care and support needs.

6.6.5. JOBY was referred to ASC. Initially, after two referrals, he did not respond to efforts made to contact him. Incidents involving other residents in the accommodation setting were seen as a matter for the police. He did receive an assessment by an occupational therapist that resulted in the provision of equipment. He is reported as having found this helpful.

6.6.6. In early 2019, JUSTIN was the subject of several safeguarding referrals and adult social care referrals following a series of incidents associated with bizarre behaviour. Assessment was undertaken but following a hospital admission he was now sober and refusing care, as a result of which the case was closed. This approach is problematic with a chronic relapsing condition such as substance misuse, where it is quite predictable that, as happened, JUSTIN quickly returned to substance use and former patterns of behaviour. A longer process of assessment and monitoring is required to understand the needs of this client group.

6.6.7. At the reflection learning event, the focus fell especially on individuals at the edge of eligibility, namely where they might not meet the eligibility criteria that would trigger a duty on ASC to respond but where there were significant risks, for example of self-neglect. Agencies needed to refer and to be clear what was being requested (a care and support assessment (section 9 Care Act 2014) and/or adult safeguarding enquiry (section 42).

6.6.8. Previous experiences of referral to ASC were reported as having been "hit and miss." Some practitioners had experienced referrals being bounced back without apparent consideration of the power available to ASC to meet any social care need (section 19). Other services needed to highlight the urgency of a situation, with the CARM procedure now providing an escalation pathway.

6.7. Responses to substance misuse and mental distress. Individuals in the grip of substance misuse do not find change easy to achieve and this realisation should be factored into how services are set up to provide support. This reinforces the commentary on executive decision-making and mental capacity assessment above. This links also to later sections on commissioning and on workforce development.

6.7.1. There were missed opportunities to consider the interface between mental health and substance misuse. AIDEN experienced anxiety, for which medication had been prescribed. Records indicate that he may have had a personality disorder and there are references in the chronology to depression. Despite this, and addiction being evidence of impulse control disorder, there was no referral to mental health services. The last contact with mental health services was in 2017 in Accident and Emergency.

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6.7.2. AIDEN had been allocated a key worker as a response to his substance misuse from March 2016. His GP is recorded as being unsure how to respond to his continued substance misuse other than to provide advice about wound management and about what medications were contraindicated because of his alcohol-dependence. There were regular discussions in the GP surgery, including with a mental health practitioner[44] and safeguarding lead, which is good practice. There is reference in the chronology to detox whilst in hospital but also to his unsuitability for a drug rehabilitation requirement when he was sentenced to a community order. However, despite the support outlined above, his misuse of drugs and alcohol continued until his death.

6.7.3. PASCAL may at one point have been allocated a clinical psychologist but there is no detail in the chronology of their involvement and this practitioner was not with the secondary NHS mental health provider. His GP discussed with PASCAL his anxiety and depression on several occasions. However, the chronology reflects that there is "no evidence of referral to appropriate services for mental health concerns" or of further discussions when "not fit for work" notes were issued. Nonetheless, conversations between PASCAL and his GP did include candid focus on risks.

6.7.4. DAWN had been drinking heavily for twenty years and had been diagnosed with alcoholic cirrhosis and depression. She was also using heroin. Her GP refused to prescribe addictive medication, which was good practice, and referred her to an adult mental health provider, which requested further information. She underwent one detox in hospital shortly before she died.

6.7.5. WILL had a history of alcohol-dependence, anxiety and depression. The GP prescribed medication but the combined chronology records that he did not find medication helpful. Less evident is how his mental wellbeing was considered and addressed alongside his substance misuse. Following one opiate overdose in April 2018 he was seen by the Mental Health Liaison Team in hospital. The overdose appears to have been assessed as accidental, no suicidal ideation was identified, and the problems were framed as homelessness and addiction, based on the extensive discussion with WILL. He was at risk of accidental harm when under the influence of substances. He was discharged back to the care of his GP. He presented to the crisis team in May 2018 and was assessed and given blankets with a follow up appointment the next day which he did not attend. Otherwise there does not seem to have been any mental health involvement with WILL before his death although requests were made. The chronology records that there was a lack of professional curiosity by this team. He had mobility issues so his non-attendance was not surprising. There was no follow-up with his offender manager, whom he was seeing weekly, or with Housing Solutions. There was no multi-agency meeting at this point. The problem was clinically assessed as primarily alcohol-related, even when subsequently WILL described his mental health as "not good" and even though there is an association in the chronology between WILL not drinking and an increase in his anxiety, and between binge drinking as a coping mechanism for paranoia and anxiety.

[44] This may have been a practice based lead and not part of secondary mental health services.

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6.7.6. WILL's relatives were critical that "nothing came of mental health referrals from his GP" and that there was "no real support" or "plan to help him" with his substance misuse and mental health. They were critical of what they felt was an absence of "therapeutic input." They described a young man who "needed to be guided", who "felt ashamed and a failure" and who "would not share things, saying he was okay when he was not."

6.7.7. JOBY was known to experience anxiety and depression, especially when alone. He had a history of attempted suicide. There does not appear to have been, at least in the timeframe under review, any involvement by secondary mental health services[45]. To his substance misuse key worker and in medical reviews completed by that provider, he would often report no mental health issues. Occasionally he reported low mood and one medical review concluded that he had "mental and behavioural disorders due to harmful use of alcohol and opiate dependence syndrome."

6.7.8. Allegations that he was selling his methadone and opiate medication do not appear from the chronology to have been followed up[46]. There was a standard response to his missed clinical reviews and key worker appointments. When he was seen, detox was sometimes discussed alongside advice regarding his physical health but without assertive outreach it proved difficult to sustain any intervention. There does not appear to have been a coherent plan that was followed through.

6.7.9. JUSTIN had a long history of substance misuse and his death was almost certainly the result of the damage done by dependent drinking. However, a problem in managing substance misuse was that assessment could be very difficult because he was very poor at reporting his patterns of use. This made it challenging to determine the best course of action and the intensity of intervention required. This highlights the benefits of a multi-agency perspective that can give a much more three dimensional picture of his drinking, by comparing his reports with information from, for example, the police or housing services. This also indicates the importance of all agencies adopting a consistent alcohol screening tool (AUDIT[47] is the preferred choice) and using it consistently with all clients.

6.7.10. JUSTIN's care also raises concern about advice around detoxification. In March 2018, his medical notes state that he was advised to abstain from drinking by his GP but without any advice on the possible risks. Addaction[48] also put him on an alcohol reduction regime. JUSTIN had a significant history of fits and it is unsurprising that he was unable to complete these regimes.

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[45] For JOBY, and the other individuals with ongoing mental health concerns, a question to be considered relates to what monitoring of mental health GPs are expected and enabled to undertake, and what involvement of, or oversight by secondary mental health services is indicated.

[46] The allegation was made anonymously to a drug and alcohol service provider in October 2018. A similar allegation was made to police regarding WILL in May 2018. The chronology states that this information was passed to a safer neighbourhood team but the chronology does not record any subsequent prevention or disruption activity.

[47] Alcohol use disorders identification test (AUDIT) AUDIT is a comprehensive 10 question alcohol harm screening tool.

[48] Drug and alcohol misuse service.

6.7.11. JUSTIN's mental health problems were known to his GP, secondary mental health and substance misuse services, police and probation. Medication was prescribed by his GP. The chronology references JUSTIN's self-report on occasion that his mental health had improved and discussion with practitioners about his mental wellbeing. There were occasions when secondary mental health services were assessed as not indicated because there was no evidence of acute mental illness when he had presented at emergency departments, with advice given to access substance misuse services and to re-refer if there were concerns about psychosis or confusion following alcohol detox.

6.7.12. Service users reported mixed experiences of mental health provision. On the one hand, crisis, early help and therapeutic responses had assisted them to manage their mental distress and to begin to address the adverse experiences that had, for instance, led to depression and anxiety. However, waiting lists and consequent delays in accessing support impacted on their ability to move on. Cancelled appointments and limitations on the number of sessions were also experienced as unhelpful.[49] The Covid-19 pandemic had also had an impact, with telephone appointments being experienced as less helpful even though the reason for them was acknowledged.

6.7.13. Practitioners observed that a dual diagnosis pathway was needed, building on the recognition in Project Brave that substance misuse often arises as a response to the impact of trauma. A both/and approach to accessing community-based mental health support when substance misuse is "chaotic", in other words collaborative arrangements, is best practice[50].

6.7.14. DAWN's relative had formed an impression that after-care, following overdoses, self-harm and attempted suicide, had been poor, which had resulted in descending spirals, use of harder drugs and loss of her accommodation and training course. She recounted that DAWN had stated that support workers were not helping her. JOBY's relative also emphasised that practitioners and services needed to understand "what deterioration looks like." They were critical of how healthcare practitioners managed his aggression when he was intoxicated, resulting in him self-discharging.

6.8. Responses to physical ill-health. Good practice is evident in response to physical health needs. Both by a GP and secondary healthcare practitioners, there were attempts to manage AIDEN's deteriorating physical health. He had CT head scans following falls, which proved unremarkable, and was referred to a seizure clinic. The GP followed-up his deep vein thrombosis and monitored his use of medications, sometimes declining to prescribe or to release prescriptions early. This was good practice.

[49] The independent reviewers have been told that therapeutic modalities have an evidence-base for the number of sessions to be provided. Cancelled appointments by the service user may indicate difficulties with engagement and a need for pre-clinical work.

[50] National guidance is available, namely: Public Health England (2017) *Better Care for People with Co-Occurring Mental Health and Alcohol/Drug Use Conditions. A Guide for Commissioners and Service Providers.* NICE (2016) *Coexisting Severe Mental Illness and Substance Misuse: Community Health and Social Care Services*. NICE (2011) *Coexisting Severe Mental Illness (Psychosis) and Substance Misuse: Assessment and Management in Healthcare Settings*.

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6.8.1. There were similar attempts by GPs and secondary healthcare providers to address PASCAL's physical ill-health, including follow-up of deep vein thrombosis and confirmation that he had Hepatitis C, not always successfully when he did not attend appointments or could not be contacted. This offers an instance where outreach health provision might have been useful.

6.8.2. Significant concern is evident regarding DAWN's physical wellbeing. She experienced seizures, a bloated abdomen, vomiting, stomach ulcers, dental abscesses and liver cirrhosis. She was appropriately referred by her GP and her physical health and alcohol use were reviewed by her substance misuse key worker and the GP. The police, when requested as a result of concerns for her safety, searched for and usually located her. On occasions she refused to be taken to hospital by ambulance, which raises a question as to her decisional capacity.

6.8.3. WILL's GP tried to keep in contact with him, which was good practice, questioned some of his requests for medication, declined to prescribe without a face-to-face appointment, and prescribed medication for depression, anxiety and panic attacks according to NICE guidelines. It appears that WILL may have been using increasingly high doses of diazepam to maintain its effect on his anxiety.

6.8.4. JOBY's physical health was monitored by both his GP and staff working for the substance misuse service, although he did not always attend appointments, including outpatient clinics to which he had been referred. Over time he was tested for Hepatitis B and Hepatitis C, which do not appear to have been detected. He had a CT scan, which was normal, after one of several falls, which may have been the result of intoxication. He explained his reluctance to be admitted and/or to remain in hospital as due to anxiety. Between early May and December 2018 the GP surgery did not see him although it did receive letters about his attendance at A&E departments. This meant that there was no follow-through on whether he had followed advice on medication and to contact Addaction. He was seen quickly in January 2019 when he requested an appointment. Responses to missed key worker appointments and clinical reviews by staff in the substance misuse service were always the same, namely sending written communications with further appointments. Persistent non-attendance did not trigger a change of approach. The approach to his physical ill-health thereby appears somewhat incoherent, the more so as his physical health declined during 2019 as a result ongoing significant substance misuse.

6.8.5. JUSTIN was, by the last few months of his life, very seriously ill. He had a range of problems including Hepatitis C, advanced alcoholic liver disease, breathing problems, seizures, incontinence, and a decreased platelet count that could lead to inter-cranial bleeds. He appears to have received good medical care generally. However, this was interrupted by his non-attendance and non-compliance with his Hepatitis treatment.

6.8.6. JOBY's relative was critical of what they saw as inaction in response to his poor mobility, not eating and swollen stomach.

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6.9. An additional feature of the evidence-base is "think family." The independent reviewers have been told that accommodation and support providers often feature think family in their work with individuals. However, there is little sense in the chronologies of the history of family relationships featuring in assessments and planning. Support was offered to AIDEN with respect to his son who was in foster care and awaiting adoption. There was concern regarding risks to his mother when she visited him. She also alerted services when she felt he was taking too much medication.

6.9.1. An aunt sometimes provided WILL with somewhere to stay when his parents could not have him home, because they were looking after his child and he was not allowed to be there[51], and raised concerns about his mental health with his GP. His mother accompanied him to GP appointments and probation and the GP liaised with his family. This was good practice. His chronology refers to agencies being aware of difficulties for some years. Missing, though, is any work with the family to explore what support they might be willing to provide. Family members have referred to a lack of support, to being "left on our own", including on one occasion WILL being dropped off outside his parents' home when he was in crisis. He did not have contact with his child but the chronology provides no insight as to the impact this had on him.

6.9.2. JOBY was often accompanied to appointments by his partner. A carer assessment was apparently discussed in April 2018 but there is no record of this having been completed. There were occasions when their relationship broke down but she does appear from agency records to have been supportive and may have helped him to engage with appointments. It does not appear from the chronology, however, that their relationship was a focus for any work, including when there were concerns that she might have been exploiting him. This would have included how she could safeguard her child when JOBY was intoxicated. Indeed, in September 2018 the chronology refers to the house in which they were living, when he was not in the accommodation with independent living staff support, as "cluttered" and a "tip". It is not clear which service submitted a "vulnerable adult" incident notice, nor is it clear what action may have resulted, included in relation to the child who was living there. It is noteworthy, in that context, that earlier in 2018 JOBY had expressed concern about the implications of his substance-dependence for his partner and her son, who had separate contact with social workers.

6.9.3. JOBY's relative was especially critical of what they regarded as a failure to explore whether his partner was financially and physically abusing him. They wondered whether this had been because he was often intoxicated. They acknowledged that both JOBY and his partner had "dependencies" but believed that insufficient protective action had been taken when he was exploited, for example when his methadone was taken from him. JOBY's relative was also critical of what they saw as a lack of information-sharing both before and after his death

6.10. Another component of the evidence-base refers to transitions. In the context of this review, transition refers to the point at which people transfer from one service to another.

[51] The chronology refers to the involvement of CAFCASS and court orders.

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It is a point of movement between, for example, hospital and community services or between community and supported living provision.

6.10.1. Prison discharge and hospital discharge are key points of transition. Looking at the six cases, some of the individuals did not appear to have the skills, resilience and capability, at least not without wrap-around support, to successfully manage transitions, for example into supported accommodation. What is being highlighted here was the need to consider what wrap-around support was necessary in order to support those who were trying to recover from the impact of trauma and adverse experiences and trying to manage their emotional responses. Project Brave has sought to address this resource gap.

6.10.2. When AIDEN was discharged from hospital in February 2020, the accommodation provider was called for an update post discharge. This was good practice.

6.10.3. In one instance (JOBY) a hospital discharge generated explicit concern. The accommodation provider indicated in late June 2020 that he could not return until there was a treatment plan. The provider discussed their concerns with a safeguarding professional at the GP Practice, who suggested that a multi-agency meeting would be appropriate prior to discharge. This was good practice. Nonetheless he was discharged from hospital without a multi-agency meeting being held. There does not appear to have been any escalation of concern about this discharge. He was readmitted in early July 2020 but discharged the same day without a package of care. The chronology records this episode as a failure in discharge planning. A similar pattern repeated in August 2020, after which his GP referred him for hospice care, which JOBY declined as he did further hospital admission. He had previously been recorded as being afraid of dying alone in hospital.

6.10.4. There is NICE guidance about the transition between inpatient mental health or general hospital settings and community settings. For people with serious mental health issues who have recently been homeless or are at risk of homelessness, the guidance[52] recommends intensive structural support to assist with finding and retention of accommodation. This support should begin prior to discharge and continue for as long as necessary. Housing and mental health services should work together to jointly problem solve. The chronology for JOBY refers to mental and behavioural disorder due to harmful alcohol use, and to anxiety and depression. Similar guidance for people in inpatient general hospital settings[53] recommends on admission that a person's housing status is established and that, prior to discharge, if a person is likely to be homeless, liaison occurs with the local authority's Housing Options service to ensure that advice and help is offered. Homelessness and safeguarding issues should be addressed by agencies working together to ensure a safe and timely discharge. Those at risk of readmission should be

[52] NICE (2016) *Transition between Inpatient Mental Health Settings and Community or Care Home Settings*. London: National Institute for Health and Clinical Excellence.

[53] NICE (2015) *Transition between Inpatient Hospital Settings and Community or Care Home Settings for Adults with Social Care Needs*. London: National Institute for Health and Clinical Excellence.

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referred to community practitioners prior to discharge for health and social care support.

6.10.5. DAWN's relative was critical of the lack of transition planning or follow-up when she was discharged after rehabilitation (detoxification), particularly the absence of support to address her mental distress.

6.10.6. PASCAL was discharged from prison before implementation of the Homelessness Reduction Act 2017. He appears to have been discharged to no fixed abode although the independent reviewers have been informed that, at the time, there was a hospital discharge homelessness worker. Moreover, provisions for homeless people in the Housing Act 1996 should have been explicitly considered.

6.10.7. Another transition is when someone moves off the streets and into some form of accommodation. PASCAL moved into a flat in May 2018 with the assistance of an outreach worker but the landlord was soon complaining about who else was accessing the accommodation. This would have been one occasion when a multi-agency meeting was indicated to determine how best to meet his diverse needs, including a review of legal options pertaining to housing, community safety, adult social care and adult safeguarding. The move coincided with ongoing attempts with DWP to reinstate his entitlement to employment and support allowance. Individuals must be provided with the basic necessities for such a move. He also alleged being bullied and threatened, which highlights that accommodation can feel unsafe because of being surrounded by and/or engaging with a high level of drug and/or alcohol abuse. The chronology contains an observation that PASCAL was staying away from his accommodation because of drug-related issues. He was eventually issued with a notice to quit by his landlord because of anti-social behaviour and he surrendered his tenancy, thereafter using a night shelter.

6.10.8. DAWN did move into a flat but found it difficult to mobilise and walk anywhere and so preferred to live on the streets. Her chronology also records that she felt unsafe in her flat, with the locks having been changed because other people had acquired the keys. DAWN's relative observed that continuity of a support worker would have been helpful at this point, to build on DAWN's ability to keep herself safe. This is another illustration of the importance of providing wrap-around support to enable a person to sustain a tenancy and address their social care and healthcare needs. It is a service now available in Herefordshire.

6.10.9. DAWN's relative recounted occasions when they had been told, or had heard her being taunted by other women in a refuge, or abused by other residents in a safe house. DAWN had told of other residents in a block of flats engaging in substance misuse. Her relative felt that she was vulnerable and had not been protected.

6.10.10. WILL was offered a flat with an accommodation provider offering support in November 2019. The chronology observes that his offender manager had persisted with efforts to find him accommodation, the initial approach to Housing Solutions having been made in March 2018. He did not maintain a

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reduction in his use of alcohol or engagement with support staff. He was using cannabis (again) in breach of his tenancy agreement. At this time he was also withdrawing from engagement with his offender manager and practitioners at the drug and alcohol provider. WILL's family members have questioned the adequacy of the level of support and oversight on offer when he was provided with accommodation.

6.10.11. There were several incidents over the months when JOBY threatened or reported being bullied, assaulted and harassed by another resident (AIDEN) living in the same accommodation setting[54]. The police responded but the incidents highlight the importance of a whole system response to ensure that accommodation provision is experienced as safe and does not break down. Indeed, the chronology records JOBY as remarking in January 2019 that peer pressure in the supported living accommodation was unhelpful.

6.10.12. One service user interviewed for this report detailed an experience of having been discharged from mental health detention onto the street (October 2018) without their welfare benefits having been sorted and with no apparent discharge plan or meeting. Provisions in the Homelessness Reduction Act 2017 would be relevant here.

6.10.13. Another example of transition is when young people known to children's social care approach and reach the age of 18. WILL was known to children's services but apparently disengaged from the 16+ team on reaching his eighteenth birthday. The independent reviewers understand that a project has been launched focused on an all-age strategy on transition. Briefings are available that offer guidance on transitional safeguarding[55].

6.11. A further element that emerged from the evidence was provision or lack of provision of <u>advocacy,</u> and Appropriate Adult support for those involved with the criminal justice system. Neither appeared in the chronologies. Advocacy may be indicated, for example, when health systems are based on self-reporting and attendance at appointments at specified times and places. Not everyone can easily engage with such a system, at least not without outreach support. If this is not provided, cases may be closed when individuals do not engage and/or are unable to readily explore what lies behind their presenting problems.

6.11.1. At the reflection learning event mention was made of the use of peer supporters, through the Hepatitis C Trust, participating in the Hepatitis C service, mobile clinic and point of care testing in care homes. Peer support and mentoring may be one option where individuals do not have a statutory entitlement to advocacy, such as with housing and/or clinical health services.

[54] Incidents are recorded during 2018 and 2019. He would not always make a complaint.

[55] Holmes, D. and Smale, E. (2018) *Mind the Gap: Transitional Safeguarding – Adolescence to Adulthood*. Dartington: Research in Practice. Holmes, D. (2021) *Bridging the Gap: Transitional Safeguarding and the Role of Social Work with Adults*. London: DHSC.

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7. Thematic Analysis – Team around the Person

7.1. From a reading of the combined chronologies, and mindful of the evidence-base, the following themes were identified for exploration at the learning event and are analysed here.

7.2. Working together. From the chronologies it is possible to discern examples of close liaison between practitioners in different services, for example variously between a probation officer, key worker from the substance misuse provider, hospital healthcare practitioners and staff from an accommodation provider (AIDEN). There were examples of partnership working between GPs and substance misuse practitioners, pharmacists or offender managers regarding prescribing and attempts to address an individual's drug use (AIDEN, WILL, JOBY). The National Probation Service (NPS) worked with welfare rights advisers to ensure individuals received their benefits (PASCAL), and with substance misuse practitioners and outreach workers to secure accommodation and maintain tenancies (PASCAL). Housing providers and outreach updated the substance misuse service on client welfare. (JUSTIN) There were instances where practitioners from different services saw individuals together (DAWN, WILL).

7.2.1. In the chronologies there were also instances where joined-up planning would have been helpful. When AIDEN dropped out of contact following a change of offender manager, breach proceedings were initiated. At this point there is no evidence of contact being made with other agencies when a more proactive approach would have been appropriate.

7.2.2. When in May 2018 WILL presented at an Emergency Department dishevelled and dirty (self-neglect), with his parents unable to accommodate him, there was no liaison with his offender manager, ASC, or a homelessness worker to explore options for emergency accommodation.

7.2.3. At the reflection learning event an impression was conveyed that multi-agency working had improved, including information-sharing about service user/patient outcomes. Sometimes this was linked with the commissioning of Turning Point as the provider of substance misuse services, both by senior leaders who were interviewed and by practitioners who attended the reflection event. Similarly there was acknowledgement of a transformation programme within secondary mental health provision, including joint work with MIND and with Turning Point, including attendance of the latter provider at multi-disciplinary team meetings (MDTs). There was, though, recognition that there remained a need to enhance working together with other services.

7.2.4. Similarly accommodation providers recognised that practitioners from other agencies were visiting accommodation sites and positive views were expressed about a recent innovation, namely high and critical risk review meetings. Another very recent positive innovation was reported by staff involved with alcohol-dependent individuals in a secondary health care setting. MDT planning meetings had been instituted that involved practitioners from the Mental Health provider and from Turning Point.

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7.2.5. Similarly, there were positive reflections at the learning event concerning outreach involving the secondary health care provider and Turning Point, with point of care testing available and collaborative working designed to tackle obstacles preventing access and/or admission to hospital. Emphasis was being placed on responding quickly to referrals, with increasing use of mobile clinics where practitioners from across providers and with a range of knowledge and skills would be present.

7.2.6. Nonetheless, notes of caution were expressed. Silo working was still a feature of local practice. Cases were described where communication between services and the use of multi-agency meetings had prevented an individual's death but it was felt that this practice had been possible because of individual practitioner relationships rather than as a result of expectations of a multi-agency system. A view was also expressed concerning the need to improve working together, including the use of MDTs, at the beginning of a person's journey. Practitioners also referred to the benefits of co-location and thought that this approach could be developed further.

7.2.7. The approach with individuals with dual diagnosis or co-occurring diagnoses remained difficult. There were positive reflections about joint working within an assertive outreach team but within a context where it was felt that care could be better coordinated in line with NICE guidance[56].

7.3. Information-sharing. There were missed opportunities to share information about adults at risk (AIDEN, JOBY, WILL). For example, when AIDEN was not compliant with medical advice, this information was not shared by the GP with his substance misuse key worker. Probation does not appear to have updated the police when AIDEN's mother was visiting him despite a restraining order being in place. It is not clear that the reasons why PASCAL would not utilise the night shelter were known to all the services working with him. The police do not appear to have shared the information that PASCAL had been reported for summons for begging.

7.3.1. WILL's GP knew that he had difficulty attending appointments on account of his mental health and mobility difficulties, and heavy alcohol use, but this information was not shared with the result that Housing Solutions closed down their involvement when he failed to keep an appointment to complete a personal housing plan. This may have been because the GP was unaware of Housing Solutions' involvement.

7.3.2. There were positive examples of information-sharing, for example when the police shared details with ASC of PASCAL's anti-social behaviour, and when they exchanged information with hospital staff when he self-discharged shortly before he died. The National Probation Service exchanged information with other services, particularly his key worker in a drug and alcohol service and the police, as part of keeping a risk management plan updated, for example when appointments were not kept (WILL). The police shared information about domestic abuse incidents and allegations with new offender managers and/or accommodation providers (WILL, JOBY). GPs, the independent living accommodation provider and substance misuse key

[56] NICE (2016) *Coexisting Severe Mental Illness and Substance Misuse: Community Health and Social Care Services*. London: National Institute for Health and Care Excellence.

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workers exchanged information (JOBY). JUSTIN's outreach worker and housing provider consistently shared information with the substance misuse service about his current whereabouts or health status.

7.3.3. At the reflection learning event some participants recounted that the General Data Protection Regulations (GDPR) had prevented information-sharing. The independent reviewers were told that an information-sharing protocol was being developed under the auspices of Project Brave.

7.3.4. The Data Protection Act 2018, which incorporates GDPR into UK law, permits the sharing of information to safeguard a child or an adult at risk, and to assist with the prevention, detection and prosecution of crime. Information-sharing remains a challenge.

7.4. Referrals. The chronologies contain examples of appropriate referrals. For example, a probation officer referred AIDEN to ASC for assessment of his care and support needs and, moreover, challenged the "no further action" outcome of a previous assessment. On two occasions the probation officer followed up their challenge, as well as escalating concern within their own service. PASCAL was referred by his GP to a vascular surgeon. After an A&E attendance in May 2018, JUSTIN was appropriately referred to a range of agencies including mental health, outreach and an accommodation provider for ongoing support.

7.4.1. The police appropriately referred domestic assaults on (former) partners to children's social care (WILL, JOBY). However, there were no referrals to ASC for care and support assessments for WILL, for example when he was offered and given a place in an independent living setting with staff support on site. Chronologies do not routinely detail the safeguarding responses by Children's Social Care, although on one occasion information was exchanged with the substance misuse provider (JOBY).

7.4.2. There are also examples of missed opportunities to make referrals. PASCAL's mental health was managed in primary care. For PASCAL, but also for WILL and JOBY who were similarly observed to experience ongoing anxiety and depression, locating lead responsibility for managing mental health may well be appropriately located in primary care. However, further consideration about access to psychological therapies also appears indicated. Nor was PASCAL referred to ASC until the month of his death. ASC's response to the referral was to send a letter to his flat even though the police had stated that he was not living there. No alternative options for attempting to make contact with PASCAL appear to have been considered.

7.4.3. DAWN was not referred to ASC, for example by her GP or by the police, despite appearing to have care and support needs, arising from physical and mental ill-health, and substance misuse, including needs relating to sustaining accommodation and maintaining a habitable environment. She was referred appropriately for outpatient appointments by her GP.

7.4.4. JOBY was referred to ASC in April 2018, with some liaison between the department and the substance misuse provider. However, the referral did not result in a focus on his care and support needs, or the needs as a carer of his

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partner. The situation appears to have been seen as one of harassment between residents within the accommodation provider setting and therefore a matter for the police. JOBY's GP did refer him to hepatology for clarity about the degree of his liver cirrhosis. In July 2020 safeguarding practitioners at a GP Practice raised concerns with ASC that current arrangements to support JOBY were inadequate.

7.5. Multi-agency meetings. Across the chronologies there is limited evidence of the use of multi-agency meetings to agree an approach to mitigating risks and meeting need. For example, a case conference or multi-agency risk management meeting should have been considered when an offender manager visited AIDEN at his place of residence and found him physically very unwell, with loss of short-term memory and slurred speech, and again when AIDEN appeared to be declining a care and support assessment, with possible confusion about what different agencies could offer and with the probation officer concerned about his unmet needs. A third missed opportunity to bring services together occurred when AIDEN was only engaging intermittently with his substance misuse key worker, when he was minimising and appeared unconcerned about his use of drugs and when his mother, his only family support, had been diagnosed with cancer.

7.5.1. In AIDEN's case a multi-agency meeting was convened in November 2019 at the request of his accommodation provider. There were concerns about his ability to mobilise and to self-care. A care package was approved but care staff would not visit because of the risks arising from used needles. Despite repetitive concerns about his inability to self-care or manage his medications, and refusals of some medical assistance, a further multi-agency meeting was not convened until early February 2020.

7.5.2. In PASCAL's case, there is evidence of liaison between practitioners across different services but no whole system meeting was convened to coordinate wrap-around support or to address his substance misuse and deteriorating health and wellbeing.

7.5.3. In DAWN's case, her agreement to professionals meeting to agree a care plan appears to have been obtained around a month before she died. This was too late, given her deteriorating physical health, the challenges she encountered trying to live in her flat and also to sustain engagement with services, and her substance misuse. No meeting appears to have been held before she died. Moreover, her consent was not formally required for such a meeting.

7.5.4. In WILL's case, a multi-agency meeting was convened in October 2018. It is not clear from the chronology who attended and what the outcomes were. It appears to have focused in part on his compliance with court orders.

7.5.5. In JOBY's case entries on the chronology emphasise that a multi-agency meeting would have been prudent, for instance after repeat domestic abuse incidents and the submission again of risk assessments by the police to ASC and Children's Social Care, or in response to non-attendance at clinical reviews in a context of increasing concerns about physical health, mental wellbeing and substance misuse. When a multi-agency meeting was suggested, this was just two months before his death and no meeting was

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held despite concerns about discharge from hospital to the independent living accommodation setting without a care and support package in a context of deteriorating health and wellbeing.

7.5.6. In JUSTIN's case there were no multi-agency meetings about his needs. This would undoubtedly have benefited the provision of care by providing a fuller picture of his substance misuse and physical and mental health.

7.5.7. In cases where incidents of domestic abuse featured, the chronologies do not indicate that episodes were discussed in MARAC meetings subsequent to police submission of risk assessments.

7.5.8. At the reflection learning event participants conveyed uncertainty about how agencies could initiate a multi-agency meeting, using the complex adult risk management (CARM) procedure. Although some good results had been obtained as a result of the use of multi-agency meeting procedures, a sense was conveyed that CARM is still being embedded, and that greater and more effective use could be made of case conferencing.

7.6. Use of policies and procedures. The evidence from the chronologies appears to be that self-neglect was mentioned but policy or procedures were not being used by all staff across all agencies as a framework within which to locate their approach (AIDEN).

7.6.1. There are also occasions when individuals do not appear to have been seen as "vulnerable" or at risk, such as when drunk, disorientated and lost (DAWN).

7.6.2. The discharge policy adopted by the substance misuse service does not appear to have been used with flexibility by staff faced with a client who was clearly having problems engaging (JUSTIN), which predates the current provider and remodeling of the service. On the other hand, his housing provider altered their missing person's procedure with regard to JUSTIN to ensure there were more regular checks on his wellbeing.

7.7. Safeguarding literacy. A recurrent theme was the lack of recognition of safeguarding needs, although all six people had histories of misusing substances, physical and/or mental health problems and several had been subject to assault, abuse, and/or self-neglect. This links to issues raised earlier regarding the lack of referrals for a Care Act assessment.

7.7.1. There were missed opportunities to refer adult safeguarding concerns for individuals appearing to have care and support needs, experiencing abuse and neglect, including self-neglect, and unable to protect themselves because of their care and support needs[57]. Examples include individuals being found incoherent, confused and/or intoxicated in a public place, sometimes being taken to an Emergency Department (AIDEN, PASCAL, DAWN, JUSTIN, WILL), and individuals sleeping rough with increasing concern for their physical health (PASCAL) or being at risk from exploitation, County Lines and risk-taking behaviour (DAWN, WILL). Services should refer adult safeguarding concerns rather than expect other agencies to do so.

[57] Section 42(1) Care Act 2014.

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7.7.2. When safeguarding concerns were referred to ASC, there were missed opportunities to convene a multi-agency meeting or complete an enquiry as a response to repetitive episodes, for example of individuals appearing unsafe and at risk to the police in public spaces (AIDEN, DAWN). When the police did submit details of adult protection incidents, the chronology is sometimes silent on any outcome (DAWN, JOBY, JUSTIN); at other times, the decision appears to have been that incidents were a police rather than ASC matter despite a repeating pattern and evidence of care and support needs.

7.7.3. Children were clearly involved in some situations, witnessing substance misuse and/or domestic abuse (WILL, JOBY). Chronologies indicate that children were not allowed to have contact when individuals were intoxicated and/or alone but, without ongoing involvement from Children's Social Care, it was unclear how services could be assured that children were being adequately safeguarded.

7.7.4. Both DAWN's and JOBY's relatives were concerned about some of the responses to referred adult safeguarding concerns (section 42, Care Act 2014), either the lack of timeliness or a care management rather than a safeguarding response.

7.8. Legal literacy. In one instance the Homelessness Reduction Act 2017 does not appear to have been considered by an Emergency Department when an individual was ready for discharge but homeless (WILL).

7.8.1. In one case the police made appropriate referrals of domestic abuse, sometimes witnessed by a child, but could also have considered use of civil orders through Domestic Violence Protection Notices and Domestic Violence Protection Orders.

7.8.2. Practitioners reflected that there was a need for better understanding of the Mental Health Act 1983 and Mental Capacity Act 2005 across all agencies.

7.8.3. Representatives of the services involved in this thematic review, and the independent reviewers, are agreed that a broad view of legal literacy should be taken by SABs and partner agencies. Focus needs to be maintained not just on understanding and application of the Care Act 2014 but also of housing, mental health, mental capacity, anti-social behaviour, criminal justice and public health legislation. This reflects the system-wide, multi-agency response that is required.

7.9 Recording. The chronologies contain examples of incomplete recording. For example, it is unclear what action the police took when DAWN was found intoxicated and unable to find her way to her flat. Records are also incomplete on the outcomes of police referral for domestic abuse following reported theft of DAWN's bank card by her partner.

7.9.1. In other cases too, judging by entries on chronologies, there were shortcomings in recording of what referrals were sent, to whom, and with what outcomes (WILL). There were also shortcomings in recording when individuals did or did not attend

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appointments, or what prescriptions were issued and why by GPs (WILL), or what had been discussed in supervision and management oversight meetings (JOBY).

7.9.2. Family relationships were clearly under strain in several cases but again records could be limited. Thus, in one case (WILL) it is not clear from agency records why family members would not offer accommodation. Feedback from family members, however, included descriptions of going missing, drinking, stealing and aggressive outbursts when at home with his parents.

7.9.3. There were some references to clear and precise case notes, for example recorded by an occupational therapist after an assessment (JOBY), and recording by a GP of alcohol use (JOBY).

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8. Organisations around the Team

8.1. Supervision and management oversight are core components of the evidence-base for best practice. The chronologies provide occasional examples of each, for instance when offender managers in NPS discussed cases with senior probation officers (AIDEN, PASCAL, WILL) and when a substance misuse key worker had a case discussion with their manager (JOBY). In the JOBY case, a GP discussed their concerns with a safeguarding lead GP. The GP also sought advice from an on-call medical consultant about treatment options.

8.1.1. At the reflection learning event an accommodation provider acknowledged that clinical supervision was now being provided for staff to assist them with responding to the needs and risks presented by residents. Staff too have acknowledged the importance and benefits of reflective practice spaces and sessions focusing on coping strategies given the increasingly complex situations that they are having to manage. Otherwise the feeling of futility that the work can generate, especially when individuals die, can prove overwhelming.

8.2. The evidence-base also refers to commissioning. HSAB has a statutory mandate to seek assurance that, in order to prevent and to safeguard people from abuse and neglect, commissioners are responding effectively to people who present with complex needs including substance misuse, offending, mental health, underlying physical health issues, and/or homelessness. Research[58] strongly recommends new commissioning approaches that deliver integrated provision and a greater number of specialist multi-disciplinary services.

8.2.1. The chronologies identify occasions when there were difficulties finding a provider that would take on a care package when there were risks arising from substance misuse (AIDEN). The chronologies also identify shortfalls in the supply of temporary accommodation, including hostel places (PASCAL), demand exceeding availability.

8.2.2. JOBY's relative expressed some unease about the response to provider concerns, namely whether action was taken and feedback given in response to issues that had been raised about delivery of care and support.

8.2.3. At the reflection learning event Turning Point referred to the provision of a female only space and to a forthcoming pathway for LGBTQ+ individuals. Other practitioners argued for more joint commissioning of pathways to treatment, including mental health and addiction, pathways to support to assist individuals to sustain their accommodation, and pathways to support effective hospital discharge.

8.2.4. Dual diagnosis remained a challenging area for those at the reflection learning event. The independent reviewers have been told of concerns about gaps in

[58] Cream, J., Fenney, D., Williams, E., Baylis, A., Dahir, S. and Wyatt, H. (2020) *Delivering Health and Care for People who Sleep Rough: Going Above and Beyond*. London: King's Fund. Weal, R. (2020) *Knocked Back: How a Failure to Support people Sleeping Rough with Drug and Alcohol Problems is Costing Lives*. London: St Mungo's.

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provision for people with co-occurring diagnoses, pointing particularly to lack of local treatment provision for particular issues, such as post-traumatic stress disorder. It has been suggested that service capacity has impacted on individuals' mental health and addiction recovery, including caseload size. Short-term funding represents an additional complication, meaning that newly commissioned services might raise hope and expectations but not prove sustainable in the longer-term. In relation to outreach homelessness support, the government's response to the pandemic brought significant increases in funding, unlocking new pathway approaches. However, this funding is fundamentally short-term.

8.2.5. There was considerable support for the principles and motivations underpinning Project Brave, with its emphasis on co-production, single assessment, and shared leadership. It was attempting to view service provision from the perspective of service users, to hear their voices and to embed their feedback into multi-agency working together. A sense was conveyed of progress towards a more holistic understanding of people's complex needs, thorough risk assessments and structured provision, and enhancement of partnership working and planning both strategically and operationally. It was seen as an opportunity for improving keyworker support and responses to mental distress, substance misuse and homelessness. Some concerns were expressed about whether Project Brave would continue.

8.2.6. What was universally supported was the need to integrate accommodation and wrap-around support, as exemplified by Housing First, so that individuals were provided with safe spaces where they could begin to address the origins of their complex needs through the presence of key relationships.

8.2.7. Several services cross local authority boundaries, particularly with Worcestershire. This includes the Clinical Commissioning Group (CCG), mental health provider and the police. However, different commissioning arrangements for provision, such as drug and alcohol services and mental health services, it was reported, can complicate joint working.

8.3. Workforce and workplace development are other components of this part of the evidence-base. When key workers changed, as a result of staff moving on, there were examples of good handover arrangements (AIDEN) and when reallocation was necessary and in line with service requirements, because of level of risk and the presence of particular types of abuse and neglect (domestic violence) (WILL). However, such changes, sometimes multiple times, could also disrupt relationship-based practice (AIDEN, WILL, JOBY) and did result in difficulties in renewing engagement with service users.

8.3.1. There were occasions when the police could not deploy, for example when AIDEN was reported by hospital staff to be disruptive, with also the probability that a girlfriend was bringing heroin onto the ward.

8.3.2. In WILL's case, when he could not see the GP with whom he usually engaged, that may have led to different prescribing practice in response to his medication requests.

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8.3.3. At the reflection learning event, availability of staffing was reported as an issue in discussion concerning work with individuals with co-occurring diagnoses.

8.3.4. Some services have begun initiatives relating to early help responses with adverse childhood experiences and with developing a trauma-informed approach. The latter development may progress further once the new integrated care system has been fully developed and agreed.

8.3.5. The challenges of assessing mental capacity were noted at the reflection learning event, with some practitioners advising of the need for further training, for example in respect of assessing executive functioning, and some also indicating the need for access to specialists to advise on complex cases.

8.3.6. Service users accessing accommodation with support recognised that there had been system change, with policies revamped and the quality of staffing enhanced. This had resulted in fewer "blue light" occurrences, less substance misuse on site and a greater sense of stability, security, support and confidentiality.

8.3.7. Both DAWN's and JOBY's relatives thought that more training was necessary, especially for practitioners, especially those working in supported accommodation settings, so that they understood mental capacity and dependence on alcohol and other drugs, and pathways for accessing help.

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9. Governance

9.1. Getting the governance right is important. Clearly, HSAB holds the statutory mandate for governance of adult safeguarding. However, there is no one forum for where governance of services for people who present with complex needs including substance misuse, offending, mental health, underlying physical health issues might reside – the SAB, Health and Wellbeing Board, Community Safety Partnership or Homelessness Reduction Board may all be appropriate choices for 'holding the ring', for providing strategic leadership and holding partners to account. What works may vary depending on local government structures. Thus, a governance conversation is recommended, inclusive of elected members, partnership and board chairs and strategic leaders, where agreement is reached on a common and shared vision, alongside roles and responsibilities for assuring the quality of policies, procedures and practice. Whatever governance arrangements are agreed locally, they must be able to hold relevant organisations and system leaders to account for delivering strategic objectives and service improvement[59]. The HSAB should consider whether to initiate that governance conversation.

9.2. The independent reviewers were told of the Homelessness Forum that provides a connection between local communities, small agencies and larger service providers. The potential contribution that Talk Community hubs could offer towards prevention was noted. Given ongoing concern regarding premature deaths, it might be timely for an appraisal of the engagement between statutory and third sector agencies, and local communities.

9.3. This thematic review has been commissioned by HSAB using its mandate in Section 44 Care Act 2014. HSAB with its partner agencies should now consider its approach to reviews of and learning from cases where neither the criteria for a mandatory or discretionary review are met, principally because the individuals concerned did not have care and support needs. Some SABs have supported the development of homelessness fatality reviews[60] and drug and alcohol fatality reviews, using the model of learning disability mortality reviews as the basis. As with SARs the focus is on implementing learning, for example on making safeguarding pathways and high risk panels more accessible, and providing staff development opportunities on safeguarding and relevant law. As with SARs, fatality reviews remind managers and practitioners of the importance of relationships in people's lives and also of the impact on staff of fatalities, whether or not they were directly involved in the case. This would be one response to the call[61] for a review of every death of an individual with complex needs while sleeping rough or in emergency accommodation.

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[59] Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness. A Briefing on Positive Practice. London: LGA and ADASS.
[60] Presentation by Gill Taylor (2019) Homelessness Fatality Review. Reported in Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness. A Briefing on Positive Practice. London: LGA and ADASS.
[61] Weal, R. (2020) *Knocked Back: How a Failure to Support people Sleeping Rough with Drug and Alcohol Problems is Costing Lives*. London: St Mungo's.

10. Revisiting the Terms of Reference

10.1. Whilst this SAR was being prepared, two national inquiries have reported that have direct applicability to reinforcing the learning from this thematic review. The Dame Carol Black report[62] concludes that public provision with respect to substance misuse is not fit for purpose. Amongst its findings and recommendations, it urges government to reverse its disinvestment in treatment and recovery services, and provide the resources and whole system approach that provides people with somewhere to live and something meaningful to do. It recognises that addiction is a chronic health condition requiring long-term follow-up, and emphasises the importance of greater coordination at national and local levels. It observes that prevention is ultimately more cost effective and that trauma and/or mental ill-health are drivers of much addiction, with the consequence that commissioners of substance misuse and secondary mental health services must ensure that individuals do not fall through the cracks.

10.2. The interim report of the Kerslake Commission[63] also recognises that ultimately investment in prevention is a more cost effective approach. It recommends a combination of government support and collaboration across and between key service providers to build on the lessons learned from the Everyone In initiative. It notes that this response to the COVID-19 pandemic saved lives and enabled many people who had been experiencing homelessness to move on into longer-term accommodation. This report also recommends a whole system approach, recognising that seeing homelessness as a public health rather than simply a housing issue led to better partnership working, understanding and treatment. The report observes the importance of good quality accommodation, food and in-reach multi-agency services but criticises short-term funding. It recommends that government leads on provision of affordable housing, pathways beyond hostels, and welfare support. It too recommends reversal of disinvestment in substance misuse services and retention of welfare changes and the derogation of rules on priority need, local connection and no recourse to public funds.

10.3. The final report of the Kerslake Commission[64] makes recommendations to both central government and local authorities. Recommendations for central government include extending the duty to refer (Homelessness Reduction Act 2017) to incorporate a duty on services to collaborate, building on the Everyone-In programme and retaining the welfare changes introduced at the outset of the pandemic, and reviewing law and policy concerning people with no recourse to public funds. Among the recommendations for local authorities and their partners are the development of integrated homelessness and health strategies, long-term strategic planning for managing winter peaks, the development of professional accreditation for staff working in the homelessness sector, and ensuring that new

[62] Black, C. (2021) *Review of Drugs, Part 2, Prevention, Treatment and Recovery*. London: The Stationery Office.
[63] McCulloch, L. with Cookson, E, Currie, H., Kulkarni, D., Orchard, B and Piggott, H. (2021) *The Kerslake Commission on Homelessness and Rough Sleeping: When We Work Together – Learning the Lessons. Interim Report*. London: St Mungo's.
[64] Kerslake Commission on Homelessness and Rough Sleeping (2021) *A New Way of Working: Ending Rough Sleeping Together.*

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ICS arrangements tackle health inequalities and provide trauma and psychologically-informed services.

10.4. One senior leader noted the impact of the national context on available local services, explicitly referencing financial austerity.

10.5. The independent reviewers have been told that there have been deaths of individuals in similar circumstances to those that form the basis of this SAR. That underscores the importance of pulling together findings with respect to the key lines of enquiry for this thematic review. These are now summarised below.

10.5.1. Multi-agency responses to individuals with multiple complex needs. The implementation of Project Brave was regarded as having achieved positive outcomes for some individuals with multiple complex needs that stand in contrast to how services worked with the six individuals whose experiences were the impetus for this review. The use of CARM procedures has also achieved positive outcomes. A frequent attenders at A&E multi-disciplinary team meeting has secured good cross-agency support and been enabled to link individuals into appropriate services with risk management plans. Panel members who supported the independent reviewers have pointed to improved communication and working together between services. However, multi-agency working together does not yet appear to have been fully embedded.

10.5.2. Service responses to the impact of physical and mental impairment or illness, including dual diagnosis. The police now participate in monthly multi-agency meetings, including mental health practitioners, to coordinate the approach with high intensity service users, with onward referral to CARM where this is indicated. The recent change of substance misuse service provider does appear to have generated some positive change but a dual diagnosis pathway remains a gap. Project Brave in terms of outreach provision, key worker allocation and wrap-around support has enabled some individuals to move on positively. Weekly multi-disciplinary meetings are now held between hospital and community services, including substance misuse services, to coordinate hospital discharge. These developments need to become embedded as standard practice, with primary care, secondary health care providers and substance misuse providers strategically and operationally committed to learning from this review and from the outcomes of Project Brave.

10.5.3. Use of Care Act 2014. There were missed opportunities to refer and to enquire into adult safeguarding concerns (section 42(1) and 42(2), Care Act 2014). There were missed opportunities to refer adults with care and support needs for assessment (section 9, Care Act 2014).

10.5.4. Use of Mental Health Act 1983 and Mental Capacity Act 2005. There were missed opportunities to consider the impact on mental capacity of addiction. There is a need to develop awareness of the potential impact on physical

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health and on cognition when individuals change their primary drug from heroin to alcohol. There were missed opportunities to seek to help individuals address the origins of their mental distress. Pathways into mental health treatment and support have been recognised in Project Brave but concerns have been expressed about their sustainability and accessibility.

10.5.5. Understanding of self-neglect. The independent reviewers understand that HSAB is completing a scheduled review of its self-neglect policy. Self-neglect was not explicitly identified in the six cases but it is one of the types of abuse and neglect now included in adult safeguarding by the Care Act 2014 and there is an established evidence-base, as this report has identified, against which SABs can audit service responses.

10.5.6. Impact of homelessness, poverty and family relationships. All six individuals had, at some point, experienced homelessness and Project Brave explicitly includes a focus on homelessness when responding to individuals with multiple complex needs. Project Brave has enabled some individuals to move away from street-based lives with accommodation and wrap-around support. In some of the cases reviewed, there were complex family relationships, some of which included children, necessitating a "think family" approach and close working together between Children's Social Care and ASC. That approach was not evident in the chronologies available to the independent reviewers.

10.5.7. Learning for the health, housing and social care system. The analysis of the information provided by agencies with respect to the six cases and the information offered by practitioners and managers provide signposts to how services have been developing, perceived gaps or vulnerabilities in current arrangements and clear endorsement for a whole system response strategically and operationally to individuals presenting with multiple complex needs. The strategic and operational architecture exists. For example, five surgeries have become a super surgery and have appointed a safeguarding coordinator. The other three surgeries left in the city centre have recently employed a care coordinator. It is reported that these roles have made a huge difference for the safeguarding of adults and children and the ability for GP information-sharing at meetings. However, a sense has been conveyed that positive developments need reinforcement to be sustained. The independent reviewers have been told frequently that, in order to design, commission, deliver and sustain effective services for people with multiple complex needs, additional resources are required. The independent reviewers understand that attempts to secure these resources for Herefordshire have been unsuccessful to date. The funds available for commissioning a wide range of services have greatly decreased over the last decade.

10.5.8. Both DAWN's and JOBY's relatives, when talking about the brother or sister that they remembered, referred to early sporting, artistic and/or career aspirations but how these had begun to unravel as a result of exploitation,

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vulnerabilities and/or relationships. Both described episodes of recovery from substance misuse, which were not sustained. Their contributions are reminders of the importance of early intervention as well as later support. As DAWN's relative observed when describing the problems she faced in her later years: "how could it get that far?"

10.5.9. The picture given by WILL's family members is similar. They described someone who was intelligent and who excelled at sport. However, he had fragile and often low self-esteem, and fractured relationships. He became drawn into a way of life and was unable to sustain periods when he would abstain from using alcohol and other drugs. According to family members, "inside he was tortured."

10.5.10. Although there have been, as already noted, deaths of individuals in similar circumstances whilst this thematic review has been underway, cases have also been shared with the independent reviewers where positive change has been achieved. In one case the CARM created an opportunity for services to agree a multi-agency action plan designed to manage risk and provide support. This action plan involved a GP carrying out specialist tests, continued mental health allocation/monitoring, ASC offering community broker options and West Mercia Police facilitating a fast track approach to decision making. Since this intervention the level of risk to the individual has reduced and she is considered more stable within her presentation.

10.5.11. A second case involved complex dynamics between mental health intervention, alcohol use and mental capacity, with services experiencing difficulties in providing a consistent risk management plan to reduce the extreme risk. CARM enabled discussion that concluded with a creative outcome to reduce the risk. This involved action by primary care, mental health and the police to ensure a consistent approach rather than the individual "bouncing" from service to service.

10.5.12. A third case concerned an individual with a long history of homelessness, temporary accommodation, disengagement, physical and mental health concerns, and self-neglect. Detailed assessments, which considered his ongoing health and social care needs, and decisional capacity, were undertaken when he was ready for discharge from an acute mental health ward. This resulted in a recommendation, which was accepted, that he be placed in a residential placement, where he is now doing well.

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11. Recommendations

11.1. Arising from the analysis undertaken within this review, the independent reviewers recommend:

11.1.1. HSAB should consider how to take forward locally the recommendations in the Black and Kerslake reports.

11.1.2. HSAB should consider using available briefings to review current approaches to transitional safeguarding and service responses to young people/young adults at risk of abuse, neglect and exploitation.

11.1.3. HSAB should consider whether further work is required to reach agreement on how the SAB, Health and Wellbeing Board, Community Safety Partnership and Homelessness Forum provide strategic leadership and hold partners to account for the care of adults with multiple complex vulnerabilities including change resistant substance misusers.

11.1.4. HSAB should seek assurance from partner organisations regarding the development and use of a local dual diagnosis pathway and whether that clarifies how services will work together in accordance with NICE and Public Health England guidance. In particular, HSAB should seek assurance about the procedure for resolving different clinical opinions about the best way to approach an individual's needs.

11.1.5. HSAB should consider whether to seek assurance from services about their responses to individuals who appear to be disengaging, with particular emphasis on assertive outreach, follow-up and flexibility of times and locations of appointments. HSAB should also consider whether further procedures are necessary to guide practitioners on how to respond to safeguarding individuals whose engagement fluctuates.

11.1.6. HSAB should consider audits of practice to be assured that the specific needs of people with multiple complex vulnerabilities are identified in care and support, risk and mental health assessments, with resulting wrap-around and where appropriate multi-agency plans.

11.1.7. HSAB should ensure that all frontline practitioners and their managers are trained in best practice in working with individuals experiencing multiple complex vulnerabilities, including the need for professional curiosity, the application of the safeguarding provisions of the Care Act (including self-neglect) and the quality of Mental Capacity Act assessments (including executive capacity).

11.1.8. HSAB should consider the need for training and awareness raising on the impact of brain injury on the behaviour and mental capacity of people who are dependent on alcohol and drugs, and the impact of Hepatitis C on the cognitive functioning and mood of clients.

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11.1.9. HSAB should consider further awareness raising of the procedures for complex adult risk management (CARM) and should consider audits of the use and outcomes of this guidance.

11.1.10. HSAB should consider further awareness raising of the components of Project Brave and subsequently how it may support and seek assurance about the outcomes of the transformational change underpinning Project Brave.

11.1.11. HSAB should consider sharing this thematic review with Worcestershire Safeguarding Adults Board and Worcestershire Children Safeguarding Partnership.

11.1.12. HSAB should consider sharing this thematic review within the region, firstly to seek usable examples of effective solutions elsewhere, and secondly to establish whether there are commonly held concerns, especially regarding available resources, that should be escalated to the Department of Health and Social Care through the escalation pathway now established via the national network of SAB chairs.

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