Safeguarding Adults Review

Learning from the circumstances of the death of 'Peter'

Michele Winter, Independent Reviewer

July 2021

Gloucestershire Safeguarding Adults Board

Note

The Reviewer would like to thank all those who have contributed in any way to this Safeguarding Adults Review (SAR) for their time, fortitude, commitment and cooperation, particularly as this has taken place during the Coronavirus (Covid-19) pandemic.

The pseudonym 'Peter' has been used to maintain confidentiality.

Contents

1. Introduction

This SAR was formally commissioned by Gloucestershire Safeguarding Adults Board (GSAB) on 10th November 2020. The subject, Peter, was found deceased by a member of the public on the pavement in central Cheltenham on 4th November 2019. Peter had been street homeless for approximately six weeks. The Coroner's Report records the cause of Peter's death as 'drug toxicity/drug related death'.

Peter was a man of white British heritage, aged fifty-nine when he died. He was well known to a range of services within Gloucestershire due to experiencing enduring mental health issues, intermittent homelessness and dependency on alcohol and drugs. Usually related to his dependencies, Peter was a suspect (and victim) in many criminal offences. Peter had several health issues and there is a query as to whether he also had some kind of an Acquired Brain Injury (ABI) from the several attacks he suffered.

Peter's history of complex needs and their context was also reviewed during the SAR, although the specific focus regarding terms of reference was on the year up to his death.

SARs were first introduced by the Care Act 2014, replacing Serious Case Reviews (SCR's). They are separate to any investigation and provide in-depth analysis and critical reflection of events as they were at the time with the aim of positively affecting future practice and systems. Guidance states that "Safeguarding Adults Boards (SABs) must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult."[1]

Whilst death by 'drug toxicity/drug related death' is not abuse or neglect, there is enough known about Peter to recognise that his vulnerabilities and experiences within the year being looked at made him, at times, an 'adult at risk' (AAR).[2] Consequently, often, Peter fitted the Care Act criteria for a Safeguarding response or at the very least for a safeguarding concern to have been raised about him. Furthermore, the commissioning of this SAR is in line with the commitment made to undertaking SARs for rough sleepers within the Rough Sleeping Strategy of 2018.[3]

[1] Department of Health & Social Care (2021), *Care and Support Statutory Guidance: Changes in March 2016*. Available online: https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-and-support-statutory-guidance-changes-in-march-2016 [accessed 27/3/21]

[2] Ibid

[3] Ministry of Housing, Communities and Local Government (2018) *Rough Sleeping Strategy: August 2018*. Available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733421/Rough-Sleeping-Strategy_WEB.pdf [accessed 14/12/20]

2. The Process of the Review

2.1 Covid-19 and related restrictions meant that all meetings and Learning Events for this SAR were either virtual (via 'Microsoft Team's') or over the telephone. The time period covered by the review was set at between 22/10/18 and 04/11/19, with an overview of Peter's life prior to this. The Terms of Reference were set by GSAB SAR subgroup.

2.2 **Terms of Reference: General**:

- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk.
- To review the effectiveness of procedures (both multi-agency and those of individual organisations).
- To inform and improve local inter-agency practice.
- To improve practice by acting on learning (developing best practice).
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.
- To connect the learning from previous Safeguarding Adults Reviews (SARs).

2.3 **Terms of Reference Specific**

- To examine the circumstances leading up to the death of Peter who was found deceased on 4th November 2019 on the pavement in Cheltenham.
- To consider whether all opportunities to ensure Peter had received appropriate care and support within the overall delivery system were identified up to the time of his death.
- To review the circumstances around the detention and subsequent discharge of Peter on 3rd November 2019.
- To review the effectiveness of multi-agency communications across the agencies involved in his care.
- To consider the response of professionals when engaging with individuals who appear not to want to engage
- To identify areas of best practice, including the way agencies worked together
- To consider the appropriateness and suitability of the accommodation provided, to meet the needs of individuals with complex mental health and substance misuse issues

2.4 Family Involvement

Where possible good practice suggests involvement of family within SARs. A letter was sent to Peter's mother. No response was ever received. Later information suggests she is now living in a dementia care home. There were several attempts to call Peter's sister. There was no response and later information was that she wanted no further contact after Peter's funeral. Consequently, there has been no family input into this SAR.

2.5 Agencies/Professionals invited to participate

- Cheltenham Open Door
- Gloucestershire Health & Care NHS Foundation Trust
- Gloucestershire Hospitals NHS Trust
- Gloucestershire Constabulary
- Cheltenham District Council
- P3
- Gloucestershire Clinical Commissioning Group
- Penderels Trust
- Gloucestershire Safeguarding Adults Team
- Gloucestershire County Council
- Cheltenham Borough Homes
- Solace
- Change, Grow, Live
- Pivotal Homes
- South West Ambulance Service NHS Foundation Trust.
- Gloucestershire Safeguarding Adults Board

2.6 Methodology

The Reviewer examined several traditional methods[4] before making the decision to utilise a mixed, 'systemic' approach for this SAR. Systems theory[5] enabled the Reviewer to holistically assess the complex relationships within and between: individuals, practitioners, agencies, processes and systems both culturally and structurally in order to establish relationship with Peter's experience and to identify learning and action.

The Reviewer also utilised relevant elements of existing models or made adaptations. This eclectic approach ensured best practice was modelled as the resulting SAR was person-centred, proportionate and outcomes focussed all of which is in line with safeguarding principles and the ethos of Making Safeguarding Personal.[6]

[4] Gloucestershire Safeguarding Adults Board (2018) *Safeguarding Adults Review Protocol: Appendix 3*. Available online: https://www.gloucestershire.gov.uk/media/2084350/gsab-safeguarding-adult-review-guidance-nov-18.pdf [accessed 5/11/20]
[5] Teater, B. (2019) *An Introduction to Applying Social work Theories and Methods.* 3rd Edition. New York. Open University Press.
[6] Local Government Association (2021) *Making Safeguarding Personal*. Available online: https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal#:~:text=%20Making%20Safeguarding%20Personal%20%201%20Implementing%20MSP.,in%20the%20context%20of%20Making%20Safeguarding...%20More%20 [accessed 5/11/20]

3. Case Summary, analysis and learning points

Whilst focus is on the last year of Peter's life, analysing concurrent themes running through his life course is necessary to more fully understand the trajectory it took. In order to avoid a long chronology, a summary of Peter's childhood, critical events in his adulthood and themes are provided along with analysis and learning points. Learning points are noted after each sub-section as are action points. Learning points are different to action points and not every learning point necessarily leads to action. Action Points specific to GSAB are listed as recommendations within Section 4.

As with the Learning Event, Peter's strengths are focussed upon first in order to create a more holistic picture of him as a man.

3.1 Peter's strengths

What became apparent to the Reviewer at an early stage in the SAR process was that 'on paper' a holistic sense of who Peter was as a person was almost non-existent. There were conflicting accounts of him with some agencies focussing on the challenges of working with Peter and others highlighting a very different man to that of the one who existed within a long list of negatively perceived labels and incidents.

During the course of the SAR, it emerged that positives and strengths in Peter's life included an early marriage that produced two children and a later long term relationship of over twenty years. Furthermore, Peter had been able to develop and maintain some constructive relationships with several professionals who appear to have known him at a deeper level. From these professionals a very different picture of Peter emerges, one who was intelligent and articulate, who enjoyed reading and discussing what he had read. Peter had loved photography in the past. Family and relationships were important and Peter would often talk of his mother and his partner. Peter was described as having a dry sense of humour and being a very politically aware and engaged man. He was not afraid to voice and debate his views on the injustices in society at all levels - ones he noticed and experienced. Peter was also depicted as a gentle giant, a very kind man who was trusting of others and generous, wanting to take people under his wing, but that his kindness and generosity at times were taken advantage of.

Learning Point

Despite the myriad of challenges Peter experienced throughout his life, there were also many positives and strengths that could have been uncovered, acknowledged and then worked with and built upon in a more holistic way by some of the agencies he came into contact with.

When working with individuals with complex needs, agencies need to share information, including the positives and strengths of the person, to ensure a holistic picture is formed. Good strengths based practice also needs to be reinforced (All agencies).

3.2 Childhood and Trauma and Loss in Adulthood

Peter was born in 1960, living with his mother, father, and sister in Cheltenham until the family moved to America when he was eleven, returning when Peter was fifteen. The reason for both moves is unknown. Peter's father was a veteran, he had Diabetes and he died in 1994. Peter's mother is thought to be living in a dementia care home although he had no contact with her or his sister for several years before his death.

Peter described experiencing physical abuse as a child (saying his father used a belt to discipline him) as well as witnessing domestic abuse between his parents.

Recent figures demonstrate that approximately one in five adults experienced at least one form of child abuse before the age of sixteen.[7] Around sixty-two percent of children living with domestic abuse are directly harmed by the perpetrator, in addition to the harm caused by witnessing the abuse of others.[8] The detrimental social, emotional and cognitive impact on children of living in this type of environment is well documented as is the association between that environment and behavioural difficulties, challenges adjusting at school and internalisation of the situation (self-blame, guilt etc.).[9] Moving to and from America at a time when peer relationships are paramount in a young person's life[10] could have added critical early experiences of loss and disruption to what appears an already traumatic childhood for Peter.

Peter completed one year at college, however, there is no data on when he left home. Peter spoke of working for Government Communications Headquarters in Cheltenham (GCHQ) early in his working life. Why and when this ended is unknown. Peter relayed to professionals that his wife committed suicide and he had lost contact with his children. His later long-term partner died of a drug overdose in 2011. After her death Peter reported finding coping with life very difficult. One worker described him as retreating into his shell at that point and others believe Peter's drinking increased. Peter described losing a number of friends to drug related deaths.

The more Adverse Childhood Experiences (ACEs) encountered, the more likely and increased risks in adulthood of mental and physical health issues, drug and alcohol dependencies, negative contact with the criminal justice system[11] and concerns around self-neglect and hoarding.[12] All of these issues featured to some degree in Peter's adult life and whilst causation cannot be assumed, correlation seems apparent. Recognition of this is in no way meant to minimise, justify or

[7] Office for National Statistics (2020). *Child Abuse Extent and Nature England and Wales: year ending March 2019*. Available online:https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/childabuseextentandnatureenglandandwales/yearendingmarch2019 [accessed 29/3/21]

[8] Safelives (2021). *Who are the Victims of Domestic Abuse.* Available online: https://safelives.org.uk/policy-evidence/about-domestic-abuse/who-are-victims-domestic-abuse [accessed 26/3/21]

[9] Caada (2014), In Plain Sight: Effective help for children exposed to domestic abuse. Bristol: Caada.

[10] Green, L. (2010) *Understanding the Life Course: Sociological and Psychological Perspectives. Polity Press. Cambridge.*

[11]Department of Health (2015). *The impact of adverse experience in the home on the health of children and young people, and inequalities in prevalence and effects*. Available online: http://www.instituteofhealthequity.org/resources-reports/the-impact-of-adverse-experiences-in-the-home-on-children-and-young-people/impact-of-adverse-experiences-in-the-home.pdf [accessed 29/3/21]

[12] Preston-Shoot, M. (2020) *Manchester Safeguarding Partnership Homelessness Thematic Review.* Manchester Safeguarding Partnership

blame others for Peter's anti-social behaviour and criminal acts. Understanding of history and context is nevertheless crucial in helping to address root cause rather than simply reacting to presenting behaviour for adults like Peter.

GCC already has an 'Action on ACEs' resource with many agencies currently using trauma-informed approaches. Trauma informed relationship based practice builds on ACE awareness to consideration of adult trauma for a more holistic approach.

Learning points

Trauma-informed practice needs to be embedded across all agencies in Gloucestershire. Sharing tools and examples of good practice between and across agencies around this topic would help partnership working and transfer of theory to practice particularly with complex cases.

GSAB should assure itself that partner agencies operate in a trauma-informed way and have policies in place that support this and that these are transferred to front-line practice.

3.3 Mental Capacity

Peter was regularly assaulted over a period of several years including violently to his head which led to some health professionals querying frontal lobe dysfunction (i.e. an Acquired Brain Injury) in 2012. Peter's prolonged use of alcohol made some consider Korsakoff's.[13] Whilst others outside of health are clear they believe Peter had full mental capacity in every area of decision making except when intoxicated or using drugs. Acquired Brain Injury and Korsakoff's were never formally assessed, neither were any formal mental capacity assessments undertaken with Peter.

Executive dysfunction from Acquired Brain Injury can be easily missed[14] but can encompass a range of cognitive, emotional and behavioural difficulties with profound effects on daily life including around motivation,[15] issues not dissimilar to that which Peter was displaying.

Presumption of capacity for people with possible Acquired Brain Injury and over-reliance on verbal assessment can lead professionals to record a person as capacitated around a decision when in fact they would have difficulty executing that decision. A professionally curious approach is needed. BASW and the Brain Injury Social Work Group have produced guidance to help with this along with a specific tool[16] for use with possibly Brain Injured people including those who are

[13] Korsakoff syndrome is a memory disorder that is commonly associated with alcoholism.
[14] See: AT 2016, GCC. Tom 2016, SCC. 'Hannah' 2017, GCC. 'John' 2018, B&NES
[15] Headway (2021). *Executive Dysfunction After Brain Injury*. Available online: https://www.headway.org.uk/about-brain-injury/individuals/effects-of-brain-injury/executive-dysfunction/ [accessed 20/11/20]
[16] BASW and BISWG (2020) Understanding *People Affected by Brain Injury: Practice Guidance for Social Workers and Social Care Teams.* BASW and BISWG.

homeless.[17] These would have been useful to consider when working with Peter along with more reflection on the need for a mental capacity assessment around specific risky decisions. Undertaking a capacity assessment to 'prove' someone has capacity when they are engaged in very high risk behaviours can help with robust recording of rationale as to why a professional may then have no power to intervene and/or their consideration of going to a higher power for judgement (e.g. Inherent Jurisdiction).[18]

We will never know if Peter's executive functioning was affected by known experiences of head injury, alcohol misuse, or indeed from coercion and control from acquaintances. Furthermore, issues with executive functioning do not necessarily mean that statutory services can intervene against a person's will; there is a balance to be had between the duty to protect and the Human Rights of the individual. However, research is clear that complex individuals are often excluded from formal assessments of mental capacity, S.9 assessment (care and support needs) and formal referral to statutory Safeguarding Teams.[19] These were all omissions with regard to Peter.

Legal literacy (the skill to link legal rules with professional practice) is therefore crucial when working with high risk individuals like Peter as is oversight and management of practice via robust and reflective supervision. This can help foster a more professionally curious approach and avoid an over-reliance on relationship in complex cases where the person is challenging, often difficult to engage with and where there are differences of professional opinion regarding possible Acquired Brain Injury and other complexities. Professional curiosity that pushes beyond 'tell me' (for example to 'show me') can help avoid a surface level assessment when complexity demands a deeper approach.

Learning Points

Where there is a possibility or a suspicion that an individual may have an Acquired Brain Injury which is masked by the person's alcohol or drug use (diagnostic overshadowing) professional curiosity needs to be demonstrated and further exploration advocated.

Agencies and professionals would benefit from further learning around Acquired Brain Injury and registering to be able to use the Brain Injury Needs Indicator (BINI) tool. (Workforce Development sub group)

Regular capacity assessments in high risk situations are recommended, rather than assuming capacity. Capacity assessment should move beyond purely verbal assessment. (MCA Governance Manager)

[17] BISWG. (2017) *Brain Injury and Homelessness.* Available online: Brain Injury and Homelessness | biswg1 [accessed20/11/20]
[18] Inherent Jurisdiction entitles the High Court to make a decision where there is no existing law available (i.e. the MCA or MHA are not pertinent).
[19] Preston-Shoot, M. (2020) *Manchester Safeguarding Partnership: Homelessness Thematic Review.* Manchester Safeguarding Partnership.

3.4 Mental health and drug/alcohol use

Mental health became an issue for Peter early into adulthood, his first diagnosis of depression came at twenty-one years old. Over the ensuing decades Peter's engagement with statutory mental health services saw him receive various medication and psychiatric labels including 'personality disorder', 'paranoid schizophrenic', 'anti-social behaviour disorder', and 'suicide risk'. Previous labels were rescinded in 2009 and his diagnosis was changed permanently to 'paranoid personality disorder'.

The impact of psychiatric labelling on Peter is difficult to explore in retrospect. Labels can have a positive impact on access to services as well as being stigmatising within and outside of mental health services.[20] Certainly, professionals who worked with Peter have said he hated, disagreed with and found stigmatising the mental health labels attributed to him, whilst at the same time utilising them when needing to access help and services.

A year after his first diagnosis of depression medical records also describe Peter as a 'problem drinker'. Comorbidity then became an entrenched feature of Peter's life progressing to include intravenous (IV) drug misuse (Heroin and later Pregabalin[21] and Fentanyl[22]). Peter's history of IV drug use was clearly noted on medical and drug agency records along with detail of track marks. However this was not the 'story' he told to mental health, housing or homeless services denying he had ever been or currently was an IV drug user. There were a couple of occasions when he reported to police he had been administered IV Heroin against his wishes by acquaintances, however he never took the accusations further. Consequently, it is difficult to establish with any certainty if Peter's IV drug use was self-administered or not. New track marks were noticed on Peter in the last months of his life coinciding with him spending time with two street living people from out of county.

There was an over-acceptance of Peter's assertion that he was not using drugs and not currently an IV drug user (relational literacy). Also possible omissions around seeking out related medical information which may have contested his view and could have contributed to professionals missing opportunities to undertake and reinforce vital harm reduction work including around his Hepatitis C status. Relationship based and person-centred practice are vital tools in practice, however they should not rule out professional curiosity, critical analysis and use of other more probing models of work such as Motivational Interviewing.

Despite attempts to engage Peter in rehabilitation work over the years and instruction to engage via the criminal justice system a few years before he died, Peter presented as ambivalent regarding stopping his substance misuse.

[20] University Of Bath. (2018) *Mental Health 'labels' can do more harm than good.* Available online: https://www.bath.ac.uk/announcements/mental-health-labels-can-do-more-harm-than-good/ [accessed 7/1/21]

[21] Pregabalin is used to treat epilepsy, anxiety and severe pain, only available on prescription it is also used as a recreational drug.

[22] Fentanyl is strong opioid painkiller only available on prescription, it is also used as a recreational drug often mixed with heroin or cocaine

Ambivalence is a characteristic of the pre-contemplation stage of the 'cycle of change'.[23] While Peter appears to have been 'stuck' at this stage, unable or unwilling to engage in help that was offered, he was still engaged with the assertive outreach team regarding his mental health. Although Peter's Care Coordinator changed, the MH SW he had known for over a decade was still actively involved with him so there was continuity of care. He was reviewed under the Care Programme Approach (CPA)[24] and his care package included assertive outreach spaced throughout the week at homeless drop-in services when he was also given limited medication for mental health and arthritis. Peter's last risk assessment was undertaken less than a month before he died and noted; risk to self, risk to others, risk from others as well as his mental health issues, alcohol/substance misuse and incidents involving the police.

Around 40% of the population in England who have mental health issues have overlapping issues including homelessness**,** substance misuse and contact with the criminal justice system.[25] Risk becomes normalised for this group meaning professional curiosity is subdued and this in turn can inhibit the initiation of or referral for S.42 enquiries.[26] At no point in the last year of Peter's life did mental health services refer Peter to GCC Safeguarding Adults Team despite him appearing to fit the criteria for a S.42 enquiry[27].

The SAR Learning Events revealed that professionals and agencies that came into contact with Peter were not aware of GSAB's High Risk Behaviour Policy. The High Risk Behaviour Policy is a multi-agency policy and procedures for working with complex, hard to reach, high risk adults such as Peter when all other processes (e.g. S.42 enquiry) have been exhausted. The High Risk Behaviour Policy was published in March 2019, in response to previous SARs undertaken via GSAB and Peter fitted the criteria.

Learning Points.

Supervision policies should ensure that supervision for all staff within all systems includes reference to Safeguarding Adults and high risk behaviours (including self-neglect); space to critically reflect on cases and learning; support for and checks regarding learning transfer; and monitoring need for, and uptake of, Continuing Professional Development.

Awareness raising of the High Risk Behaviour Policy is needed across all agencies. A review of the High Risk Behaviour Policy is also needed including discussions around its suitability for use to support complex cases. If the High Risk Behaviour Policy is not intended for this purpose, supplementary guidance needs to be developed regarding complex adults who fall between services, eligibility, safeguarding and High Risk Behaviour Policy criteria.

[23] Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: Applications to the addictive behaviors. American Psychologist, 47, 1102-1114. PMID: 1329589

[24] The Care Programme Approach is a framework used in specialist mental health services to assess needs and plan, implement and evaluate care.

[25] Bramley et al. (2015) *Hard Edges: Mapping severe and multiple disadvantage.* Lankelly Chase Foundation.

[26] Martineau, S. and Manthrope, J. (2020). Safeguarding Adults Reviews and Homelessness: Making Connections. In Journal of Adult Protection. May 2020

[27] I.e.: (a)has needs for care and support (whether or not the authority is meeting any of those needs), (b)is experiencing, or is at risk of, abuse or neglect, and (c)as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

3.5 Money management

Peter would often spend all of his money on binge drinking, leaving him without money for essential food, clothes or further alcohol until his next benefit due date. An Appointeeship[28] was arranged with Peter's consent in February 2017 to help him with money management. No formal assessments of capacity are recorded around finances.

Peter was subsequently provided with a pre-payment card, loaded regularly with small amounts of his funds for his personal use. All other needs (e.g. rent, bills etc.) were paid direct by the Trust so Peter was never able to access large amounts of money. This meant that Peter drank regularly rather than bingeing. There seems to have been no formal arrangement to review this method of controlling Peter's alcohol intake with a drug/alcohol specialist.

Peter did not directly engage with the Trust, his MH SW was the point of contact. Peter often reported his card was lost or stolen, along with clothes and property or that clothes and property needed replacing as they were unusable (for example due to his continence issues). As a consequence, the Trust were frequently arranging for clothes or food vouchers for Peter or loading additional money onto his card (e.g. for cleaning property). They appear to have been operating above their commissioned service level in response to the chaos that typified Peter's life, having almost daily contact from professionals at points within the last year of Peter's life with additional money last requested just days before Peter's death.

Learning point.

Regular, planned reviews of how someone's money is being managed needs to be owned by the agency who instigates an Appointeeship, be multi-agency and incorporate reference as to the primary reason and need for Appointeeship. (Agencies involved in Appointeeship)

3.6 Housing and Homelessness

Peter first became known to homeless support services in 2014 as he was facing eviction from his Cheltenham Borough home property due to anti-social behaviour. There was also mention of self-neglect and hoarding at this point. An independent tenancy was acquired, with Peter moving up to high support accommodation when he was unable to manage this and his needs increased including at one point to a twenty-four hour staff presence service.

Peter was mixing with street drinkers, causing nuisance to neighbours, often intoxicated and frequently incontinent of urine – a pattern that persisted over these further tenancies as did eviction due to anti-social behaviour. By 2018 Peter was rough sleeping and referred to Intensive Housing Management via Pivotal a service for people with vulnerabilities who cannot cope in mainstream accommodation.

[28] An Appointee can act on someone's behalf who is in receipt of benefits, this can be a friend, relative or an organisation. In Peter's case this was the Penderels Trust.

Peter's homeless support worker continued to work with him through all re-housings and he continued to attend informal drop-in services for homeless people. Peter's alcohol and drug misuse was escalating as was his anti-social behaviour. Solace attended Peter's last address in August 2019 due to these issues plus aggression and violent behaviour towards staff. Peter then made threats to Solace staff. He was issued with his notice on 15 August 2019 and was not allowed back from the next day. All involved professionals were notified.

A combination of temporary B&B accommodation, then sofa surfing and rough sleeping followed whilst Peter's homelessness application was investigated. Peter was successfully managed into being assessed and accepted for accommodation via Safe Spaces on 24th October 2019. However, all beds were full so he was to be contacted as soon as a bed became available. In the interim, no B&B's or any other short-term accommodation was available or accessible due to Peter's past anti-social behaviour including risk to others.

On the 4th November a bed became available from that evening. However, Peter had died before he was able to be made aware of this. Peter's homeless support worker was called upon to identify his body on the street where he died and she scattered his ashes as there was no family who could or would.

Since first becoming homeless, additional support was provided to Peter both within housing services and via P3 to try to help him sustain tenancies and meet his complex mental health and substance misuse issues. However, Peter clearly had difficulties. An escalating cycle of tenancy break down, homelessness, re-housing, eviction and homelessness ensued. Peter's drinking worsened, his drug misuse continued, his self-care needs increased (e.g. around continence) and his ability to maintain a home environment decreased. This downward spiral included entrenched ambivalence towards services that could help him address root causes.

It is hard for accommodation (even high support housing) to 'hold' complex individuals like Peter without putting others at risk. Whilst an understanding of Peter's complexity and trauma based history is important, agencies have a duty of care to the safety of staff and residents. There was no other recourse for Peter at the time. He sat outside of Mental Health Act detainment, residential rehabilitation for drug/alcohol dependencies requires motivation to change and housing services had been exhausted due to Peter's anti-social behaviour.

Recent Government statistics show that street homelessness has nearly halved since Peter died, due to numerous government directives (local and national) like the 'Everyone In' scheme and the 'Protect Programme' that have been implemented as a direct response to Covid-19.[29] If these had been in place at the time of Peter's need, outcomes may have been different for him. However, caution is needed here, and as such schemes come to an end note must be taken of figures showing that, in fact, homelessness has been rising since 2010.[30]

[29] Shelter (2020). *Covid-19: Homelessness.* Available online: https://england.shelter.org.uk/legal/housing_options/covid-19_emergency_measures/homelessness [accessed 4/1/21]
[30] Office for National Statistics (2020) Deaths of Homeless People in England and Wales 2019 Registrations. Available online:

The issues that faced Peter, and that facilitated his life trajectory, were more complex than simply needing a bed. Access to care and support and recognition of safeguarding issues are vital.[31] Consequently, despite street homelessness being less visible since Covid-19, and positive change increasing in part due to the pandemic, the lessons identified in this SAR regarding Peter are still pertinent and resonate across all sectors of GCC.

Learning points

Compassionate persistence is needed when working with complex individuals. And multi-agency perseverance is needed if a situation is high risk and an individual is not engaging.

A scoping exercise to establish how GSAB work to support agencies holding complex cases such as homelessness, mental health issues (particularly personality disorders) and drug and alcohol issues and that fall between criteria is needed.

A scoping exercise around specialist supported housing in Gloucestershire is needed in order to establish if there is a gap in service regarding highly complex, risky individuals.

3.7 Contact with police

Peter first became known to police services aged twenty-three. Over the years records note Peter as offender regarding shoplifting, threatening behaviour, possession of offensive weapons, assaulting a constable, assaults, criminal damage, anti-social behaviour and being drunk and disorderly.

Records note Peter as a victim regarding burglary, theft, assault, robbery and administering of a poison (Peter had reported offenders had entered his room and injected a liquid into his hand). Additionally, police attended Peter due to 'incidents' around his behaviour such as intoxication, fighting, disturbances, aggression and threatening behaviour to staff within various accommodation settings.

Police note that all of the above were as a result of misuse of alcohol and/or drugs. Also that despite them taking Peter's experience of crime seriously, and on occasion investigating, he declined support to prosecute or to provide further details and appeared to continue to be friends or associated with the people he had identified as suspects.
There was no recorded criminal activity between October 2018 and February 2019. This coincides with Peter being housed and regularly accessing support. Peter's behaviour then deteriorated and he became aggressive (verbally, sexually

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2019registrations#deaths-by-region [accessed 4/1/21]

[31] Association of Directors of Adult Social Services (27/2/20) (2020) "*ADASS responds to rough sleeping snapshot in England, Autumn 2019*" Available online: https://www.adass.org.uk/adass-responds-to-rough-sleeping-snapshot-in-england-autumn-2019 [accessed 20/11/20]

and physically). Peter was in denial that he was a drug user and at this time disassociated from other ACTion Glos clients. The shift to escalation coincides with housing issues and homelessness and reports of Peter associating with more risky street sleeping people from out of area.

The last police contact for Peter was on 3rd November 2019 when he was picked up on the street after an alert that he was waving a syringe and displaying erratic and paranoid behaviour. Peter was tasered and taken under Section 136 of the Mental Health Act (MHA)[32] to A&E and then transferred to the designated venue within the hospital for a mental health act assessment.

The Vulnerability Identification Screening Tool (VIST) is used by police services to capture vulnerability, and from there for discussion within a Multi-Agency Safeguarding Hub (MASH). At no point over the decades of police knowing Peter was a VIST raised for him despite him having warnings on their systems around mental and physical health concerns, self-harm, regular victim of crime and known to be in either high support accommodation or as street homeless. Consequently, Peter was never considered at the MASH which is how the police trigger a Safeguarding Adult referral.

The need for use of and development of a new vulnerability approach was highlighted within another GCC SAR published in January 2019,[33] just ten months before Peter died. Thus issues with VIST appear to have been an ongoing issue.

Work has already been undertaken with police staff within the MASH around understanding of Safeguarding Adults criteria and a rollout to officers on the ground is being undertaken.

Peter seeming to remain friends with suspects he accused of harming him and not taking accusations further is not unusual and can be due to coercion and grooming as has been learnt from work around child sexual and criminal exploitation.[34]

Learning points

Any refinement to the VIST needs to take into account that an adult suspect or perpetrator can also be a victim and vulnerable and thus guard against unconscious bias around criminal labelling. (Police)

Police services developing an adult focussed service mirroring their 'Criminal Child Exploitation Team' would demonstrate transfer of learning and commitment to providing parity for adults who are vulnerable. (Police)

[32] S.136 of the MHA gives police the power to remove (someone from a public space) where they appear to be mentally disordered to a place of safety or keep you in a place of safety so that a mental health assessment can be undertaken by the relevant professional.

[33] Spreadbury, K. (2019). *Learning from the circumstances of the life changing injury to Z.* Gloucestershire Safeguarding Adults Board.

[34] National Crime Agency (2021) *Child Sexual abuse and Exploitation*. Available online: Child sexual abuse and exploitation - National Crime Agency [accessed 6/4/21]

3.8 Health and Hospital

Peter was not registered with a GP from March 2019 and refused to register in October 2019. However, he was a regular user of emergency services, making seven 999 calls within the last year of his life and attending A&E sixteen times. There were seven contacts with ambulance services in the last year of Peter's life. Whilst the last four recorded factors of vulnerability these were not acted on through completion of a Safeguarding Adult referral.

Out of the sixteen attendances Peter was admitted six times, five of which were for less than twenty-four hours, one (in April 2019) was for four days. However Peter did not meet the quota for the Trust's 'frequent attender' criteria because his admissions were spread out and not within the cluster system being used at the time which required nine admissions within a three month period.

The numerous related notes evidence that in the last year of his life Peter was injecting again. Peter's health also declined in this period, he had a complex list of health conditions that he neglected. Peter experienced seizures for which he was prescribed medication, he had leg ulcers that needed attention, cellulitis, arthritis (for which he took medication), varicose veins and infected IV sites at times. Peter also took medication for his mental health. Alcohol related bladder dysfunction had worsened for Peter. Furthermore there is the Acquired Brain Injury query from health professionals in 2012. In short, Peter was a vulnerable man with complex psychological and physical health needs who clearly presented as self-neglecting to a high degree alongside the self-harm via drugs and alcohol.

Peter's penultimate attendance was on 2nd November after an overdose of Pregabalin with alcohol. The following day was Peter's last attendance. Both were facilitated by ambulance services. On the 3rd November 2019 Peter was first admitted to A&E to be checked as he had been tasered and had been attempting to inject Pregabalin into his hand (this was not medication prescribed to Peter and is not in a preparatory ready for IV use). Peter was established as medically fit and discharged to the mental health unit within the hospital in order for a Mental Health Act assessment. Peter was deemed as not requiring detainment and was discharged to the street.

In 2018 a SAR was commissioned by GSAB for Danny.[35] Although there are differences between Danny and Peter, there are similarities around mental capacity, 'executive' functioning and hospital discharge. Danny's SAR recommended a joined up system to record keeping and information sharing and that the Multi-Agency Hospital Discharge Policy be reviewed in particular around essential information requirements, arrangements for monitoring, expectations on communication and timeliness.[36] Some of these recommendations were transferred to practice.

However, there is no record of communication with, or referral to, the Emergency Duty Team (EDT) regarding Peter even though staff knew Peter to be homeless, vulnerable, it was a Sunday and there was a clear pattern of escalation of

[35] See: 'Danny' 2018, GCC.
[36] Ibid.

behaviour and risk. An Approved Mental Health Professional (AMHP) could have been called upon to use a specific budget for one night in a Travelodge in these circumstances. However, discharge to the streets was normal procedure for GHT at the time and in line with their Multi-Agency Hospital Discharge Policy and, indeed, had been experienced by Peter the previous night from A&E.

In 2021 the Trust revised the 'frequent attender' criteria to eight admissions within three months. Peter would still not have reached this threshold despite his obvious and escalating vulnerabilities. However, the Multi-Agency Hospital Discharge Policy has also now been updated. Consequently if Peter presented today as he did in 2019, he would not now be discharged to the street. He would now be assigned to the Homeless Specialist Nurse who has since been appointed where there is a focus away from frequency of admissions and onto the individual circumstances of the person.

Learning points

Acute Trust to consider whether there is a place for professional judgement alongside quotas within the 'frequent attender' criteria as there is within other risk assessment systems such as MARAC.[37]

Ambulance and hospital staff (in particular A&E and mental health) need to actively utilise the EDT as a resource for out of hour's concerns particularly with regard to acutely vulnerable people. (Acute Trust and SWAST)

3.9 Frontline staff

Leads reported feeling supported nationally around complex cases. However, at that time frontline staff were often holding high and complex caseloads involving individuals like Peter who had experienced trauma and whose behaviour was challenging. In these situations, there is a risk of Vicarious Trauma or 'burnout' and proactive engagement becomes more unlikely, with the default being a reactive, firefighting style of practice. Workers who are exposed to clients' trauma can themselves display signs such as depression, intrusive thoughts, anxiety, hopelessness, cynicism, increased anger and agitation, hyperarousal and hypervigilance, lack of empathy and disconnection from their work and clients.[38]

Caseloads in the homeless sector within GCC have been reduced in the last year due to Covid-19. However, high turnover of staff in all 'helping' professions is testimony to how working with complex, challenging adults can impact on frontline staff.

There is little point in top tiers (Leads) feeling supported if this is not mirrored for frontline staff. In order to thrive and not just survive, in order to avoid a culture of

[37] MARAC: Multi-Agency Risk Assessment Conference requires 14 ticks on a DASH. However, referral can also be made based on professional judgement e.g. around increased vulnerability, escalation. FFi see MARAC-protocol-Final-2018.pdf (glostakeastand.com) .

[38] British Medical Association. (2020) *Vicarious Trauma: Signs and Strategies for Coping.* Available online: Vicarious trauma: signs and strategies for coping (bma.org.uk) [accessed 6/4/21]

cynicism and normalisation of burnout, there is a need for front-line practitioners to be given access to opportunities to process feelings, reflect on cases, critically analyse information, and gain clarity around reasoning and conclusions, particularly in relation to mental capacity, mental health, and high risk and safeguarding situations.

Learning Points

Protected time around Continuing Professional Development and reflective supervision needs to be created and maintained within and across all systems and agencies.

Supervision learning point previously detailed in 3.4.

3.10 Multi-Agency Communications

Multi-agency communication on the ground appears to have been good (e.g. between frontline agencies working with Peter). Multi-agency meetings regarding high risk adults regularly discussed Peter. However crucial information held by health on IV drug use and their concerns around Acquired Brain Injury was not accessed by these agencies or shared with them.

Limited data sharing and use of different systems appear to have created barriers and made it hard for frontline practitioners to know when there had been contact with other services and what form that took, affecting practice with Peter. *Policy in Practice*, working with partners across the West Midlands, has developed the Multi-Agency Safeguarding Tracker[39] platform to tackle the issue of limited data sharing. The Multi-Agency Safeguarding Tracker will give multi-agency safeguarding (MASH) teams, social workers and frontline safeguarding teams information to improve communication, liaison and decision making

Learning points

Any multi-agency meetings need to record and monitor actions and outcomes within a multi-agency Care Plan (including referral via the High Risk Behaviour Policy and referral to GCC Safeguarding Adults Team). A Lead Professional should be identified to coordinate such meetings. Partners to be made aware they can challenge outcomes, engagement from agencies and utilise the Escalation Policy if appropriate.

The Multi-Agency Safeguarding Tracker (MAST) appears to fit with ideas already being mooted within GSAB. Use of the Multi-Agency Safeguarding Tracker should be considered. (Policy & Procedures sub group)

[39] FFI: MAST and/or access WEBINAR Boost safeguarding through multi-agency data sharing - Policy in Practice

3.11 Working with complex individuals who appear not to want to engage

The term Multiple Exclusion Homeless (MEH) refers to people who experience extreme marginalisation that includes ACEs, physical and mental health issues, substance misuse and homelessness. People who are Multiple Exclusion Homeless are often excluded not just from formal mental capacity assessment but also from referral for and/or undertaking of S.9 assessments regarding care and support needs, formal referral to Safeguarding Adults services[40] and hospital discharge.[41] People who are described as Multiple Exclusion Homeless often fall through the gaps between service criteria and thresholds. And yet, the 'tri-morbidity' combinations typifying Multiple Exclusion Homeless are associated with premature mortality.[42] The importance of 'no wrong door' and 'wrap around' health, mental health and social care support is emphasised.[43] However there is also a tension between these people refusing services, and being unwilling or unable to engage and the duty to promote wellbeing.[44]

Making Every Adult Matter (MEAM) [45] is a coalition of national charities that work together to support local areas to develop effective, coordinated services for those adults within its area facing multiple disadvantages including where individuals do not appear to want to engage. Research is a key element of this in terms of what does and does not work when complex needs and high risk are present. The Making Every Adult Matter approach is currently being used by partnerships of statutory and voluntary agencies in 31 local areas across England. At the moment GCC is not one of those and although the High Risk Behaviour Policy and other initiatives are in line with the ethos of Making Every Adult Matter, GCC could be benefited and supported more formally from this initiative.

Learning points

In order to avoid further stigmatisation and marginalisation of Multiple Exclusion Homeless individuals like Peter, systems need to be adaptable and flexible and staff need to be creative, be professionally curious and robust enough to question criteria, be empowered to use their professional judgement and know the law. (All agencies).

The Making Every Adult Matter (MEAM) approach could be usefully researched as a tool for agencies. (GSAB)

[40] Preston-Shoot, M. (2020) Manchester Safeguarding Partnership Homelessness Thematic Review. Manchester Safeguarding Partnership
[41] Martineau, S. and Manthrope, J. (2020) *Safeguarding Adults Reviews and Homelessness: Making Connections*. In Journal of Adult Protection. May 2020.
[42] See 44 above
[43] Preston-Shoot, M. (2020) *Adult Safeguarding and Homelessness: A Briefing on Positive Practice.* ADASS
[44] See 45 above
[45] Making Every Adult Matter (2021) *Working Together to Tackle Multiple Disadvantage.* Available online: Home - MEAM Approach [accessed 8/12/20]

3.12 Safeguarding and Risk

Peter had a multitude of physical and mental health issues, he was regularly assaulted (physical abuse), he was self-neglecting to a high level and his ability to protect himself was questionable due to a possible Acquired Brain Injury, unstable mental health and entrenched drug/alcohol dependencies. In short Peter appears to have met the criteria for a safeguarding response and consequently there was a legal responsibility for all partnership agencies who knew Peter to have made a referral to GCC Safeguarding Adults Team.

In total, four legitimate Safeguarding Adults referrals were made for Peter over his life course. The first three on 30/11/2009, 14/8/12, 24/3/16, and 27/6/18 did not result in an enquiry. The last in June 2018 resulted in a non-statutory enquiry[46] whereby GCC Safeguarding Adults Team sent a list of recommendations and related actions to the statutory mental health service and P3. There is no record of these being actioned, of any outcomes or of Peter's knowledge of this enquiry. The case was then closed by the GCC Safeguarding Adults Team stating appropriate agencies were supporting Peter and he was able to protect himself by accessing support when needed.

In the month before he died, a comprehensive risk assessment was undertaken with Peter. In his last year there were numerous multi-agency meetings about risky individuals where Peter was discussed. A plethora of agencies were involved with Peter. Despite all of this, no formal Safeguarding Adults referrals were made for Peter in the year leading up to his death.

During that year, GCC was running a Safeguarding Adults Advice Line for professionals. Agencies could have utilised this service to discuss Peter, although formal referrals would still have been required. The fact that one agency thought they could and had made three telephone Safeguarding Adults referrals and a different professional asked at a Learning Event how to make a formal referral indicates that within some systems there was, and still is, confusion around how to make a formal Safeguarding Adults referral. This is further evidenced by the hospital staff contacting the wrong team for advice, and then being given advice that was not accurate.

Furthermore, the never completed recommendations and actions for the non-statutory enquiry in 2018 indicates a lack of understanding of roles and responsibilities. As does the lack of follow-up by the agency that tried to make telephone referrals as they were unaware these hadn't been logged or taken forward.

When questioned by the Reviewer about the omission of a Safeguarding Adults referral for Peter one professional's repeated response was 'for what purpose'? Other approaches seem to have been used as an alternative (i.e. Care Programme Approach CPA). A culture may have developed within some agencies that Safeguarding Adults would add nothing to the situation for Peter or any Safeguarding Adults referrals would be rejected by the GCC Safeguarding Adults Team.

[46] A non-statutory enquiry is where the person does not meet all of the elements of the criteria for a S.42 enquiry as outlined in the Care Act. However the LA feels there is sufficient risk for an enquiry to be instigated.

Since the time in focus, systems have changed within GCC, the Safeguarding Adults Advice Line has been withdrawn to remove any confusion and all referrals are now required to be made online using a bespoke form. However, GHC has set up their own Safeguarding Adults Advice Line. Whilst agencies do need to all take responsibility for Safeguarding Adults and appoint Leads, and having an agency advice line could be useful within big organisations, this could potentially add confusion if it is not made absolutely clear where roles and responsibilities differ.

All agencies must still formally raise a safeguarding concern with GCC where this is indicated, regardless of the systems they set up within their own organisations. Professionals who disagree with advice they are given within their own agencies and/or by GCC Safeguarding Adults Team should utilise the GSAB 'Escalation Policy' to seek resolution.

As established, Peter's entrenched behaviour, complex needs, erratic engagement and difficulties accepting formalised support made him high risk from his own and others behaviour. GSAB produced and published a High Risk Behaviour Policy[47] in March 2019, eight months before Peter's death. However, despite being discussed at several multi-agency meetings about high risk individuals, no proper Safeguarding Adults referral was made and as a consequence the High Risk Behaviour Policy was never able to be considered as an option for Peter.

The S42 enquiry process has the added benefit of the sharing of risk, support and guidance to agencies and professionals. Peter's outcomes might not have been changed by a S42 enquiry or by consideration by the High Risk Behaviour Policy panel. However, professionals could have felt validated, supported and had a shared sense of holding risk.

All of the above points indicate pockets of general lack of legal, organisational and decision making literacy. This is puzzling given GSAB have comprehensive Safeguarding Adults webpages with robust policy and procedural guidance (including in Easy English) regarding responding/reporting, information sharing, Self-Neglect, High Risk Behaviour Policy and Escalation of Professional Concerns Protocol as well as a full Training Programme.[48] There is clearly not an issue around lack of access to information or training. However, in order for information and training to improve the care that service-users like Peter receive there needs to be good knowledge transfer.

Good knowledge transfer requires four essential elements: motivation to learn; information and training geared to what needs to be known and how to put this into practice; a workplace that is ready to support putting new knowledge into practice; and finally a culture that is accepting of new ideas and knowledge.

[47] GCC SAB (2019) *High Risk Behaviour Policy: Multi-Agency Policy and Procedure: March 2019*. Available online: https://www.gloucestershire.gov.uk/media/2089819/gsab-multi-agency-high-risk-behaviour-procedures-march-2019.pdf [accessed 7/1/21]

[48] Gloucestershire Safeguarding Adults Board (2021). *Multi-agency Safeguarding Policy and Procedures*. Available online: https://www.gloucestershire.gov.uk/gsab/i-am-a-professional/multi-agency-safeguarding-policy-and-procedures/multi-agency-safeguarding-policy-and-procedures/ [accessed 6/4/21)

Learning points

Potentially the work of GSAB is not reaching frontline professionals. Knowledge transfer from training, policy, practice guidance, SAR's and so on needs to be monitored and assessed. (All agencies).

Safeguarding Leads across the multiagency partnership must ensure that professionals are not using internal processes as alternatives to Safeguarding Adults referrals or for S.9 assessments.

3.13 Good practice

We learn from acknowledging and sharing good practice as well as from when things could have been done better or differently. Validation of good practice is important. The SAR identified the following areas of good and/or effective practice:

- Peter (if he chose to) could have had access to a specialist drugs/alcohol worker during the time he was part of ACTion Glos. (Part of the service P3 provided until September 2018).
- Police services took seriously Peter's experience as a victim of crime and investigated as far as was possible.
- Peter had consistent key workers, independent of his housing situation (e.g. MH SW, frontline homeless support worker, homeless charity worker). These workers seemed to have good relational literacy.
- The front-line homeless support worker identified Peter's body and also scattered his ashes as there was no-one else available.
- Safeguarding Adults Leads reported feeling supported at a national level.
- There is evidence of multi-agency working and meetings (e.g. between housing, homeless and mental health services, and the police).
- Hospital staff had taken on board some recommendations from earlier reviews such as quoting Peter directly, naming people who accompanied him and seeking names of 'friends' who accompanied him.
- Early in the SAR process, some agencies were able to identify learning and consequently effected changes and/or undertook internal investigations (e.g. the Ambulance Service and the Trust who looked after Peter's money).
- Peter's homeless support worker continued to work with him through all re-housing episodes and Peter continued to attend informal drop in services for homeless people.

4. Recommendations for GSAB

The aim of this SAR was to examine the complex circumstances leading up to Peter's death in order to establish if there was learning that could be extrapolated and utilised.

The SAR found that nobody actively did anything wrong with regard to Peter. However, there were omissions. There were also some blockages and barriers between and within systems and a lack of a whole system approach at times.

Some improvements have already been made - certain improvements were in motion at the time of Peter's death, some have been enacted due to Peter's death, and some have come as a result of Covid-19. However, moving forward it is clear that further improvements and learning transfer are needed across the range of agencies to continue momentum as identified throughout the previous section.

Learning points have been listed at the end of each sub-heading within the previous section and will need to be taken forward by the relevant agencies. Learning points and subsequent recommendations specifically for GSAB have been included below.

4.1 A review of the High Risk Behaviour Policy is needed as a matter of urgency including discussions around it's suitability for use to support complex cases, for example where safeguarding criteria is not met, yet high risk remains for very vulnerable, complex cases.

4.2 If the High Risk Behaviour Policy is not intended for this purpose, supplementary guidance needs to be developed regarding complex adults who fall between services, eligibility, safeguarding and this policy's criteria.

4.3 Once reviewed a clear strategy of dissemination of the High Risk Behaviour Policy (and any other supplementary guidance) to all partnership agencies needs to be implemented and from there to all systems within partnership agencies (i.e. Safeguarding Adults leads, management, frontline staff etc.).

4.4 A clear plan on education around the content and use of the High Risk Behaviour Policy is needed in order to ensure transfer of knowledge.

4.5 GSAB would benefit from signing up to the 'Care in Health and Improvement Programme' (CHIP), a joint initiative by ADASS and LGA which has developed

a framework to help untangle the Safeguarding Adults criteria and provide resources and recommendations as to how to do that.[49]

4.6 Partners to be made aware they can challenge outcomes, engagement from agencies and utilise the Escalation Policy if appropriate.

4.7 Proactive engagement by GSAB with *Policy in Practice* would enable current conversations, ideas and projects to be brought to fruition within GCC around more inclusive multi-agency working and communication.

4.8 The Multi-Agency Safeguarding Tracker (MAST) appears to fit with ideas already being mooted within GSAB. Use of the Multi-Agency Safeguarding Tracker should be considered. (Policy & Procedures sub group)

4.9 GSAB to include guidance and related tools on Brain Injury on their webpages and share this information with all partnership organisations, who then need to share within their systems at all levels.

4.10 GSAB would benefit from becoming more 'Making Every Adult Matter (MEAM)' aware by mapping existing good practice and innovative initiatives within GCC to this approach, accessing the 'Making Every Adult Matter' learning and research and signing up to the roll-out of this approach so they receive national support.

4.11 GSAB should assure itself that partner agencies operate in a trauma-informed way and have policies in place that support this and that this is transferred to front-line practice.

4.12 A scoping exercise to establish how GSAB work to support agencies holding complex cases such as homelessness, mental health issues (particularly personality disorders) and drug and alcohol issues and that fall between criteria is needed.

4.13 A scoping exercise around specialist supported housing in Gloucestershire is needed in order to establish if there is a gap in service regarding highly complex, risky individuals.

[49] See: Understanding what constitutes a safeguarding concern and how to support effective outcomes | Local Government Association and for tools see: https://www.local.gov.uk/understanding-what-constitutes-safeguarding-concern-and-how-support-effective-outcome-appendices

5. Glossary of terms used

ADASS- Association of Directors of Adult Social Services
B&NES – Bath and North East Somerset
CCG- Clinical Commissioning Group
Covid-19 - Coronavirus Disease 2019
GCC – Gloucestershire County Council
GSAB – Gloucestershire Safeguarding Adults Board
Ibid – same source as the one preceding
ISCM – Integrated Social Care Manager
LGA – Local Government Association
MARAC – Multi-Agency Risk Assessment Forum
MH SW – Mental Health Social Worker
SAB – Safeguarding Adults Board
SAR – Safeguarding Adults Review
SCC – Somerset County Council
VIST – Police Vulnerability Indicator Screening Tool

6. References

Association of Directors of Adult Social Services/Local Government Association (2016) "*Adult Safeguarding and Homelessness: A Briefing on Positive Practice*" Available online: https://www.local.gov.uk/sites/default/files/documents/25.158%20Briefing%20on%20Adult%20Safeguarding%20and%20Homelessness_03_1.pdf [accessed on 9/11/2020]

Association of Directors of Adult Social Services (2020) "*ADASS responds to rough sleeping snapshot in England, Autumn 2019*" Available online: https://www.adass.org.uk/adass-responds-to-rough-sleeping-snapshot-in-england-autumn-2019 [accessed 20/11/20]

BASW and BISWG (2020) Understanding *People Affected by Brain Injury: Practice Guidance for Social Workers and Social Care Teams.* BASW and BISWG.

BISWG. (2017) *Brain Injury and Homelessness.* Available online: Brain Injury and Homelessness | biswg1 [accessed20/11/20]

British Medical Association. (2020) *Vicarious Trauma: Signs and Strategies for Coping.* Available online: Vicarious trauma: signs and strategies for coping (bma.org.uk) [accessed 6/4/21]

Bramley, G., Fitzpatrick, S., Edwards, J., Ford, D., Johnsen, S., Sosenko, F., and Watkins, D. (2015) *Hard Edges: Mapping severe and multiple disadvantage.* Lankelly Chase Foundation.

Braye, S. and Michael Preston-Shoot, M. (2018). *Safeguarding Adults Review: 'John'.* Available online: https://www.safeguarding-bathnes.org.uk/adults/local-safeguarding-adults-board/6-safeguarding-adult-reviews Bath and North East Somerset Local Safeguarding Adults Board. [20/11/20]

Caada (2014), In Plain Sight: Effective help for children exposed to domestic abuse. Bristol: Caada.

Clifford, B. (2017). *Safeguarding Adults Review re Hannah.* Available online: http://www.gloucestershire.gov.uk/gsab/safeguarding-adults-board/safeguarding-adults-reviews/ Gloucestershire Safeguarding Adults Board. [accessed 20/11/20]

Department of Health (2015). *The impact of adverse experience in the home on the health of children and young people, and inequalities in prevalence and effects*. Available online: http://www.instituteofhealthequity.org/resources-reports/the-impact-of-adverse-experiences-in-the-home-on-children-and-young-people/impact-of-adverse-experiences-in-the-home.pdf [accessed 29/3/21]

Department of Health & Social Care (2021), *Care and Support Statutory Guidance: Changes in March 2016*. Available online: https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-and-support-statutory-guidance-changes-in-march-2016 [accessed 27/3/21]

Foster, J. (2018). *Safeguarding adults Review Report: Danny.* Available online: Safeguarding Adults Reviews - Safeguarding Adults in Gloucestershire [accessed 20/11/20]

Flynn, M (2016). The death of Tom: A Serious Case Review. https://ssab.safeguardingsomerset.org.uk/wp-content/uploads/Tom-SAR-Final-June-2016.pdf Somerset Safeguarding Adults Board [20/11/20]

Gloucestershire Safeguarding Adults Board (2018) *Safeguarding Adults Review Protocol: Appendix 3*. Available online: https://www.gloucestershire.gov.uk/media/2084350/gsab-safeguarding-adult-review-guidance-nov-18.pdf [accessed 5/11/20]

Gloucester Safeguarding Adults Board (2019) *High Risk Behaviour Policy: Multi-Agency Policy and Procedure: March 2019*. Available online: https://www.gloucestershire.gov.uk/media/2089819/gsab-multi-agency-high-risk-behaviour-procedures-march-2019.pdf [accessed 7/1/21]

Green, L. (2010) *Understanding the Life Course: Sociological and Psychological Perspectives.* Polity Press. Cambridge.

Headway (2021). *Executive Dysfunction After Brain Injury*. Available online: https://www.headway.org.uk/about-brain-injury/individuals/effects-of-brain-injury/executive-dysfunction/ [accessed 20/11/20]

Jasper, S. (2016). Practice and Learning Review into the death of AT. Available online: http://www.gloucestershire.gov.uk/gsab/safeguarding-adults-board/safeguarding-adults-reviews/ Gloucestershire Safeguarding Adults Board. [accessed 20/11/20]

Local Government Association (2021) *Making Safeguarding Personal*. Available online: https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal#:~:text=%20Making%20Safeguarding%20Personal%20%201%20Implementing%20MSP.,in%20the%20context%20of%20Making%20Safeguarding...%20More%20 [accessed 5/11/20]

Making Every Adult Matter (2021) *Working Together to Tackle Multiple Disadvantage.* Available online: Home - MEAM Approach [accessed 8/12/20]

Martineau, S. and Manthrope, J. (2020). *Safeguarding Adults Reviews and Homelessness: Making Connections*. In Journal of Adult Protection. May 2020.

Ministry of Housing, Communities and Local Government (2018) *Rough Sleeping Strategy: August 2018*. Available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733421/Rough-Sleeping-Strategy_WEB.pdf [accessed 14/12/20]

National Crime Agency (2021) *Child Sexual abuse and Exploitation*. Available online: Child sexual abuse and exploitation - National Crime Agency [accessed 6/4/21]

Office for National Statistics (2020) Deaths of Homeless People in England and Wales 2019 Registrations. Available online: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2019registrations#deaths-by-region [accessed 4/1/21]

Office for National Statistics (2020). *Child Abuse Extent and Nature England and Wales: year ending March 2019*. Available online: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/childabuseextentandnatureenglandandwales/yearendingmarch2019 [accessed 29/3/21]

Preston-Shoot, M. (2020) *Adult Safeguarding and Homelessness: A Briefing on Positive Practice.* ADASS

Preston-Shoot, M. (2020) Manchester Safeguarding Partnership Homelessness Thematic Review. Manchester Safeguarding Partnership

Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: Applications to the addictive behaviors. American Psychologist, 47, 1102-1114. PMID: 1329589.

Safelives (2021). *Who are the Victims of Domestic Abuse.* Available online: https://safelives.org.uk/policy-evidence/about-domestic-abuse/who-are-victims-domestic-abuse [accessed 26/3/21]

Shelter (2020). *Covid-19: Homelessness.* Available online: https://england.shelter.org.uk/legal/housing_options/covid-19_emergency_measures/homelessness [accessed 4/1/21]

Spreadbury, K. (2019). *Learning from the circumstances of the life changing injury to Z.* Gloucestershire Safeguarding Adults Board.

Teater, B. (2019) *An Introduction to Applying Social work Theories and Methods.* 3rd Edition. New York. Open University Press.

University Of Bath. (2018) *Mental Health 'labels' can do more harm than good.* Available online: https://www.bath.ac.uk/announcements/mental-health-labels-can-do-more-harm-than-good/ [accessed 7/1/21]

7. Reviewer Biography

Michele Winter has no personal or professional connections with Peter, his family, or with any agency participating in this SAR. She qualified as a Social Worker from the University of Bath in 1999 having worked for many years in the social care sector including within learning disability residential settings. Qualified practice areas include: Drugs and Alcohol, HIV/AIDS, Mental Health, Learning Disabilities, Hospital, and Safeguarding Adults.

Michele has a PGCE as well as various post-qualifying awards. She has combined practice with teaching and training within Local Authorities and Universities. Michele became an Independent Social Worker in 2014 and now mainly provides teaching and training around Safeguarding Adults. Publications include:

Winter, M. (2014) *Domestic Violence and Abuse*. In Teater, B. (Ed) Contemporary Social Work in Practice : A Handbook for Students. Maidenhead: Open University Press/McGraw Hill.

Signed and dated by:
Reviewer: 10th July 2021