Safeguarding Adults Review 'Martin' Overview Report

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Approved by GSAB
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Table of Contents

1. Introduction ... 3
2. Pen Portrait ... 3
Protected Characteristics ... 4
3. Approach to Review ... 5
Purpose of a Safeguarding Adult Review ... 5
Key Lines of Enquiry ... 5
Methodology ... 6
Involvement of Family and Friends ... 7
SAR Process ... 7
Parallel Processes ... 7
4. Research & Best Practice ... 7
5. Analysis and Findings ... 13
KLOE 1: Suicide Prevention ... 13
KLOE 2: Multi-Agency Case Management ... 19
KLOE 3: Approaches to Working with Trauma ... 26
National Context ... 32
6. Changes Since Martin's Death ... 32
7. Conclusion ... 34
8. Recommendations ... 34
References ... 37

1. Introduction

1.1 In April 2025, a Safeguarding Adult Review referral was made by Gloucestershire Constabulary in respect of 'Martin', who died by suicide in December 2024. Martin lived with complex mental health and drug and alcohol dependency needs and was at risk of self-neglect and financial abuse.

1.2 The pseudonym 'Martin' has been selected to protect the identity of the deceased and the privacy of his family.

1.3 The SAR referral was discussed by the Gloucestershire SAR Subgroup, and it was agreed the mandatory criteria under Section 44 Care Act (2014) had been met. Gill Taylor, an Independent Reviewer with twenty years subject matter expertise in homelessness and multiple disadvantage, was commissioned by Gloucestershire Safeguarding Adults Board (GSAB) in June 2025.

1.4 The Reviewer wishes to share her deepest condolences with Martin's family for their loss, and the especially distressing circumstances in which his death occurred.

1.5 The reviewer also wishes to extend gratitude to the frontline practitioners and clinicians who worked with Martin, for sharing their insights sensitively and conscientiously throughout the Review.

2. Pen Portrait

2.1 This review relates to Martin, a 55-year-old white British man who died by suicide in Gloucester in December 2024.

2.2 Martin was a brother, a father and a grandfather. Despite the challenging and complex nature of his life and his behaviour, his daughter tried to maintain a relationship with him and to offer support, until it was unsafe for her to do so. Martin spoke about his family with professionals often and these were clearly important relationships in his life, albeit that they were complex and largely estranged. Agencies felt that the final incident with his daughter that resulted in her withdrawing from the relationship in September 2024 marked a sharp downward turn for Martin, which they feel corresponded with a deep sense of shame.

2.3 Agencies reflected that Martin could be cheerful and pleasant, easy to talk to and with a good sense of humour. However, he could also sometimes be "cruel" towards others, starting arguments and making hurtful comments to "intentionally cause issues". Practitioners who knew Martin reflected that he often told agencies conflicting stories about his life and circumstances, some that were untrue, including about the deaths of loved ones. It's not clear why he did this but in one record of a conversation between Martin and a support worker it's recorded that he reflected "agencies only want to know him when things are bad", which indicates that some of the stories he told, and the conflicts he initiated, may have been his way of seeking help and attention.

2.4 Martin is said to have taken pride in his appearance, even when he was rough sleeping, although some agencies reflected that they had needed to offer support around self-care and personal hygiene at times. Agencies felt that concerns about self-neglect were complicated because his appearance, self-care and self-injurious behaviour were changeable and not

everyone knew about these fluctuations or how to make sense of them. Agencies shared that he was deeply lonely and isolated, and that this may have been the root of some of his distress.

2.5 Martin was illiterate, which was a source of shame for him, but agencies spoke about how he had once engaged with reading classes at a local library and had received positive feedback from the tutor. They reflected that he was really proud of this and that it was a pleasure to see 'the look on his face at how well he was doing". This brief reflection from before the review period offers a glimpse into a very different man to the one described in agency chronologies and reflections in the final two years of his life.

2.6 Martin was a poly drug user and drank alcohol heavily at times, although agencies reflected that his drug and alcohol use was likely much less significant than he indicated, noting that he did not experience withdrawal symptoms when he stopped drinking. They noted the increase in his drug use in the final months of his life, triggered, they felt, by his shame and distress at the breakdown of his relationship with his daughter and grandchild.

2.7 Martin lived with complex emotional and mental health needs. At the time of his death, he was diagnosed with an Emotionally Unstable Personality Disorder (EUPD), having previously been diagnosed with schizophrenia. Martin lived with very high levels of emotional distress and there were frequent incidents of self-harm, suicidal thoughts and attempted suicide during the review period.

2.8 In the years before his death, Martin experienced intermittent street homelessness and was frequently evicted from supported housing placements due to inappropriate and violent behaviours, primarily towards himself but also to others. Martin was the subject of at least 21 police call outs and 9 arrests in the final two years of his life alone, which were frequently followed by attendances at hospital. Agencies who knew Martin, reflected that being street homeless was a cause of significant distress to him, and that when he secured hostel accommodation and a room of his own this made him very happy and "he kept that room immaculate".

2.9 Martin experienced multiple and overlapping needs that brought him into wanted and unwanted contact with statutory and voluntary agencies. Although he struggled to execute the things that he wanted to achieve, Martin consistently sought help from the Complex Homelessness Partnership Support Services (CHPSS) and Via drugs service, maintaining some engagement with both services during the review period. In particular it was noted that he engaged well with Occupational Therapy, which included cooking and shopping assessments and gardening activities. This was understood by those professionals to mean that, at least until the final year of his life, he retained the hope that he could improve his circumstances and regain control of his mental and physical health.

Protected Characteristics

2.10 Martin was a working age white British man who had lived experience of inpatient psychiatric care, trauma, homelessness and addiction. Documentation and reflections from practitioners suggest that agencies were not formally aware of his sexuality or religious beliefs, although he is known to have been married to a woman and was not known to attend a place of worship or to discuss spiritual beliefs.

2.11 Martin’s ‘protected characteristics’, such as gender, age, sexuality and religion, as defined by Equality Act (2010), are not documented in agency decisions related to his care and support needs, homelessness or health concerns, nor in how the risk and vulnerability he experienced was understood and responded to.

2.12 Martin’s mental health and drug and alcohol use were central features in agency responses towards him. According to the social model of disability[1], Martin could be considered a disabled man, which is evident in the earlier part of the review period when he had input from statutory agencies in respect of his mental health. However, it is unclear from the documentation provided if he understood himself to be disabled and what it meant to him if he did. Documentation provided does not identify if and how the social model of disability was applied by agencies, when considering the barriers he faced in accessing services, achieving goals and protecting himself.

3. Approach to Review

Purpose of a Safeguarding Adult Review

3.1 The purpose of a SAR is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died. The purpose of a Safeguarding Adult Review (SAR) is to establish whether there are lessons to be learned, from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults and the factors that enable and constrain this. This typically involves reviewing the effectiveness of practices and procedures (both multi agency and those of individual organisations) in order to inform the improvement of interagency practice and strategic planning.

3.2 There is a strong focus on understanding the underlying issues that informed professional actions and what, if anything, prevented them from being able to help and protect Martin from harm. As well as local factors, it is good practice to highlight the impact of national policy and legislation on effective single and multi-agency practice as part of this. The learning produced through a SAR concerns ‘systems-findings’. Systems findings identify legal, political, social and organisational factors that make it harder or easier for practitioners to provide quality care and support that meets the needs of the people they work with.

Key Lines of Enquiry

3.3 The review considered the period January 2023 to December 2024, the final two years of Martin’s life.

3.4 A SAR Panel, made up of key local agencies, was established to support the Review. The Panel agreed the following three key lines of enquiry, each with a series of guiding sub-elements:

1. **Suicide Prevention:**
   - Risk assessment & escalation
   - Understanding risk factors for ‘high risk’ groups
   - Service availability and barriers to accessing support whilst homeless
   - Stigma & risk normalisation

[1] The social model of disability is a way of viewing the world, developed by disabled people. The model says that people are disabled by barriers in society, not by their impairment or difference. Barriers can be physical, like buildings not having accessible toilets. Or they can be caused by people's attitudes to difference, like assuming disabled people can't do certain things. Read more here: [Social model of disability | Disability charity Scope UK]

2. **Multi-agency case management:**
   - The appropriate use of Multi-Agency Risk Meetings (MARMs) and s42 enquiries
   - Information sharing
   - Hospital discharge planning
   - Planned release from prison or custody
   - Eviction prevention/tenancy sustainment
   - Approaches to service withdrawal and maintaining contact

3. **Approaches to Trauma:**
   - Professional curiosity around personal history
   - Trusted professional relationships
   - Understanding behaviour
   - Responding to emotional distress and challenging behaviour

Methodology

3.5 On reviewing the summary information provided by relevant agencies from this period, the Panel agreed that SAR Martin should adopt a hybrid methodology, drawing on the Appreciative Inquiry[2] (AI) approach alongside SCIE's 'Learning Together[3]' and 'Whole System Understanding'[4] tools.

3.6 Appreciative Inquiry (AI) does not negate problems or ignore systemic issues. However, it recognises that by shifting the frame of reference away from defining "what's wrong" and towards "what's working" and "what do we want to strengthen" opportunities for change can expand. Appreciative Inquiry is a process of generating new knowledge, through dialogue that is provocative, future-focussed and resistant to hopelessness.

3.7 This methodology co-created multi-agency learning with practitioners and local agencies who support adults living with multiple disadvantage[5], which is sometimes referred to as multiple exclusion homelessness[6]. These terms relate to the experiences of people living severely marginalised lives defined by deprivation, inequality, abuse and trauma that result in cycling experiences of at least three of the following experiences: homelessness, mental ill-health, domestic abuse, criminal justice involvement and drug/alcohol dependency.

3.8 The following agencies were represented on the SAR Panel, provided documentation to support the SAR and/or representatives at the learning events:

- Gloucestershire County Council – Adult Social Care
- Gloucester City Council – Housing & Homelessness
- Gloucestershire Housing Partnership
- Gloucestershire Hospitals NHS Foundation Trust
- Gloucestershire Health and Care NHS Foundation Trust
- Gloucestershire Integrated Care Board
- Gloucestershire Constabulary

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[2] https://www.researchinpractice.org.uk/media/hpsba3z3/developing-effective-safeguarding-adult-review-learning-events_pt_web.pdf and https://www.iriss.org.uk/resources/insights/forming-new-futures-through-appreciative-inquiry

[3] https://www.scie.org.uk/safeguarding/children/case-reviews/learningtogether/

[4] Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews.' Journal of Adult Protection, 17 (1), 3-18.

[5] The most commonly used definition can be found here: http://meam.org.uk/multiple-needs-and-exclusions/

[6] A useful summary of this term and research about it can be found here: https://www.communitycare.co.uk/2011/11/17/research-multiple-exclusion-homelessness/

- Gloucester City Mission
- Kingfisher Treasure Seekers
- Southwestern Ambulance Service
- Via Substance Use Service

Involvement of Family and Friends

3.9 The Reviewer made initial contact with Martin's son and through two phone calls he considered the invitation to participate. It is understood he spoke to other family members about the invitation too. However, the shocking manner of his father's death, and the significant complexity of their relationship prior, led him to conclude that participating in the Review would be 'too much' for him. Therefore, this report is published without family or next of kin input.

SAR Process

3.10 This SAR took place over a 7-month period. It was an engaged Review, with contributions from voluntary and statutory agencies and a meaningful commitment to practice improvement.

Parallel Processes

3.11 A Coroner's inquest is due to take place following the conclusion of this SAR, to formally determine the cause and manner of Martin's death. The outcome of this review will be shared with the Coroner following approval by the Safeguarding Adults Board.

4. Research & Best Practice

4.1 Safeguarding Adult Reviews draw on research and best practice to identify relevant themes and practice issues that may be related to the individual who is the focus of the review. The purpose of including is to draw attention to best practice and also to highlight what is known about the wider systemic and structural factors that influence and impact the provision of relevant care and support beyond the local context.

4.2 Michael Preston-Shoot (2019) posits that "*drawing on existing evidence about effective practice would mean that reviewers are not starting out with a blank canvas. What is proposed here is that SARs begin explicitly with the available evidence-base, using it as a lens with which to scrutinise…what facilitates good practice and what presents barriers to effective practice*". The advantage of this approach is that reflection and systemic analysis is foregrounded within the SAR process.

4.3 Research into safeguarding practice around homelessness, self-neglect and substance dependency has underlined the need for a holistic whole-systems approach for people who may fall outside of statutory thresholds and eligibility criterion. As such, review findings and recommendations will consider four domains of effective practice outlined by the Local Government Association[7] :

- Direct Practice with Individuals
- Multi-Agency Team Around the Person
- Organisations Supporting the Team

[7] Michael Preston Shoot (2021) 'Adult Safeguarding and Homelessness: A briefing on positive practice', Local Government Association. Available at: https://www.local.gov.uk/publications/adult-safeguarding-and-homelessness-experience-informed-practice

- Strategic Governance

4.4 Given the vast array of relevant research and practice concerned with the experiences and needs Martin lived with, it is not possible or useful to include all the information considered as part of the Review in this report. The sections below attempt to draw out research and practice findings in key areas.

Wellbeing & Prevention

4.5 The wellbeing principle and safeguarding obligation to adults with care and support needs was deliberately widely defined in the Care Act 2014 by Parliament. Since April 2015, Section 1 Care Act requires local authorities to promote an individual's wellbeing whenever it is carrying out any care and support function; this is a general duty applying to all residents within a local authority area as well as a specific responsibility that local authority officers should uphold when carrying out duties under the Care Act. Considerations of wellbeing need to consider the suitability of accommodation, a person's ability to make choices and the quality of their relationships with others.

4.6 Section 2 of the Care Act obligates local authorities and relevant partners[8] to provide services or take other steps it considers will prevent or delay the development of care and support needs by adults in its area. The Care and Support Guidance, which accompanies the Care Act, dictates an early response to emerging harm is essential to stop risks from escalating. It also clarifies that local authorities have duties when the adult's needs for care and support are due to a physical or mental impairment or illness and that they are not caused by other circumstantial factors. This includes '*physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury. The authority should base their judgment on the assessment of the adult and a formal diagnosis of the condition should not be required*.' [9] Section 11(2) provides an enduring duty to offer an assessment when an adult with care and support needs has experienced, or is at risk of abuse or neglect, including sexual exploitation.

4.7 Finally, Section 42 of the Care Act 2014 requires that each local authority must make (or cause others to make) enquiries, decide what must be done and by whom whenever an adult with care and support needs is at risk of, or experiencing, abuse or neglect. This includes taking action to prevent abuse and neglect and to working with people at risk of abuse and neglect in accordance with Making Safeguarding Personal principles.

Adverse Childhood Experiences & Trauma

4.8 There are strong evidentiary, as well as instinctive, links between childhood abuse and neglect and the experience in adulthood of mental ill health, excessive use of drugs and/or alcohol, self-neglect and chaotic and abusive personal relationships (Lewis et al, 2021; Maniglio, 2019; Greenfield, 2010).

4.9 These traumatic events in childhood are often referred to as ACE's (Felitti et al, 1998). There is not a definitive list of ACE's, but they include experiences such as domestic abuse and violence, parental substance misuse and mental ill-health, poverty and losing a parent (WHO, 2012). Exposure to ACEs has been associated with poor health outcomes in adulthood including substance use, mental distress, obesity, heart disease and cancer, as well as unemployment

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8 Section 6 and 7 of the Care Act 2014 obligates relevant partners (police, NHS, district or county councils, prison, probation, department of work and pensions and providers of health or social care services) to cooperate in the delivery of respective functions to adults with care and support needs and their carers.

9 Paragraph 6.104 Care and Support guidance, DHSC

and continued involvement in violence. Importantly, the impact of ACEs appears to be cumulative, with risks of poor outcomes increasing with the number of ACEs suffered. Significantly, people who have been exposed to multiple ACEs are more likely to die at a young age from natural causes, suicide or homicide (Bellis et al, 2013) and more likely to struggle to engage with services (Skuse and Matthew, 2015)

4.10 There is also evidence from neurological research, that the brains of young adults go through significant changes into adulthood which are not complete until approximately age 25 (Giedd et al, 2004). This mental maturation is complicated and sometimes delayed by the experience of mental ill health and trauma (Davis and Vander Stoep, 1997). There are differences in "executive information processing" between "immature and maturing brains" i.e., those generally under the age of 25 years old, and "mature" brains i.e., those people aged 25 years and over who have not experienced life trauma and have not developed mental health problems (Casey et al, 2008). The features of "immature and maturing brains" include reduced representational knowledge (of rules, conventions and social and cultural norms); reduced operational processing skills (planning ahead, being organised and the ability to connect intentions and goals with the actions necessary to implement and achieve them) and reduced self-regulation (the ability to resist distractions, impulses and to generally resist behaving in unhelpful and unproductive ways), compared to "mature" brains.

4.11 The purpose of a safeguarding adult review is not to retrospectively diagnose an individual's health conditions or experiences. However, given Martin's life experiences and reflections from practitioners about his behaviour, learning from this research indicates the value of considering the neurological and executive functioning impacts of trauma as part of risk management and care and support planning for adults experiencing multiple disadvantage.

4.12 Practice guidance in working with the expression of trauma in adulthood abounds, as the concept of 'trauma-informed care' is increasingly mainstreamed as it's evidence base grows. The Office for Health Improvement & Disparities sets out six principles as the foundation for trauma-informed practice: safety, trust, choice, collaboration, empowerment and cultural consideration[10]. The emphasis, across the wide variety of trauma-related research and practice guidance, is on working with people in ways that recognise how their current behaviour is shaped and triggered by past events and then adapting professional practice to create safe environments and relationships that enable new and safer coping mechanisms and behaviours to emerge (Homeless Link, 2017; Shemmings, D. 2019; Young Minds, 2018). Crucially, trauma-informed care is relational; it requires trust, empathy and curious communication to be effective. A trauma-informed system would offer the same to its practitioners, freeing them up to act responsively, flexibly and according to the dynamics of the relationships they are building with the people they support – without fear of reprisal when things don't work or the pressure to achieve pre-conceived outcomes which may themselves be unhelpful and even harmful. Although the level of flexibility and creativity will be different between agencies and roles, particularly for professionals with certain legal duties, evidence suggests it would be nonetheless relevant to consider how this can be maximised in all roles and all agencies.

Self-Neglect

4.13 Research about self-neglect and people who've experienced homelessness and multiple disadvantage concludes that there are uncertainties within contemporary social work, including whether people fall under the 'umbrella' of Adult Social Care and adult safeguarding (Harris et

[10] https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice#key-principles-of-trauma-informed-practice

al, 2022). Learning from practice also concludes that narratives of 'lifestyle choice' and mental capacity sometimes derail responses to referred adult safeguarding concerns (Preston-Shoot, 2021) which indicates the need to reshape attitudes of professionals and the structures that enable successful multi-disciplinary support for adults who self-neglect but who may appear not to fall easily into established definitions and categories.

4.14 Self-neglect in adults who've experienced homelessness and exclusion may be harder to detect and may less easily fall within established adult safeguarding responses and interventions than other forms of abuse and neglect. There may be particular challenges in identifying if self-neglecting behaviour is about 'unwillingness' or 'inability', which can be further complicated by drug and alcohol use, executive functioning concerns and the impact of life circumstances.

4.15 GSAB has a robust self-neglect best practice guide in place that outlines how this type of abuse may result from care and support needs, trauma, health concerns and other personal factors. The guide advises that social and environmental factors are taken into consideration when identifying and responding to self-neglect (Braye, Orr, Preston-Shoot, 2015) and includes case examples, decision flowcharts and practice guidelines to support agencies to consider if a multi-agency response, including through Care Act adult safeguarding duties powers, is needed to support people who are self-neglecting. The guide draws on a range of sector-led research and best practice guidance to ensure that:

- Adults who are self-neglecting are empowered, as far as possible, to understand the implications of their self-neglecting behaviours with a focus on Making Safeguarding Personal principles
- A shared, multi-agency understanding and recognition of the issues involved in working with adults who self-neglect.
- Effective multi-agency working and practice, whether this falls within a Section 42 safeguarding enquiry or outside of this. Decisions will be made on a case-by-case basis as to whether the lead agency will be the local authority or another agency.
- Agencies and organisations uphold their legal and organisational duties of care.

4.16 Importantly, the procedures centre the role of relational approaches around self-neglect; get to know the person, act with integrity and honesty and take action in personalised and iterative ways that accord with the adult's mental capacity, personal priorities and their desired pace of change. It draws on Social Care Institute for Excellence (SCIE) guidance[11] to encourage a 'Knowing, Being, Doing' approach:

- **Knowing**, in the sense of understanding the person, their history and the significance of their self-neglect, along with all the knowledge resources that underpin professional practice.
- **Being**, in the sense of showing personal and professional qualities of respect, empathy, honesty, reliability, care, being present, staying alongside and keeping company.
- **Doing**, in the sense of balancing hands-on and hands-off approaches, seeking the tiny opportunity for agreement, doing things that will make a small difference while negotiating for the bigger things, and deciding with others when the risks are so great that some intervention must take place.

[11] https://www.scie.org.uk/app/uploads/2024/06/report69.pdf

Suicide Prevention

4.17 Suicide prevalence data[12] shows men are almost three times more likely to die by suicide than women. It is also more prevalent for people who are living in poverty to end their own lives[13], with suicide accounting for 13.4% of deaths affecting people experiencing homelessness[14]. Studies show that suicide attempts were around 3 times more likely to occur in people who have experienced abuse and neglect as children[15]. Further, it is well understood that previous suicide attempts are a strong predictor of subsequent death by suicide. Research has also identified that the risk of suicide increases following traumatic brain injury, which is especially relevant when considering the risk of brain injury to those experiencing homelessness and addiction. In simple terms, research shows that Martin was at much higher risk of completing suicide than his peers who had not experienced the ongoing impacts of such a traumatic start in life.

4.18 NICE guidelines QS189[16] state that suicidal concerns need to be responded to, not with a risk assessment that distinguishes based on method and a statement of intent, but a comprehensive and immediate psychosocial assessment and engagement in a therapeutic relationship. This should then facilitate development of a care plan to prevent the escalation of self-harm and risk management plan to include a crisis plan outlining self-management strategies and how to access services during a crisis when self-management strategies fail. GPs need to be an integral part of the inter-professional risk holding network.

4.19 Research shows an association between a wide range of mental health needs and suicide, to the extent that suicide is a relevant risk factor in all people with diagnosed or suspected mental health difficulties (Harris et al, 2020). This presents the difficulty in practice that a diagnosis of mental illness does not necessarily help to identify people who may try to take their own lives. It follows that good practice would be to place significant emphasis on dynamic and holistic risk assessment which identifies the interconnectedness of multiple risk factors, protective and supportive relationships and mitigations, triggers and coping strategies in a non-judgemental approach that centres the individual and their wishes.

4.20 Finally, Article 2 of the European Convention on Human Rights (ECHR) places a duty on public bodies to prevent avoidable deaths. This must be balanced against the right to freedom from inhumane treatment (Article 3), the right to liberty (Article 5) and respect for private and family life (Article 8). The right to life is not an absolute right, but there are numerous examples from caselaw and Prevention of Future Deaths Reports of breaches of Article 2 when suicide occurs after failures to adhere to policy or operational practice/clinical guidance.

4.21 An article written by Homeless Link outlines how best practice in suicide prevention and post-vention lies in adopting a whole-organisation approach, not treating suicide prevention as an isolated task for frontline staff. Key recommendations include:

- **Develop a Suicide Prevention Protocol** tailored to the service setting (e.g. day centres, hostels)
  - Promote shared responsibility across the team or multi-agency group
  - Build staff awareness of wider causes of suicidal thoughts

[12] https://www.samaritans.org/about-samaritans/research-policy/suicide-facts-and-figures/latest-suicide-data/
[13] https://www.samaritans.org/about-samaritans/research-policy/inequality-suicide/
[14] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2021registrations
[15] https://www.manchester.ac.uk/discover/news/child-abuse-linked-to-risk-of-suicide-in-later-life/
[16] NICE (2019) 'Suicide Prevention' Available at: www.nice.org.uk/guidance/qs189

- Give staff clear pathways for referrals and escalation
- **Train and support staff** to feel confident in asking about suicidal thoughts, doing so in a compassionate way, and using agreed safety planning processes
- **Use collaborative safety planning** with service users, drawing out their own coping strategies, trusted contacts, preferred responses in crisis, and external supports
- **Plan for after a suicide occurs** within the service, including:
  - Rapid support for staff (e.g. counselling, supervision)
  - A serious incident review to learn lessons
  - Clear communication with other service users and friends of the person who has died about what happened, offering support and resisting silence & stigma

Personality Disorder

4.22 People experiencing homelessness face systemic barriers when seeking access to mental health services. In real terms, this means that many people who rough sleep or stay in hostels are living through acute episodes of emotional and mental disturbance as well as enduring distress, resulting in high rates of suicide, acute hospital admissions, interactions with criminal justice agencies and without the ongoing therapeutic input they need to regain a sense of stability[17].

4.23 People experiencing homelessness are disproportionately affected by adverse childhood experiences, such as neglect, exposure to violence, unexpected bereavements, poverty, and physical or emotional abuse[18], which may go some way to explaining the high prevalence of personality disorder traits and diagnoses amongst homeless populations[19].

4.24 Research highlights social and professional stigma towards people whose behaviours are characterised as 'Personality Disorder' (Mind, 2022). A Royal College of Psychiatry (2018) study identified the negative attitudes of clinical staff towards patients with diagnosis of personality disorder. The study specifically referenced nurses as scoring lowest, using self-rating scales, on caring attitude towards patients. Professional attitudes influence care planning and responses to risky behaviour and distress; people diagnosed with personality disorder experience high levels of criminalisation, excessive detention and containment, and disproportionate deaths by suicide[20] compared with people living with other diagnoses. This prevails despite more than twenty years of intentional government policy to 'break the cycle of rejection' where personality disorder is a diagnosis of exclusion[21]. Whilst it is not clear from the information shared as part of this review if Martin experienced direct stigma, reflections from practitioners surrounding how he was perceived and how agencies responded to his experiences of victimisation, suggest that it would be valuable for all agencies to reflect on how stigma and unconscious bias plays a role in their work supporting adults with complex experiences commonly associated with personality disorder.

4.25 There are examples of innovative practice around personality disorder stigma from Scotland, where attempts to improve responses to people living with personality disorder through the

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17 https://www.england.nhs.uk/wp-content/uploads/2016/07/stop-the-scandal.pdf

18 Herman D. B., Susser E. S., Struening E. L., Link B. L. (1997). Adverse childhood experiences: Are they risk factors for adult homelessness? *American Journal of Public Health*, 87(2), 249–255. https://doi.org/10.2105/AJPH.87.2.249 and Koegel P., Melamid E., Burnam M. A. (1995). Childhood risk factors for homelessness among homeless adults. *American Journal of Public Health*, 85(12), 1642–1649. https://doi.org/10.2105/AJPH.85.12.1642

19 Fazel S., Khosla V., Doll H., Geddes J. (2008). The prevalence of mental disorders among the homeless in western countries: Systematic review and meta-regression analysis. *PLoS Medicine*, 5(12), e225. https://doi.org/10.1371/journal.pmed.0050225

20 https://www.nhsconfed.org/events/watch-personality-disorder-no-longer-diagnosis-exclusion-call-action

21 Department of Health (2003) Available at: https://www.candi.nhs.uk/sites/default/files/Documents/pd_no_longer_a_diagnosis_of_exclusion.pdf

provision of multi-agency training and learning spaces for practitioners have been effective in improving care[22]. Given the prevalence of personality disorder diagnoses in the population of people living with multiple disadvantage and homelessness, as well as its clear links with trauma and social exclusion, there is value in exploring local policy and practice in this area further.

Multiple Disadvantage

4.26 According to the Making Every Adult Matter coalition:

> *"People facing multiple disadvantage experience a combination of problems. For many, their current circumstances are shaped by long-term experiences of poverty, deprivation, trauma, abuse and neglect. Many also face racism, sexism and homophobia. These structural inequalities intersect in different ways, manifesting in a combination of experiences including homelessness, substance misuse, domestic violence, contact with the criminal justice system and mental ill health.*
>
> *Multiple disadvantage is a systemic, not an individual issue. People facing multiple disadvantage live in every area of the country. They are often failed by services and systems that focus on singular issues. This makes it harder for individuals to address their problems, lead fulfilling lives and contribute fully to their communities."*

4.27 The **Hard Edges** report (2015) estimated that 58,000 people face problems of homelessness, substance misuse and offending in any one year. When the research was expanded to considered gendered violence and mental health, in a report called Gender Matters (2020) this figure rose to an estimated 336,000 people.

4.28 Research exploring multiple disadvantage is growing, and with it the evidence base of effective practice. One of the most comprehensive and relevant considerations of effective practice with people living with multiple disadvantage arose from the Fulfilling Lives programme, which worked between 2014 and 2021 in twelve areas of the country, including Sussex. Their evaluation[23] made clear the following foundations for effective work with people living with the effects of multiple deprivation, trauma and co-occurring conditions:

- Removing arbitrary barriers to accessing support services
- Co-production of new and changed services, with the people who use them
- Improving the training and learning opportunities available for frontline practitioners, and giving them the flexibility to use it in their practice
- Improving access to mental health services
- Improving transitions between services and settings

5. Analysis and Findings

KLOE 1: Suicide Prevention

- Risk assessment & escalation

[22] https://blogs.iriss.org.uk/homelessness/personality-disorder/
[23] https://www.tnlcommunityfund.org.uk/media/insights/documents/Summary-of-programme-achievements-evaluation-findings-learning-and-resources-2022.pdf?mtime=20221128143121&focal=none

- Understanding risk factors for 'high risk' groups
- Service availability and barriers to accessing support whilst homeless
- Stigma & risk normalisation

5.1.1 Martin was understood by all agencies to be at risk of suicide, and these concerns were frequently shared during the review period albeit that his behaviour and life circumstances, rather than his suicidal thoughts, were often the prevailing concern.

5.1.2 The Complex Homelessness Partnership Support Services (CHPSS) team conducted comprehensive risk assessments with Martin throughout the review period and there is evidence that these were robust and shared appropriately with other agencies. Case records indicated that Martin was assessed by this team as 'high risk' overall, due to concerns about the interconnectedness of rough sleeping, drug and alcohol use, vulnerability to abuse and other health issues, but only 'medium risk' for suicide. In learning events they reflected that because Martin frequently presented at hospital and spoke freely with professionals about his suicidal thoughts, he was considered at lower risk than others in this domain. Their engagement with Martin was fairly regular and of good rapport, therefore they were able to identify fluctuations in wellbeing and moments of elevated concern more confidently than services with less or purely reactive interaction with him. Their assessment of risk considered that he voiced his concerns to professionals freely, that he sought help when he needed it, and that his suicide attempts were often quite superficial in respect of risk to life. This is substantiated in case notes from his GP, Police, Ambulance Service and housing support services.

5.1.3 The CHPPS team also undertook regular routine 'mental state examinations' in response to comments from Martin about wanting to end his own life. These included questions about his intentions, plans and awareness of consequences and took place informally during their meetings with Martin in the community, which is good practice indicative of the specialist and multi-disciplinary nature of this service.

5.1.4 Similar assessments were conducted by the Mental Health Liaison Team (MHLT) when Martin was a patient at Gloucestershire Royal Hospital (GRH). Martin was seen and assessed by MHLT on at least 11 occasions during the review period. There is evidence from case notes that these assessments were conducted sensitively and rapidly, that past notes were considered, physical health reviews occurred alongside them and Martin's mental capacity was explored, which meets expected standards of care[24]. Further, there is good practice in the interface between the MHLT and P3, who provided support to homeless patients in the hospital. However, although suicide risk was identified as part of these psychosocial assessments, there are no notes that reflect Martin was asked meaningful questions about his coping strategies and protective factors, and there was little to suggest that cumulative risk was considered or that actions taken to reduce suicide risk, including referrals/signposting to specialist onward help, except advice to call the local Crisis Team should he feel he needed to. This is an opportunity to strengthen future practice in the team, who are clearly committed to continuous improvement.

5.1.5 In September 2024, Martin was detained at GRH under Sec 136 of Mental Health Act after a suicide attempt at his supported accommodation placement. Case records indicate that his history of suicide attempts was considered, as was his diagnostic history and presenting

[24] Royal College of Psychiatrists (2022) PLAN, 7th Edition Standards. Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/psychiatric-liaison-services-plan/plan---7th-edition-standards.pdf?sfvrsn=b1a9b1a3_3

behaviour. It was decided at this time that an admission to hospital under Sec 2 or 3 of the Mental Health Act was not indicated as he was "*future-oriented albeit with inconsistencies in this regard and willing to work with aforementioned services*". During learning events hospital and police representatives reflected that in hindsight Martin may have benefitted, at this moment or in previous similar incidents, from an informal admission to hospital to offer a period of stabilisation, better understand his presenting needs and break the cycle of escalation. However, this reflection was accompanied by recognition of the significant pressure on beds in inpatient settings and how informal admissions of this nature were perceived as "largely a thing of the past".

5.1.6 Martin attended fairly regular GP appointments; case records from these meetings indicate that he shared a lot about his life circumstances in these conversations, albeit that some of what he shared was untrue e.g. the deaths of close family members. The risk of suicide was noted, alongside other primarily physical health concerns, but case notes suggest that safeguarding concerns were not raised by the GP following any of these conversations. Nor was information shared with other agencies about said risks, except in two instances where his accommodation provider and the ambulance service contacted the GP directly. Case notes indicate that Martin's GP was not effectively engaged as part of multi-agency discussions, and therefore information held by the GP practice was not included in risk assessments about him. Whilst the risk of suicide was well known to other agencies, it is not clear how relevant information held by the GP, such as prescribed medication, was shared or understood by agencies working with him. Given the frequency of suicide attempts by overdose, information sharing by and with the GP should have been a higher priority for agencies.

5.1.7 During the review period, Martin was not in receipt of any formal treatment around his mental health or wellbeing, although it is understood that he had been under community mental health services for the majority of his adult life and remained open to the Gloucester Recovery Team until June 2023 when a CPA review concluded that he should be discharged due to 'non-engagement'. It is understood by agencies and substantiated in case notes that Martin was living with an Emotionally Unstable Personality Disorder (EUPD), which had been previously diagnosed as schizophrenia, and was prescribed anti-depressants during the review period, although it's unclear if he was regularly taking these. The information provided as part of this review indicates that secondary mental health services had no engagement with Martin, nor the agencies supporting him, from June 2023 until his death. The CHPPS team reflected that attempts to re-engage them in assessing Martin had not proven fruitful and that there did not seem to be much curiosity about possible changes in his mental health or the escalating risk of suicide. A representative from a supported housing provider reflected that "*because the CHPPS team were involved other health agencies could justify stepping back".* Whilst the motivations for action and inaction on the part of mental health social work and locality teams within Gloucestershire Health and Care NHS Foundation Trust (GHC) cannot be understood from the case records and chronologies shared, the absence of planned mental health input around Martin's needs and risks is notable, especially in response to safeguarding concerns shared with them by Adult Social Care which do not appear to have been acted on, including to inform the Council's safeguarding team that they were no longer involved.

5.1.8 Martin's use of drugs and alcohol was well known and documented by all agencies, with various attempts by the Via drugs service to engage Martin with support, including by the Police Custody Liaison Worker and by the CHPPS Team. It is good practice that he was given a Naloxone kit, and advice on how to use it, in October 2024 after presenting at Via's Gloucester Hub. However, beyond this there appears to have been limited engagement from all professionals, about the risk

of accidental suicide following the consumption of drugs and alcohol, although this is a known risk-factor and considering that Martin's behaviour around drugs and alcohol were chaotic and not well-informed.

5.1.9 Several agency records (Via, P3 and CHPPS) reflect that Martin's actual use of drugs and alcohol was likely lower than he stated, because on the one hand, he was known to "*tell agencies what he thought they wanted to hear in order to get their attention and support*" and on the other "i*t's likely he didn't even really know what he was taking because he often acted impulsively*". It was noted that he did not experience withdrawal from alcohol or drugs when in hospital or custody, and several voluntary drug tests results did not correlate with information Martin shared (which could relate to his lack of knowledge). It is good practice to discuss the risks of accidental overdose, or other death by misadventure related to drug and alcohol consumption, with people who use drugs. If this was not possible or appropriate to do with Martin, professionals could have explored this together and agreed actions to better understand his drug and alcohol consumption and the effects on his wellbeing and behaviour.

5.1.10 Whilst the ongoing assessment of suicide risk was evident, the extent that this knowledge informed assessment and planning around relevant triggers and protective factors in Martin's life is less clear. For example, case records refer to Martin's homelessness as a risk factor in his suicidal thoughts (Police, October 2024) and the CHPSS Team reflected that Martin's suicide attempts typically followed incidents with family members, but there is little to suggest that this was explored further or that actions were agreed about how trigger events might be responded to or prevented. As part of the review several agencies reflected that the final episode of estrangement from his daughter in September 2024 was a key moment of downward turn for Martin; following this, incidents escalated in both frequency and severity. However, case records indicate an overall absence of professional curiosity around Martin's suicidal thoughts and triggers, with little to suggest these were meaningfully explored by his GP, the Mental Health Liaison Team (MHLT) or CHPSS.

5.1.11 Practitioners and clinicians who attended the learning events had a reflective discussion about the desensitising impact of frequent suicidal and self-injurious incidents, and how this may have played a role in the normalisation of risk in Martin's life. One practitioner reflected that "suicidal thoughts are normalised for people experiencing homelessness" meaning that it's seen as obvious and even inevitable that someone who has nowhere to live might feel suicidal as a result. They reflected that this dismisses the individual, and that of course not all people experiencing homelessness feel suicidal "*so perhaps the fact that we think that needs to be challenged, so that we look underneath the homelessness for other factors*". GHC reflected that they did not find any evidence that suicidal thoughts are normalised for people experiencing homelessness.

5.1.12 Police practice in response to suicide-related incidents involving Martin was robust, sensitive and appropriate. Case notes show that the Crisis Team were engaged appropriately, use of Section 136 powers was proportionate and signposting information was given to other support. The Crisis Team had attended custody to visit Martin several times in the months leading up to his death. However, following his final arrest—the day before he died—they did not attend the police station to assess him due to capacity issues. Although there is no indication that their involvement at that time would have changed the outcome, the Police later reflected that Martin's behaviour that day and in the days before might have indicated suicidal intent different from previous incidents.

5.1.13 Gloucestershire Royal Hospital shared that they have made improvements in how they manage mental health presentations, by introducing a more effective triage process, ensuring rapid initial conversations, and focusing on diversion and planning work, aided by the 'working age' team being based on-site. Additionally, they connected inpatient and acute support with recent developments in community mental health services, including adopting a "no wrong door" approach and commissioning the Complex Emotional Needs Team (discussed more in later paragraphs of this chapter). The aim is to ensure that individuals seeking help are supported and directed to appropriate services, regardless of how or where they first seek assistance. This is excellent practice and a clear indication of commitments to continuous improvement and innovation. It is clear that Martin benefitted from some of these improvements (discussed below) but there is little in case notes or review activities to suggest that the improved connections between acute support and community mental health services was supportive for Martin. It would be beneficial, as part of the implementation of Making Every Adult Matter (read more about Chapter 6) to review how these improvements are impacting on the outcomes of adults experiencing multiple disadvantage and homelessness.

5.1.14 In case records, learning events and 1:1 discussions there was a strong sense that agencies feel at a loss when supporting people with very complex needs, especially where these are connected to a personality disorder diagnosis. One agency reflected that his EUPD "*shouldn't be a diagnosis of exclusion*" and that although Martin's challenging behaviour and inconsistent engagement with support were factors, it does seem to have been the case that Martin's diagnosis resulted in an overall absence of mental health involvement in the final years of his life. Agencies reflected on what might have been different in their responses to suicide risks and acts of self harm if Martin's behaviour had been less challenging, or if he had different personal characteristics. They reflected that maybe his behaviour escalated, in part, because he was unable to articulate his fear of loss and abandonment, but understood that high-profile incidents always elicited a response.

5.1.15 The CHPPS Team pointed to the support available from the Complex and Emotional Needs (CEN) Team provided by GHC, reflecting that they had a number of very helpful conversations with the team about Martin. However, most agencies involved in the review did not yet have a clear understanding of the support available from the CEN Team, with some commenting that there was not a service for people with personality disorder in the area and others not being clear on this teams remit or how to approach them for help. Information shared with the reviewer in a 1:1 discussion with the team, suggests that the CEN Team offer a range of support to individuals living with complex emotional needs, and to the teams that support them, through their *System Wide Support Offer* of training, 1:1 case discussions and knowledge sharing input. The team are committed to working with a broader range of agencies/teams, identifying an opportunity to promote the service more widely and to ensure uptake of their learning and support offer.

5.1.16 There was a strong sense from all agencies that there is limited support available for people at risk of suicide who are living with additional complexities and challenging life circumstances, such as homelessness and personality disorder. It was noted that the pre-requisite to be 'stable enough' to access support from The Anchor program provided by Kingfisher Treasure Seekers, and the Open Access Therapeutic Support service by the CEN Team, was a barrier even though both services are intentionally low-threshold. The CEN Team reflected that the support these initiatives offer can be challenging to engage in, requiring motivation and commitment from the individual to develop new coping mechanisms. Without stable housing it is rarely possible for people to safely begin this complex therapeutic work. Whilst this is understandable, people

experiencing the instability of homelessness alongside their emotional needs are unable to access meaningful support to manage their wellbeing or develop coping strategies for managing distress. One agency reflected that *"mental health services aren't mental health services. They're mental illness services. They are psychiatric services for the treatment of mental illness, not for emotional well-being. And I think the difference between those two things is key here because what is there for people like [Martin]?"*

5.1.17 Agencies reflected that a model similar to 'pre-treatment support' in the substance use field might be highly beneficial for people like Martin. They reflected that helping people living with the highest degree of complexity and distress to establish some stability, build long-term professional relationships and identify key areas where the person would welcome support could offer significant individual and system-wide benefits. It was understood by all that a key pillar in the success of this type of support would need to be suitable accommodation, that can 'tolerate' high levels of emotional distress and challenging behaviour. It was reflected that current homelessness supported accommodation providers typically find it extremely difficult to support people with complex emotional needs and personality disorder diagnoses, especially when there is not a clear pathway or network of support from other statutory and voluntary agencies around such individuals. This point is made again in discussion at 5.3.10.

5.1.18 Agencies also reflected that the low threshold offer from The Cavern is brilliant, with many people experiencing homelessness and social isolation in Gloucester attending the late-night drop-in support there. All agencies expressed a desire to see this support offer expand and strengthen to support people like Martin, who may need more active input than the service can currently offer. Suggestions included commissioning on-site mental health navigators to support this provision, later opening hours and joint working protocols with mental health, domestic abuse and rough sleeping services to ensure appropriate information sharing and joint working.

5.1.19 Learning event discussions considered the availability of multi-agency suicide prevention training. Overall agencies shared that they did not feel adequately trained to identify suicide risks and to work collaboratively to develop safety plans or de-escalation strategies. Some agencies who had access to 'generic' suicide prevention training reflected that this was inadequate to understand and respond to suicide risks associated with multiple disadvantage; homelessness, drug and alcohol use and behaviours associated with trauma and personality disorder. In addition to the research evidence that people experiencing homelessness, addiction and mental health needs are at elevated risk of suicide, the suggestion to commission/provide specialist or supplementary multi-agency training around suicide is substantiated by the local findings of this review.

5.1.20 The Gloucestershire Suicide Prevention Strategy 2024-2029[25] establishes suicide and self-harm as key strategic priorities, pointing to commitments made in mental health and joint health and wellbeing strategies for the county. Suicide prevention activity is overseen by the Gloucestershire Suicide Prevention Partnership (GSPP) Steering Group, with multi-agency input and practice sharing at the GSPP Forum. The steering group includes representatives from the Coroner's Office, Gloucestershire Health and Care NHS Foundation Trust, Gloucestershire Constabulary, and the Integrated Care Board and reports to the Gloucestershire Mental Health and Wellbeing Partnership Board.

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[25] The strategy, alongside other information about the Gloucestershire Suicide Prevention Partnership, can be found here: https://www.ghll.org.uk/about-ghll/partnership-projects/gloucestershire-suicide-prevention-partnership/

5.1.21 The strategy outlines how the county intends to reduce suicide by taking a partnership-based, evidence-informed and whole-system approach. It recognises that no single organisation can prevent suicides alone and builds on past local work and national priorities. It emphasises the importance of early intervention, tailored support for higher-risk groups, reducing access to means, improving crisis and postvention support, and addressing wider risk factors such as isolation, financial hardship and poor physical health. The strategy is supported by an action plan and a governance framework to monitor delivery and progress of key commitments:

- Establish and maintain strong partnership governance via the Gloucestershire Suicide Prevention Steering Group and broader forum
- Use high-quality data, real-time surveillance and local audits to inform where action is needed
- Focus on reducing access to the methods and means of suicide (e.g., public-place prevention work)
- Provide tailored and timely support for people bereaved or affected by a death by suicide.
- Promote online safety and responsible media reporting on suicide and self-harm
- Provide effective crisis support for individuals at imminent risk and ensure continuity of care through discharge and transitions.
- Target higher-risk groups (e.g., men, people with prior self-harm, those in contact with mental health services) with tailored prevention efforts.
- Address common population-level risk factors such as social isolation, financial difficulty, poor physical health and substance misuse.
- Build awareness, training and capacity in organisations and communities

5.1.23 Although agencies and individuals involved in the review made clear links between suicide prevention and adult safeguarding, the interface between GSAB and the GSPP was unclear, even to those involved in one or both groups. This indicates an opportunity to improve both internal and public-facing communication around suicide and adult safeguarding, and to work collaboratively to embed learning from this review.

KLOE 2: Multi-Agency Case Management

- The appropriate use of Multi-Agency Risk Management meetings (MARMs) and s42 enquiries
- Information sharing
- Hospital discharge planning
- Planned release from prison or custody
- Eviction prevention/tenancy sustainment
- Approaches to service withdrawal and maintaining contact

5.2.1 Case notes and learning events demonstrate a strong commitment from agencies to work together to support adults experiencing multiple exclusion homelessness. The CHPSS Team is an exemplar in this regard. The service is multi-disciplinary and multi-agency by design, and it is evident that people accessing support from the service are offered person-centred, flexible support from practitioners with the organisational permission and personal motivation to do so effectively. Notably, the team employs best practice 'lead professional' arrangements and weekly case discussions to ensure that patients have a single point of contact, supported by a wider specialist team of health, social care and substance use professionals. However, the team's lead professional arrangement is 'internal' to CHPSS, and is not necessarily recognised across the

system. There is not currently a system-wide understanding of what a 'lead professional' is and does, and agencies reflected that this could be an important development in the Making Every Adult Matter approach (more on this later).

5.2.2 As well as weekly internal multi-disciplinary team meetings, the CHPSS Team also convened at least two (June 2024 and October 2024) wider multi-agency meetings to discuss their mounting concerns about Martin. Although these were both well attended, it is notable that local authority Adult Social Care were not present which left a gap in exploration of statutory duties and powers in respect of safeguarding and risk management. Whilst the CHPSS team's internal social care navigator was present, this role does not have full statutory social work obligations nor powers.

5.2.3 Further good practice can be found in the clear commitment, across the system, to bring professionals together to support those individuals where engagement is difficult or not working. The diagram below identifies a number of key local multi-agency initiatives, that agencies involved in this review participate in and value.

5.2.4 Each of these multi-agency meetings is concerned with how the local system of agencies can work better together to support adults who experience interconnected needs that might place them at risk of harm. It is beyond the scope of this review to outline the role and remit of each meeting or group, but the existence of multi-agency case management discussions and collaborative forums is positive practice. Learning from this review suggests that there is an opportunity to clarify how these groups are governed, how they interact with each other (if at all), and what should take place when someone is discussed at one or more forums but their risks remain unchanged or escalating. Agencies reflected that "the system is too complex" and that reducing the number of forums or panels might be beneficial.

5.2.5 Martin was discussed as part of the Complex Case Cell (in the year prior to the review period), CHPSS Multi-Disciplinary Team and Rough Sleeping Meetings, ensuring that concerns about his

vulnerability and unmet need were known by system partners. Whilst this is good practice, case notes do not evidence that discussions in these meetings generated a shared plan of action for agencies supporting Martin. Agencies involved in the review reflected that although the existence of multi-agency meetings is positive, the interface between them is unclear, meaning someone may be discussed at multiple meetings in an uncoordinated and potentially contradictory way. Agencies also reflected that there wasn't a single governance structure for case management meetings about people living at high-risk of harm, these were led by different statutory partners under a range of strategic priorities. It is also unclear the extent that any of these discussions are formally understood as mechanism of adult safeguarding. During the review period, Gloucestershire County Council began implementation of the Multi-Agency Risk Management (MARM) approach, which will address some of these uncertainties and enable formal multi-agency discussions to take place about adults at risk, even if concerns do not meet the threshold for sec42 safeguarding enquiries.

5.2.6 During the review period, Martin had at least 21 significant interactions with Police and more than 25 visits to A&E. In each of these incidents, agencies communicated effectively, generating a uniform understanding of what had happened and ensuring his presenting needs were met without delay. The approach taken by police when Martin was in custody was commendable and demonstrates a meaningful engagement with the principles of Right Care, Right Person[26] for adults with complex mental/emotional health and substance use needs. On all but the final occasion that Martin was taken into custody, he was seen by either (and sometimes both) the local Crisis Team and a Via Substance Misuse Worker. These visits ensured that his specific vulnerabilities in the custody environment were understood, information was appropriately shared and follow-up referrals and signposting were offered. Nonetheless, it is concerning that responses to Martin's distress were almost exclusively reactive and driven by crisis or acute health episodes, rather than through planned support that sought to stabilise, de-escalate and prevent future incidents.

5.2.7 That Via are the commissioned provider for both the custody substance use worker and as part of the CHPSS team, enables rapid information sharing between agencies. For Martin, this meant that agencies knew when he had been arrested or conveyed to hospital by police and were able to arrange visits and follow-up care with him as appropriate. Similarly, that P3 are the provider of homelessness supported accommodation in Gloucestershire and also the provider of a homelessness navigator service in Gloucestershire Royal Hospital enables rapid information sharing and person-centred care across settings.

5.2.8 Similarly, although his behaviour in hospital and the community could be challenging, it was only in the final two months of his life that Gloucestershire Royal Hospital (GRH) staff felt unable to manage Martin's presentation and required police assistance. Representatives from GRH reflected that, in hindsight, the escalation in frequency and severity of incidents involving Martin is clear, but at the time staff were responding to the complexity of what was happening in front of them and due to capacity pressures and the reactive nature of their interaction with Martin, noticing the pattern of escalation was challenging as was establishing plans with him, or those who supported him, to make hospital attendances calmer. Avoiding hindsight bias is an important aspect of Safeguarding Adult Review practice, so although this reflection is helpful it does not indicate poor practice by GRH at the time Martin was in their care.

[26] https://www.gloucestershire.police.uk/advice/advice-and-information/concern-for-welfare/right-care-right-person/

5.2.9 Gloucestershire Royal Hospital representatives reflected on a missed opportunity to support Martin as part of the High Intensity Use (HIU) and FERN programme. Although Martin did come to the attention of the programme in late 2024, a Personal Support Plan was not developed which may have enabled a wider view of his needs and presentations to hospital as well as engaging other teams and services to de-escalate his use of acute care and support him in the community. Martin was rarely admitted to hospital, and his injuries and illnesses were rarely of significant clinical concern. Nonetheless, a multi-agency discussion and shared plan around reducing the use of 'blue light' services might have explored how to intervene in the regularity and then escalation of his attendances, might have identified actions to explore this with him, including making a further request for input from mental health and housing services.

5.2.10 As incidents escalated in the final months of Martin's life, so did the Police response. Martin was detained under Section 136 of the Mental Health Act twice (October and December 2024) and was arrested four times for either threats of violence or actual assaults (October-November 2024). In November 2024, Martin was tasered by Police during an incident where he had a weapon, which resulted in him being conveyed to GRH (not due to the use of the taser but due to an overdose he had taken prior) and being arrested (although not subsequently charged) with assault of an emergency worker. In December 2024 he was charged with making threats of violence during an incident at his daughter's home in September 2024. In hindsight, agencies reflected that this breakdown in the relationship with his daughter was clearly a turning point for Martin, that resulted in increased aggression, threats and the actual or threatened use of weapons.

5.2.11 Like GRH staff, Gloucestershire Police reflected on learning from this period in respect of 'frequent flyers', this time in custody. They reported that there is a local approach in place that offers multi-agency support to women who are frequently brought into custody, in recognition of the relationship between unmet needs for support, trauma and criminalisation. This support is not currently available to men, and because Martin's arrests largely related to low-level criminal offences and in only one case to being charged with a crime, his situation also did not meet the threshold for multi-agency case management under the Integrated Offender Management approach. As such, although Martin's frequent interactions with Police were known to agencies, a multi-agency discussion to explore how to intervene in this cycle of arrests and custody stays did not take place.

5.2.12 Given these reflections, learning from this review should be of interest to the Gloucestershire Inter-Agency Monitoring Group[27], who focus is on responding to people in mental health crisis who come to the attention of the police. In particular, a discussion about the specific needs of men in mental and emotional health crises, who frequently come to the attention of police and acute hospital settings, could be beneficial.

During the review period Martin's homelessness was considered by all agencies to be a factor in the frequency and escalation of incidents and that it frustrated attempts to engage him in other support. Agencies pointed to significant increases in rough sleeping in Gloucester in the last two years, and how this has created significant challenges for local services. Official statistics captured as part of the MHCLG rough sleeping annual snapshot[28] support these reflections, identifying a 47% increase in rough sleeping in Gloucester between 2023, and the most recent count in 2024,

[27] Some information about this group can be found here: https://www.ghc.nhs.uk/news/supporting-those-in-need-of-emergency-mental-health-support-in-gloucestershire/

[28] MHCLG (2025) Rough sleeping snapshot in England: autumn 2024. Available at: https://www.gov.uk/government/statistics/rough-sleeping-snapshot-in-england-autumn-2024/rough-sleeping-snapshot-in-england-autumn-2024#main-findings

from 19 to 28 people[29]. This is the highest number of people ever recorded sleeping rough in Gloucester, and although the city receives funding from the Rough Sleeping Prevention and Recovery Grant this is not sufficient to meet need, especially for those requiring specialist supported accommodation due to the complexity of their needs.

5.2.13 During this time Martin accessed support from Gloucester City Mission, who expressed that his behaviour was highly challenging in that setting, causing and contributing to incidents involving other people using the service and having an impact on their staff, who often felt at a loss as to how to support him. A number of housing referrals were made during the review period, with options for accommodation at a number of services partially explored, but not completed as Martin was either unable or unwilling to attend assessment interviews made for him. Martin was evicted from three accommodation placements (June 2023, October 2024 and December 2024) and each of these evictions created an opportunity for multi-agency planning that were not realised. Multi-agency meetings were suggested, by P3 in November 2024 and by the Rough Sleeping Coordinator in December 2024, but these came too late and there were opportunities in June 2023, when Martin was evicted from long-term mental health supported housing, to bring agencies together to explore suitable long-term accommodation and a pathway to securing this. It is good practice that following this eviction, Gloucester City Council identified temporary accommodation for Martin whilst his circumstances were better understood. Although it is unclear if Martin would have met the criteria for 'priority need' status under the Housing Act 1996 in the long-term, the Housing Partnerships Team should have taken a lead role in convening such joint planning at this time.

5.2.14 During the review period nine safeguarding concerns were formally raised with Gloucestershire Council Safeguarding Adults team and a further nine reports were shared regarding incidents involving police. Martin's rough sleeping/homelessness was mentioned in at least one of these reports, but they predominantly focussed on suicide and mental health concerns, submitted in response to incidents where Martin came into contact with police and GRH. None of these concerns, in isolation, were deemed to have met the threshold to trigger a Section 42 safeguarding enquiry and these decisions appear sound. However, overall safeguarding practice in respect of Martin fell short of the standards set in the Care and Support Statutory Guidance in respect of Making Safeguarding Personal, the exploration of self-neglect and opportunities for prevention. Nor did it reflect the guidance issued in the joint ministerial letter of May 2024, which encouraged robust and proactive application of powers and duties under s42 in respect of adults at risk who are rough sleeping.

5.2.15 Safeguarding concerns were forwarded to other teams, including Housing Commissioning, Rough Sleeping and Mental Health Locality Teams, which is appropriate but there is no information confirming that these were followed up, nor feedback requested on actions taken by those agencies. Despite an escalation in the frequency and severity of concerns raised from September 2024 until Martin's death in December 2024, there is no evidence that those receiving or reviewing concerns employed professional curiosity or Making Safeguarding Personal Principles in respect of Martin's care and support needs, ability to protect himself or any protective factors that may have been available to him. Notwithstanding that thresholds for formal safeguarding activity had not been met, concerns about Martin did not trigger the informal

[29] Data specific to Gloucester can be found in the data tables that supplement the statistical bulletin, here: https://www.gov.uk/government/statistical-data-sets/tables-on-rough-sleeping

convening of a multi-agency meeting[30], nor the completion of a care and support needs assessment, nor any kind of communication between the safeguarding team and Martin or the agencies working closest with him, namely CHPSS. As such the cumulative impact of risk and harm on Martin was absent from agencies discussions and each safeguarding concern and incident was seen in isolation.

5.2.16 Discussions during the review indicated that although some agencies felt he was living with self-neglect, this was not formally recorded in safeguarding concerns raised, and nor was it considered by social care staff triaging concerns. There was an engaged discussion about the uncertainties around identifying self-neglect in adults experiencing homelessness and how atypical expressions of self-neglect can be missed for this population. Whilst it's not clear that Martin was experiencing self-neglect, this was not explored. It was felt that additional guidance and awareness of how self-neglect might show up for people experiencing multiple exclusion homelessness would be beneficial.

5.2.17 A discussion with GCC Adult Social Care indicated that mechanisms intended to streamline the process and practice of raising safeguarding concerns were not routinely known about or utilised in respect of Martin. A single point of access (SPA) for professionals was in place, which agencies could have used to speak to qualified social work practitioners and raise concerns without going through the social care helpdesk, where concerns are screened by administrative staff rather than practitioners. Agencies involved in the review did not mention the SPA and there is no evidence in case notes that it was made use of for Martin. GCC Adult Social Care reflected that, at the time, there was insufficient awareness of the SPA between agencies. Further, the screening process employed by the adult social care helpdesk did not contain robust enough mechanisms for referring complex/borderline/atypical safeguarding concerns to a qualified practitioner. Action has to be taken to address these gaps, discussed in 6.5.

5.2.18 Southwestern Ambulance Service reflected on the challenges of recognising, reporting and following-up on safeguarding concerns when providing brief emergency support. They recognised missed opportunities to raise safeguarding concerns about Martin, and reflected that these arose partly because the overlapping nature of his needs resulted in uncertainties around meeting Section42 thresholds. They reflected that their learning from this review is to be proactive about raising concerns about adults whose level of need and risk is unclear, recognising that statutory safeguarding teams are best placed to access a fuller picture of the person and to take a broader view of the cumulative effects of exposure to risk and unmet need.

5.2.19 It is notable that a formal assessment of Martin's care and support needs was not undertaken at any time during the review period, although it was indicated this should be considered in February 2024 to understand his need for specialist supported living accommodation. In March 2024, following a referral for a care and support assessment by the CHPSS Team, Martin was referred to the Enablement Team which was an appropriate preventative response. However, after the team completed an assessment with Martin (May 2024) they were unable to engage him further and there was no follow-up in respect of alternative steps to support him, nor to suggest that a Care Act assessment should now be explored. During the review, representatives from Gloucestershire County Council Adult Social Care cited the implementation of 'Prevent, Reduce, Delay[31]' principles to understand the absence of a formal assessment of Martin's needs. They

[30] Which would have been appropriate and proportionate given Martin's circumstances, in line with 14.44 of the Care and Support Statutory Guidance

[31] Described in commentary to the Care Act 2014 here: https://www.legislation.gov.uk/ukpga/2014/23/section/2/notes with practice guidance available here: https://www.scie.org.uk/care-act-2014/legal-impact/prevent-reduce-delay/

were not confident that completing a care and support needs assessment with Martin would have added anything to the multi-agency response, although they agreed that this position should have been reviewed when the Enablement Team were unable to successfully engage Martin with support.

5.2.20 Actions to prevent, reduce or delay needs from occurring or escalating should be active rather than passive; the statutory guidance requires local authorities to identify people and carers with unmet needs, map relevant services and shape the local market to commission or provide appropriate preventative support[32]. There is also an expectation[33] of integration with health and housing services to meaningfully prevent, reduce and delay needs, which is highly relevant in respect of Martin. A care and support needs assessment may not have identified eligible needs, but it would have identified meaningful opportunities for prevention, for considering the impact of EUPD on his wellbeing and of possible multi-agency actions to reduce risk and prevent harm. Importantly, this was a moment for the local authority to convene a meaningful and authoritative multi-agency response to Martin's needs, with agreed actions for agencies and appropriate monitoring of escalation. This opportunity was missed.

5.2.21 Relatedly, contributors to the review reflected on an overall lack of 'ownership' of those adults whose needs don't meet statutory thresholds, stating "*they fall through the gaps over and over again ending up in a revolving door of arrests and admissions, like Martin was*." It was noted by a number of agencies that this is an acknowledged gap, which has been discussed at Gloucestershire SAB and as part of the Suicide Prevention Steering Group. Encouragingly, Gloucestershire Safeguarding Adults Board identified a priority at 3.4 of their 2022-2026 Strategic Plan[34] to:

> *"GSAB will seek to help Gloucestershire establish a clear and inclusive pathway for Individuals who lead complex lives owing to their health (including alcohol and substance misuse, and through exploitation) and social care needs (including homelessness) in order to achieve better outcomes and keep them safe."*

5.2.22 Activity in respect of this strategic plan priority includes the development and implementation of a Multi-Agency Risk Management[35] approach and becoming a Making Every Adult Matter adoption area in October 2024. These developments were not in place when Martin was alive and as such, are discussed in Chapter 6 of this report.

5.2.23 The governance of housing and homelessness was also raised briefly as part of senior management discussions in this review. The Gloucestershire Housing Partnership governs activity in respect of homelessness and rough sleeping[36], and contributors to the review were aware of both directly provided and commissioned support for adults experiencing street homelessness. However, practitioners and senior managers reflected that there are definitely opportunities to strengthen the interface between homelessness and adult safeguarding, to maximise evidence-informed commissioning and to ensure that leadership of this work is more visible to frontline officers and voluntary and community partners. Learning from this SAR should create an opportunity to do this through the convening of a multi-agency practice sharing summit.

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32 2.26 of the Care and Support Statutory Guidance
33 2.34, 15.62, and 15.63 of the Care and Support Statutory Guidance
34 https://www.gloucestershire.gov.uk/media/2wgivllz/gsab-strategic-plan-2022-26docx.pdf
35 https://www.gloucestershire.gov.uk/gsab/i-am-a-professional/multi-agency-risk-management-marm/
36 A useful overview of the work of the partnership in this respect, can be found here: https://glostext.gloucestershire.gov.uk/documents/s98449/Item%204%20-%20Homelessness%20and%20Rough%20Sleeping%20Powerpoint.pdf

5.2.24 Whilst examples of good practice and supportive service delivery are clear, agencies reflected that the local system around Martin was reactive and short-term rather than preventative and forward-looking. One learning event attendee reflected "*Did it meet his needs? No. Did it meet his presentation? Yes.*" This sentiment is substantiated by the absence of coordinated planning for Martin, and in the reactive nature of support, albeit that some attempts were made to engage Martin in longer-term support, such as Occupational Therapy and substance use support, which he engaged with to some extent. Learning generated by this key line of enquiry is well summarised in this quote from an agency representative involved in the review: *"Unless good service input is matched by system wide cohesion then it's difficult to make meaningful progress with someone. Without housing and long-term support, what chance did Martin really have?"*

KLOE 3: Approaches to Working with Trauma

- Professional curiosity around personal history
- Trusted professional relationships
- Understanding behaviour
- Responding to emotional distress and challenging behaviour

5.3.1 Trauma-informed care is a strengths-based approach to working with individuals living with multiple disadvantage and other complex needs. Although trauma-informed practice takes many forms, the phrase describes a range of approaches to housing, health and care interventions which are grounded in the understanding that trauma can impact an individual's neurological, biological, psychological and social development and as such their responses to professional involvement in their life. Trauma-informed practice acknowledges the need to see beyond an individual's presenting behaviours and to ask, '*What does this person need?*' rather than '*What is wrong with this person*?'[37].

5.3.2 Personality disorder diagnoses and trauma are closely linked; early or prolonged exposure to traumatic experiences—such as abuse, neglect, or instability—can profoundly shape an individual's sense of self, relationships, and emotional regulation. Many behaviours categorised as personality disorder, such as intense fear of abandonment, impulsiveness, emotional volatility, or distrust of others, may represent learned survival strategies developed in response to chronic stress or perceived and actual threat. In this way, both trauma responses and personality disorder traits can include coping strategies that may once have been supportive but that become maladaptive or harmful over time. Best practice in this regard is to conduct assessments that seek to explore personal histories, coping strategies and future goals, alongside exploring the meaning behind behaviours that have become problematic to the individual.

5.3.3 Martin clearly experienced multiple events that may have been traumatic, during the review period and in the years before it. These included experiences with the police, suicide attempts, the breakdown of important relationships and periods of rough sleeping. Although it's not clear what happened during his childhood, Martin told more than one person he had experienced violence and abuse in his early life, including from his mother. Considering this information and the evidence base around trauma and its effects, it is reasonable to surmise that Martin was living with the effects of trauma, that coalesced in his emotional distress, drug and alcohol use, self-harm, and sporadic engagement with services.

5.3.4 Whilst trauma may have been a significant factor in Martin's behaviour, the intention of trauma-

[37] https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice

informed care is not to absolve adults of their responsibilities towards self or others. Martin displayed sexually inappropriate behaviour towards women, including professionals and people he lived with, and this had an impact on the willingness of other accommodation services to consider a placement for him. He also made threats of harm to others, in some instances involving the threat of weapons and arson, which were understandably deeply concerning to those involved and elicited police intervention on several occasions. In September 2024, his relationship with his eldest daughter broke down for the final time, when he entered her house without permission and an altercation with her partner ensued, which was witnessed by her young son. She subsequently sought an injunction against him which came into effect in December 2024. The provision of trauma-informed care in respect of this, would be to understand the root causes of harmful behaviour and to identify opportunities for de-escalating the emotional distress that seems to have been a factor in these incidents.

5.3.5 It is equally important to reflect on the trauma of chronic and enduring isolation, loneliness and perceptions of abandonment. This report makes mention on multiple occasions to the impact of the loss of relationships on Martin's emotional wellbeing, both those that happened during the review period and those in the years prior. Martin had lost his sense of belonging, being uprooted by homelessness and by the cumulative effect of his inability to control his emotions. Representatives from Via reflected on the community support available to Martin to make new connections, to meet people and to engage with help informally and without the need for referrals and appointments. Whilst Martin did attend the Gloucester City Mission, this appeared to have been quite difficult for him to manage at times. The Via service shared that they have recently implemented 'community drop-in' support, where people can access informal support, meet others looking to access drug treatment or harm reduction help and just generally make new connections. Although this wasn't available when Martin was alive, it is hoped this new approach adds to the community support offer available to people who might be similarly isolated.

5.3.6 Information shared with the reviewer as part of this SAR demonstrates that agencies in Gloucestershire are on a journey to embed trauma-informed practices. The practitioner and manager events, in particular, highlighted a shared understanding that working in trauma-informed ways can be beneficial for people like Martin and agencies provided a number of examples of how trauma-informed approaches were taken, as well as others that are being developed and implemented currently. Agencies reflected that moving towards a trauma-informed system is an aspiration and welcomed the learning from this review as an opportunity to further that work, moving from individual agency practices to a more systemic approach.

5.3.7 There are a number of examples of positive practice in respect of trauma-informed work in Gloucestershire. Chief amongst these is the approach of the CHPSS team, where a number of key best practices were evident in written documentation and agency reflections as part of the review. The team reflected on how smaller caseloads enabled more time to build trusting relationships, to offer flexibility in where and when appointments happened and to act as informal advocates for their patients. Referral processes in this service identify the presence of previous trauma, which informs work with that individual going forward. The team also adopted best practice 'lead professional arrangements', which is where a single practitioner/clinician is identified as the 'lead' in discussions about and interactions with individuals accessing their support. This gives individuals a key point of contact, who knows them well and who can ensure they are kept informed and their voice heard in professional discussions.

5.3.8 The CHPSS team reflected that trauma-informed service delivery has developed over time and is ongoing, pointing to recent developments to support the emotional regulation of people going to hospital, as an example. They shared that the phrase 'trauma-informed care' can sometimes feel quite academic and intangible, something other agency representatives agreed with, and pointed to the value of small practical actions that help people feel calmer in situations that are likely or known to be re-traumatising or triggering. Offering a distracting conversation, a cup of tea, a colouring book or something to eat are small but meaningful acts of trauma-informed care that can aid the completion of assessments, medical care etc. Their ways of working provide an excellent opportunity for local learning that expands best practice beyond the CHPSS team and across the system.

5.3.9 There does not appear to have been a shared understanding between agencies about how Martin's behaviour could be understood in respect of his Emotionally Unstable Personality Disorder diagnosis. When he was discharged from the care of the Recovery Team in June 2023, it's unclear how information about his mental health and emotional distress were shared with agencies who would go on to support him. It does not appear that opportunities to engage the Complex Emotional Needs Team as part of a planned discharge of care were considered or taken up. Several agencies involved in the review were unclear about the support available to people living with complex emotional needs and personality disorder, and the Council's Housing Partnerships Team reflected that "*there are several accommodation providers in the county who have expressed that people with a diagnosis of EUPD are too high in support need to be accommodated. We have had some success in evoking a Team Around Me approach for individuals with the diagnosis, however when there is an outburst due to EUPD resulting in property damage or verbal threats to staff, accommodation is ceased making ongoing support a greater challenge. It is my opinion that those with a diagnosis of EUPD are more vulnerable when rough sleeping due to feelings of shame and guilt at losing support and accommodation as well as vulnerabilities to exploitation."* Again, the connection between housing insecurity and emotional distress looms large, and there is clearly a need to strengthen the support not only for individuals, but for agencies supporting them, so that rough sleeping can be more effectively prevented for people experiencing multiple disadvantage.

5.3.10 Rather than centring risk and mitigation, trauma-informed approaches to risk assessment are strengths-based, with a greater focus on safety and protective factors. Trauma-informed risk assessment tools could have explored how Martin experienced safety, with who and in what circumstances and attempted to strengthen these situations and relationships. Such an assessment might also have considered how Martin coped with and managed risks he understood, what he felt would meaningfully improve his safety (both personal, interpersonal and social) and how he would like professionals to respond in certain situations. A multi-agency trauma-informed approach to understanding needs and risks could have been beneficial to Martin, and to agencies working with him, in response to the withdrawal of support from mental health services and in exploring possible self-neglecting behaviours, emotional distress and self-harm incidents.

5.3.11 Martin had significant literacy issues, which were a cause of shame and would likely have made appointments with professionals daunting and confusing for him. He also experienced significant challenges with relationships; his sense of loss and abandonment and difficulties in group settings making it difficult for him to access opportunities for conversation and connection. Therefore, when Martin briefly accessed Occupational Therapy support in May 2024, it is notable that he did well and engaged fairly consistently. Notes from these sessions indicate meaningful

conversations between Martin and the OT including some rare future-focussed thinking. It's notable that his work with the OT was 1:1, practical and consistent which aligns with trauma-informed principles and, whether intentional or accidental, appeared to meet his need for focussed 1:1 support, using tools and activities where he could feel a sense of achievement.

5.3.12 During Occupational Therapy it was discussed that Martin might benefit from the Anchor Project, a behavioural change programme provided by Kingfisher Treasure Seekers to support adults who face significant struggles to cope with life. A referral was made but Martin wasn't deemed stable enough, at the time, to make the commitments required. This option wasn't ruled out in perpetuity, but sadly Martin never became stable enough to be reconsidered. A similar determination was made by Via about Martin's ability to participate in group work around his drug use. Although both of these decisions appear to be appropriate and realistic, they identify a gap in the support available for adults experiencing multiple disadvantage to prepare for more structured programmes of support and group work, especially when rough sleeping is a factor in an individual's instability. As mentioned in 5.1.17, in the substance use field this is often called 'pre-treatment' and refers to stabilisation support that helps people create the best possible conditions for engaging with more formal treatment and recovery interventions.

5.3.13 Prior to the review period, agencies reflected that Martin had lived stably in a supported housing placement for almost ten years, acting 'mischievously' but not aggressively or violently. What changed is unclear, although agencies pointed to the impact of the loss of this long-term accommodation (which arose because he was not attending appointments with secondary mental health services, was not taking medication and was no longer considered to have a diagnosis of schizophrenia) as a likely trigger and downward turn. Case notes recognise that the insecurity, isolation and deprivation of rough sleeping were significant for Martin, as was the trauma of actual or perceived loss and grief in his life. It is telling that incidents escalated in periods when Martin was facing eviction or immediately afterwards. Further, he often told professionals that someone had died, when this is not believed to be the case, indicating that he was experiencing difficult feelings about loss that may have warranted trauma-informed exploration around his personal relationships and sense of belonging, connection and self-worth. Case notes from Martin's GP related to these disclosures of loss, there were missed opportunities to employ professional curiosity around grief and loss, or to suggest to more appropriate agencies that this would be a beneficial course of action.

5.3.14 Given the evidence that up to 92% of homeless adults have experience of trauma[38], it is crucial that homelessness services are equipped to support this need. Agencies involved in the review reflected that hostel and supported housing services in Gloucestershire are not sufficiently equipped or resourced to manage how trauma is expressed, especially given most services accommodate multiple individuals with fairly low staff ratio's, and tenancy conditions that limit the degree of flexibility that can be afforded to individuals exhibiting challenging behaviour to self and others. It is understood by the reviewer that commissioned homelessness services in Gloucestershire are contractually obligated to ensure staff have access to training about trauma-informed care, which is good practice. However, agencies reflected that applying this learning in practice is challenging and that there is a gap in the provision of specialist supported housing for those who need more intensive support and higher levels of risk tolerance. Agencies reflected that there is currently a significant gap between what is available via housing-related support services and the support provided by adult social care services, reflecting that an accommodation

[38] https://www.oasiscommunityhousing.org/wp-content/uploads/2022/10/The-prevalence-of-trauma-among-people-who-have-experienced-homelessness.pdf

service that combines the two area specialisms would have been beneficial for Martin and the growing population of people locally with similar needs.

5.3.15 Trauma-informed approaches to addressing the underlying causes for chronic homelessness and multiple disadvantage "*value and encourage the development of relationships, not only for their intrinsic worth, but also for their power in driving transformative change in people's lives*"[39]. One area where this could have been implemented to positive effect was in respect of supporting Martin's relationship with his daughter and other family members. Martin spoke about his children frequently, and although what he shared was sometimes contradictory and unclear, it is clear these were important relationships to him. For several months during 2024 Martin's daughter reached out to agencies to share concerns about him, and it is good practice that a consultant psychiatrist who saw Martin in GRH in September 2024 recommended that his daughter be involved in next steps around his care. It does not appear that this was followed up, which may have been due to the incident at her home that followed a week later. Nonetheless, consideration of Think Family approaches might have been beneficial when agencies were first aware that Martin was in contact with his daughter. This might have included securing Martin's consent to speak to his daughter, potentially leading to conversations with her and the invitation to share her concerns or insights about her father. It might also have brought in elements of Making Safeguarding Personal guidance[40], specifically those that consider the role of important relationships in the life of adults with care and support needs who are at risk of abuse and neglect.

5.3.16 One aspect of trauma-informed care lies in understanding an individual's capacity to weigh up information, understand consequences and execute decisions. This is particularly the case for adults who may have experienced traumatic brain injury. Martin experienced a head injury in February 2023, reported severe head pain in November 2023 to his GP and reported other head injuries in May, September and October 2024. It is good practice that head CT scans were undertaken in GRH on several occasions where head injuries were suspected, which came back normal. It is also good practice that mental capacity concerns were noted in decisions to convey Martin to hospital by police and ambulance crews and further that brief assessments of Martin's mental capacity were undertaken by Mental Health Liaison Teams when Martin attended GRH. It is unclear if an assessment of Martin's executive function was ever considered by adult social care, or the extent that fluctuating capacity (due to severe distress and intoxication) was explored by any of the teams who had longer-term engagement with Martin and would have been in a position to do so.

5.3.17 Concerns about Martin's cognitive abilities are noted in case records by several agencies, and concerns were raised formally to adult social care by CHPSS in February 2024, noting issues with memory, understanding information and executing decisions. However, when Martin did not engage with the Enablement Team referral that flowed from this concern there is no indication that these concerns were followed up, nor that a formal mental capacity assessment was considered. Learning events and supplementary information provided to the Reviewer suggest that there is a knowledge gap around mental capacity amongst frontline practitioners and that the multi-agency training offer provided by Gloucestershire County Council around mental capacity is not widely taken up, especially by housing providers and voluntary sector agencies. There is therefore an opportunity to promote the current learning offer more widely, and to consider a skills audit to better understand legal and practice literacy around mental capacity and the Mental Capacity Act in respect of agencies and practitioners working with adults experiencing multiple

[39] https://cuf.org.uk/uploads/resources/TN_Relational_Working_Exec_Summary_Web.pdf
[40] https://www.local.gov.uk/msp-toolkit

exclusion homelessness and multiple disadvantage.

5.3.18 Practitioner and manager events highlighted the challenges of meaningfully embedding trauma-informed practice in systems where choices are often limited by resource pressures and where the role and function of individual agencies may themselves be re-traumatising or negatively connected with earlier experiences. Notably, colleagues working in acute hospital settings reflected how the notion of trauma-informed practice is somewhat contradictory, because personal agency and choice are highly limited and the physical environment in A&E can be chaotic and over-stimulating by nature, rather than calming or therapeutic. Both Police and GRH contributors to the review shared examples of efforts to increase awareness of and engagement with trauma in these settings, which included staff training, reviewing key policies and working practices and the creation of specialist roles (chiefly a trauma-informed nurse specialist at Gloucestershire Royal Hospital). Agencies pointed to the offer of trauma-informed crisis support at The Cavern, an out of hours crisis space provided by Treasure Seekers who also provide on-site support at the hospital in the evenings for those presenting with emotional distress. This is good practice, as were reflections that these developments had identified the importance of tackling stigma and unconscious biases when developing trauma-informed approaches to adults whose behaviour is challenging and aggressive.

5.3.19 There was broad agreement from agencies involved in the review that system-wide training around trauma-informed care would be beneficial, not only in supporting individuals but also in developing a shared approach to how, when and by who this support would be offered. It is understood that the Complex Emotional Needs team offer this training, although most agencies involved in the review were not aware of this. The Gloucestershire Housing Partnership worked with the Nelson Trust to facilitate training for frontline practitioners, managers and strategic leads, recognising that trauma-informed practice can only be meaningfully delivered when it is supported by a whole system/whole organisation response, which is best practice. There is an opportunity to revisit the training offer around trauma-informed care as part of the development of Making Every Adult Matter approaches discussed in the next chapter, but more importantly there is an opportunity to look at what a trauma-informed system would look like, how it would be enabled by strategic leadership, governance and commissioning activity and not only frontline practice.

5.3.20 Importantly trauma-informed care also recognises the impact of secondary or vicarious trauma on staff working with individuals experiencing harm and trauma directly. Agencies involved in the review identified the impact of ‘burn out’ on professional curiosity and empathy in respect of Martin, noting the frequency of incidents as having a negative impact on staff wellbeing. A number of agencies pointed to the availability of reflective practice, group supervision and organisational cultures in respect of this which is good practice, but this was not present across the board nor in a multi-agency format.

5.3.21 As part of the review, reflections were shared about the impact Martin’s death had on the staff, who had interacted with him on that day and on several other occasions. They shared that their roles bring them into contact with many people who are experiencing distress, but that their involvement can be somewhat ‘invisible’ compared to that of social workers, housing officers and other professionals – meaning that they do not receive training on de-escalating challenging behaviour, are not confident in how and with who to share pertinent information and not necessarily offered support following serious incidents. Learning from this review suggests that investing in training and support for all staff who have regular interaction with local residents

would be beneficial, as would consideration of a protocol for responding to risk concerns and serious incidents that happen.

National Context

5.4.1 The first and second national analyses of SARs[41] concluded that insufficient attention was given in SARs to the national legal, financial and policy context that shapes local practice.

5.4.2 During practitioners' events the national context of acute resource pressures, short-term funding cycles and the severe lack of appropriate and affordable housing were highlighted as major challenges in supporting vulnerable adults in Gloucestershire. Specifically, agencies highlighted the specific challenges of meeting Martin's need for specialist supported accommodation, with agencies pointing to the impact of budget pressures on effective 'non-statutory' commissioning.

5.4.3 Agencies also pointed to the intense resource pressures impacting the capacity of inpatient mental health services. They reflected that there were occasions during the review period when Martin may have benefitted from a period of inpatient care to stabilise his mental health following suicide attempts and other incidents, but that the idea of an 'informal admission' in the current pressurised operating environment was 'infeasible'. These comments reflect agency perceptions about changes in mental health care, and representatives from GHC stated that "had an inpatient admission been clinically indicated, a bed would have been found, even if it was out of the county".

5.4.4 As well as situating challenges in local practice within the context of national funding pressures, agencies pointed to gaps and uncertainties within the law around self-neglect, mental capacity and adult safeguarding. In particular, agencies felt that the interaction between self-neglect and mental capacity is challenging to assess and determine, especially when someone is known to use drugs and alcohol. Some agencies were concerned that it was presumed Martin had mental capacity because "*they wouldn't have known what to do with him if he hadn't*". Their reflections echo those of the House of Lords select committee in their 2014 post-legislative scrutiny of the Mental Capacity Act, when they concluded that *"The presumption of capacity, in particular, is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm. In some cases, this is because professionals struggle to understand how to apply the principle in practice. In other cases, the evidence suggests the principle has been deliberately misappropriated to avoid taking responsibility for a vulnerable adult"*[42]. Agencies involved in this review welcomed further training and practice guidance but pointed to the specific challenges of applying the legislation to adults whose needs and decision-making abilities are not sufficiently considered by the Act, specifically adults living with the effects of alcohol and drug use and trauma. Further agencies were unclear about how duties and powers related to mental capacity and adult safeguarding interact and felt that this was a gap in national guidance for practitioners.

6. Changes Since Martin's Death

6.1 A strong positive aspect of this review lies in the demonstrable commitment to continuous development around support for adults experiencing multiple exclusion homelessness and

[41] Braye, S. and Preston-Shoot, M. (2024) Final report: Stage 2 analysis, Analysis of learning in Second national analysis of safeguarding adult reviews. Local Government Association, London, UK. Available at: https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023

[42] Select Committee on the Mental Capacity Act 2005 (2014) Mental Capacity Act 2005: post-legislative scrutiny. House of Lords. Available at: https://publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/139.pdf

multiple disadvantage. There are several examples described throughout the report, but this section takes particular note of two initiatives which were not in place during Martin's life that are clearly indicated as learning from this review.

6.2 The first relates to the establishment of a Multi-Agency Risk Management (MARM) approach, which was implemented in April 2025. This review, and existing systems learning, indicates that a standardised approach to supporting adults who do not fall within existing multi-agency processes or where these approaches have not enabled positive change, would be beneficial. The establishment of the MARM approach is supported by a suite of guidance and template documents for use by practitioners and stakeholders aimed to standardise and streamline the approach. At the time of writing, a new role of MARM Coordinator is vacant and subject to successful recruitment – this role will be crucial in collating and sharing learning from the MARM process, providing assurance to the Safeguarding Adults Board and identifying ongoing changes to the approach that ensure its effectiveness.

6.3 In October 2024, Gloucestershire became a Making Every Adult Matter (MEAM) adoption area. This had been identified as a recommendation in SAR Peter, commissioned by GSAB in 2021. The MEAM approach looks at how local housing, health, care and justice systems can reduce the barriers to good outcomes by improving coordination, simplification and opportunities for peer learning. At the time of writing, the newly appointed MEAM Coordinator has started work, and has established the following priorities for action:

- Identifying a target cohort to support by testing new approaches
- Establishing a MEAM Steering Group made up of key agencies, and a Lived Experience Advisory Group
- Establishing a Gloucester City Homelessness Forum (starting in January 2026)

6.4 Early work has begun to identify three focus areas/populations for MEAM input in Gloucester. These are activities that address the 'revolving door' of homelessness, activities to reduce risk in adults whose experiences do not meet thresholds for formal safeguarding enquiries under Sec42 and activities to prevent and reduce high usage of acute services such as police and ambulance. System improvements in these areas will be identified by direct work with the target cohort, from discussions in a newly formed multi-agency Community of Practice and from evidence from other MEAM areas. It is hoped that learning from this review will support these emergent aims and ways of working.

6.5 There have also been a number of developments in adult social care, which are already having a positive impact on how safeguarding concerns are explored and responded to. The safeguarding SPA has been much more widely promoted and the Reviewer understands local agencies are using it more consistently, something that is under review by GCC. As part of an audit, gaps in the recognition and response to cumulative risk were identified and the social care helpdesk process has been amended accordingly to ensure more input from qualified practitioners following repeat concerns. Lastly, the Reviewer understands that the County Council is bringing the delivery of statutory mental health social work functions back in-house in 2026. Work is already underway to achieve this, which is expected to have considerable positive impacts on the delivery of Care Act duties and the continuity of support for adults with complex care and support needs. Learning from this review suggests that this change should embed, and be embedded within, learning and practice from the emerging MEAM and MARM approaches.

7. Conclusion

7.1. This Safeguarding Adult Review highlights the profound challenges faced by Martin, living with the overlapping effects of multiple disadvantage and, the significant challenges faced by the local system in meeting his needs. His experiences underline how the complexity of service pathways, the chronic shortage of specialist accommodation and uncertainties in practice around suicide prevention and complex emotional distress can combine to create a series of barriers that make accessing stability and recovery extremely difficult, even when services are present and engaged. The review has shown that while there were dedicated professionals involved in supporting Martin, the system as a whole struggled to provide coordinated, sustained, and trauma-responsive support that matched his level of need.

7.2. A recurring theme throughout this review was the fragmented nature of service pathways. Navigating different referral routes, thresholds, and eligibility criteria was challenging not only for Martin but also for practitioners trying to advocate on his behalf. The absence of clear lead professional arrangements and opportunities for creative solutions for those with atypical needs, meant that responsibility shifted between agencies, often leaving gaps in housing, support and care during moments of acute vulnerability. These gaps were particularly significant for someone whose experiences of trauma, homelessness, substance use, and mental distress already reduced their capacity to self-advocate and engage consistently. In the vacuum created, Martin relied heavily on acute and reactive support and did not have a consistent trusted professional relationship he could rely on to help him navigate his needs, experiences and goals for the future.

7.3. Trauma-informed practice was evident in parts of the system, but not yet embedded as a universal approach. Similarly, whilst there were some excellent examples of information sharing and multi-agency planning, this was inconsistent and did not always make the best use of local guidance, training and system support.

7.4. As a result, interactions between Martin and agencies sometimes inadvertently reinforced feelings of mistrust, hopelessness, or disconnection. For individuals living with the cumulative impact of trauma, services need to be flexible, patient, and relational, with an emphasis on understanding behaviour as communication rather than non-compliance. Agencies involved in this review are ambitious about the possibilities for practice improvement afforded by the implementation of the Making Every Adult Matter and Multi-Agency Risk Management approaches, which began as this review concluded.

7.5. Martin's death is a stark reminder of the consequences for individuals when systems are unable to meet demand or to work in coordinated ways, especially where there is a need for specialist supported accommodation. Learning from this review concludes that future homelessness commissioning should actively seek to meet the needs of homeless adults facing multiple disadvantage and be sufficiently resourced to reduce the risk of eviction for adults living with emotional distress and challenging behaviour.

8. Recommendations

8.1 The key lines of enquiry explored as part of this Review have identified a number of learning points as well as areas of strength and emergent good practice. The aim of the following ten recommendations is to enable Gloucestershire Safeguarding Adults Board, and key partner agencies, to continue to improve the quality and outcome of health, social care and safeguarding

activity for people living with the effects of multiple disadvantage/multiple exclusion homelessness.

8.2 A number of relevant SAR's have recently been completed in Gloucestershire exploring homelessness, challenging behaviour and multiple disadvantage, including SAR 'Nadia' (2024), SAR Peter (2021) and SAR 'WH' (2023). The recommendations made in these reviews are highly relevant and significant progress has been made already; recommendations from these reviews should be reviewed and, where relevant, integrated with those below to synthesise relevant learning and to avoid duplication of effort.

1. **GSAB to convene a Homelessness and Safeguarding Summit,** bringing agencies together to share practice and learning from their work with people like Martin. Importantly this is an opportunity to strengthen alignment between the two areas of practice, to connect national policy with local practice and to listen to insights from people with lived experience. Importantly this event also creates an opportunity to engage system partners in the MEAM approach

2. **GSAB to strengthen information and guidance about identifying and responding to self-neglect, fluctuating capacity and executive functioning. As a priority this should include the creation of a multi-agency training module about self neglect and a guidance note that considers the discrete experiences of people facing homelessness and multiple disadvantage[43].** Activity might also include seeking assurance from key partners about how self-neglect is reflected in individual agency policies and procedures, system-wide promotion of the GSAB Self-Neglect Guidance and the gathering and sharing of evidence from practice elsewhere in the country.

3. **GSAB and the Gloucestershire Suicide Prevention Partnership to collaborate on a joint initiative about suicide risks affecting 'high risk groups'.** This should include wide circulation and promotion of the local strategy, multi-agency promotion of existing guidance and e-learning, and the development of a discrete practice guide to aid dynamic risk assessment and safety planning with people experiencing homelessness, multiple disadvantage and complex emotional needs.

4. **The Independent Chair of GSAB to write to the Department of Health and Social Care about commitments in the NHS 10-Year Plan around the creation of 'mental health emergency departments'**[44]. Specifically, the letter should highlight learning from this SAR and point to opportunities to embed trauma-informed care and multi-agency coordination for inclusion health groups, as part of the development of these new services.

5. **GSAB to revisit the recommendations made in the Joint Ministerial Letter of May 2024 and** assure itself that a robust interface exists between homelessness/rough sleeping and adult safeguarding practice and governance. Consideration should be given to the development of a Homelessness Fatality Review process for the city and county, under Section 44(4) of Care Act, ensuring all homeless deaths are reviewed and learnt from, even where thresholds for Safeguarding Adult Reviews are not met.

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[43] For example, written by North East SAR Champions is a useful example: https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Health-and-social-care/Care%20support%20for%20adults/safeguarding%20adults/7-SN-Reg7MB-Homelessness-04-04-2022.pdf

[44] https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future/fit-for-the-future-10-year-health-plan-for-england-executive-summary

6. As part of the developing MEAM and MARM approaches, **Gloucestershire County Council to map existing multi-agency forums and case discussions, including information about referral processes, governance and escalation.** The map and accompanying information about each forum/panel should be published and promoted to encourage coordinated multi-agency action and to ensure that decisive action is taken when risk remains high or is escalating.

7. **GSAB to make multiple disadvantage/multiple exclusion homelessness a strategic priority for the 2026-2030 Strategic Plan,** which should include seeking assurance about the development and impact of MARM and MEAM approaches in respect of this group of adults.

8. As part of the development of MEAM and MARM approaches, **Gloucestershire County Council to establish the multi-agency 'Team Around Me' approach and to develop guidance supporting people where 'engagement is difficult or not working'.** Guidance should be co-designed with people with lived experience of multiple disadvantage.

9. **GSAB to work with Gloucestershire County Council and Gloucestershire Health and Care NHS Foundation Trust to raise awareness of the support available to adults living with personality disorder diagnoses and complex emotional needs.** This should include clarity about the individual and system support available from the Complex Emotional Needs Team and how to access it, promotion of available training and consideration of the need for additional guidance for organisations supporting adults who struggle with emotional regulation and acute distress.

10. **Gloucestershire County Council to review the support and guidance available to resident-facing staff related to safeguarding and serious incidents.** This should include a review of training availability and uptake on adult safeguarding, de-escalation and conflict resolution, and an overview of trauma-informed care. Importantly, a protocol is needed to describe the organisational response to serious incidents; it should outline what is expected from staff and the wellbeing support available to them, mechanisms for debriefing and reflection and the appropriate recording and reporting of concerns and incidents.

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