

**Safeguarding Adults Review**

**Tower Hamlets Safeguarding Adults Board**

**Title**: Ms H and Ms I – Thematic Safeguarding Adult Review

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# Introduction

* 1. Tower Hamlets Safeguarding Adults Board (THSAB) received two referrals for consideration as Safeguarding Adult Reviews (SARs) in early 2019. The THSAB SAR sub-group considered both referrals and in May 2019 decided upon a thematic review methodology. This decision was informed by the apparent similarities between the two cases, namely self-neglect, homelessness, substance misuse and multiple physical health needs.
	2. Ms H, a White British woman, died aged 52 on 1st April 2018, in accommodation belonging to a friend where she had been staying. She was found unresponsive by a care worker who called the London Ambulance Service. She was pronounced deceased at the scene. The Coroner established cause of death as due to morphine and gabapentin[[1]](#footnote-1) toxicity, a drug-related conclusion. The Coroner did not issue a Regulation 28 notice[[2]](#footnote-2) in this case.
	3. Ms I, died in hospital aged 33 on 2nd June 2018. Her ethnicity is not recorded on the SAR referral form. The Coroner recorded cause of death as a methadone overdose. The Coroner found that she had taken illicit drugs whilst an inpatient on top of prescribed medication, including methadone, unintentionally causing her death. Her presence on the floor in her room under a pile of clothes and surrounded by drug paraphernalia went undetected for approximately ten hours, during which time she was believed to be off hospital premises. Hospital CCTV was not checked. The Coroner was unable to determine whether earlier detection of Ms I in her ward room would have saved her life.
	4. In this case the Coroner issued a Regulation 28 notice on 16th November 2018. The Coroner listed several concerns, namely that:

1.4.1 there was no nursing plan to address the likelihood of Ms I taking illicit drugs when in and out of hospital;

1.4.2 there was a lack of awareness amongst some staff about Ms I going off ward to take drugs;

1.4.3 a drug chart was missing;

1.4.4 she was thought to have left the ward to smoke but no-one had seen her leaving;

1.4.5 hospital security personnel had not been notified that she was missing and that there was confusion amongst staff about when the missing person policy should be followed.

* 1. Barts Health NHS Trust replied to the Coroner on 15th January 2019. It accepted that, although medical and nursing staff had advised Ms I against taking illicit drugs, the nursing plan should have been more explicit about this risk so that all nursing staff were aware of her behaviour. Staff have been reminded of the importance of documenting suspected drug misuse and including such risks in nursing handovers. The Hospital has reviewed the controlled drug registers and is able to account for the doses of methadone given. However, it accepted that the missing drug charts was a “serious failure” for which it apologised. A move to electronic prescribing is envisaged to eliminate risk of loss of paper charts.

1.6 The Hospital observed that her room was crowded with possessions such that a search was difficult. It accepted, however, that well-meaning tolerance of the state of her room was not in her best interests and staff have been reminded of the need to ensure that rooms are tidy and organised. It accepted that the room checks had not been adequate, and staff have been reminded of the danger of making assumptions, in this instance that patients have left hospital premises. Finally, the Hospital stated to the Coroner that Ms I was judged to have capacity to decide to leave hospital premises and therefore they did not have powers to prevent this. Accordingly, she would not have been classified as a missing person but as a self-absenting patient. Hospital policy in that instance is that security staff would not be called. The Hospital added, however, that if there was concern that she as missing on the premises, then security staff should have been notified. Again, staff have been reminded of the dangers of making assumptions.

1.7 The thematic review was commenced in May 2019.

# Safeguarding Adults Reviews

* 1. THSAB has a mandatory statutory duty[[3]](#footnote-3) to arrange a SAR where:
* An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and
* There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.
	1. THSAB has discretion to commission reviews in circumstances where there is learning to be derived from how agencies worked together but where it is inconclusive as to whether an individual’s death was the result of abuse or neglect. Abuse and neglect includes self-neglect.
	2. It is important to emphasise the distinction between the mandatory and the discretionary criteria because this is not always appreciated. Under current law (Care Act 2014), for the mandatory criteria to be met, a SAB must have reasonable reason to believe that the adult whose case has been referred has/had care and support needs, has/had experienced abuse or neglect, including self-neglect, and there is/was reasonable cause for concern about how agencies worked together in that case.
	3. In response to rising concerns about, and increased visibility of homelessness as an issue across the country, but particularly in big cities, the Government has released its Rough Sleeping Strategy: <https://www.gov.uk/government/publications/the-rough-sleeping-strategy>
	4. The Strategy says…

*“We agree with the Advisory Panel, who were clear that Safeguarding Adult Reviews are powerful tools, which unfortunately are rarely used in the case of people who sleep rough. We will work with Safeguarding Adult Boards to ensure that Safeguarding Adult Reviews are conducted when a person who sleeps rough dies or is seriously harmed as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. Lessons learned from these reviews will inform improvements in local systems and services”.*

* 1. The reason for emphasising the distinction between mandatory and discretionary reviews in section 2.3 above is that the Government Strategy appears to fail to recognise that, for the mandatory criteria to be met, the adult must appear to have/have had care and support needs as defined by the Care Act 2014[[4]](#footnote-4).
	2. THSAB’s SAR sub-group considered that the mandatory criteria for SARs had been met in both cases. The THSAB exercised the discretion that is afforded to it in statutory guidance[[5]](#footnote-5) to determine the most appropriate and proportionate methodology for the review. I was confirmed as the reviewer and overview report writer in May 2019.
	3. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future[[6]](#footnote-6). The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.
	4. Agencies involved in providing services to Ms H and/or Ms I have co-operated fully with this thematic review.

# Review Process

# 3.1 Focus

* + 1. THSAB agreed that a themed approach would be taken. Rather than a traditional review that would concentrate on a detailed chronology of a single case, this thematic review would look across the two cases for learning from recurring themes that would indicate systemic issues to be addressed.
		2. From the SAR referrals and initial chronologies, the following themes were identified as the initial terms of reference:

3.1.2.1 Work with adults with multiple health and care needs;

3.1.2.2 Barriers to information-sharing;

3.1.2.3 Commissioning of care and support;

3.1.2.4 Responses when adults are homeless or threatened with homelessness;

3.1.2.5 Responses when adults are engaged in long-term substance misuse;

3.1.2.6 Work with adults who self-neglect;

* + - 1. Partnership and collaborative working.
		1. It was agreed that the information made available by the agencies involved would be compared and contrasted with the evidence-base that is available for working with adults who self-neglect[[7]](#footnote-7). This evidence-base has been extended to incorporate what is known about best practice with adults who misuse substances and/or are homeless. The terms of reference therefore included a requirement to analyse the degree to which practice and policy in these two cases corresponded with “what good looks like”.
		2. The review has adopted a whole system focus. What enables and what obstructs best practice may reside in one or more of several domains, as captured in the diagram. Moreover, the different domains may be aligned or misaligned, meaning that part of the focus must fall on whether what might enable best practice in one domain is undermined by the components of another domain.



* 1. Methodology
		1. Individual agency chronologies and independent management reviews (IMRs) were submitted by partner agencies. Completed section 42 (Care Act 2014) enquiries were also submitted as part of the review process. The chronologies were combined by the reviewer and themes extracted from these, the IMRs and the section 42 enquiry reports for discussion by the review panel and subsequently at a learning event. It was agreed that the chronologies would report in detail contact with Ms H or Ms I from 1st April 2017 whilst also highlighting significant events prior to that date. This was part of the proportionate approach taken for this review.
		2. A review panel was established to support the independent reviewer. Membership comprised:
* Tower Hamlets Adult Social Care
* Tower Hamlets Housing Options
* Metropolitan Police
* Clinical Commissioning Groups
* General Practitioners
* East London Foundation Trust
* Barts Health NHS Trust
* St Mungo’s
* Excelcare
* Look Ahead Care and Support
* Providence Row
	+ 1. At its first meeting the review panel agreed the terms of reference, endorsed the evidence-base to be used to inform the thematic analysis and considered family involvement. At its second meeting the review panel discussed the themes that appeared to be emerging from the combined chronologies, identified further information that was necessary from partner agencies and endorsed the format for the learning event.
		2. A learning event with practitioners and managers involved in the cases, or in the strategic development and/or delivery of services, explored key themes that had been extracted from the combined chronologies and other material submitted for the purposes of the review. The learning event offered an opportunity for those involved in working with homeless people, with individuals who misuse substances and/or self-neglect and with adult safeguarding more generally to comment on what they believed was working effectively in Tower Hamlets and on where they felt that improvements were required.
		3. A third meeting of the review team evaluated the outcomes of the learning event and discussed a draft of this report.
	1. Family Involvement
		1. Family members were approached to invite their participation in the review. Ms H’s mother spoke with the independent reviewer by telephone. She was able to offer reflective insights into her daughter’s life and expressed her appreciation for the efforts made by services to help and support her. Her contribution is woven into the analysis that follows.
		2. Ms I’s partner also expressed a wish to be involved and the independent reviewer met with him along with his support workers. The independent reviewer is very grateful for the reflective insights that Ms I’s partner was able to offer, about Ms I as a person, about how services supported her, and about his own experience of receiving support. It took considerable courage and strength to revisit the circumstances that ended with the loss of the person he loved. The pain of loss is still very real for him but he expressed the hope that this review would be one way of achieving “justice” for Ms I and that managers and practitioners would learn from “mistakes” that might have been made. His contribution is woven into the analysis that follows.
1. Two Cases
	1. Ms H was well-known to agencies for many years. Two children had been removed from her care when she was living in another London Borough. According to her mother, they had been adopted and there was twice yearly letter-box contact. She experienced multiple health problems. These included bilateral leg ulcers, incontinence and instability, for which reason she used a wheelchair. She had Chronic Obstructive Pulmonary Disease, Hepatitis C and high blood pressure. She had been treated for an abscess on the brain secondary to sepsis and had cognitive impairment affecting her memory. Although details are sparse, it appears that she had a difficult relationship with her parents. Her mother is recorded as stating in 2010 that her daughter had a diagnosis of bipolar disorder.
	2. Her history included drug and alcohol misuse, suicidal ideation, self-neglect, housing crises, self-discharges from hospital and non-engagement with services. She had been a victim of domestic violence and had convictions for theft, shoplifting, criminal damage, harassment for money, possession and substance misuse, dating back to 1995. Her history included a pattern of multiple hospital admissions and self-neglect (personal health and care). She appeared unable to maintain a habitable environment. She had a history of insecure accommodation and homelessness. She was at risk of homelessness at the time of her death.
	3. During the period under review, essentially the last year of her life, when not in hospital she stayed in a friend’s flat. It appears that this was because she had been evicted from her own accommodation due to significant rent arrears. This friend died in February 2018, after which efforts were made to find Ms H accommodation or a placement in Kent. She rejected the placement and died before the threat of homelessness had been averted.
	4. Throughout the period under review she continued to misuse drugs and alcohol, including when in hospital. She had three admissions, the longest between June and September 2017 when there were concerns at the involvement of friends in relation to her continued substance misuse. She took her own discharge in September 2017 having refused the offer of a placement in Kent. Deprivation of Liberty safeguards had not been authorised.
	5. There were at least four safeguarding referrals during the period under review, one referral for advocacy and at least one safeguarding planning meeting. Nonetheless, her erratic engagement with services continued, including with the care agency commissioned to assist her with activities of daily living, as did her self-neglect and substance misuse.
	6. Ms I was also well-known to agencies for many years. There is evidence that she had been sleeping rough since 2000 (aged 16) and she had a long history of homelessness. Details of her family background are also patchy but include reports of the suicide of a brother, a mother with alcohol problems and unspecified childhood trauma. She had a history of depression and had been diagnosed as having an emotionally unstable personality disorder. She could be challenging and difficult to support, aggressive and non-compliant with hostel rules and/or medical treatment.
	7. Ms I’s partner reflected that he did not know much about her childhood as she would not easily talk about her family. He knew that she had been close to her father who had died when she was a teenager. He believed that she had experienced a poor relationship with her mother and she did not have contact with a sister. He believed that she had been abused as a child but did not know details. She had also been abused by a previous partner. He agreed that, as a consequence, her “real self” was often “hidden.”
	8. Ms I’s partner described her as a very complex person. She could be cheeky and charming, sometimes almost child-like, but he also described her ability to manipulate people and to let people know when she was unhappy with them. The support workers present when he was describing her character agreed that this was how she often presented. Ms I and her partner had been together for about seven years.
	9. Her engagement with services varied between erratic and poor. She had a history of overdoses and was the subject of a suicide marker periodically. She had a longstanding history of alcohol and drug misuse. She experienced physical health problems, including TB, asthma, epilepsy, pneumonia, and osteomyelitis. She had experienced cellulitis due to intravenous drug use and alcohol-related pancreatitis. One necrotic finger was amputated during the period under review. She had also experienced deep vein thrombosis and ulcerated feet.
	10. Ms I had been imprisoned for assault and been arrested and/or convicted for assault, possession, public order offences, begging, grievous bodily harm and breach of anti-social behaviour orders. During the period under review there was one use of section 136, Mental Health Act 1983, and four hospital admissions. The high risk of serious harm, including death, non-engagement and self-neglect prompted at least one safeguarding alert, in November 2017, but this did not result in a safeguarding plan. In 2017 there were two professionals’ meetings but Adult Social Care was not invited to either meeting. There was a case conference in April 2018.
	11. Initially in the period under review Ms I resided in a hostel but was often missing, sometimes to sleep rough with her partner because there was nowhere where they could stay together. Her hostel place was withdrawn in November 2017 because she was not using the room, which by then was unkempt. She was effectively homeless until May 2018, except when accessing severe weather provision. Before the final hospital admission, when she died, she was using a temporary assessment hostel bed, although perhaps erratically. That same month the Street Outreach Team discussed her situation with Adult Safeguarding.
	12. These cases exemplify multiple exclusion homelessness. This comprises extreme marginalisation that includes childhood trauma, physical and mental ill-health, substance misuse and experiences of institutional care[[8]](#footnote-8). Adverse experiences in childhood can include abuse and neglect, domestic violence, poverty and parental mental illness or substance misuse[[9]](#footnote-9). These cases demonstrate again that, for many, street sleeping is a long-term experience and associated with tri-morbidity (impairments arising from a combination of mental ill-health, physical ill-health and drug and/or alcohol misuse) and premature mortality[[10]](#footnote-10).
	13. This thematic review also presents a rare opportunity to explore the experiences of women who experience multiple exclusion homelessness. The majority of reviews have concerned men[[11]](#footnote-11). Research[[12]](#footnote-12) has found that the causes of homelessness are multi-faceted and impact differently on men and women. Routes into homelessness can have a gendered dimension, founded in abuse and violence in close relationships. Support is often fragmented, available across separate agencies, with budget cuts intensifying this picture. The research has found positive appreciation of keyworker and women only provision but frustration at having to engage with multiple services at the same time and with provision that was not personalised to their needs. Adverse childhood experiences have resulted in homeless women experiencing a complex range of social and health needs and their situation exposes them to risk of further abuse.
2. The Evidence-Base for Best Practice
	1. Reference was made earlier (section 3.1.3) to research and findings from SARs[[13]](#footnote-13) that enable a model of good practice to be constructed in relation to adults who self-neglect. The model comprises four domains. In line with Making Safeguarding Personal, the first domain focuses on practice with the individual. The second domain then focuses on how practitioners worked together. The third domain considers best practice in terms of how practitioners were supported by their employing organisations. The final domain summarises the contribution that Safeguarding Adults Boards can make to the development of effective practice with adults who self-neglect. The domains are summarised below.
	2. For the purposes of this thematic review, evidence has been integrated into these domains regarding best practice drawn from research and SARs on multiple exclusion homelessness and substance misuse.
	3. It is recommended that direct practice with the adult is characterised by the following:
		1. A person-centred approach that comprises proactive rather than reactive engagement, and a detailed exploration of the person’s wishes, feelings, views, experiences, needs and desired outcomes; work to build motivation with a focus on a person’s fluctuating and conflicting hopes, fears and beliefs, and the barriers to change[[14]](#footnote-14);
		2. A combination of concerned and authoritative curiosity appears helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills; early and sustained intervention includes supporting people to engage with services, assertive outreach and maximising the opportunities that encounter brings[[15]](#footnote-15);
		3. When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person’s refusal to engage; loss and trauma often lie behind refusals to engage; failing to explore “choices” prevents deeper analysis;[[16]](#footnote-16)
		4. It is helpful to build up a picture of the person’s history, and to address this “backstory”[[17]](#footnote-17);
		5. Recognition and work to address issues of loss and trauma in a person’s life experience;
		6. Recognition and work to address repetitive patterns;
		7. Contact should be maintained rather than the case closed so that trust can be built up;
		8. Comprehensive risk assessments are advised, especially in situations of service refusal and/or non-engagement, using recognised indicators to focus work on prevention and mitigation[[18]](#footnote-18);
		9. Where possible involvement of family and friends in assessments and care planning[[19]](#footnote-19);
		10. Exploration of family dynamics, where appropriate, including the cared-for and care-giver relationship;
		11. Thorough mental capacity assessments, which include consideration of executive capacity; assumptions should not be made about people’s capacity to be in control of their own care and support[[20]](#footnote-20);
		12. Thorough mental health assessments;
		13. Careful preparation at points of transition, for example hospital discharge, prison discharge, end of probation orders and placement commissioning;
		14. Use of advocacy where this might assist a person to engage with assessments, service provision and treatment;
		15. Thorough assessments, care plans and regular reviews, comprehensive enquiries into a person’s rehabilitation, resettlement and support needs[[21]](#footnote-21); taking into account the negative effect of social isolation and housing status on wellbeing[[22]](#footnote-22).
	4. It is recommended that the work of the team around the adult should comprise:
		1. Inter-agency communication and collaboration, working together[[23]](#footnote-23), coordinated by a lead agency and key worker[[24]](#footnote-24), with named people to whom referrals can be made[[25]](#footnote-25); the emphasis is on integrated, whole system working, linking services to meet people’s complex needs[[26]](#footnote-26);
		2. A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture;
		3. Detailed referrals where one agency is requesting the assistance of another in order to meet a person’s needs;
		4. Multi-agency meetings that pool information and assessments of risk, mental health and mental capacity, agree a risk management plan, consider legal options and subsequently implement planning and review outcomes[[27]](#footnote-27);
		5. Use of policies and procedures for working with adults who self-neglect and/or demonstrate complex needs associated with multiple exclusion homelessness, with specific pathways for coordinating services to address such risks and needs as suitable accommodation on discharge from prison or hospital[[28]](#footnote-28);
		6. Use of the duty to enquire (section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy;
		7. Evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy;
		8. Clear, up-to-date[[29]](#footnote-29) and thorough recording of assessments, reviews and decision-making; recording should include details of unmet needs[[30]](#footnote-30).
	5. It is recommended that the organisations around the team provide:
		1. Supervision that promotes reflection and critical analysis of the approach being taken to the case;
		2. Support for staff working with people who are hard to engage, resistant and sometimes hostile;
		3. Access to specialist legal, mental capacity, mental health and safeguarding advice;
		4. Case oversight, including comprehensive commissioning and contract monitoring of service providers;
		5. Agree strategically and operationally how different social issues will be connected in policy, procedures, protocols and practice, through the operation of MAPPA, MARAC, MASH and other complex case or multi-agency panel arrangements, namely anti-social behaviour, domestic violence, offending (community safety) and vulnerability[[31]](#footnote-31); strategic agreements and leadership are necessary for the cultural and service changes required[[32]](#footnote-32);
		6. Agree indicators of risk that are formulated into a risk assessment template that will guide assessments and planning;
		7. Attention to workforce development[[33]](#footnote-33) and workplace issues, such as staffing levels, organisational cultures and thresholds.
	6. SABs are recommended to consider:
		1. The development, dissemination and auditing of the impact of policies and procedures regarding self-neglect;
		2. Review of the interface between housing/homelessness and adult safeguarding, and including housing in multi-agency policies and procedures[[34]](#footnote-34);
		3. Establishment of a system to review the deaths of homeless people and/or as a result of alcohol/drug misuse;
		4. Working with Community Safety Partnerships, Health and Wellbeing Boards and partnership arrangements for safeguarding children and young people, to coordinate governance, namely oversight of the development and review of policies, procedures and practice regarding multiple exclusion homelessness;
		5. Workshops on practice and the management of practice with adults who self-neglect.
	7. This model enables exploration of what facilitates good practice and what acts as barriers to good practice. The thematic analysis that follows draws on information contained within the chronologies and IMRs, group discussions during the learning event, and feedback from review group members. Where relevant, it also draws on available research. It follows the whole system framework for analysis presented above, beginning with the components of direct work with individuals and moving outwards to the legal, policy and financial context within which adult safeguarding and work with homeless people and those misusing substances are situated.
3. Evidence-Based Model of Good Practice – Thematic Analysis of Two Tower Hamlets’ Cases
	1. The analysis in this section is mainly derived from the chronologies and IMRs submitted by the agencies involved. The analysis is located within the components of the evidence-base for working with adults who self-neglect and who experience issues connected to homelessness and substance misuse.
	2. It is recommended that direct practice with the adult is characterised by the following:
		1. *A person-centred approach that comprises proactive rather than reactive engagement, and a detailed exploration of the person’s wishes, feelings, views, experiences, needs and desired outcomes*. The picture that emerges reveals inconsistencies in approach. The section 42 enquiry concluded that, with Ms H, Adult Social Care staff frequently avoided opportunities to engage in face-to-face work. The section 42 enquiry report into Ms I’s case concluded that the social worker did genuinely try to locate Ms I but that delays in meaningful action exposed her to further risk because she was evicted from the hostel where she was residing during that period of delay. It concluded that there was a failure to work in a person-centred way consistent with Making Safeguarding Personal, that there was no attempt to contact or listen to the person at the centre of the case.
			1. More positively, with Ms H, the RLH IMR notes that consideration was given to the need to balance the risks presented by those visiting her in hospital with her feeling of isolation whilst an inpatient. Records also detail why she was unhappy with a potential placement in Kent.
			2. Outside the scope of the timeline, Ms H had three children removed from her care when she was living in another London Borough. After she moved into Tower Hamlets there does not appear to have been any observable work to support her through the impact of their removal. The RLH IMR also records several MDT and professionals’ meetings. Ms H does not appear to have been invited, the rationale for which is not stated. It is unclear how her views were represented and what feedback was given to her after the meetings.
			3. With respect to Ms I the St Mungo IMR observes that staff offered consistent support. The Look Ahead IMR observes that her partner was sometimes allowed to stay to help Ms I settle and manage the suicide risk. The ELFT IMR states that care was personalised and respected her wishes, her needs were met and she was challenged about her engagement. The RLH IMR notes that in December 2016 her wishes, likes and dislikes were established but that this information does not appear to have been used subsequently.
			4. Ms I’s partner observed that she wanted to make changes in her life but she did not always have the strength to achieve this. He suggested that those professionals involved with her might not have appreciated how difficult it can be for people to achieve the changes they want.
		2. *A combination of concerned and authoritative curiosity appears helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills*. With respect to Ms H, the section 42 enquiry concludes that a Senior Practitioner did not display professional curiosity to check how her co-residence with an elderly gentleman was impacting on him, how their relationship had been formed and whether this was a situation where Ms H or other drug users had cuckooed the elderly gentleman’s address. More positively, the RLH IMR gives details of reviews, for example mental health reviews, where her feelings about being in hospital are evident. In relation to evident non-compliance with treatment and hospital rules, and in relation to the risks she was running, however, it is unclear to what degree she was challenged and what her response was.
			1. Ms H’s mother acknowledged that her daughter could be “feisty” and would not readily accept help. She said that services would have needed “stamina” in their interactions with Ms H as “she did not like officialdom.”
			2. The section 42 enquiry regarding Ms I found that there was a failure of professional curiosity, even in the face of serious concerns such as inability to locate her. The Providence Row IMR concludes that staff could have tried to contact Ms I between her presentations at the service. More positively, the Look Ahead IMR notes multiple attempts to engage Ms I. The RLH IMR provides examples of where she was given but rejected advice.
			3. Ms I’s partner was able to reflect, both in respect of Ms I and himself, that access to non-judgemental services was vital and helpful, and that support was especially important when individuals were striving to be alcohol and drug free. It was during these times that stress, anxiety and painful feelings could “bubble up”, prompting a return to substance misuse to suppress what it was very hard to acknowledge and work through.
		3. *When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person’s refusal to engage; loss and trauma often lie behind refusals to engage*. The section 42 enquiry and Adult Social Care submissions regarding Ms H comment that staff frequently recorded that she had not replied to their telephone calls or letters and that this gives a sense of a culture in which the responsibility for non-engagement and the reason for closing Ms H’s case was located with her. There was a lack of clarity in recognising that the very substance misuse problems which were the reason for Ms H’s referral to Adult Social Care were the cause of the lifestyle which made it difficult for her to respond to letters and telephone calls, and that it is the nature of professional social work with this client group that it requires flexibility and tenacity. In March 2018 a further refusal of services was not responded to.
			1. From the GP IMR it appears that sometimes Ms H turned away District Nurses and did not attend for appointments. The same IMR indicates that there were repeated refusals to engage with offered help and that she refused help. Best practice evidence would advise outreach and an active response to DNAs. The Care Provider IMR notes when she refused entry to care workers or missed their visits. These were reported to Adult Social Care and sometimes to the GP. It is not clear that any action was considered as a result. There were, however, persistent efforts by Care Provider staff to engage. The RLH IMR records many occasions when she was non-compliant with hospital rules, for example about use of alcohol on the ward. There are discussions noted about her intentions to self-discharge and some evidence that the risks were explained.
			2. The author of the section 42 enquiry report concerning Ms I has identified a stereotype of her as present within Adult Social Care, namely that she was able to choose to engage and get help if she wanted to but did not do so. This notion failed to take into account the complexities of her high need drug dependency, which meant that Ms I would daily be driven by physical impulses which were not rational because they stemmed from the physiology of drug dependency. They also failed to recognise the change in her attitude and the rise in her distress, despite being aware that she had expressed notions of wishing to die. There was an absence of any systematic risk analysis in response to all of the concerns received or any critical thinking testing the notion that this was an empowered woman making decisions. Use of a Mental Capacity Act assessment to try to understand any vulnerabilities does not seem to have been considered at all.
			3. The St Mungo IMR observes that high substance use was a barrier to engagement with Ms I. The RLH IMR notes the many occasions when she refused assessments and treatment, sometimes absconding, sometimes taking her own discharge. There is no evidence in the IMR that her reasoning was sought. Perhaps it was difficult because of her aggressive behaviour.
			4. The observations from Ms I’s partner reported in the previous section reveal the falsehood of “lifestyle choice”. He described times when she would “panic without vodka”, not having the strength to stay drug and alcohol free because of what had resurfaced from her past. He thought that she did not really want to kill herself.
			5. Ms I’s partner’s reflections chime with the recognition that the problem is not the problem but a way of coping[[35]](#footnote-35). However dysfunctional there is a logic behind behaviour, a positive function. Attempting to change someone’s behaviour without understanding its survival function will prove unsuccessful. It is responding to symptoms and not causes. Put another way, individuals like Ms I and Ms H are in a “life threatening double bind, driven addictively to avoid suffering through ways that only deepen their suffering.”[[36]](#footnote-36)
		4. *It is helpful to build up a picture of the person’s history*. For Ms H, the RLH IMR notes that she had three children not in her care but not the history of this. There is little evidence that anyone was focusing on her feelings and reactions to this loss during the period under review. There is also little sense of the history of her relationship with her parents other than a comment that they went to live in Kent to get away from her.
			1. Ms H’s mother dated her daughter’s challenges from a cot death, which appeared to have exacerbated the challenges she experienced in looking after herself and the significant increase in her substance misuse. Ms H’s mother attributed the substance misuse as “something to take the pain away.” There is a link here with the impact of loss and trauma (see below). The parallels with the case of Ms I are clear.
			2. On Ms I, the RLH IMR notes that there is little or no reference to her social history. There was no real attempt to find out who she was and what life had entailed before her current chaotic state. Ms I’s partner has also stated how little he knew of her background as she disliked talking about it.
		5. *Recognition and work to address issues of loss and trauma in a person’s life experience.* For Ms H, there is no sense of work on the background to her alcohol and drug misuse. The section immediately above details Ms H’s mother’s observations about one trigger for substance misuse. For Ms I, the RLH IMR identifies the likelihood of trauma and records that her mother was alcoholic, her brother committed suicide and that her father may have been involved in her childhood trauma. This information does not appear to have been explored with her during the period under review. As Ms I’s partner knew, not least from his own experience, it could be very difficult and would take considerable time, support and resilience to begin to work through painful and/or abusive lived experiences.
		6. *Contact should be maintained rather than the case closed so that trust can be built up*. For Ms H, in January 2018, Adult Social Care managers agreed to case closure. There does not seem to have been any consideration of the impact of closure on her. There may have been a stereotypical view of Ms H as someone who would not engage. The ELFT IMR states that the case was closed at the end of November 2017. Once again the rationale for this closure is not entirely clear. It is also uncertain whether the closure was decision was discussed with the other agencies involved beforehand.
			1. The section 42 enquiry and Adult Social Care submissions regarding Ms I observe that both the Social Worker and the Manager who endorsed his work failed to recognise that there will be a very significant difference for the outcomes for a person depending on whether they are offered the services they need and do not take them or whether they are actually receiving those services they need. The Social Worker was explicitly told by both the Dellow Centre and RESET that Ms I was declining services that she needed and yet the referral was closed. Both the Social Worker and the Team Manager were service-focused rather than person-centred; they judged that services being available to the service user was an adequate situation and did not think through the risk implications for Ms I of the reality that she was declining the services which could have helped her with her health and substance misuse problems. They also took no account of the fact that she was street homeless which is a danger to the health of even the most robust of people.
		7. *Comprehensive risk assessments are advised, especially in situations of service refusal*. In its submission regarding Ms H, Adult Social Care observes that towards the end of her life, operational staff dealing with the case failed to recognise that risks to her safety were escalating. This was clearly recognised by both the Service Manager with lead responsibility for safeguarding and the Principal Social Worker, both of whom concurred in seeing her recent eviction and the death of the elderly gentleman who provided her with a home as a double bereavement which would aggravate risks of self-harm. They alerted the then Divisional Director to their concerns a few weeks before Ms H’s death after the Manager of the Assessment and Intervention team declined to allocate a Social Worker to her case. In May 2017 it is unclear why the case was placed by a Senior Practitioner on a ‘screening waiting list’ rather than being screened and assessed for risk by that Senior Practitioner. The Adult Social Care submission also concludes that risk assessments were not person-centred. In March 2018, the evidence of escalation of self-neglect was very clear but the Social Worker did not respond to this.
			1. There was concern about risk assessment when Ms H was living with an older man and possibly abusing him financially. The Care Provider IMR notes when risks were communicated to other agencies, such as taking medication with alcohol, but this does not seem to have prompted review of the case. There are repeating patterns in this case but these did not prompt a review of the approach to the case. When Ms H self-discharged to an undisclosed address, with the consequence that a care package could not be put in place, a review of risks does not seem to have occurred.
			2. The RLH IMR gives a clear indication of the risks she was running, which were explained to her. There were concerns about her visitors and on one occasion a plan suggests that their visits should either not be allowed or be supervised. This was not maintained, perhaps because of her feelings of boredom and entrapment in hospital, but this meant that she took alcohol and/or drugs whilst in hospital. By July 2017 the risks included death or serious injury. The risks do not change substantially during this long hospital stay and, in the light of repeating patterns, might there have been more contingency planning, including possible referral to the Court of Protection?
			3. Documentation submitted by Adult Social Care relating to Ms I recognises that it failed to respond adequately and proportionately to an explicitly stated high risk of serious harm. There was also evidence of increasing risks, including confirmation that Ms I was street homeless and with a serious health condition. This was not recognised by the Social Worker. Risk assessment was poor and the case inappropriately closed. From the MPS IMR a repeating pattern emerges of Ms I going missing, begging in a state of self-neglect, leaving hostels and being homeless, and committing assaults and other crimes. However, such a pattern does not appear to have triggered reassessment of risk or of the approach to the case.
			4. In November 2017, because of non-use of her hostel room, because she wanted to be with her partner, a hostel abandonment notice was issued and she became homeless and then difficult to find. This turning point does not appear to have prompted discussion of any alternatives or to have significantly updated risk assessment and planning. The Look Ahead IMR notes the advice that Ms I was given but not the response when she did not follow this advice.
			5. The RLH IMR concludes that there was no clear plan about how the risks and her behaviour would be managed. Staff were aware of the risks and sometimes discussed the risks with her but there was no clear risk management plan. In December 2016 a management plan for future admissions was discussed, with the intention to use reasonable boundaries and explanations, rather than just saying no, which she found difficult, and working with her long-term partner on not bringing drugs and alcohol into the hospital. It identified what she found difficult, including authority figures and strict rules. To what degree this plan was widely shared and used subsequently is less clear. It is not clear whether risk assessments were updated as she continued to refuse assessments and treatment. There were repeating patterns in this case, especially overdosing, suicidal ideation, non-compliance and frequent hospital attendance (by May 2018 there had been 28 ED attendances in the past year).
			6. The section 42 enquiry report concludes that there was an absence of a clear and rigorous assessment of the risks of overdose while an inpatient during her final hospital admission. Given what was known by staff she should have been seen as a high risk patient. That report also observes that a plan, namely to discharge her with antibiotics unless she complied with withdrawal medication and stopped taking illicit drugs, was not followed through.
			7. Ms I’s partner, reflecting on her final time in hospital, said that she was a high risk patient and there should have been more regular checks of her whereabouts, using CCTV for example. He thought that this might have prevented her death. He reflected on the challenge of knowing when to allow a person freedom of movement and when, for their own benefit, to curtail or supervise this. He described this as a “moral question.” It is indeed a question that, in a multi-agency and multi-disciplinary forum, needs to be answered in each unique situation, drawing on an analysis of risks and mental capacity.
		8. *Where possible involvement of family and friends in assessments and care planning.* Ms H’s mother is referred to, for example in the Care Provider IMR, but it is unclear how actively she was involved in attempts to work with her daughter or to understand her life journey. The ELFT IMR suggests that her mother was involved in care planning around September 2017 and discussion of accommodation options. The extent of this involvement is less apparent. It is also unclear whether a picture was obtained of what relationships were like at this time between mother and daughter. Was she, or could she have been, for instance, part of a circle of support? The RLH IMR details attempts to contact her mother and occasions when this was successful. Her mother had some involvement with her finances. She appears to have been unable to offer support but did express a wish that Ms H be placed nearer to her in Kent.
			1. Ms H’s mother was able to clarify that she and her husband had moved out of London in order to obtain some distance from her daughter who was, and continued to be “demanding”, for example for money. She had not seen her daughter for a considerable number of years but she frequently telephoned and was a “continuous worry.” She summarised her daughter as “a bundle of trouble.”
			2. Regarding Ms I, the RLH IMR suggests that her partner might have been contributing to her problematic situation and not entirely supportive but work with him on this appears to have been intermittent. Ms I’s partner, himself, stated his regret that, because of struggling with his own problems, he was not as available as he would have wished during the period shortly before her death. It does not appear that there was much in the way of attempting to work with Ms I and her partner as a couple.
		9. *Exploration of family dynamics, including the cared-for and care-giver relationship*. It is unclear what Ms H’s family history was and whether this was known to those working with her and thought to be a significant factor in her presenting problems. It is also unclear, for example from the RLH IMR, how Ms H saw her relationship with her (ex) partner. Ms H’s mother was able to give detail about the strains that her daughter put on the rest of the family.
			1. With Ms I, it is not clear how much work, if any, was done with her, and by whom, with respect to her longstanding relationship with her partner, for example on the incidents of domestic violence. From the RLH IMR it appears that her family history was not explored. There is limited reference in IMRs to attempts to work with Ms I and her partner as a couple. Case discussions were held at one time to explore possible placements for them as a couple but Ms I’s partner in particular wished to preserve some space and independence for himself.
		10. *Thorough mental capacity assessments, which include consideration of executive capacity*. The GP IMR states that Ms H had capacity the whole time but it is unclear whether this was the result of formal assessments and reviews. It is certainly questionable given the likely impact of her life journey, and her drug and alcohol misuse on her decisional and executive capacity. By contrast, the Care Provider IMR, referring to her health issues, notes cognitive impairment and fluctuating capacity. However, it is not clear how this translated into capacity assessments. Indeed, the Care Provider IMR also indicates that there was no concern about her ability to make decisions. The ELFT IMR refers to Deprivation of Liberty Safeguards during their early contact with Ms H in mid-2017, which would suggest that she had been assessed as lacking decisional capacity regarding treatment when in hospital. The same IMR refers to self-discharge in September 2017, a decision for which she had been found to have decisional capacity. This is an interesting conclusion since the same IMR also refers to her having cognitive impairment and delirium. The ELFT IMR concludes that it is unclear how the medical team reached a decision that Ms H had mental capacity around September 2017 and self-discharge given her cognitive impairment.
			1. The RLH IMR gives some detail here. Ms H was assessed as having capacity to refuse care in early April 2017. However, there does not appear to have been an assessment regarding her non-compliance with treatment. For a hospital admission in May 2017 there was some delay in assessing her capacity but it appears that treatment was provided in her best interests and a Deprivation of Liberty Safeguard was in place. An assessment deemed her to have capacity to self-discharge. Having been admitted to hospital on 18th June 2017, she was subsequently assessed as lacking capacity and a Deprivation of Liberty Safeguard was completed. Care and treatment were given in her best interests. There are references throughout this long hospital admission to cognitive and physical deficits. On 23rd August she did not have capacity regarding leaving the ward. By early September 2017 she was stated to have capacity to decide to leave hospital and yet she had limited insight into her abilities, she had physical and cognitive impairment, and her cognition fluctuated. By 22nd September, the IMR records difficulty assessing her cognitive functioning and capacity due to drinking and sedation. At an MDT meeting frontal lobe testing and Deprivation of Liberty Safeguard assessments were planned. However, she self-discharged on 27th September, having it is said capacity to take that decision. With complex cases of fluctuating capacity, the Court of Protection is an option, which does not appear to have been considered here.
			2. Focusing on Ms I, the Adult Social Care submissions highlight a failure to recognise that there were clear indicators that she might lack mental capacity to understand and weigh the decisions she was making to decline clinical help. The failure to seek to conduct any Mental Capacity Act assessment was a significant omission because without that assessment Ms I’s needs and the risks to her health could not be fully understood. There was a lack of professional curiosity. Both the Social Worker and the Manager who endorsed his work failed to consider use of the Mental Capacity Act despite clear evidence from the Dellow Centre of regular emotional distress in the context of Police reporting suicidal ideation, and of the clear impact of substance misuse on her life and wellbeing. There was clear evidence that there were issues to be explored about what was driving Ms I’s behaviour, including a risk that her emotional and mental state might not be such that she could understand and weigh the risks of declining clinical help. The divided case record also included clear evidence in the safeguarding referral from Station House hostel on 25th November regarding Ms I’s extreme fear of clinical interventions and her reported inability to recall perpetrating an assault which again raised questions of capacity to understand and weigh the risks of declining treatment.

* + - 1. St Mungo’s IMR states that her capacity was not questioned. The Look Ahead IMR, when referencing the October 2017 case conference, notes a proposed Mental Health Act and mental capacity assessment. There is also a passing reference to a non-capacity route. What was meant by this? In any event the IMR does not record whether the proposals were followed through by the agencies involved after the case conference, for example by an AMHP? It states that her physical condition was affecting her mental state and ability to engage. The same IMR observes her high level self-neglect, a co-dependent relationship with her partner, and her inability to cope with treatment or remain in hospital, her overuse of medication and misuse of substances, all of which should have prompted detailed assessments, risk planning and, if mitigation could not be achieved, possible referral to either the Court of Protection or High Court.
			2. The GP IMR states that mental capacity was “not relevant.” Is that sustainable given what was known about her? The ELFT IMR refers to a diagnosis of “emotionally unstable personality disorder” alongside alcohol and poly-substance misuse, diagnoses which should have informed mental capacity and mental health assessments. The same IMR notes, in relation to self-discharge, that she had capacity for this decision. Yet the same IMR also refers to her lived experience of trauma affecting her ability to engage. The ELFT IMR concludes that a review should be held of how agencies weigh up and respond to unwise decision-making. Certainly her executive capacity should have been thoroughly assessed.
			3. The RLH IMR contains several references to mental capacity assessment. In May 2014 she was deemed not to have capacity but for what is unclear, probably hospital treatment, and she also needed restraining. In November 2016 she was recorded as having capacity. In December 2016 the medical team assessed her as having capacity about not accepting treatment. In October 2017 there is an entry that indicates that she had not demonstrated that she had capacity regarding refusal of assessment and treatment when this could hasten her death, and an entry that states that she had capacity to make decisions regarding taking drugs. In May 2018 there are entries to the effect that she had capacity, but for what is not stated, and that there was no reason to think she did not have capacity regarding refusing treatment and leaving the ward. It is unclear whether her executive capacity was assessed. She did not stick to plans and agreements. Her abuse of alcohol and drugs was longstanding but with what effect on her mind and brain?
			4. Reference has already been made to Ms I’s partner’s observation that at times “she could not help herself” because of the feelings that were resurfacing. He also observed that “drink changed her.” There may be a link here to the importance of assessing executive capacity as part of mental capacity assessment. Guidance has commented that it can be difficult to assess capacity in people with executive dysfunction. It recommends that assessment should include real world observation of a person’s functioning and decision-making ability[[37]](#footnote-37), with subsequent discussion to assess whether someone can use and weigh information.

* + 1. *Careful preparation at points of transition, for example hospital discharge and placement commissioning.* Ms H sometimes took her own discharge. Despite the risks this pattern did not prompt a multi-agency response or a completed accommodation plan. The RLH IMR gives limited evidence of planning for discharge in April 2017 other than referrals regarding community support and medication. The IMR gives no evidence of discharge plans when she leaves of her own accord in early June 2017. The IMR does give considerable detail of the efforts made to find a placement for Ms H between June and September 2017.
			1. The Providence Row IMR refers to Ms I’s self-discharge to a hostel towards the end of her life. St Mungo’s IMR also refers to self-discharges. The Look Ahead IMR also notes self-discharges and the serious, indeed potentially life-threatening health/medical problems at the time. The repetitive nature of taking her own self-discharge would suggest that agencies coming together to consider the implications for any risk management plan would have been appropriate. The RLH IMR documents several occasions when discharges were planned and sometimes delayed because of her treatment/detox needs or because there were no housing options available. In April 2017 she could not stay with her partner and there were no hostel options as she had not stayed at the last hostel and her place had been cancelled. There was some flexibility shown by agencies in response to her complex needs, for instance allowing her partner to stay the night in her hostel or not discharging her because it would have been to no fixed abode or because she needed to complete detox.
			2. NICE has issued guidance about the transition between inpatient mental health or general hospital settings and community settings. For people with serious mental health issues who have recently been homeless or are at risk of homelessness, the guidance[[38]](#footnote-38) recommends intensive structural support to assist with the finding and retention of accommodation. This support should begin prior to discharge and continue for as long as necessary. Housing and mental health services should work together to jointly problem solve. Similar guidance for people in inpatient general hospital settings[[39]](#footnote-39) recommends on admission that a person’s housing status is established and that, prior to discharge, if a person is likely to be homeless, liaison occurs with the local authority’s Housing Options service to ensure that advice and help is offered. Homelessness and safeguarding issues should be addressed by agencies working together to ensure a safe and timely discharge. Those at risk of readmission should be referred to community practitioners prior to discharge for health and social care support.
		2. *Thorough assessments for care and support, care plans and regular reviews.* Whilst a Social Worker who was, in time, allocated the case did work on practical issues to support Ms H towards the end of her life, it is arguable that insufficient attention was given to her suicidal and self-destructive ideation and need for emotional support. Around February 2018, Adult Social Care case notes do not reflect the level of distress for Ms H recorded in other case notes. The section 42 enquiry also comments that it is difficult to understand why Care Act assessment received such a focus when the biggest and most imminent risk was of Ms H becoming street homeless.
			1. Care Provider staff really tried to engage with Ms H and to implement the care package. The ELFT IMR provides evidence of regular reviews. The RLH IMR notes that when she took her own discharge in September 2017, the Social Worker refused to provide a package of care because she was living, or proposing to live, in two places and, possibly, there were safeguarding issues relating to the men who were providing a place to stay. The Social Worker did make efforts to find a suitable placement for Ms H but this was very difficult due to the complexity of her needs. It is not clear from this IMR whether a section 9 Care Act 2014 assessment was completed. When in hospital, there were reviews of her mental health, tissue viability, and drug/alcohol use.

* + - 1. In Ms I’s case, in May 2018 the second Social Worker failed to action a care and support needs assessment as requested by her Senior Practitioner. St Mungo’s IMR notes the efforts made to find hostel accommodation that could provide for both Ms I and her partner. When this did not materialise, she left accommodation to sleep “rough” with him. The Look Ahead IMR refers to a full needs assessment and risk management plan. It appears, however, that the planned mental health and mental capacity assessments were not done because Ms I was “not there” so the plan may just have lapsed. The ELFT IMR refers to there being an agreed plan after each referral based on a review of the risks. However, the risks repeated and it is not clear that this repetitive pattern occasioned a reappraisal of the approach to the case.
			2. The RLH IMR records a mental health review in April 2017 and a diagnosis of emotionally unstable personality disorder alongside alcohol and polysubstance drug misuse, epilepsy, depression and asthma. She is recorded elsewhere as being bipolar and having liver disease and intravenous drug use. The review records the risk level as moderate to high. Self-neglect is recorded. This should have occasioned a reappraisal by all the agencies involved of her mental capacity and of the management plan for the case.
	1. It is recommended that the work of the team around the adult should comprise:
		1. *Inter-agency communication and collaboration, coordinated by a lead agency and key worker, which may be termed working together*. Focusing on Ms H – Adult Social Care staff do not seem to have used multi agency links like the Community Health team who were involved with the other vulnerable adult with whom she was living before her death to arrange visits. The RLH IMR records collaboration, including in MDT meetings and professionals meetings, between different professionals/agencies. No lead agency or key worker is evident. There does not appear to have been any liaison between Children’s Social Care and Adult Social Care during the period under review. The information passed to the Care Provider by Adult Social Care was incorrect, resulting in delays in contacting the GP and Ms H. The GP IMR records that there was no response to a GP referral from the Consultant Psychiatrist for substance misuse.
			1. On Ms I, there were a number of missed opportunities in which Adult Social Care could have utilised the concerns received from other agencies to lead self-neglect oriented safeguarding work, co-ordinating the work of various agencies, many of which held a large amount of information about the risks to Ms I’s health. However, Adult Social Care never took on this role, closing the case without having taken this leadership action and leaving other agencies to handle the risks. The section 42 enquiry concludes that the Social Worker does not seem to have thought of contacting the Street Outreach Team who know rough sleepers very well. The two separate recording profiles for Ms I reflect a lack of rigorous checks when case records have been entered. In common with many people whose drug-related offending brings them into regular contact with Police, Ms I used different variations of her name and offered different dates of birth on occasion. This evidently contributed to the two different profiles but, if care had been taken on entering the records to check for similar existing names, then this could have been avoided. Had Adult Social Care staff worked with a more multi-agency orientation, particularly with Police colleagues who held all the information about name variations and dates of birth, this would probably have come to light very much sooner.
			2. Providence Row staff made some appropriate referrals in response to her substance misuse. St Mungo’s IMR also mentions referrals to other agencies, for example for mental health support but does not state the outcome. Look Ahead IMR concludes that there was good working together with some agencies. The same IMR states that there was a key worker for Ms I at the hostel. The RLH IMR records contact between different practitioners within the hospital and there is one reference to a social work/social care assessment being required but little evidence of a multi-agency approach to risk management. The RLH IMR observes that there is a need to link more effectively with Adult Social Care colleagues.
			3. Particularly when agencies undergo restructuring but also because of the complexity of provision that is commissioned, workers across the statutory and third sectors may have an incomplete understanding of what is available and of the pathways to access provision. For example, a map may be useful to guide Housing Association and third sector agencies in the substance misuse field in accessing Adult Social Care and Adult Safeguarding.
		2. *A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture*. Focusing on Ms H, the Care Provider IMR notes when information about risks was shared with Adult Social Care but this did not seem to prompt an urgent review of the approach to the case. Information shared by Adult Social Care in the referral to the Care Provider was very limited and in crucial respects inaccurate. The RLH IMR records one occasion when information was not shared between different parts of the hospital relating to her history.
			1. Focusing on Ms I, in relation to all safeguarding referrals, there was a failure to work in a multi-agency way and gather information and perspectives from the range of agencies who knew her. The November 2017 referral from Station House hostel was a very rich source of information about the risks which could have become the core of building a multi-agency perspective. It is very concerning that no information was gathered from the Police, the GP surgery which treated Ms I, or the Street Outreach Team until they made their own referral some months later. There was little analysis of the risks by the Social Worker, although these had been highlighted in some detail by the Station House referrer. The Providence Row IMR notes that staff there did not have details of hospital admissions when she overdosed. The same IMR does note good information-sharing with the Street Outreach Team regarding hospital admissions and discharges.
		3. *Multi-agency meetings that pool information and assessments of risk and mental capacity, agree a risk management plan, and consider legal options*. In Ms H’s case, Adult Social Care submissions to the review observe that referral to the multi-disciplinary high risk panel which supports Social Workers in challenging and complex safeguarding cases was suggested by the Service Manager with responsibility for safeguarding who chairs it. However, the suggested referral was not speedily addressed and Ms H died before this could occur. In March 2018, no request for an emergency high risk panel meeting was raised. No urgent action was taken in response to her refusal of care. The option had been there to ask for an urgent meeting of the high risk panel or to undertake an emergency visit with the Police.
			1. From the MPS IMR it is clear that Ms H was a victim of domestic violence but, if there was any MARAC involvement, its outcome was unclear. The GP IMR refers to MDT meetings in the context of her repeated refusals to engage with the help being offered but without detail about who was involved or what the outcomes were. The RLH IMR records a number of MDT and professionals’ meetings in the long hospital stay between June and September 2017 but not from the very outset. Risks and care needs were discussed and plans formulated. There was one occasion when a scheduled MDT meeting was postponed because of time constraints and outstanding social and housing issues. Plans set at the last meeting in September 2017 were overtaken by her self-discharge and no contingency plan appears to have been in place, despite ongoing recorded risks of absconding.
			2. Regarding Ms I, the Providence Row IMR lists a case conference to discuss wrap-around care in October 2017. Another conference is listed for May 2018. It is not clear from the IMR how effective these conferences were in agreeing mitigation plans and considering what options were available, including legal routes, if risk could not be minimised. Equally there is no reference to MARAC involvement as the MPS IMR notes that she was a victim of domestic violence. The St Mungo IMR also refers to case conferences in October 2017 and April or May 2018 but it is not clear whether Adult Social Care was involved or what the outcomes were and whether there was a Plan B if agreed plans did not work out. It is very clear from the RLH IMR, at April 2017, that she was a complex and high risk patient, non-compliant with plans, running out of housing options and difficult to manage. That would have suggested a multi-agency meeting and process for such patients/service users. None was convened at that time.
		4. *Use of policies and procedures, for example for escalation of concerns or for working with adults who self-neglect.* There is no reference to policies in any IMR for either Ms H or Ms I. For Ms H, when a Social Worker would not provide a care package because she was living in two places, it is unclear whether that was a decision following local policy and, if so, whether the exercise of any discretion was considered. There is also reference in September 2017 to the Admission Avoidance and Discharge Service refusing to see her at home as she had not been seen as an inpatient, despite the high risk of readmission. Again, what was the rationale for this decision, was it based on policy and what discretion was considered if so?
			1. The section 42 enquiry report, drawing on the serious incident investigation and report completed by Barts Health NHS Trust, observes in relation to Ms I that accounts by staff indicate a belief that security staff should have been notified and CCTV checked but that this was not done. It is possible to conclude that staff are unclear about when the policy should be applied.
		5. *Use of the duty to enquire (section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy*. Although one Social Worker conducted a robust and person-centred safeguarding enquiry when Ms H was in hospital and at risk of overdose being facilitated by her partner, Adult Social Care submissions for this review conclude that Adult Social Care contact and intervention were frequently distant, impractical and unrealistic as a response to a chaotic drug user. In May 2017 there was a failure to safeguard the second vulnerable adult in the picture. The referral identified that Ms H, with her substance misuse problems, was residing with a vulnerable adult with care needs. The Senior Practitioner did not display professional curiosity to check how this was impacting on the elderly gentleman, how their relationship had been formed and whether this was a situation where Ms H or other drug users had cuckooed the elderly gentleman’s address. At this time the section 42 enquiry concludes that there was a failure to safeguard two vulnerable adults in person-centred way. The Social Worker had an opportunity to visit Ms H since District Nurses were regularly going to the address. This might have enabled her to understand Ms H’s view of the situation and understand the outcomes she wanted. The Social Worker failed to recognise or take any action in relation to the elderly gentleman whose flat was now a home to drug users. The completed risk assessment lacked person-centred information so was not sound. In June 2017 the Social Worker recorded passing a safeguarding concern to duty but it would seem nothing was done to try to identify a possibly abusive male because the alert was passed to the hospital team who seem to have omitted to consider this part of the picture.
			1. The MPS IMR lists her criminal record and their contact with Ms H. The MERLINS sent by MPS did not trigger a safeguarding enquiry and the Police did not formally raise a safeguarding concern. The Adult Social Care IMR and the GP IMR express concern about whether there was an adequate investigation of financial exploitation by Ms H of the friend with whom she was staying. The Care Provider informed Adult Social Care of what took place when Ms H allowed entry and when she refused. However, might the Care Provider have escalated concerns, for example by suggesting a section 42 enquiry? The Care Provider IMR appears to suggest that there were no safeguarding episodes but is this sustainable based on what was known? The RLH IMR notes that Ms H was a vulnerable adult but no safeguarding referrals appear to have been made.
			2. Regarding Ms I, in November 2017 two safeguarding alerts were received which should have alerted Adult Social Care to the serious nature of the risks to Ms I’s health and a destructive orientation which, as the author of the section 42 enquiry noted, was a significant change from her usually extrovert, if challenging behaviour. This change in manner should have been recognised as a significant indicator of risk. That enquiry also concluded that a Social Worker failed to action an allocated safeguarding case in November 2017 and a Senior Practitioner failed to make checks on the case within reasonable timescales. There was a lengthy delay in case allocation of a safeguarding case to a Social Worker. In January 2018 there was another two day delay before the Senior Practitioner took any action on this case which she had allocated to herself. This was in addition to the two-month delay in taking action on the safeguarding alert which had already occurred.
			3. The enquiry report concludes that the Senior Practitioner failed to safeguard Ms I adequately in that she failed to alert Police that Ms I was potentially a missing person in that she had not been seen by services who knew her for some months in the context that Ms I had made an allegation that she was subject to a very serious offence restricting her liberty, which should also have been reported to the police. In May 2018 there was delay in beginning safeguarding work with no attempt to make contact with Ms I. The Social Worker delayed three days before taking any action. Her only action then was to leave a message for the referrer asking her to do a joint visit, effectively putting the responsibility for the safeguarding work back to the referrer. She made no attempt to contact or listen to Ms I. At the end of May 2018 the section 42 enquiry concludes that there was a failure to safeguard Ms I adequately. The Social Worker declined to attend the hospital and see Ms I, stating that this work was no longer her responsibility but rather the responsibility of the Hospital Social Work Team. The Social Worker failed to consider both that a safeguarding task had been given to her to complete and that the re-allocation of work is a matter for management. She did not contact the Hospital Social Work Team to ask them to work with the safeguarding issues nor did she approach her own line management to discuss which team should best deal with the matter. Her unilateral decision that she would not work on Ms I’s case without communicating this to other Adult Social Care staff left Ms I with no responsible authority undertaking safeguarding support and no imminent opportunity for her to obtain any, since the Social Worker’s Manager believed her to be progressing the work.
			4. The Providence Row IMR notes evidence of increasing chaos in her life but this does not appear to have triggered safeguarding referrals. Similarly, when Ms I refused towards the end of her life the offer of emergency services, no alerts were raised. The MPS IMR lists substantial contact in 2017 and 2018 but no safeguarding referrals, possibly because key workers/agencies were aware of her case. This was, however, a missed opportunity to coordinate and/or review the approach to the case. The same IMR lists repeating patterns but none of the events appear to have been interpreted as raising vulnerable adult concerns. This might be explained as evidence of having become acclimatised to this case. The St Mungo IMR refers to a safeguarding referral being made in May 2018 but it is not clear why it was not made sooner. The IMR concludes that a safeguarding referral should have been sent earlier. The Look Ahead IMR states that a formal safeguarding concern with Adult Social Care was made when they issued the abandonment notice but was this response good-enough given the risks in the case? It also concludes that such a referral should have been sent earlier. The GP IMR refers to de-registration as a result of her assault on a member of the surgery team but no safeguarding referral was sent at that point. Social Services were not advised of this de-registration but should have been. The ELFT IMR concludes that a review is required of adult safeguarding thresholds.
			5. The section 42 report also expresses surprise that the Hospital Trust did not make a section 42 safeguarding referral after Ms I was found deceased.
		6. *Evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy.* There is no reference in the IMRs for Ms H or Ms I of different legal options being considered in response to the repeating and escalating risks. Reading the RLH IMR for Ms H, especially when a Deprivation of Liberty Safeguard was in place, it appears that referral to the Court of Protection was not considered despite the challenges noted about assessing capacity and the difference between her and the treating team about what was in her best interests, for example about placement in Kent.
			1. In the RLH IMR also it is stated that on her discharge on 18th April there was nothing regarding her housing that could be done because her eviction was not until later that month so she was not yet homeless. That misunderstands the Housing Act 1996 and the Homelessness Reduction Act 2017 as duties arise when someone is threatened with homelessness.
			2. The Look Ahead IMR for Ms I lists the challenges faced in her case, namely high level self-neglect, inability to cope with treatment or stay in hospital, over-use of medication alongside drugs and alcohol, and declining mental health and physical health. Mental health and mental capacity assessments were to be done in October 2017 but it is unclear whether all possible legal options were considered, and what the outcome of the assessments was and how that informed future planning. For Ms I, the RLH IMR records that in January 2017 there were no grounds for Deprivation of Liberty Safeguards when there was evidence of self-neglect but there was no consideration of legal options in April 2017 when the risks were evidently high. The IMR concludes that there is now a heightened awareness of self-neglect and records an example of where Deprivation of Liberty Safeguards have been used for a patient, with better case outcomes the result.
		7. *Clear and thorough recording of assessments, reviews and decision-making*. On Ms H, the section 42 enquiry is critical of poor, limited or delayed recording by Adult Social Care throughout the period under review. For example, it is unclear what the safeguarding alerts were or why they should have been passed to a Senior Practitioner in a different team when a Social Worker was already working on safeguarding issues for Ms H. The record lacks important detail, for instance on her medical condition when admitted to hospital and what best interests steps were taken. The RLH IMR notes that the rationale for 1:1 observation was not stated at the beginning of the May 2017 hospital admission.
			1. Focusing on Ms I, the section 42 report and Adult Social Care submission found that poor recording was also a significant issue. There were also two profiles on the Adult Social Care case record which were never merged into one accurate record. Poor recording was demonstrated when no explanation was recorded on why the case was reallocated or why there were delays in responding meaningfully to known risks. The case record is also very unclear as to whether or when the Street Outreach Team had seen Ms I. The Senior Practitioner closed the contact on one of the two case records but did not link the records. Adult Social Care has also confirmed that safeguarding referrals were recorded on contact episode forms rather than safeguarding concern forms which provide prompts towards a fuller analysis of risk than that demonstrated by staff in the case. The use of the safeguarding concern form in a timely manner is a requirement in the Safeguarding Procedures.
			2. The Providence Row IMR notes that the records are unclear about what support was provided to Ms I when she was very unwell in 2017. On their records there are no details of the outcome of a case conference in October 2017. It comments that there are multiple gaps in recording, for example about her suicide attempts in November 2017 and the case conference in May 2018. The St Mungo IMR refers to an agreement at the last case conference to refer for a mental health assessment because of severe self-neglect. The RLH IMR observes that not all recording was clear or contemporaneous.
			3. The section 42 enquiry observes that there appear to be no contemporaneous records evidencing when Ms I’s hospital room was checked and how that was done. It concludes that she would not have been seen unless very thorough checks had been conducted and asks the question whether it is reasonable and proportionate to expect staff to complete such thorough checks.
	2. It is recommended that the organisations around the team provide:
		1. *Supervision that promotes reflection and critical analysis of the approach being taken to the case*. The chronologies do not record supervision and the IMRs do not refer to it.
		2. *Support for staff working with people who are hard to engage, resistant and sometimes hostile.* Managers in Adult Social Care failed to enable their staff to develop the skills they needed or to hold them to account to be tenacious in seeking to both engage with Ms H and to safeguard her. In May 2017 the Senior Practitioner failed to hold the Social Worker to account to make sure that the actions that had been deemed necessary were in fact undertaken. She also showed a lack of understanding of the safeguarding workflow and safeguarding procedures. The Adult Social Care IMR also notes that the Senior Practitioner did not challenge inaccurate information that had been recorded and should have escalated this to the Safeguarding Lead to challenge. The RLH IMR notes that an outcome of the early September 2017 MDT was that the Social Worker would discuss the case with her Senior Managers and Homelessness staff with other Housing colleagues. Whether this happened and with what outcome is not recorded.
			1. Focusing on Ms I, the section 42 enquiry concludes that the Senior Practitioner seems to have lacked professional confidence and clarity in her decision-making, referring the matter back to a Senior Practitioner who had worked previously on the case. The divided state of the case record may have aggravated confusion here. The RLH IMR observes that staff must be aware of conscious and unconscious bias regarding homeless people with addiction issues. It also observes that work with self-neglecting patients can be emotionally draining and expresses concerns about the level of resources required.
			2. It has been suggested that all staff need to have a greater understanding of homelessness and rough sleeping, and the stigma that individuals can face when approaching services for support. A perceived negative reception can deter people experiencing multiple exclusion homelessness from accessing services subsequently. Ms I’s partner was very clear that accessibility and reception were important factors in enabling him to return.
			3. It has been suggested that some staff across different services may struggle to work with people experiencing multiple exclusion homelessness, with the result that relationships do not form. A review of training and staff support may therefore be indicated. Just as homeless individuals often feel alone and isolated, so too can workers.
		3. *Specialist legal and safeguarding advice*. This does not feature in the chronologies or the IMRs.
		4. *Case oversight, including comprehensive commissioning and contract monitoring of service providers*. In the case of Ms H, following discussion with the Principal Social Worker, the Service Manager responsible for Adult Safeguarding requested her Safeguarding Senior Practitioner to personally assess the risk of suicidal ideation as both Senior Managers felt that the risks warranted this. The Senior Practitioner allocated the task to a Social Worker without informing her Service Manager.
			1. The RLH IMR notes the difficulty of finding Ms H an appropriate placement. This would suggest commissioning issues here.
			2. Several commissioning points have been made to the independent reviewer. Firstly, Ms I’s partner was clear that he and Ms I had not always received sufficient support when they had been housed and that, as a result of bullying, cuckooing and abuse/exploitation, they had been unable to sustain living in accommodation. “Wrap-around” support is known to be crucial when individuals are provided with accommodation after periods of sleeping rough[[40]](#footnote-40). Secondly, it has been suggested that there is insufficient “out of hours” support available when sleeping rough is not just a 9am to 5pm phenomenon.
			3. Thirdly, it has been suggested that there is no clear pathway for those individuals with dual diagnosis to access support. Finally, hostel services can feel very institutionalised rather than psychologically-informed and therapeutic environments that encourage engagement with support and seek to promote a better sense of wellbeing. It is also important that there are sufficient resources for keyworker staff to accompany individuals to appointments.
		5. *Attention to workforce and workplace issues, such as staffing levels, organisational cultures and thresholds*. For Ms H, staff on the hospital wards were often not in a position to escort her off the ward. Ms H’s mother was very positive about the services involved with her daughter, stating that they had done the best they could with the resources they had. However, she did state that training was important, basing that observation on what some staff had said to her about the lack of professional development that had been offered to them. With respect to Ms I, the St Mungo IMR observes that staff turnover across services made it difficult to maintain working together. The RLH IMR expresses concern about the resources required to manage patients like Ms I more effectively.
	3. SABs are recommended to consider:
		1. *The development, dissemination and auditing of the impact of policies and procedures regarding self-neglect*. The chronologies and IMRs do not comment on this. Currently THSAB and its partners do not have a document outlining policy and procedures for cases of self-neglect.
		2. *Workshops on practice and the management of practice with adults who self-neglect*. The RLH IMR indicates that raising awareness of self-neglect is a priority. It also highlights the need for workforce development on mental capacity assessments for patients leaving wards and self-discharging, and the need for a multi-agency approach from the outset for complex cases. The RLH IMR notes the need for training on self-neglect and mentions a summit on learning from this case.
		3. *Learning from the IMR process*. The MPS IMR submitted regarding Ms H does not use the template but lists events in a separate document, largely without reflection or analysis. Some IMRs contain reflective analysis; others much less so.
1. Themed Analysis
	1. This section explores the learning themes that clearly emerge from the SAR reviewer’s integrated analysis of the information submitted by agencies. These learning themes were examined and have been informed by the perspectives of practitioners and managers who attended the learning event. Those attending the learning event believed that the two cases in this thematic review were representative of numerous similar cases. The focus falls on how agencies understood and responded to Ms H’s and Ms I’s circumstances, their health needs and mental capacity, how risks were assessed and managed, and the nature of interagency communication and case coordination.
	2. From the domain of direct practice with individuals, five themes were apparent from the review of the chronologies and IMRs, namely:
		1. *Professional curiosity in response to service refusal*. In line with Making Safeguarding Personal, best practice indicates the importance of finding out about the person, their life experiences and history, and their hopes and desired outcomes. Whilst some practitioners did attempt to “stay alongside” Ms H and/or Ms I, the chronologies and IMRs do not give a sense of exploration, inquiry and challenge regarding what lay behind suicidal ideation and/or substance misuse, or whether either woman could envisage a different life trajectory than the one into which they had become locked. Service refusal and non-engagement or disengagement appears often to have been seen as a lifestyle choice, however unwise, rather than a response occasioned by substance misuse, physical disability, mental ill-health or trauma. Equally, when people lead chaotic lives indicative of complex personal challenges, it may be unrealistic to rely on engagement as expected by services. Important then become assertive outreach and support to engage, proactive rather than reactive responses and case closures. Underpinning the questioning of how practitioners responded to Ms H and Ms I is how addiction is regarded and whether staff have confidence to explore difficult issues.
			1. Those attending the learning event expressed various views about the challenges in engaging patients/service users. The difficulty of this work was evident. Person-centred work was experienced as challenging when services are refused and cases closed, perhaps as one view surmised because of a fear of accountability. Some of those present, however, felt that services, such as those for substance misuse, only wanted to work with those who were willing to engage. Alternatively, a concern was expressed that Adult Social Care would be expected to continue managing risks, with cases “dumped”. Others observed that there was no policy on how to respond when people did not attend appointments, which could result in a revolving door pattern as a result of a person’s reluctance to engage or difficulty in responding. Others felt that more could be done to approach cases within a prevention and relationship-based lens but recognised time constraints when having to find out a person’s routine and habits and the impact of training in task-centred methods of work.
		2. *Involving family and friends*. In both cases there were concerns about the friends keeping Ms H and Ms I company. The degree to which they were challenged about their relationships and interactions with Ms H or Ms I appears to have been limited. Equally, there does not appear to have been any sustained examination of whether and how any friends or partners could prove a circle of support. There was some limited contact with Ms H’s mother. Ms I’s partner was known to services. Might more information have been elicited from family and friends? Were there concerns about sharing information?
			1. The importance of thinking family was recognised at the learning event. However, staff need to feel confident about information-sharing and information-seeking legal provisions, now embedded in the Data Protection Act 2018.
			2. Ms I’s partner also raised a specific issue about involvement. He remarked that there was a delay in him being informed of his partner’s death.
		3. *Recognising, assessing and responding to risk*. Documentation supplied by the agencies involved raises questions about the degree to which risks were recognised and assessed in a holistic, person-centred manner. Repeating patterns do not seem to have been addressed. Responses to risks involving drug and alcohol misuse, homelessness, mental health and neglect of care and support needs were not addressed in an integrated, coordinated way. Thus, there are questions about the scope of risk assessment, planning and review. There are also questions about when risks prompt consideration of section 42 enquiries or multi-agency high risk panels.
			1. Ms I’s partner made specific observations about her. He described her as a high risk patient who deserved a duty of care that he did not feel she received. He thought greater care should have been taken about the medication that she was given since he believed that she was able to obtain medication that she did not actually require. He was also concerned about whether she had been able to access medicine cabinets.
		4. *Assessing mental capacity*. The chronologies and IMRs provide evidence in both cases of the challenges of responding to cases where capacity fluctuates. The cases also raise the question of whether the impact of trauma and longstanding substance misuse on mind or brain is recognised and assessed, and most particularly whether executive capacity is considered. Neither the High Court nor the Court of Protection appear to have been considered as legal routes in either case.
			1. Time pressures, assumptions of capacity and lack of confidence were seen as impacting on mental capacity assessments. Some of those present at the learning event found it difficult to complete assessments when individuals did not engage. There seemed to be uncertainty about what to do next.
		5. *Hospital discharge*. There were several hospital admissions in both cases and key episodes relating to self-discharge. Taking their own self-discharge cut across attempts to resolve homelessness or to embed treatment for substance misuse. The chronologies raise a question, therefore, of how agencies might best respond when patients take their when discharge against advice.
			1. Some of those attending the learning event had encountered unsafe hospital discharges characterised by an absence of a multi-disciplinary approach. There was a view that a multi-agency approach should be taken with respect to complex cases before discharge, with agencies sharing information and working together.
	3. From the domain of the team around the individual, four themes were apparent from an analysis of the chronologies and IMRs, namely:
		1. Multi-agency working. The chronologies and IMR raise several questions. Firstly, the use of multi-agency risk management meetings, high risk panels, multi-disciplinary meetings and section 42 enquiries. Secondly, the involvement of service users/patients in meetings to discuss risk management and safeguarding. Thirdly, whether there are pathways for whole system and integrated working with multiple exclusion homeless people (homelessness + substance misuse + offending + mental and physical ill-health). In neither case does there seem to have been a lead agency or keyworker. Use, monitoring and review of plans in response to risk and safeguarding concerns were variable. Given the repetitive pattern of non-engagement or non-compliance, there was an absence of contingency planning. There was information-sharing but arguably an absence of coordination between hospital and community provision, mental health and drug/alcohol services, and between statutory and third sector staff. There appears to have been an absence of parity of esteem of voices between statutory and third sector professionals.
			1. Several aspects of working together drew comment at the learning event. Prominent were concerns about information-sharing, with observations about the challenges presented by different services having different information/recording systems and the lack of feedback on adult safeguarding referrals. Another significant concern was the withholding of information from service providers, perhaps out of fear that if everything was disclosed providers would not accept referrals. Some practitioners had also experienced being sent into situations without knowing the context of the case, and having to be assertive and persistent in order to establish trust and rapport with the person.
			2. There appeared to be general acknowledgment that working together could be improved across health, social care, mental health, substance misuse and voluntary sector agencies, leading to a recommendation that reviews such as this should lead onto a sustained initiative to build integrated working and coordinated provision for people experiencing multiple exclusion homelessness. The current approach was too fragmented and encouraged silo working, although some participants thought that there was improved linkage between some services individually addressing homelessness and substance misuse.
			3. Also expressed was a lack of knowledge about available services, especially specialist settings for rehabilitation, and concern that referral pathways, for instance into mental health services, did not facilitate a rapid response when support was needed.
			4. Examples were given about the exclusion of third sector agencies from case discussions and concern that “key players” were missing from meetings because of hierarchy. Another systemic issue that some of those attending identified was teams not taking responsibility, perhaps because of financial pressures, allowing service users/patients “to fall through the net.”
		2. *Safeguarding literacy*. The chronologies and IMRs indicate concerns about awareness and use of safeguarding pathways within and across agencies. They also raise questions about the thresholds in use for safeguarding referrals and enquiries. Finally, there are questions too about the use of escalation when there are concerns about risk and working together that appear to be overlooked.
			1. The different types of risk management panels, including MARAC, Community MARAC and high risk panel, were confusing for some participants at the learning event. Concern was also noted about the use and impact of thresholds and the failure by agencies to escalate concerns.
		3. *Legal literacy*. In both cases legal powers were used in the form of mental capacity assessments, best interest decisions, Deprivation of Liberty Safeguards and sections within the Mental Health Act 1983. However, the chronologies and IMRs invite review of whether there is sufficient knowledge of legal options, confidence in using powers and duties, and whether all options were considered for responding to complex cases, fluctuating capacity and extreme risk of self-neglect.
			1. One observation at the learning event was the absence of clear direction or guidance on legal options and process, resulting in a recommendation of training on engaging with legal practitioners and courts. There was also comment on the discontinuity caused by high staff turnover in the legal department. Another comment referred to Housing staff taking legal action on hoarding cases without the opportunity to explore other (legal) options in a multi-agency context. Finally, views were expressed about the lack of training on law, for example the Care Act 2014, leading to different understandings between agencies and services.
		4. *Recording*. Some recording has been described as poor, limited and/or delayed. It was not always clear how, why and by whom decisions are reached. Defensible decision-making requires that recording of risk, needs and capacity assessment is clear. That was not always the case here.
	4. From the domain of organisations around the team, two themes were discussed at the learning event, namely:
		1. *Management oversight*. Both cases raise questions about management oversight and supervision of complex, high risk cases. Embedded in these two cases are concerns about unconscious bias in the form of how addiction, homelessness, non-compliance and self-neglect are viewed. A view was also expressed at the learning event that staff were not following agreed policies and procedures, and that this was not being challenged.
		2. *Workforce and workplace issues*. Both cases raise questions about the resources available for responding to cases where needs are complex and risks high. In a context of high demand for services, there is a question about whether workloads are manageable and staff suitably qualified and experienced.
			1. Some participants at the learning event were of the view that agencies were service-driven because of the pressures under which they were working. Limited resources were seen as negating longer-term involvement with individuals with complex health, housing and social care needs. However, it was also recognised that there was a lack of knowledge about substance misuse, addiction and self-neglect across the workforce as a whole, that staff skill-sets were sometimes limited, and that staff attitudes and working styles could cut across a person-centred approach.
2. Recurring Themes
	1. Tower Hamlets Safeguarding Adults Board has published several SARs that contain recommendations pertinent to this thematic review. The need to improve understanding and use of the Mental Capacity Act 2005, especially in relation to assessments of fluctuating capacity, appears in several reviews[[41]](#footnote-41). The need to improve risk assessments, for example in cases of self-neglect and/or suicidal ideation has also been prominent[[42]](#footnote-42).
	2. Appointing a lead agency and/or keyworker in complex cases in order to coordinate agency responses has been advised[[43]](#footnote-43). Improving clarity and awareness of referral pathways concerning people at high risk, including homelessness and suicide, has been recommended, strengthening the links between Housing Options, Mental Health and Adult Safeguarding[[44]](#footnote-44).
	3. The development of robust arrangements for escalating concerns and for convening multi-agency meetings as well as for staff support, supervision and management, has also been advised[[45]](#footnote-45).
	4. At least one previous review[[46]](#footnote-46) has also commented on parity of voice, making sure that the practitioner and the service that knows a person well is heard.
	5. The Board might consider revisiting the outcome of previous SAR recommendations as part of any action plan developed following this thematic review and to keep under constant review progress in embedding recommended change in procedures and outcomes of practice. Keeping the learning alive and revisiting the degree to which change has been achieved should be the follow-up to any review[[47]](#footnote-47).
3. Legal, Policy and Financial Context
	1. At the learning event links were made between housing benefit, universal credit, budget constraints and homelessness. It would be wrong to ignore the impact of policies adopted by various governments on local services. A whole system approach is required if issues that are associated with street homelessness are to be tackled effectively. The lack of alignment across central government policies makes prevention of ongoing homelessness more difficult; people cannot be moved on and so remain trapped in homelessness.
	2. The constraints placed on local authorities by successive governments have left a shortage of affordable housing, including supported accommodation, which means that it is difficult for the reality of practice to match the aspirations of policy with respect to housing homeless people and eliminating rough sleeping. The Homelessness Reduction Act 2017, whilst aimed at promoting inter-agency collaboration in order to prevent homelessness, has not tackled the lack of supply of affordable housing and affordability of available accommodation. Welfare reforms have had a negative impact by creating landlord mistrust of universal credit and by failing to assist people into the private sector due to the rise in rents not being matched by the level of assistance available.
	3. Research[[48]](#footnote-48) has also shone the spotlight on the financial context, noting the impact of financial austerity on the capacity of Adult Social Care, for example, to absorb the workload arising from recognition of the care and support needs, and safeguarding concerns of people sleeping on the streets. Research[[49]](#footnote-49) has also highlighted that resource scarcity can lead to unlawful gatekeeping and the exclusion of street homeless people from care and support. At the learning event reference was made to the volume of work coming through the front door of different services.
	4. Review panel members have commented on the effect of budget cuts and workloads, highlighting especially the impact on judgements about, and responses to individuals who do not engage with services and who self-neglect.
	5. Those Safeguarding Adults Boards that have undertaken SARs, including thematic reviews, on cases involving multiple exclusion homelessness, might usefully work together to draw to the attention of central government departments the impact of the lack of policy alignment on efforts to prevent and eradicate rough sleeping.
4. Conclusion: Revisiting the Terms of Reference
	1. In both cases it is possible to discern good practice, most especially in attempts by individual practitioners to remain alongside or to reach out to Ms H and/or Ms I, and in the use of discretion by services to meet their care and support needs. For instance, the RLH IMR observes that a pathway homelessness team worked with Ms I for some time.
	2. It is also clear that the agencies involved have already begun to learn lessons from the two cases. A summit about working with adults who self-neglect has been held. The policy and procedures regarding people missing from hospital wards have been reviewed. A homeless pathway for patients in secondary care settings, as part of a multi-disciplinary team approach, is being developed.
	3. However, in examining practice against the evidence-base for working with adults who self-neglect and/or experience multiple exclusion homelessness, as required of this thematic review, it is also possible to identify learning. To begin with, practice with respect to individuals who self-neglect and/or who experience multiple exclusion homelessness was taking place in something of a policy and procedure vacuum. Locally agreed procedures, which draw on the evidence-base for best practice, would clearly locate THSAB expectations of multi-agency partners. Such procedures and expectations would, for instance, clarify the need for professional curiosity about a person’s self-neglect and/or substance misuse rather than relying on assumptions about lifestyle choice.
	4. The terms of reference included a focus on partnership and collaborative working. It is clear from comments at the learning event and within the chronologies and IMRs that there are lessons to be learned here. They include the apparent absence of case coordination, especially but not just at points of transition, and the advisability of appointing keyworkers for complex cases, and uncertainty about pathways for referral and escalation of concerns. Agencies must know what other services are doing and research on best practice advises system-wide integrated working[[50]](#footnote-50). Commendably a number of panels have been established, including Community MARAC, Self-Neglect and Hoarding, and High Risk. Clarity of when to refer to which panel would be helpful for practitioners across the statutory and third sector. Work also appears necessary to ensure parity of esteem across the different workforces, so that all those with a contribution to make are present at multi-agency and multi-disciplinary meetings. Finally, there may be a case for reviewing whether the development of additional procedures locally would be helpful, for example on self-discharge, led by THSAB.
	5. One key interface where partnership working is required is that of Housing and Adult Social Care. Section 23 Care Act 2014 covers the boundary between care and support and housing legislation. The statutory guidance[[51]](#footnote-51) that accompanies the Act, Chapter 15, provides further detail. The lack of suitable accommodation puts health and wellbeing at risk. Suitable accommodation is one way of meeting a person’s care and support needs. However, where a local authority is required to meet a person’s accommodation needs under the Housing Act 1996, it must do so. Where housing is part of the solution to meet a person’s care and support needs, or prevent them, then the care and support plan may include this, even though the housing element is provided under housing legislation. Any care and support required to supplement housing is covered by the Care Act 2014.
	6. However, homeless people experience difficulties accessing personalised support through Adult Social Care[[52]](#footnote-52). There is also evidence[[53]](#footnote-53) that Social Workers may see homelessness purely as a housing problem to be dealt with under housing legislation and not as an issue involving social care. Social Workers and Social Care staff may also be uncertain how wellbeing and the criteria regarding eligible needs are to be applied, for example to promote homeless people’s social inclusion[[54]](#footnote-54). Case law[[55]](#footnote-55) has also established that local authorities must consider if care and support needs are accommodation related and must involve an advocate in assessment and care planning. It is difficult to conceive of situations in which homelessness does not have a significant impact on an individual’s wellbeing. All of which would suggest a required focus on how the provisions in the Care Act 2014 relating to care and support are being implemented with respect to homeless people.
	7. The terms of reference also directed attention towards work with and responses towards adults with multiple health and care needs, adults who self-neglect, individuals who are homeless and individuals who have long-term issues with substance misuse. Feedback from the learning event and analysis of the chronologies and IMRs would suggest that substance misuse is not always recognised as a form of self-neglect and that the possible drivers underpinning long-term substance misuse may not be fully appreciated or explored over time. There are no quick fixes here and workloads will need to be adjusted to allow for long-term relationship-building work as a precursor to addressing causes rather than or as well as symptoms of self-neglect and substance misuse. There is certainly a need to understand patterns of behaviour and the influence of a person’s history on current behaviour. What also emerges in this thematic review is the question of confidence and scope of mental capacity assessments, including executive capacity and the impact of long-term substance misuse and of trauma and adverse life experiences on decision-making. Finally, a renewed focus on risk assessment, including the use of tools and templates to assist consideration of the likelihood and significance of diverse risks would assist with multi-agency risk management.
	8. Barriers to information-sharing also featured in the terms of reference. At times, judging by the content of the chronologies and IMRs, this was poor. Holding regular multi-agency meetings for complex cases may help to overcome such barriers, as well as an expectation that a keyworker is informed of significant developments, such as self-discharge or relapse. Integrated recording systems would also be helpful.
	9. The terms of reference also referred to commissioning of care and support. There does appear to be justification for an analysis of gaps in provision, highlighted by the two cases, but also consideration of how commissioning can be used to achieve greater integrated, whole system working.
	10. There was considerable investment from diverse agencies in attempting to meet the needs of Ms H and Ms I. However, it is arguable that much of this took place on parallel lines. It was also suggested at the learning event that the pathway for cases of dual diagnosis could be clarified and that perhaps more could be done to establish “wrap-around” support when people are housed away from the street.
	11. Members of the review panel have also commented that the shortage of registered care homes for people who misuse substances is a gap in service provision, and have noted the absence of a dual diagnosis service.
5. Recommendations
	1. Arising from the analysis undertaken within this review, the SAR review panel and independent reviewer recommend that the Tower Hamlets Safeguarding Adults Board:
		1. produce and disseminate multi-agency procedures for working with people who self-neglect, such procedures to include clear pathways for convening multi-agency panel meetings and for escalation of concerns, and arrangements for agreeing on lead agency and key worker to coordinate practice;
		2. produce and disseminate best practice guidance for working with people who experience multiple exclusion homelessness, such guidance to include clear pathways into mental health support and a protocol for the management of cases of dual diagnosis;
		3. commission multi-agency training on self-neglect, legal literacy (including information-sharing), unconscious bias, trauma-informed practice, mental health and mental capacity assessments (including a focus on executive capacity), and risk assessment;
		4. commission regular audits of the effectiveness of multi-agency high risk panels;
		5. convene a multi-agency summit to review commissioning of services in response to the needs of people experiencing multiple exclusion homelessness, concluding with proposals for further service development where gaps in provision are identified;
		6. convene a multi-agency summit to plan development of a more trauma-informed approach to practice;
		7. request that senior managers in Children’s Social Care and Adult Social Care discuss the learning from this report as it impacts on current cases where there are a combination of children’s safeguarding and adult safeguarding factors that require a think family approach, and disseminate guidance about best practice;
		8. audit progress on learning from this SAR after one year from publication.
1. An anticonvulsant medication used to treat seizures and neuropathic pain. [↑](#footnote-ref-1)
2. Schedule 5 (7) Coroners and Justice Act 2009; The Coroners (Investigations) Regulations 2013, Regulations 28 and 29. [↑](#footnote-ref-2)
3. Sections 44(1)-(3), Care Act 2014 [↑](#footnote-ref-3)
4. The Care and Support (Eligibility Criteria) Regulations 2014 [↑](#footnote-ref-4)
5. DHSC (2018) Care and Support Statutory Guidance: issued under the Care Act 2014. London: The Stationery Office. [↑](#footnote-ref-5)
6. Section 44(5), Care Act 2014 [↑](#footnote-ref-6)
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