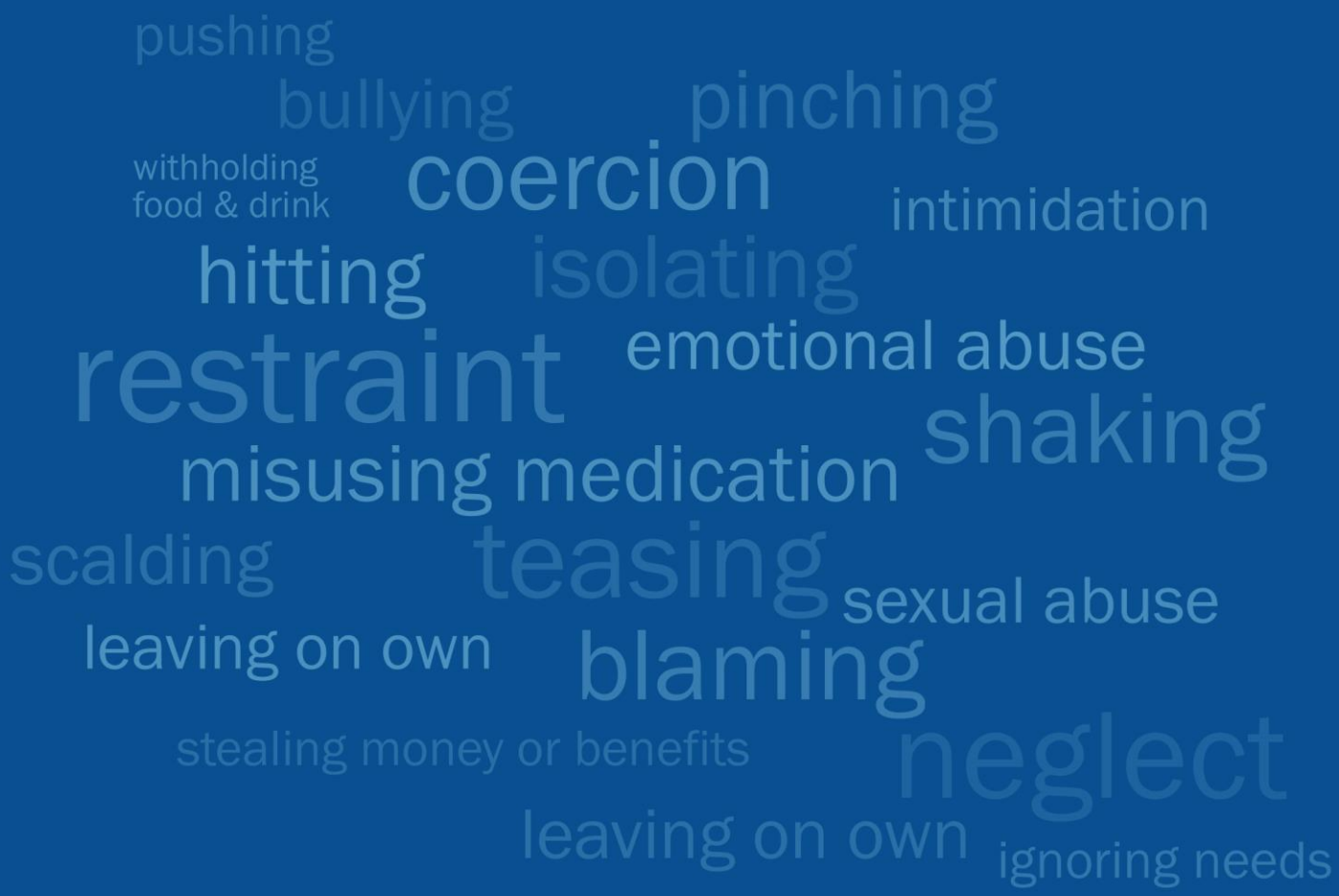
Solihull Safeguarding Adults Board
Protecting Adults Together

SAFEGUARDING ADULT REVIEW

REPORT

PAUL



Contents

1. Introduction

In March 2019 Solihull Safeguarding Adults Board received a request from Solihull Community Housing for a Safeguarding Adult Review under s44 of The Care Act 2014. In part this referral was made in line with the Rough Sleeper Strategy: Delivery Plan published in December 2018 by the Ministry of Housing, Communities and Local Government which suggests the death of a person sleeping rough should be considered for a Safeguarding Adult Review so that lessons can be learned to inform improvements in local systems and services.

Paul had a long history of sleeping rough in Solihull and Birmingham. He was known to have an addiction to alcohol and drugs and was previously a victim of an arson attack and a serious sexual assault in Birmingham. At the time Paul passed away in early 2019 he was in a supported housing scheme for homeless persons. Paul was also known to the SIAS outreach and drug and alcohol housing support services which is provided through the Council's Housing Support for Vulnerable Adults contract. Birmingham and Solihull Coroner concluded Paul's death was alcohol/drug related.

A Panel of senior officers who had not had direct contact with Paul considered scoping information from Solihull Metropolitan Borough Council (SMBC), West Midlands Police, Birmingham and Solihull Clinical Commissioning Group (BSOL CCG), Solihull Community Housing and West Midlands Ambulance Service to determine if the case met the criteria for a Safeguarding Adult Review.

The Panel concluded this case did not meet the criteria for a Safeguarding Adult Review set within s44 (1) and (2) of the Care Act 2014. However due to the concerns about how organisations and people with relevant functions worked together to safeguard Paul, specifically in relation to sharing information and a coordinated multi-agency approach to safeguard him, the Panel believed s44(4) of the Care Act was met and therefore recommended a review be arranged under this section of the Care Act.

The purpose of a Safeguarding Adult Review under s44 of The Care Act 2014, is to determine what the relevant agencies and individuals involved in a case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons can be applied in practice to prevent a similar situation occurring again.

It is not the purpose of a review to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial.

Paul's mother met with the Safeguarding Adults Board Business Manager and shared her memories of Paul and her experience of services during the period under scope. This report has also been shared with Paul's mother who has asked that we use his name within this report and not a pseudonym. The Board is extremely grateful to Paul's mother for her contribution.

2. Background

Paul was a qualified plasterer, who prior to 2015 was in a stable relationship and held a tenancy on a flat in Birmingham. Paul is described as being a very friendly person, who would trust everyone; he would not want to upset anyone and would easily forgive people. Paul liked a drink and was close to his brother and mother. Due to his trusting and friendly personality he was very vulnerable to being exploited. After the breakdown of his relationship Paul's vulnerability increased and over the following years he experienced some significant events:

- He lost his tenancy after two men took over his flat and bullied him; he began sleeping on the street in Birmingham and Solihull.
- His tent was set on fire with him in it by a long standing friend who was convicted for attempted murder.
- He was sexually and physically assaulted, bullied, robbed.
- He was alcohol and drug dependent. He attended detox treatments and was prescribed methadone to treat his opiate addictions.
- During 2018 he attended Accident and Emergency approximately 40 times.

When Paul passed away aged 44, he was in a supported housing scheme for homeless persons and was due to collect keys for a flat.

3. Methodology

Given some significant changes in legislation and practice since Paul's death, the panel decided that the most effective method of review for Paul's case would be a Multi-Agency Practitioner Workshop; this was organised on 9th September 2019. The aim of the event was to:

- Reflect on Paul's story.
- Consider other similar situations in Solihull, regionally and nationally.
- Understand the current housing and social care legislation.
- Look at local initiatives and best practice.
- Understand each agency's role and responsibilities.
- Identify any gaps in support and service provision.

Practitioners from Solihull Metropolitan Borough Council (SMBC) Adult Social Care, SMBC Housing Client Function, Birmingham and Solihull Mental Health Foundation Trust, SIAS (Solihull Integrated Addictions Service), University

Hospitals Birmingham, Solihull Community Housing, Ipswich House, Reach out Recovery, West Midland Ambulance, Birmingham and Solihull Clinical Commissioning Group, Birmingham Safeguarding Adults Board, West Midlands Police and SMBC Public Health participated in the workshop.

The workshop began with a presentation detailing Paul's story covering both Solihull and Birmingham and detailing what is happening regionally and nationally in relation to reviews following the deaths of adults sleeping rough.

Following this presentation participants were asked to identify the key issues from Paul's case.

This was then followed by three presentations on:

- Homelessness strategy and initiatives in Solihull to support rough sleepers
- University Hospital Birmingham's Homelessness Patient Pathway
- The Care Act 2014.

Finally there were table discussions to consider the current offer to people who are homeless or at risk of homelessness in Solihull, and identify any remaining gaps both in service provision and in staff knowledge, skills and confidence.

4. The Learning Event

4.1 Key issues from Paul's story.

Transitions

Paul moved between Solihull and Birmingham. The response from the police, ambulance service and University Hospitals was largely consistent within and across boundaries, with the exception of referrals to adult social care; Paul was referred to and was known to Birmingham Adult Social Care but was never referred to Solihull Adult Social Care. The reasons for this could not be identified, although it was suggested at the learning event that as Paul's engagement with services improved towards the end of his life in Solihull, perhaps the input of Adult Social Care was not felt to be required.

In addition, moving between Birmingham and Solihull presented challenges in terms of prescribing medication as Paul was required to change GP and also moved from Birmingham's drug and alcohol support service to the service covering Solihull, meaning new relationships needed to be built with him. Whilst professionals from the drug and alcohol services felt they had worked well together to transfer Paul's care, it was recognised that the transfer itself would still have been difficult for him, and staff had to be very tenacious in order to maintain contact with him.

Another significant point of transition for Paul was his discharges from hospital. Many of these were disrupted as Paul self-discharged on numerous occasions before receiving treatment. However where discharges were overseen by the hospital(s) they did not seem to take account of Paul's history, there was no evidence that he was asked if he had a safe place to go to upon discharge and

although information was often shared with the GP, discharges were not felt to be collaborative in approach.

Holistic approach

In 2018 Paul was taken to various Accident and Emergency departments in Birmingham approximately 40 times, often self-discharging before receiving treatment. In the same time period there were multiple DNA (Did Not Attend) GP appointments and some significant police involvement as detailed in section 2 of this report. There is no evidence to suggest services were building up a picture of Paul based on his contact (or lack of) with services; each contact was treated as a one off, often in response to a crisis, and the opportunity to identify a pattern was missed. There is no evidence to suggest a structured partnership approach to safeguard and promote Paul's wellbeing was considered or used, which would also have provided an opportunity for partners to come together and build a picture of Paul's life and experiences and work together.

Legal literacy

Agencies' interpretation of Paul's vulnerabilities, eligibility under the Care Act 2014 and 'life style' choices were inconsistent resulting in different responses at different times to similar incidents – sometimes safeguarding referrals were made, other times they were not, some safeguarding referrals were accepted by adult social care and persistent attempts made to contact Paul by both adult social care and police, others were closed by adult social care at the point of referral due to a 'lack of engagement'. This suggests there may be differences in the understanding of the definition of safeguarding within the Care Act and the associated responsibilities of professionals.

Training, skills and knowledge

Linked to legal literacy is the skills and knowledge of practitioners to work with people who are homeless and experiencing multiple challenges. It was identified at the learning event that models of engagement with people who are sleeping rough differ between agencies. Solihull Community Housing has trained staff in Psychologically Informed Environments (PIE); a framework for working with individuals who have experienced complex trauma. The framework can be used to redesign a service in a way that takes into account the emotional and psychological needs of the individuals using them. Other agencies had not heard of this framework and were unfamiliar with the terminology associated with it.

There was discussion during both the initial panel meeting and at the learning event, as to whether Paul was self-neglecting. There were often times when services could not engage Paul, when he would tell professionals he didn't need help and when he stated that he did not want to press charges against those who had assaulted him. Additionally he missed a number of appointments with various services. These decisions were accepted as capacitous decisions by Paul, however there is no evidence of formal assessments of capacity being completed by professionals or of consideration as to whether he was the victim of coercion.

Conditional support

For Paul the provision of accommodation was linked to an agreement from him that he would abstain from drugs and alcohol. However when considering his case history, all indications suggested he would struggle to do this. Indeed in September 2018 Paul completed a successful alcohol detox and moved to a dry house, however later that month he was removed from the dry house due to being under the influence of substances. There was discussion at the learning event as to how individuals can be expected to abstain from substance use when they do not receive support around the trauma they have experienced and often continue to experience.

The following section describes how the housing service in Solihull has learned from this and has implemented Housing First.

4.2 Homelessness Strategy and initiatives in Solihull to support rough sleepers

The Homelessness Reduction Act 2017 came into force on 3 April 2018. It is the biggest change to homelessness legislation in 40 years and brings in new duties to prevent and relieve homelessness. In addition to working under this new legislation, the West Midlands was the first region to provide housing for rough sleepers as part of Housing First; a flagship government policy.

Housing First England is a new project to create and support a national movement of Housing First services, improving the lives of, and support for, some of society's most excluded people. Housing First is a housing and support approach which:

- Gives people who have experienced homelessness and chronic health and social care needs a stable home from which to rebuild their lives.
- Provides intensive, person-centred, holistic support that is open-ended.
- Places no conditions on individuals; however, they should desire to have a tenancy.

There are also a number of services and initiatives in Solihull which have a role in supporting individuals experiencing or at risk of homelessness.

Solihull Community Housing (SCH) is the Arm's Length Management Organisation (ALMO) set up in April 2004 to run the housing service on behalf of Solihull Council.

Solihull St Basils runs a drop-in project for those 'at risk of homelessness', providing 'floating support' to young people identified as at risk of homelessness, and emergency accommodation through their Nightstop scheme and has a supported accommodation scheme housing young people who would otherwise be homeless.

Solihull Integrated Addictions Services (SIAS) is a partnership between five organisations jointly responsible for the delivery of drug, alcohol and gambling support services in the Borough of Solihull: Birmingham and Solihull Mental

Health NHS Foundation Trust, Aquarius, Welcome, Changes UK and Urban Heard. SIAS also delivers support to families and friends affected.

Change into Action – an alternative giving scheme to encourage the public to donate to local organisations rather than give directly to those begging on the streets was launched in Solihull in September 2019 to support the specialist organisations who already work with homeless people in Solihull, making sure that money given by the public helps to change the circumstances of rough sleepers and those at risk of rough sleeping.

Solihull's Harm Reduction and Vulnerable Victims Forum has been set up on behalf of the Safer Solihull Community Safety Partnership and Solihull Safeguarding Adults Board to effectively case manage and provide a multi-agency response to vulnerable individuals who may be victims of hate crime, anti-social behaviour and repeat callers to emergency services and partner agencies.

Solihull MBC has recently recruited a **Rough Sleeper Coordinator** whose role will be to work jointly with Council officers, Solihull Community Housing, representatives of other organisations, (including commissioned services), and Members of the Council and will have responsibility for Solihull's policy to prevent rough sleeping; implementing current strategy and policy and identifying and addressing gaps in existing provision.

The Rough Sleeper Co-ordinator will also provide comprehensive management for the delivery of a range of services and projects for rough sleepers, devising and managing projects from planning to evaluation stage, ensuring effective service responses are in place and deliver measurable outcomes for individuals. This will include reviewing the Rough Sleeper Protocol to meet the aims of the National Rough Sleeper Strategy and co-ordinating partners across the statutory and voluntary sector to share information and agree appropriate service responses to known and suspected rough sleepers.

Street Link is a national website, mobile phone app and telephone service for anyone to use to alert of a person sleeping rough so positive action can be taken. When making an alert, Street Link needs to know the location and general appearance of the person sleeping rough. Streel Link will then share this information with independent local homelessness outreach teams so they can locate the individual and connect them to support services.

4.3 University Hospitals Birmingham Homeless Patient Pathway

Across Solihull, Heartlands and Good Hope Hospital sites, UHB have developed a Homeless Patient Pathway as they recognise managing homeless people who are admitted to hospital can be challenging, often having a "tri-morbidity" – a combination of physical health, mental health and substance misuse. This can create challenges in planning and coordinating discharge. The pathway involves organising healthcare services in the hospital setting to promote safe discharge, and then to coordinate external agencies such as

housing, social care, the voluntary sector alongside specialist community services to build a care package for a marginalised group of vulnerable patients.

When staff identify an individual is homeless or at risk of homelessness a referral is made to the Homeless Patients Pathway (HPP) service and the Homeless Nurse Practitioner will aim to see the patient as soon as possible to conduct an assessment in order to source suitable support and accommodation.

4.4 The Care Act 2014

The 2014 Care Act provides the legal framework for adult social care and places a duty on councils to promote people's wellbeing. There are a number of sections which could be relevant in supporting an individual who is experiencing or at risk of homelessness. Section 1 details the Local Authority's duty to promote individuals wellbeing. Section 9 details the Local Authority's duty to carry out needs assessments. Section 11 details for Local Authorities the circumstances when they should carry out a needs assessment when someone refuses. Section 42 details Local Authority Safeguarding Adults duties and Section 67 and 69 details when the Local Authority must arrange independent advocacy support.

Whilst The Statutory Guidance which supports the Care Act details how to apply the Section 42 safeguarding duty, the interpretation of Section 42 varies nationally. In addition, paragraph 14.44 of the guidance allows for local authorities to choose to undertake safeguarding enquiries for people where there is not a Section 42 duty, if the local authority believes it is proportionate to do so, and it will enable the local authority to promote the person's wellbeing and support a preventative agenda. Again, use of this power across the country is variable and Solihull is not alone in recognising the need to explore this further.

5. Summary of Findings

During the time period scoped in this Safeguarding Adult Review under s44 (4) of The Care Act 2014 - 1st February 2017 to 28th February 2019:

- The Homelessness Reduction Act 2017 has been enacted placing a duty on local housing authorities to intervene at earlier stages to prevent homelessness and introduced a duty on specific public authorities to refer individuals they think may be homeless or threatened with homelessness.

- University Hospitals Birmingham at the Heartlands, Solihull and Good Hope sites implemented a Homeless Patient Pathways Team to support nurses with referrals to support services.

- The Housing First initiative in Solihull means individuals can access a tenancy without conditions, with supportive services available in an effort to prevent an individual returning to homelessness.

After the timeframe of this review but important to note, is the Local Authority's:

- Change into Action alternative giving scheme
- The appointment of a Rough Sleeper Coordinator

The impacts of these services and initiatives are yet to be realised but provide positive opportunities to effect change. Participants at the workshop were aware of some of these initiatives but not all and not everyone was aware of the established Solihull Harm Reduction Forum or of the national charity Street Link, both are important resources. Referral routes and key individuals to contact were also not found to be widely known. Whilst it was recognised that increased awareness of the changes that have been made to policy and practice in Solihull is necessary, it was positive that participants felt that many of the key issues identified in Paul's story could be addressed by these changes; namely improved discharges from hospital using the HPP, improved access to a tenancy and wrap around support via Housing First and improved oversight and coordination of services that support individuals experiencing or at risk of homeless with the appointment of a rough sleeper coordinator.

Participants also identified areas where it was felt gaps remain and these largely centred on knowledge, skills and confidence of staff both around legislation and in feeling confident and capable to support people experiencing multiple disadvantages including homelessness, self-neglect, previous trauma, mental health difficulties and substance misuse.

A significant discussion at the workshop and with Paul's mother was whether Paul was seen as having 'vulnerabilities' and agencies' interpretation of 'care and support needs'. Many agencies at the learning event felt Paul's substance dependencies, possible mental health needs combined with sleeping rough suggested he met the definition under the Care Act 2014 of having care and support needs. However there was no evidence an assessment was offered or carried out and Birmingham City Council did not initiate safeguarding adult procedures as they did not assess that the duty under s42 of the Care Act 2014 was met. It is unknown if paragraph 14.44 of the Statutory Guidance which supports the Care Act was considered. There was also a view expressed by professionals from a number of agencies at the learning event that the "threshold" for accessing both adult social care and mental health support is high and decision making in this area is not always perceived to be consistent. No referrals for a needs assessment or safeguarding were made to Solihull MBC it is therefore not possible to comment on their response. However it would seem appropriate based on the findings, to audit current practice within Solihull in relation to decision making on safeguarding concerns which do not progress to enquiry. This is included in the recommendations below.

A positive finding from the learning event was that in the last few months of Paul's life he was accepting of and receiving support from a number of agencies to help him with his substance use and homeless situation. Housing and drug

and alcohol support services were co-ordinated and felt clear about one another's role and remit.

6. Recommendations

1. SSAB to seek assurance services, pathways and multi-agency decision making forums available to professionals supporting individuals experiencing or at risk of homelessness are clear and this collective resource is widely available and kept up to date.

2. SSAB to explore, via multi-agency consultation, levels of confidence and understanding in supporting individuals experiencing multiple disadvantages, including when to refer as a safeguarding concern, how to assess mental capacity and how to identify coercion, and to consider a training programme to address learning needs where this is required.

3. SSAB to share this report with Birmingham SAB in order that it can inform current and future action planning by BSAB where necessary.

4. SSAB partners, as part of their regular audit process are asked to consider auditing cases where decisions are made not to progress a safeguarding concern to the Local Authority to ensure that decision making is evidence based, appropriate and consistent. For the Local Authority, as the lead agency for safeguarding, any audit should consider cases where a decision has been made not to progress a safeguarding concern to a Section 42 enquiry.

5. One year on from publishing Paul's SAR, SSAB to conduct a review to identify progress in implementing the recommendations and to understand the impact new initiatives discussed in this report have had on the lives and experiences of adults sleeping rough or at risk of homelessness in Solihull.

This report has been produced by the SAR Panel:

Sue Dale	Solihull Metropolitan Borough Council - Adult Social Care
Richard Bridgeman	West Midlands Police
Anna-Marie Boyd	Birmingham & Solihull Clinical Commissioning Group
Maria Kilcoyne	University Hospitals Birmingham
Surjit Balu	Solihull Community Housing
Melanie Mills	Birmingham & Solihull Mental Health NHS Foundation Trust
Date:	**7th January 2020**

Appendix 1

The Care Act – Section 44 - Safeguarding adults reviews

(1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) where is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(2) Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.