# WORCESTERSHIRE SAFEGUARDING ADULTS BOARD

# THEMATIC
# SAFEGUARDING ADULTS REVIEW
# REGARDING
# PEOPLE WHO SLEEP ROUGH

**Date: September 2020**

| VERSION CONTROL | |
|---|---|
| 2020 04 30 | V0.1 emailed by BC to SC/BB/SW |
| 2020 06 05 | V0.2 amendments from SBU made by BC |
| 2020 06 26 | V0.3 amendments made by BC following KB/HD feedback |
| 2020 08 14 | V0.4 amendments made by BC following CRG feedback |
| 2020 08 31 | V0.5 amendments made by BC following CRG meeting 24/08/20 |
| 2020 09 03 | V0.6 amendments made by BC following V0.5 |

# FINAL

When asked what he needed, Mr Frisby replied *"Some love, man. Family environment. Support."* ... He said that he wanted to be part of something real, part of real society and not just 'the system'.

*From the summary on the circumstances of Mr Terence Frisby cf. para. 3.3, one of the people, now deceased, who slept rough in Worcestershire*

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## 1.0 COVID-19 AND THIS REVIEW

**1.1** The UK national public emergency associated with the attempts to manage the impact of the COVID-19 virus interrupted the final stages of this Thematic Safeguarding Adults Review (SAR) of adult safeguarding and the experience of people often referred to as "rough sleepers."

1.2 Like many other parts of the country, with regard to people who sleep rough across the county of Worcestershire and the impact of COVID-19, attention naturally turned to the immediate challenges of the impact of the pandemic on people who were sleeping rough. [1] If and when current responses change, the situation for people who sleep rough may be very different – or not. It is understood that the local COVID-19 Homelessness Taskforce has a "recovery" workstream which is aiming to make sure things are different going forward.

1.3 After formally launching the thematic SAR in November 2019, the middle phase of the planned activity in one-to-one and/or group discussions, face-to-face or by telephone was undertaken.

1.4 As these discussions reached their final stages, a Stakeholder Event arranged for 28th March 2020 was cancelled due to the impact of COVID-19.

1.5 This means that the SAR was about to move into its final phase after the Event when a formal Report would be drafted and considered by the Worcestershire Safeguarding Adults Board (WSAB.)

1.6 In the light of the situation, as so much work had been done, in consultation with the WSAB Chair, a pragmatic decision was made to proceed with the drafting of a report for consideration by the WSAB in what would have been the expected way following the Stakeholder Event.

1.7 At the time of writing, an option has been left open to hold an appropriate event at a later date in which stakeholders could reflect on the learning and process at that point of time in the light of events at that point.

1.8 The impact of the COVID-19 situation is one which is likely to remain relevant to plans and progress, at least in the near-future (from May 2020,) if not beyond.

1.9 It is understood that many positive developments for people who sleep rough have been achieved by partners across Worcestershire in the responses to the COVID-19 scenario.

## 2.0 THEMATIC SAR - INTRODUCTION, PROCESS AND CONTEXT

### 2.1 WHO ARE THE PEOPLE THIS SAR IS ABOUT?

2.1.1 In September 2019, WSAB identified the experience of five people as collectively meeting the criteria required for a SAR. The experience of these people was united by the fact that they all lived in such a way that they were included amongst individuals sometimes referred to as "rough sleepers."

2.1.2 Four of the people identified were deceased. Of these, one died in hospital, one died whilst sleeping rough and two ended their own lives. One of the five was alive and although he had been sleeping rough, he had acquired a settled address by the time of this SAR.

2.1.3 The names of two of the people concerned – both deceased - are in the public domain. Their real names are used in this Report. Their names are: Mr. Remigiusz (Remi) Boczarski; Mr. Paul (known as Jobey) Sparrey.

2.1.4 The names of the remaining two people who are deceased are not in the public domain. Their names are anonymised. They are referred to in this Report as Mr Larry Jones and Mr Terence Frisby.

2.1.5 The name of the remaining person who is alive is not in the public domain. He is referred to in this Report as Mr Mike Ridell.

2.1.6 The WSAB decided to undertake a thematic review in response to the experience of the five individual people concerned on the basis that the individual experience of all the individuals may not have met the criteria for a SAR - taken collectively, however, it was felt that a "thematic" approach allowed the opportunity for further review.

2.1.7 WSAB also decided to take into account a Report [2] undertaken for Worcester City Council into the experience of the late Mr. Cardon Banfield who died whilst rough sleeping in July 2016.

2.2 **TIMESPAN -** A time period for focus of the review was agreed as approximately the previous two-three years prior to the start of the SAR. This is consistent with wider approaches to SARs in specifying a timespan recent to the events under review so as to maximise learning. Nevertheless, there may be reference to events which are outside of that timescale where deemed relevant e.g. the experience of Mr. Banfield.

2.3 **SARs AND THE CARE ACT 2014**

2.3.1 The WSAB website states that *"The main purpose of WSAB is to promote wellbeing and reduce the risk of harm for people with care and support needs."* [3] As part of this purpose, the WSAB must undertake a SAR when serious harm – including a death - has occurred to a person within the WSAB area. The Care Act 2014 and associated Guidance state that SARs are commissioned when [4]

- *there is reasonable cause for concern about how WSAB members or other agencies providing services, worked together to safeguard an adult, and*
- *The adult has died, and WSAB 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); or*
- *The adult is still alive, and WSAB knows or suspects that the adult has experienced serious abuse or neglect.*

2.3.2 The Care Act Statutory Guidance states that the purpose of SARs should be to *"seek to determine what the relevant agencies and individuals involved … 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 applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account*. [5] Therefore, SARs are not investigations and do not seek to attribute blame.

2.3.3 In terms of approach, the SAR process sought to build on the Care Act focus, the Making Safeguarding Personal (MSP) framework and overall developing strengths-based approaches to practice and review. It sought to avoid "hindsight bias" and took a broadly hypothesis-testing approach to the activity.

2.3.4 With recommendations for learning in mind, the focus which was sought was on **recommendations which WSAB can implement**, not recommendations requiring national action.

2.4 **SAR QUALITY -** This SAR has drawn on the "Quality Markers" developed by the Social Care Institute for Excellence (SCIE,) [6] to maintain effective standards in SAR practice. These Quality Markers are consistent with the six adult safeguarding principles derived from the Care Act 2014, in particular that of "proportionality" [7] i.e. a SAR should be proportional to the

circumstances it reviews. Based on this approach, some points applied in this instance included, firstly, completing the SAR within a reasonable time period so that colleagues are as close to the events under review as possible. As outlined above, however, the events associated with the impact of COVID-19 have impacted on this commitment. Secondly, producing a report of an appropriate length with recommendations which WSAB could implement locally, integrated into existing / on-going plans of WSAB partners / agencies.

2.5 **TERMS OF REFERENCE**

2.5.1 Terms of Reference were drafted in response to the SAR referrals. They were the subject of engagement with stakeholders at an event held at the Warndon Community Centre on 7th November 2019. As a result of that engagement, the draft Terms of Reference were amended in response to feedback received and shared further with attendees. The final Terms of Reference agreed were as follows:

*To review the response to rough sleepers encompassing neighbourhood, district and county-wide responses to risk and vulnerability experienced by people sleeping rough in Worcestershire by:*

*TOR1 Understanding the multi-agency and public responses made in respect of the men who are the subject of this SAR and how we might be more likely to help prevent the deaths of adults sleeping rough in Worcestershire through developed coordination and engagement across relevant boundaries / sectors further as needed*

*TOR2 Considering the impact of physical or mental impairment or illness, including substance dependency and dual diagnosis on the risks experienced by adults who are rough sleepers and the service response to those issues;*

*TOR3 Reflecting on learning about any relationship between the safeguarding and assessment duties of the Care Act 2014 and safeguarding good practice such as Making Safeguarding Personal (MSP,) other relevant legislation (e.g. the Mental Health Act 1983 as amended, the Mental Capacity Act 2005 and specific housing legislation) and the experience of rough sleepers;*

*TOR4 Identifying any other specific themes in the experience of those who are the subject of the SAR such as experience of debt, family support, cause / symptom issues or similar which might have an impact on learning from this thematic review overall*

*TOR5 Specific consideration to the issues of self-neglect as a Care Act 2014 category of safeguarding links to issues for rough-sleepers.*

2.5.2 These Terms of Reference are used to structure the Report and analysis below in Section 5.0. Perhaps inevitably, themes inter-relate. Therefore, although there is some specific consideration of each theme under the relevant heading, the report needs to be understood as a whole. A neat separation wasn't achievable in what is a very complex scenario.

2.6 **ENGAGEMENT -** Engagement with all concerned is a key part of the SAR process. There were five aspects to engagement activity undertaken in this thematic SAR.

2.6.1 Firstly, the Independent Reviewer engaged directly with Mr. Mike Ridell as one of the **subjects of the SAR.**

2.6.2 Secondly, to increase awareness and contribution from **people with lived experience,** the Reviewer:

- discussed with someone who had lived experience as a rough sleeper;
- had brief interaction with one person currently living at a local homelessness resource about his experience;

- met people who were sleeping rough or "on the street" in Worcester city when the Independent Reviewer and Safeguarding Board Manager accompanied a local Outreach worker in March 2020. Four people – Amanda, Frank, Steve and Paul – (names anonymised) shared their views / experience with the Independent Reviewer and colleagues.

- Read reports directly informed or influenced by people with lived experience of rough sleeping e.g. James Fuller in Martineau *et al.* [8]

2.6.3 Thirdly, with regard to **family / relatives** of the people who are the subject of this SAR**, a**s per local arrangements, reasonable efforts were made by the Worcestershire Safeguarding Adults Board Business Unit to clarify who the family of the five subjects of this SAR were with the following outcomes:

- Relatives of Mr Terence Frisby responded that they did not wish to be involved.
- The relatives of Mr Larry Jones and Mr Paul Sparrey did not respond to enquiries made.
- It is understood that Mr Remigiusz Boczarski's relatives lived outside the United Kingdom and was therefore not practicable to contact.

2.6.4 Learning from other SARs suggests that engagement with families can sometimes be difficult to achieve.

2.6.5 It is understood that the Worcester City Review relating to Mr Banfield did not include engagement with family. Although it became clear after the Report was published that he did have relatives, they lived outside the United Kingdom and it is probably unlikely that it would have been seen as practicable to contact at the time. [9]

2.6.5 Fourthly, the views of people who sleep rough were, to some extent, also represented through some comments from **patient representative, staff or campaigning perspectives**.

2.6.6 Finally, with regard to **staff and managers** of relevant agencies, the WSAB has an established "scoping" process as it decides on whether or not a referral meets the criteria for a SAR. Some individual agencies undertook post-incident reviews in response to the experience of some of those identified in the group of five e.g. Worcester City Council's reviews concerning the late Mr. Larry Jones [10] and the late Mr Cardon Banfield [11] as did a Voluntary and Community Sector (VCS) provider concerning their interaction with Mr. Remigiusz Boczarski.

2.6.7 Within the timespan of the process, the Independent Reviewer engaged with:

- o about 50 people who attended the 07/11/19 Stakeholder Event at Warndon Community Centre (content of the event attached at Appendix 2;)
- o about 30-40 individuals and / or small groups in one-to-one or small group discussions / interviews between November 2019 and April 2020
- o about eighty people were invited to the Final Stakeholder Event planned for 27th March 2020 cancelled due to COVID-19 impact**.** The planned content of the meeting is attached as Appendix 3.

2.6.8 Beginning with the Stakeholder Event of 07/11/19, all were invited to contact the Independent Reviewers to ensure that as many as possible might contribute to the process and reminders were emailed on three occasions. The positive, solution-focussed approach by contributors was appreciated by the Independent Reviewer.

2.7 **LIMITATIONS -** The theme and experiences of each individual person considered were complex. It is possible that in the context of the wider review, unique factors in the experience of each individual may not be reflected as strongly as some may have hoped due to the emphasis on the overall theme of rough sleeping and safeguarding. Other limitations included:

- o Engagement – the Independent Reviewer did not meet any family members of those who are the subject of the SAR. Sickness, work demands, and the impact of COVID-19

meant that the Independent Reviewer may not have met all possible practitioners or managers.

- Time limitations – the SAR was a big project meaning focus on what was achievable within the time available had to be practical and achievable.

- Practice realities / working practices have changed since the events covered in this SAR. Rightly, colleagues have not waited for the outcome of the SAR before developing new services or approaches. Likewise, all who participated were involved at different points, to differing degrees and occasionally had no direct involvement with the individuals or events reviewed.

- The postponement of the planned March 2020 Stakeholder Event reduced the contribution which reflections from that event would have made to collective insight cf. the agreed content for the Event attached at Appendix 1.

- With regard to the impact of COVID-19, the wider social response for people who sleep rough specifically with many being given rooms in local hotels may mean the questions which seemed relevant when this SAR was commissioned have changed somewhat over time. But this is impossible to tell at the time of writing.

2.8 **CONTEXT -** It was clarified during the SAR set-up phase that the Coroner considered the deaths of three of the five people whose experience is the subject of the SAR as well as that of Mr Cardon Banfield. [12] Also, it was confirmed that no disciplinary action had been taken in respect of any employee involved in the support of any of the six people included as subjects of the SAR. In stating this, there is no implication that any such action was required.

## 3.0 THE EXPERIENCE OF FIVE PEOPLE WHO SLEPT ROUGH IN WORCESTERSHIRE

### A. THOSE WHOSE EXPERIENCES WERE SUBJECT OF THIS REVIEW

3.0.1 A synopsis of the circumstances for each person is presented below using the names / pseudonyms referred to at para. 2.1 ff. The synopses are based on information shared in the SAR. The level of detail available varies.

### 3.1 MR. MIKE RIDELL

3.1.1 Mr. Ridell has lived in the Worcester City locality all his life. He had lived with family with whom he still seems to have some contact. It is understood that he raised a child on his own and with whom he still has some contact following the death of his partner / wife many years ago.

3.1.2 Professionals have known Mr. Ridell for some years. They commented that he is seen as someone who seems to get on with everyone and "doesn't cause any trouble." One member of the team said that she had "*good in-depth chats where he seems to have a lot of insight and forethought."* He is seen as *"harmless,"* as having a *"good personality,"* being *"quiet"* but can *"close down"* simply stating that he is "*OK."* For example, Mr Ridell states that he has had a shower and does not drink, but staff cannot be sure if this true. Staff felt that to some extent Mr Ridell can state what he thinks the listener wants to hear. There were also views that Mr Ridell may have an unspecified learning difficulty or mental health issue such as depression and anxiety.

3.1.3 In terms of housing, Mr Ridell appears to have used much of the local provision including what is regarded as poor-quality private landlord provision. He has housing debts which have been a reason for evictions. He has been supported in attempting to change an acquired lifestyle including with bids into the tenancy system. His ability to maintain a perceived fit state for his accommodation had led to difficulties in sustaining tenancies over time.

3.1.4 Mr Ridell has also used other public services including a number of visits to the acute hospital A&E connected to use of alcohol. Mr Ridell was under the care of a GP via a support service for homeless people. His mental capacity appears to have been accepted. Having met Mr Ridell, it seemed understandable to the Independent Reviewer why this view could be taken as Mr Ridell appeared responsive and engaged with the conversation.

3.1.6 As far as rough sleeping is concerned, his circumstances were the subject of some local media reporting. [13] He has displayed behaviour consistent with definitions of hoarding and self-neglect.

3.1.7 A safeguarding referral was made in response to apparent self-neglect. Whilst sleeping rough, Mr Ridell had been incontinent of both urine and faeces around this time. Rats were observed crawling over him in his location. Safeguarding action was not developed, however as it was judged that Mr. Ridell had mental capacity and referrers were directed to the WSAB Self-Neglect Policy. In discussion, there was a sense that self-neglect tended to be focussed on people's experience within a home environment rather than a rough sleeping one, "on the streets" where perhaps self-determination issues were given greater force.

### 3.2 MR. LARRY JONES

3.2.1 Mr Jones had grown up in the Worcester locality. He was father to some children and seems to have had some contact with his family. It appears that Mr Jones had had struggles with his use of alcohol over many years. He seems to have used mental health services earlier in life, but this does not seem to have been a feature of his later years.

3.2.2 In terms of accommodation, it is known that he lived with a partner at an Registered Social Landlord (RSL) provided address for over 13 years prior to his death in November 2017. The RSL knew that Mr Jones was in the property, but the tenancy was in the name of Mr Jones's partner. Mr Jones's partner managed the practicalities relating to the tenancy. She died in December 2016 and prior to her death there were no tenancy related issues. Arrangements for tenancy "succession" planning began on the death of Mr Jones's partner. Mr Jones returned some required forms signed to the RSL, but a Death Certificate was not provided by him as required. This was an action which the housing provider had to complete itself in due course, which was unusual. This helped establish rights of succession and the subsequent pre-eviction protocols were followed. In the opinion of the Independent Reviewer, it is impossible to say if a different approach would have made any difference to Mr Jones's conduct of his life at the time, given the understanding that he had negative feelings about the accommodation after the death of his partner.

3.2.3 In February 2015, it was understood that Mr Jones had left his partner and had been rough sleeping since then. Street drinking had been a feature of his life and attempts to engage with an alcohol rehabilitation provider from October 2015 came to nothing. The provider "closed the file" in January 2016 as there had been no contact.

3.2.4 Mr Jones remained in touch with his GP. There was clear awareness of physical and mental health needs and medication was prescribed. In November 2015 Mr Jones was admitted to hospital in connection with a chest condition. He did not want to stay however and efforts to ensure his engagement with treatment plans did not work out. He attended a Day Centre four times in November / December 2015 and was not engaging or taking his medication appropriately.

3.2.5 The death of Mr Jones's partner in December 2016 seemed to have had a significant impact on him. It appears that Mr Jones began to drink more alcohol. Mr Jones found it very difficult to stay at the shared property due to memories of his late partner.

3.2.6 During 2017 services reported that Mr Jones was rough sleeping, street drinking and engaging in anti-social behaviour which brought him to contact with police. It came to be understood that he had effectively abandoned the property in which he had previously lived with his partner.

3.2.7 There was increased contact with the police up to the time of his death. Similarly, there were numerous contacts with ambulance service, local acute hospital and RSL services.

3.2.8 On 26th September 2017 Mr. Jones collapsed on a street in Worcester city and was taken by ambulance to hospital where he died aged 55 years.

3.2.9 A Coroner's Inquest Hearing of December 2017 confirmed that Mr Jones had died from a cardiac arrest, biventricular hypertrophy, Chronic Obstructive Pulmonary Disease (COPD,) and ingestion of alcohol and morphine. The Coroner concluded that Mr Jones's death was related to the abuse of drugs and alcohol.

3.2.10 Worcester City Council commissioned an Independent Review into the death of Mr Jones which they received in July 2018 [14] consistent with the changed requirement for reviews of deaths of homeless people. [15] Recommendations included a range of awareness raising activity about local services and specific ideas to ensure information was shared even more effectively amongst partners.

### 3.3 MR. TERENCE FRISBY

3.3.1 Originally from the Worcestershire area, Mr Frisby had travelled and lived in various parts of the country. He had moved back to the Worcestershire area in October 2018.

3.3.2 Professionals who knew him most recently stated that Mr Frisby could be chatty at times, but he was perceived as somewhat *"closed"* and not easy to get to know. Mr Frisby didn't seem "*to mingle"* and discussions with him could end in arguments. He appeared to be angry with the world.

3.3.3 Perhaps he had reason to be so. Multiple adverse experiences could be identified in his early life. It seems that he experienced some unspecified abuse/violence in childhood. He was "in care" for some time and had lived with foster parents. Some early misuse of alcohol seemed to have stopped many years ago. He was in and out of jail and rehabilitation with a long history of offending (mostly theft, but also domestic violence) and short jail sentences, some of which were drug related. He was the victim of aggression himself.

3.3.4 Nevertheless, Mr. Frisby had some periods of stability. He maintained his own tenancy between 2010-2014. He held down some jobs including as a care worker for a council social services department. He was also skilled in plastering. His interests were known - reading and walking.

3.3.6 In terms of relationships it is understood that he had married twice. In his first marriage, a child died near-term. The couple then lost custody of a second child who was later adopted. He referred to this as *'The Big Thing'.* He stated that he had no current contact with any family members. When asked what he needed, he replied "*Some love, man. Family environment. Support."* Mr Frisby said that he wanted to be part of something real, part of real society and not just *'the system.'* It is thought that the second, most recent relationship was "a bad split."

3.3.7 In Worcestershire, Mr Frisby was registered with a GP. He was diagnosed with depression and described his own mental health as poor. It was understood that he was in receipt of Universal Credit. With regard to his rough sleeping, he used various Worcestershire-based services over time and lived rough including sleeping in a tent in a city centre location. The owners of a shop seemed to develop a positive understanding with him that he could sleep behind their premises and this seemed to work for both parties. He had challenges connected to his use of substances, but he didn't engage with the main substance misuse rehabilitation provider in the area.

3.3.8 There was concern for Mr Frisby in the last year of his life due to behaviour which had been observed and it was thought that he was attempting to end his own life.

3.3.9 It is understood that not long before his death, Mr. Frisby had stated that he wanted to see a psychiatrist. In the last year of his life, ambulance attended to him on three times, including at

the location where Mr Frisby ended his own life. The Coroner reviewed the circumstances of Mr Frisby's death and delivered a verdict of death by suicide.

### 3.4 MR. REMIGIUSZ (REMI) BOCZARSKI

3.4.1 Mr Boczarski was believed to have been born in Poland. It is known that he had family / next of kin as they had contacted the managers of the land where Mr Boczarski ended his own life to ask for an appropriate memorial to be placed at the location where he had died aged forty.

3.4.2 He was at least ten years younger when he arrived in the UK, [16] therefore, as he seems to have been designated as "homeless" in the Worcestershire area around 2011. It seems that Mr Boczarski moved to the UK after his partner had died. One can only speculate about what this experience meant to him. It seemed that he found it difficult to find a route through "forms and red tape." He told practitioners that he worked in cash-in-hand jobs.

3.4.3 Interviews suggested his English language was good and not perceived as a barrier for him in interactions with others.

3.4.4 He appeared to have had friends: one helped him to collect his belongings in September 2016 on eviction from an RSL accommodation.

3.4.5 In terms of accommodation, he started a tenancy with a local RSL in February 2013. He was found to be "very compliant." However, his income stopped in January 2015 and the Income Management team began to work with him. This resulted in a court hearing in January 2016 and, by September 2016, an eviction.

3.4.6 In late 2017, housing staff met Mr Boczarski in Malvern Library where he appeared to be shy. He was referred to a community support agency where he seemed to enjoy a good working relationship with the worker allocated. There was liaison amongst colleagues at this point in Local Intelligence Group meetings to clarify who was leading in response to Mr Boczarski's situation. It was thought that too many people involved would disturb Mr Boczarski.

3.4.7 By now, Mr Boczarski had become well-known locally as he began to occupy one or other of two bus shelters in the vicinity as places to sleep and would often be seen outside the Waitrose supermarket in the town. The managers of the land, the bus-stops and the police were aware of his presence and interacted with him during this time.

3.4.8 It appeared that some local people were visiting Mr Boczarski, taking him food, blankets and the like. It was reported that someone played dominos with him and children brought him pictures. One member of the public in the locality tried to help him practically over time. Mr Boczarski's belongings were very orderly and folded away during the day.

3.4.9 There was some social work involvement in February 2018 following contact from the district council. The judgement at the time was that there were no specific adult social care needs and any discussion of mental health were not referred for further assessment. Contact with the Police was suggested due to the extreme cold temperatures at the time.

3.4.10 Mr Boczarski was referred into a "crash pad" provision where he stayed for about three weeks in March 2018. It was noted that he did not use the bed in the room at the time but slept in a sleeping bag on the floor. This behaviour was understood as something not uncommon amongst people who sleep rough for a long time i.e. this is where people can feel most comfortable and familiar. Towards what became the end of his stay, Mr Boczarski began to choose to sleep outside and it became clear that Mr Boczarski was in possession of a knife. The provider contacted police in accordance with their policy that no weapons are allowed on the premises, in view of the needs of all people using the premises being paramount. It was made clear on admission to Mr. Boczarski that no weapons are allowed. Police took Mr Boczarski from the premises via an arrest on 21st March 2018. He returned on 22nd March 2018 to collect his belongings and move on. There did not appear to be anyone for the provider to refer to, with respect to the events associated with Mr. Boczarski leaving the provision.

3.4.11 The helpful member of the public in Malvern contacted the local Housing Officer in May 2018 and expressed concerned about Mr Boczarski's mental health. He appears to have been at a Ledbury address in July 2018. He attended a GP appointment a couple of days before he took his own life with physical health worries about stomach symptoms for which he was booked-in for blood tests. His befriender / advocate phoned NHS 111 when trying to find accommodation for Mr. Boczarski when he seemed to feel unwell. It is understood the Call Handler spoke directly to Mr. Boczarski and asked him if he was contemplating suicide. He replied "*yes and no*." It seems that it was not felt that this response was recorded properly by the responder.

3.4.12 Out-of-hours housing services found Mr Boczarski a place at a local Premier Inn. Mr Boczarski was also referred to the "No-Second-Night-Out" (NSNO) provision but did not attend on the night of the 29th October 2018. To help with "tracking," the NSNO provider emailed the Local Housing Authority with a list of who did or didn't attend. There was no communication with the referrer as the provision was a contract for the offer of a bed and no further support.

3.4.13 Mr Boczarski's body was found near Earnslaw Quarry car park, a twenty-minute walk from the bus stop he used for sleeping. Ambulance services attended and performed CPR to no avail. One of the policing team who knew Mr Boczarski attended the scene shortly after the alert had been raised and was able to identify Mr Boczarski.

3.4.14 The Coroner judged that Mr Boczarski had taken his own life due to a combination of anxiety, abdominal issues and alcohol misuse. [17]

### 3.5 MR. PAUL (JOBEY) SPARREY

3.5.1 Mr. Sparrey was a tenant of a local RSL from December 2012 when he took up tenancy in a "hard-to-let" flat. Aspects of his behaviour were concerning to those working with him and he could appear as intimidatory. It seemed that it was known that Mr. Sparrey had had a poor experience of childhood. This manifested itself arguably in the reports of drug dealing which began around January 2013. It appears that whilst a tenant he also begged on the street. A structured programme of contact was undertaken with regular visits to discuss his situation. He was given Notice to Quit after four months tenancy and the RSL regained possession by August 2013.

3.5.2 Sometime afterwards he seems to have occupied a derelict caravan which in due course he was asked to leave prior to living more "on the streets." His life was affected by misuse of substances and there were instances attached to him of being a perpetrator of anti-social behaviour and domestic abuse.

3.5.3 Mr Sparrey seemed to have a strong relationship with a worker from the specialist substance misuse rehabilitation service. By early June 2018, Mr. Sparrey was one of a couple of individuals who would sit on a bench by the railway station drinking alcohol. Over time, larger numbers seemed to congregate. There appears to have been positive inter-action between agencies in response to this and Mr. Sparrey was found to be extremely courteous in his responses to staff and volunteers. There was concern about the environment generally and public protection orders were discussed as a possible action. Around this time, the ambulance service attended to Mr. Sparrey in response to his drinking at the funeral of a relative. He declined the hospital attendance offered on that occasion.

3.5.4 Local Housing Authority services reportedly found Mr. Sparrey quite "difficult to engage." At the beginning of December Mr. Sparrey was begging in Malvern. He was allocated a housing officer who was proactive in looking for Mr. Sparrey. The Officer saw Mr. Sparrey on five occasions in December. Mr. Sparrey was offered NSNO and Severe Weather Emergency Protocol (SWEP) accommodation around 19th December 2018 but he didn't want to travel to Worcester where the service was located. (There is now a more local provision in Malvern and Evesham with a set of services in Malvern opened in 2019.)

3.5.5 It appears that Mr. Sparrey had long-standing physical health problems and this was referred to in a media report of the Coroner's assessment of Mr. Sparrey's death alongside drug use.[18]

Ambulance services attended to him when the alert was raised on Christmas Day when he was found dead in the doorway of a local department store.

## B. EXPERIENCE TAKEN INTO ACCOUNT - MR CARDON BANFIELD

### 3.6 MR CARDON BANFIELD

3.6.1 A Report commissioned by Worcester City Council, "*Individual Review into the death of a person sleeping rough C – May 2018,"* [19] explains that Mr. Banfield was born in St Vincent and the Grenadines. It is understood that he moved to the UK around 1960 and worked in the Merchant Navy. Apparently, he did not like settling and reported that he was not in contact with his family, living a solitary and transient life since about 1966.

3.6.2 His presence in Worcestershire was first noted via Housing Benefit claims in 2004 - 05. The next local service records in Worcestershire refer to Mr Banfield's attendance at a Day Centre in Worcester city in 2013 around which time he had been living in the Birmingham area.

3.6.3 It appears that he used the community provision available for a short period around this time and then Mr Banfield lived at a housing provision in the city of Worcester. It's understood that Mr. Banfield applied for Council Tax from his address there in 2014.

3.6.4 In July 2016, Mr Banfield's decomposing body was found when staff at Worcestershire County Cricket Club were alerted by a member of the public to a strong odour coming from a tent pitched in the area. Police undertook a DNA analysis and deemed his death non-suspicious. Mr Banfield was aged 74 at his death.

3.6.5 A Coroner's Inquest took place in October 2016 and confirmed that the body was that of Mr Banfield and that he had died in the tent in which he was found some time before the date on which his body was found. An open verdict was recorded as Mr Banfield's remains had decomposed to such an extent that the Coroner was unable to determine an exact date of death, medical cause of death or how his death had occurred.

3.6.6 It is relevant to note that the social and practice environment has changed since Mr Cardon's death both locally and nationally. For example, national requirements about reviewing the deaths of people for whom sleeping rough was a feature of their experience has been confirmed. [20] And locally, issues connected to sharing of information appear to have been resolved in the meantime. In taking into account the review of Mr Banfield's experience, this thematic SAR should not re-run the Review commissioned by the City Council at the time. However, the Independent Reviewer has heard an argument that no rough sleepers died in the locality under the community support arrangements available shortly before Mr Banfield's death compared to the more current arrangements. This may be a statement of fact. Whether or not a causal link can be established, however, is impossible to confirm given the number of variables at play cf. para. 5.0.1. It is accepted that it appears that the challenges for Worcestershire appear similar to wider national challenges given the number of deaths of people sleeping rough which have occurred elsewhere cf. **para. 4.9.**

## 4.0 TERMS OF REFERENCE - PRELIMARY ANALYSIS: SAFEGUARDING AND PEOPLE WHO SLEEP ROUGH

4.1 Given the circumstances outlined of the people who are subjects of this SAR above in Section 3.0, a number of general responses to the Terms of Reference on safeguarding and people who sleep rough were highlighted for sharing at the planned March 2020 Stakeholder Event cf. Appendix 1. They are summarised here as follows.

4.2 The question of why some people sleep rough is a key one to understand overall as it impacts on safeguarding practice. Glasser and Bridgman [21] argue that there are two approaches - the "personal pathology" and the "structural." The personal pathology approach concentrates on the responsibility of the individual for their circumstances including mental capacity. The "structural" approach emphasizes the influence of wider factors. There is, perhaps, a continuum between these two overall explanations which refine various aspects of each

broad understanding. These would present a view of the person sleeping rough as a "ne'er do well" on the one hand and a "victim" or "innocent" on the other. Whichever of these perspectives informs policy and practice with regard to safeguarding will affect the actions undertaken, locally as well as nationally.

4.3 In addition, theories on "Adverse Childhood Experiences" (ACE) and related trauma-informed environments practice are influential now. The experiences of Mr. Frisby and Mr Sparrey echo aspects of this approach. Those such as Kelly-Irving and Delpierre [22] offer an extension of the insights provided by the ACEs approach which leaves room for acknowledging greater influence of experiences as an adult. These were mentioned by many contributors in the SAR - redundancy; relationship breakdown or loss such as bereavement which was an experience of four of those people who are subjects of this SAR; transition to reliance on benefits; migration issues; or the like. The validity of both perspectives is assumed in this Report. They are all powerful insights which drive the methods adopted in responding to people who sleep rough and their safeguarding. They all seem to be used amongst Worcestershire partners.

4.4 Secondly, there are issues connected to terminology. This relates to terminology used about people who sleep rough and with regard to understanding of the term "safeguarding." Both of these can affect safeguarding practice.

4.5 With regard to terminology used about rough sleepers, a variety of words / terms were used by practitioners and leaders which occasionally made it challenging to clarify the underpinning thoughts of colleagues in discussing the themes and their consequences for safeguarding cf. Appendix 1, Slide 19/57. Words / phrases identified included: h*omelessness; rough sleeping / sleeping rough; street – based lives and behaviours – drinking, begging; street homeless; roofless / rooflessness including different types – initial or episodic rooflessness and/or roofless(ness) after resettlement; living on the liminal / margins of society; "hippy;" "tramp;" and "open air deaths."* Any, or all of the words, may have differing implications when connections to safeguarding are concerned. In the experience of Mr Sparrey, for instance, he had been a tenant but was also, by all accounts, begging on the street. Due to the complexity of the situations, Martineau *et al* [23] use the phrase "Multiple Exclusion Homelessness" (MEH) to encompass the range of terminology used to cover the complexities involved.

4.6 With regard to understanding of the term safeguarding, the Care Act 2014 Guidance defines adult safeguarding as "…protecting an adult's right to live in safety, free from abuse and neglect." [24] The Guidance goes onto specify many points relating to the way partners should work together, the need to recognise that adult's situations can be complex, principles for safeguarding and the need to promote wellbeing for individuals amongst other factors. The 2019 LGA *Making decisions on the duty to carry out Safeguarding Adults enquiries Suggested framework to support practice, reporting and recording* [25]adds further context for understanding. Indeed, there is no dearth of written material on safeguarding definitions. And yet, colleagues continue to experience tensions in understanding. This adds force to the need for activity amongst colleagues to undertake activity which can support them to acquire and use shared understandings to better benefit for people sleeping rough who are using support or care services.

4.7 Thirdly, in terms of history it is perhaps significant to note that the experience of people sleeping rough is not a new phenomenon. This is perhaps reflected in the fact that a very old law, The Vagrancy Act 1824 [26] still applies today when the understanding and response to people who sleep rough has developed so much, not least with consideration of safeguarding.

4.8 Fourthly, the idea that a "rough sleeping culture" exists is important. This may be a "counter-culture" but people also create a sense of belonging in the rough sleeping group. [27] This insight is noteworthy with regard to safeguarding in appreciating the value which a person sleeping rough may give to their way of life. Practitioners noted that often, people who were sleeping rough in Worcestershire looked out for one another.

4.9 Fifthly, in terms of incidence of those who are counted as "homeless," for the Independent Reviewer it is clear that the deaths of those concerned in Worcestershire can be seen as part of a wider nationwide pattern. In 2017, there were 597 deaths in England and Wales. It seems

clear, therefore, that this is a challenge beyond the borders of Worcestershire.[28] In Worcestershire itself, figures seem to suggest that, anecdotally but based on local evidence, about 100 people may be defined as sleeping rough at any one time.[29] The deaths of homeless people can also be understood in the context of significant health inequalities analyses. For example, the Kings Fund states that "*In 2018 the average age of death for people who died while experiencing homelessness was more than 30 years below that of the general population, with women on average dying at the age of 43 years old – 38 years earlier than women in the general population." [30]* In seeking to develop its response to safeguarding people who sleep rough, Worcestershire is not alone. Indeed, local media has also recognised the challenges faced when help is declined by the person who is sleeping rough. [31]

4.10 A wider specific factor, sixthly, is current and recent national policy. This shapes the environment in which people are sleeping rough and in which safeguarding practise occurs. For example, the Homelessness Reduction Act 2017 [32] has aimed to strengthen the framework for action by all concerned. The Office of the Chief Social Worker for Adults in the Department of Health and Social Care has backed this up in a 2019 letter to Principal Social Workers reminding them of the social work role in this duty to refer. The Government published a *Rough Sleeping Strategy* in August 2018 with the aim of halving rough sleeping by 2022 and ending rough sleeping entirely by 2027 through "*prevention, intervention and recovery*." [33] The impact of the transition to Universal Credit for some was mentioned often amongst participants to this SAR particularly with regard to perceived negative impacts of the scheme on individuals [34] such as delays in receiving payments.

4.11 This change can be seen most sharply, perhaps, in respect of Mr. Banfield's death as law and the shape of local services have continued to change. In terms of law, the Homelessness Reduction Act 2017 introduced the requirement for a plan for each homeless person which could theoretically have been applied to Mr Banfield had the City Council known of him at the time he lived in the Council area. In terms of the shape of local services, a Homelessness Strategy was established for the period 2012-2017. This was delivered in the context of reductions to the Supporting People programme. This seemed to impact on the capacity of local services. Reduced capacity had to be managed as well as possible alongside other factors linked to public policy e.g. development of Universal Credit system. At the time of Mr Banfield's death, nevertheless, there was a "link-up" information system which appears to have been a way to help agencies know who the people in its locality were. It is understood that this system was stopped at the end of the strategy period / when recommissioning occurred in the context of reduced funding due to the lifting of the Supporting People ring - fence and wider public sector austerity.

4.12 Requirements about knowing who the rough sleepers are in the area has now changed. Agencies can refer to one another as they become aware and the Homeless Reduction Act 2017 introduced the duty to refer for some public sector bodies. It is reported that awareness of who is in the area is raised by regular street walks by staff when tents might be observed. Staff reported that the rough sleeping community itself makes known new people in their midst to the staff and if they have concerns for someone. Members of the public will alert and a national Street Link system [35] is also available to support individual referral. Refuse collectors, councillors and businesses also alert, it was reported. It remains possible that the presence of a given individual may be missed, of course.

4.13 Strategic leadership for the response to the presence of "rough sleepers" across the Worcestershire area is provided by the Worcestershire Strategic Housing Partnership (WSHP.) This links to the Worcestershire Health and Well Being Board (WHWBB) with the aim of promoting co-ordination across all activities to address rough sleeping and wider homelessness challenges. Some partners will also be members of, or represented by, colleagues at the WSAB. Partners have recently completed an updated *Worcestershire Homelessness and Rough Sleeping Strategy 2019-2022*. [36] A *Rough Sleeping Task and Finish Group* met during 2019 to address the specific rough sleeping elements of this work. The strategy recognises the need to remain responsive to changing needs and it may incorporate a more overt approach to safeguarding of rough sleepers which otherwise is not mentioned explicitly in the document.

4.14 Issues raised with regard to the practice of the WSAB in undertaking SARs in relation to the deaths of people who sleep rough is resolved to some extent through the national Rough Sleeping Strategy [37] guidance. This requires SABs to consider undertaking reviews although the criteria to be applied in making the decision has not changed. Haringey appear to have established a process for theirs which they call "Homelessness Fatality Reviews." [38] This may provide a model for WSAB and / or the HWBB so that a process in which everyone has confidence given the importance of the issue, is the same as a pragmatic solution.

4.15 Within the overall strategic arrangement for multi-agency working outlined above, the Worcestershire area has a range of support and operational service arrangements working to address the challenges presented by the presence of people sleeping rough in the locality and working to safeguard them as well as possible. These are in public provision on a county level e.g. adult social care and NHS services; or other wider regional footprints e.g. police and fire services; housing provision with about 20 RSLs in the area including district council lead as the Landlord; Local Housing Authorities; a diverse voluntary, community and faith sectors working to support people who are homeless and / or sleeping rough across a variety of geographies; individual actions taken by local people in giving money, food or other goods as well as time to some who are sleeping rough or, perhaps, begging across the area.

## 5.0 TERMS OF REFERENCE - ANALYSIS AND REVIEW

5.0.1 With these general reflections in mind, in the spirit of learning adopted through the SARs, it seems that a number of variables were evident for all concerned across the Worcestershire area in the values, principles and practice adopted in their work as it impacted on safeguarding people who sleep rough. These variables included:

- respect for the human freedom of individuals to live as they appeared to wish
- concern for the welfare of people who seem to choose to sleep rough or do so for other reasons, including the mental capacity of the individuals concerned to make that decision about their own life
- the consequences for others in families, friends, neighbours and wider communities about an individual's action particularly with regard to wellbeing and safeguarding;
- the response of people in local communities – this is a continuum from distress felt for people who are "sleeping rough" and an associated desire to assist as best they can on the one hand, to a perception that the freedom of others to live as they appear to choose should not impinge on the freedom of another to be free of some of the consequences of that choice e.g. in not experiencing behaviour perceived as intimidating, such as "begging;"
- where volunteers aim to make a contribution, how this can be most effectively linked to part of the wider "system" of other voluntary endeavour or statutory action to respond further to people who are sleeping rough;
- interactions between different parts of that system in response to "multiple exclusions" [39] experienced by the person sleeping rough.
- the shape of support and services overall and safeguarding arrangements i.e. quality services and support can reduce or eliminate the need for safeguarding; and
- overall, the challenges and opportunities to develop multi-agency working and work with the public have been seen in this SAR as, amongst other possible factors, organisational, geographical, professional, sectoral, inter-personal and intra-personal.

5.0.2 In the midst of this complex reality, leadership on the issue of rough sleeping and safeguarding for people who sleep rough is clearly a key consideration. It is recognised that this is not easy. The number of factors involved mean that rough sleeping is an example of what are sometimes described in public policy literature as a "wicked" issue [40] where numerous issues are at play and attempts to pull them together may have been frustrated over a long period of time.

**5.1** ***TOR1 Understanding the multi-agency and public responses made in respect of the men who are the subject of this SAR and how we might be more likely to help prevent the deaths of adults sleeping rough in Worcestershire through developed coordination and engagement across relevant boundaries / sectors further as needed***

5.1.1 Partners in the locality have clearly moved in an encouraging direction. For example, there has been an attempt in part of the county area to develop a shared narrative or "doctrine" and a "Charter" mechanism to the approach to "rough sleepers." This is very positive as it begins to create a sense of shared understanding for shared action. To move onto the next stage of implementation, the "shared narrative" and Charter content probably needs to become more widely embraced as a unifying mechanism for partners in multi-agency work and for the public across the whole. The updated *Worcestershire Homelessness and Rough Sleeping Strategy* provides a focus for updating and renewing shared approaches to safeguarding people who sleep rough including involvement of adult social care.

5.1.2 With leadership in mind, embedding this narrative more widely amongst partners could be enhanced as learning from other areas is incorporated into Worcestershire approaches. For example, through the SAR process there was interest in the public health approach taken by the City of Wolverhampton under the leadership of the Council Leader at the time, as a way of further strengthening coordination. The Council Leader's role seemed to provide an "honest broker" amongst partners to good effect, not least for safeguarding people who have been sleeping rough.[41] This would be particularly important in response to an issue identified by a number of SAR participants that small-scale services / support initiatives such as soup kitchens or the like, were not always easy to bring into the dynamic of co-ordination. This kind of leadership may allow local Worcestershire arrangements to be built on to promote dialogue and understanding between these sectors driven by shared concern for safeguarding people who sleep rough.

5.1.3 A variety of comments in the SAR process witnessed what seemed like a mixed picture about joint or partnership work experience "on the ground" with associated impact on safeguarding. At the individual level, many colleagues respected and were impressed with one another and the efforts made by all concerned e.g. in relation to work with Mr. Sparrey and Mr. Jones. There was also evidence of challenge amongst partners, too. This is surely positive where it is aimed at improving the experience and safeguarding of people who are sleeping rough.

5.1.4 In addition, there was a desire to ensure that colleagues could achieve a greater level of shared purpose and reduce frustrations which can be associated with joint working. This showed itself to some extent in the expectations of partners around the understanding of "safeguarding" and how it might be applied to the situation of people who are sleeping rough. It is important to note that this is not just a challenge for colleagues in the Worcestershire area.

5.1.5 SAR participants stated that different agencies seemed to have different views of what one another do and their remit and this came into sharp focus in relation to safeguarding. For example, when housing colleagues alerted adult social care to the circumstances in which Mr Ridell found himself, it was not clear to housing colleagues why it was judged that a safeguarding response did not appear to be the route needed by Mr Ridell. It seemed hard to them to appreciate how someone who had been doubly incontinent did not need to be safeguarded. However, the decision-point here that given Mr Ridell's mental capacity, it was the Self-Neglect policy which was being applied. This may have created miscommunications between those in dialogue at the time.

5.1.6 This was a complex scenario in which differing understandings of safeguarding could be seen. Going to the next level on working with complexity is very much a theme of this SAR which may help. For instance, Davidson Knight *et al's* [42] work on "Funding and Commissioning Complexity" is really helpful in this context arguing that the shift required is to make *"…taking responsibility for our impact beyond our immediate sphere of influence, acknowledging that what we do affects not just those we have a direct relationship with, but the wider ecology as well. We are not lone rangers, and we shouldn't seek to be. Our strength lies in positive collaboration, in honesty, openness and generosity in sharing what does and*

*doesn't work – and in hearing, acknowledging and responding to others' views on this, too."* It would seem, therefore, that a renewed drive to help workers in Worcestershire learn from different work backgrounds, learn one another's professional language and parameters would promote more effective experience for staff and people sleeping rough in their experience of staff and decisions.

5.1.7 Some were not involved in relevant forums e.g. an RSL was not invited to a "Blue Light Forum" for the City of Worcester (an information sharing arrangement about people with alcohol-related challenges which impact on services and the local community. This may have been an over-sight which this SAR gives opportunity to amend as part of an inclusive approach to safeguarding people who sleep rough. However, it could also be that the number of RSLs creates a practical co-ordination challenge of how all housing providers be represented in relevant arrangements. Some shared resource solution may be a way around this as discussed below cf. para. 5.1.13. In addition, it should be noted that the Forum is only in one area, that of Worcester City. It is acknowledged that similar forums in the Districts may be better able to achieve consistency in this relationship.

5.1.8 Such approaches would help practitioners and managers across partner agencies to avoid the temptation to be more protocol-driven in their approach to thresholds than they need to be in a work environment increasingly shaped by MSP. "*Safeguarding is everybody's business"* is the helpful refrain used to assert that we all share a moral and legal responsibility in respect of safeguarding people who sleep rough. We do not want to "*pass the buck*" on safeguarding in Worcestershire - we want to find a way of sharing it.

5.1.9 Other examples included discussion about the limitations of contracts for providers on what they might or might not do in response to the person who is a rough sleeper. Again, it is recognised that this is a complex issue. On the one hand, there is the force of argument about the contract specification for providers and keeping to "the letter" of the contract. Providers have an understandable concern to assert this when they believe resources provided do not meet capacity required and at worst, to avoid exploitation. On the other hand, "the letter" of an agreement might be regarded as a "cold" way to approach some aspects of human need, even within a contract-operating environment. So, for instance, when Mr Boczarski moved on from a provider, it appeared that the provider had nowhere to share with the community – even if they had wanted to - what had happened so that the community would at least be aware. If they had, then it's possible - but by no means certain - that some other form of support might have been secured for him which may have led to a different outcome.

5.1.10 It is noted that there were numerous positive instances of information sharing between agencies. The police's "Concern for Welfare" process was known about and used. A Local Intelligence Group process appeared to be a really positive and valued work arrangement. It seems that there were some similar arrangements going back some years to the time when Mr Banfield died. However, the consistent spread and reach across the whole county did not seem totally secure in the time in which the SAR was undertaken. Achieving a single, understood and used process for the whole county would be a positive achievement and enhance safeguarding practice. The experience in Stoke (Multi-Agency Resolution Group,) Plymouth (Creative Solutions Forum) or Leicester (Street Lifestyle Operational Group) [43] all attached at Appendix 3 may provide models which can prompt relevant consistent application across the whole of the county of Worcestershire. Local decision-makers will be able to sense-check if their arrangements are consistently applied for all citizens within the county.

5.1.11 It was good to note a range of methodologies used to create "holding" conversations between partners in response to challenges perceived or presented by individuals sleeping rough. The substance misuse rehabilitation provider has a good range of meeting types such as "complex case meetings." They included / modelled a way of demonstrating greater personalisation e.g. in not using the "DNA" category anymore and has been replaced with an Engagement Policy. If more formalised approaches to multi-disciplinary working could be developed then the safeguarding community may wish to encourage greater use of Family Group Conferences, for instance, (which are used in L.B. Camden in supporting people who sleep rough [44]) or similar approaches to promote greater involvement of the person who is the subject of concern and anyone acting in their best interests. For agencies to pull together,

perhaps learning from children's services provides a further model where something akin to the Independent Reviewing Officer Chair in children's services might be used as appropriate in an updated structure for monitoring, reviewing and developing support and services for individual sleeping rough further. It seems that this may merely be a "tweaking" of current arrangement across the county. It is recognised that there is work underway on related approaches.

5.1.12 As the approach to case (person) conference methodologies is developed further, then an agreed approach to hand-offs between organisations can be reviewed and clarified so that all partners are using a common framework with agreed expectations of all contributors. The aim here would also be to enhance safeguarding of individuals.

5.1.13 One participant suggested that a "single point of access" model for services might enhance approaches to all rough sleepers and their safeguarding. Such an approach could be made possible through the kind of enhanced leadership model discussed earlier. It is a positive thing that housing services are included as "virtual" partners in the countywide hub arrangements for adult safeguarding. That probably goes some way towards the idea of a "single point of access" in respect of safeguarding adults who sleep rough. It might also be that another alternative which promotes greater integration would be a single voice for all RSL's as a part of the safeguarding arrangements. This could be clarified by reviewing the way in which housing and the wider safeguarding community interact with one another in the current Safeguarding Hub. However, it was noted that occasionally, referral to the safeguarding system may be used as a potential route to acquire involvement of adult social care. These circumstances seemed to be where that service might have denied access through other routes. A different service model might allow better use of resources to respond to the perceived need.

5.1.14 Issues connected to transitions in contract awards were mentioned in the SAR. For example, those mentioned with regard to the experience of Mr Banfield now appear clear in the community. The transfer of data between providers is clearly required to ensure continuity of service provision and commissioners ensure that happens. Communication is a challenge where support services are revised, and expectations can be difficult to manage where services have been established on a lower available budget.

5.1.15 The current revised focus for services on prevention is a laudable aim which would avoid the progress in a person's experience to becoming "entrenched" in their rough sleeping behaviour. The focus of this SAR indicates that there remains a challenge for the locality of the kind of arrangements which will work best for those whose rough sleeping behaviour is sometimes described as "entrenched."

5.1.16 In seeking to change the behaviour of the public in supporting the work undertaken by statutory and voluntary agencies, "co-production" ("doing-with" rather than "doing-to") is seen as important. The aim is to improve safeguarding for people who sleep rough. This is another thing which is not easy and will require constant application and renewal. However, within the wider county itself, there already seems to be some evidence of success in achieving this. The instance is in the approach taken by a District Council in the way it developed the dialogue with the public in the time up to the implementation of their "Housing First" [45] approach to people sleeping rough in their locality. It included work to try and remove stigma and discrimination against people who sleep rough in the public as well as amongst partner agencies so as to allow the innovation to happen. It seems that overall, the consent of the public was sought and won in the approach developed through structured engagement activity. This could provide a model where the need for a consistent approach across the whole county geography to secure on-going and improved safeguarding for people sleeping rough is addressed.

5.1.17 The experience of Mr Frisby and the shop where he sometimes slept is a reminder that liaison with businesses around town centres may vary across the county, but they can play a critical part. Their further engagement in the kind of process envisaged above with regard to engagement of the public, offers further opportunity to improve coordination further. An idea to mark items such as sleeping bags which one part of the system / community had given to

the person sleeping rough for free only to be moved / destroyed by another part by shops or the Council Environmental Services is a case in point of trying to find a solution which is focussed on and beneficial for, the person sleeping rough.

5.1.18 In addition, although all agencies across Worcestershire may not have the same level of resources as large multi-national organisations, there is an opportunity for a planned "social marketing" campaign to support overall awareness raising and behaviour changes amongst local citizens, building on their natural concern for the well-being of people who sleep rough. It may be hard to know to what extent the general public in Worcestershire are aware of the contribution they can make through resources such as https://www.streetlink.org.uk/ (although this facility can't be used on Ambulance Service phones) or "Alternative Giving" [46] schemes which could make some difference as part of wider coordinative efforts. In seeking greater co-operation and co-production with the public and local communities, it is accepted that not all people will support this approach. Perhaps a strategy to engage with Worcestershire philanthropists [47] might also be a way to enliven the commitment to maximising resources for communication or further support/ service development in the area.

5.1.19 Another feature which was echoed in Worcestershire and noted by Martineau *et al* [48] relates to those comments which were made about the need to ensure that mutual respect between all professional groups. Some housing and day care professionals, for instance, felt that the care / safeguarding system did not give equal weight to their contributions and queries about safeguarding. This is a challenge for partners who would want to ensure that equal weight is given in deliberative processes to clarify next steps focussed on safeguarding the person who is rough sleeping. Any actions which support that - such as joint -based models for practitioners in a given geography to build on current activity - would support efforts to improve mutual understanding, for example. [49]

5.1.20 Based on experience of developing support or services for people who sleep rough in Worcestershire, a wider point was made in the SAR process which impacts on safeguarding and multi-agency working with regard to schemes which are developed using funding provided by agencies outside of Worcestershire such as the Big Lottery. The way in which safeguarding requirements are featured in the service delivery agreements does not seem to be sufficiently clear and it is recommended that discussions are held with such bodies to ensure that safeguarding is a central feature of the agreement reached.

5.1.21 Unfortunately, there was no contact with probation or prison services in the course of the SAR. Partners will have views about current relationships as they impact on people who sleep rough and can take the opportunity afforded by the completion of this SAR to incorporate any actions for improvement into updated plans.

### *5.2 TOR2 Considering the impact of physical or mental impairment or illness, including substance dependency and dual diagnosis on the risks experienced by adults who are rough sleepers and the service response to those issues*

5.2.1 The link between rough sleeping and mental health needs is recognised. [50] Homeless Link found that as many as 80% of homeless respondents reported experiencing a mental health issue.[51] They also argue that *"The psychological impact of trauma,* (…including multiple traumas…) *makes it difficult for people to cope with the innumerable obstacles they face in the process of exiting homelessness."* Such approaches are embraced in Worcestershire along with other insights [52] which are all great practice. But a "new normal" has emerged over the last thirty years or so, of people with mental health needs rough sleeping and / or living street-based lives. It can't have been in the mind of policy designers that in the laudable desire to close large institutions that anyone with a mental health need should be sleeping on the street.

5.2.2 The latest national *Community Mental Health Framework for Adults and Older Adults* [53] is being used locally in Worcestershire to lead change. From this and in response to the situation outlined in above in para 5.2.1, it is arguable that there is greater acceptance of the need to make public services more personalised in their response to people in all sectors. This doesn't mean that it always happens and that there are no challenges. However, it

remains the case that it is the individual person who may experience the reality of one or more physical health needs, a mental health need and where relevant, dependency on one or more substances, all at the same time. Practitioners in Worcestershire are beginning to use the phrase “co-occurring conditions” to emphasise the experience of the person as opposed to the “dual diagnosis” phrase which is professionally orientated and may determine action in that frame, as a result.

5.2.3 So professionals in Worcestershire responding to the needs of people with co-occurring conditions, do so in the context of a recognisable debate about the relative merits of “generic” versus “specialist” professional responses. With healthcare as focus, Juahar (2014) [54] outlines challenges involved in the generalist / specialist practice in healthcare and Britnell (2011) assumes the benefits of specialisation in the health care sector. [55] Differing influences within each sector (inclusion principles in social care, for instance, are likely to support a generic approach) may compound the challenge of finding a positive consensus amongst professional groups as well as interested wider society for a number of reasons.

5.2.4 Firstly, there is the challenge of the circumstances for people living with co-occurring conditions. With regard to people who sleep rough in Worcestershire and their safeguarding, there is concern amongst colleagues that in practice some people who sleep rough “fall through gaps” in relation to their mental health needs and therefore, perhaps, with safeguarding. This dilemma is played out in local provision for people with co-occurring conditions in Worcestershire. Expertise from a variety of services are required to respond; substance misuse rehabilitation from either community or residential base; specialist medical, health or social care; providers of supportive accommodation and the like.

5.2.5 More specifically, secondly, the GP capacity and specialist interest in the City of Worcester area which uses the premises of one of the formal homelessness services, seems to provide a more tailor-made experience for people who use the day service. However, discussion showed that it is unlikely that a specialist model for GP provision for people who are sleeping rough for the whole county may be difficult to replicate across the county. But perhaps each Primary Care Network (PCN) could consider if the provision of a nominated GP Lead for people who sleep rough might work. Colleagues may wish to reflect on this as a further way to enhance clinical and mental health support services and safeguarding for people who sleep rough in the area.

5.2.6 Thirdly, in other areas of the health services delivery pathway such as the acute hospital; setting, there appears to be large numbers of people presenting at the hospital with drug and alcohol problems, some of whom may be sleeping rough. The work of the Acute Hospital Homelessness Liaison Pathway Officer and the Homeless Patients Pathway to promote positive outcomes for people attending is acknowledged. WSAB partners may wish to continue exploring learning from other areas for the Worcestershire context to promote improved experience for people sleeping rough and their safeguarding. Two areas have been highlighted recently: Southampton and surrounding [56] area Homeless Healthcare Team and Sandwell and West Birmingham NHS Trust’s “Homeless Patients Pathway” [57] where there is a clinical lead in the hospital location.[58] It is acknowledged that demographics and scale of challenge may be different in those locations which requires their local responses. Overall, however, in relation to healthcare and the safeguarding of people who sleep rough, this brings into focus the relative benefits of specialist or generic response and the “wicked” nature of the practice and policy challenge cf. para. 5.0.2. The challenge of making acute hospital A&E arrangements work for everyone has been a long-standing one and anything which can help continually improve experience for all concerned including those who sleep rough and their safeguarding will be welcome.

5.2.7 Fourthly, with regard to the contribution of the NHS Psychology service to the mental health care of people who sleep rough in Worcestershire, during the SAR, we learned that a national homelessness charity [59] was beginning to employ specialist Psychologists to work specifically with homeless people including rough sleepers. This was helpful because it appeared that the psychology service offered in Worcestershire currently was on a general basis. Given the complexity of the situation for people who sleep rough, therefore, there may be a case to consider how a greater specialist psychology in-put might strengthen current arrangements. It

may be timely, therefore, as part of overall response to the way in which mental health support for people sleeping rough is developed further to promote next steps in safeguarding those who sleep rough to consider to what extent local psychology services might be developed further in the locality with specific benefit to rough sleepers in mind. In this way, the challenge of the psychology of the person who sleeps rough may develop helpfully into a discrete area of expertise akin to other areas such as for people living with "personality disorder" or "anorexia."

5.2.8 The basis on which professionals can respond to people who sleep rough and experience co-occurring conditions also brings the role of the motivation of the individual to the fore. The need for motivation on the part of the person is often asserted in mental health theory and its application in practice can impact on safeguarding decisions. The local substance misuse rehabilitation provider is set-up on this basis, for instance and responded to those men who are subject of this SAR with whom they had some involvement in this way. For example, when Mr. Jones did not engage with the service as arranged, after a due process the provider "closed the file." Likewise, someone with lived experience told the Independent Reviewer that his failure to comply with the requirements with his accommodation provider resulted in his being evicted. He slept rough for the duration of his eviction. Happily, he was able to return to the provider in due course.

5.2.9 The wider practitioner community can be left with a dilemma, therefore. It can appear that when someone who is rough sleeping and has co-occurring conditions is unable to access one service when their motivation was not secured for that one condition, the person may still be engaged with another service area. It is really skilled work to create and use the point of "readiness" with a person and practitioners are aware of that and colleagues are aware of that. For instance, it was noted as a possible missed opportunity in contact with Mr Sparrey at the point at which he moved on from using the derelict caravan may have been a possible point for intervention. Substance misuse programmes are other examples. It is a really skilled matter to agree and to use that moment of readiness with the individual and to maintain through a number of phases towards exiting rough sleeping. Practitioners are aware that setbacks occur and can work with them. This is good practice. It is recognised that occasionally a specific support to an individual cannot continue e.g. the instances of the men concerned involving the substance misuse rehabilitation provider where the service "closed the file."

5.2.10 It should be noted, however, that there is explicit use of relevant psychologically informed practices such as "trauma informed environments" in the formal support services for people sleeping rough in the area. [60] This is good practice. Expectations and aspirations amongst colleagues with regard to mental health services were a feature of discussion, however. Some would welcome closer involvement of the general mental health services in the work to support with people sleeping rough. This may be something which could be achieved alongside consideration of the contribution of psychology services to the response to people who are sleeping rough and also experience co-occurring conditions.

5.2.11 Overall, Davidson Knight *et al's* [61] approach on complexity may also offer a practical route of further reflection in Worcestershire about how it organises itself in response to the apparent complexity brought about by the experience of people living with co-occurring conditions. The changes in community – based outreach provision in the area over time may be an example of the challenges faced with regard to complexity. The substance misuse rehabilitation provider used to have a valued out-reach provision, for instance, which is missed by others. Support for people with co-occurring conditions may be enhanced by using a more complexity-informed model to design solutions within resources available.

### *5.3 TOR3 Reflecting on learning about any relationship between the safeguarding and assessment duties of the Care Act 2014 and safeguarding good practice such as Making Safeguarding Personal (MSP,) other relevant legislation (e.g. the Mental Health Act 1983 as amended, the Mental Capacity Act 2005 and specific housing legislation) and the experience of rough sleepers*

5.3.1 There was evidence of flexibility and connectivity in the locality between housing and care law. For example, changes in one district between local social care teams and housing staff meant that social care assessors began to meet with homeless people in their location, wherever that was, rather than for the person to attend an office location. Similarly, a Psychiatrist visited a rough sleeper "on the street." Such "mobile" approaches by professionals are good practice and consistent with the flexibility envisaged in MSP, with the focus on the person who is sleeping rough.

5.3.2 The MSP initiative promotes the idea that a wide variety of provision is required to best support the personalisation aim in safeguarding. There is clearly some good provision in the Worcestershire area. This embraces the services aimed at supporting people who sleep rough on an outreach, "day centre" and accommodation basis. There is some variety in accommodation which ranges from emergency provision, to medium / longer term units including move-on accommodation for people undergoing rehabilitation for substance misuse. At the same time, some colleagues reported that the choice of accommodation across the county can undermine somewhat the best response to safeguarding people who sleep rough. Specifically, there appear to be few appropriate "move-on" options. A commissioning / planning response to this may be to promote the idea mentioned by some that there is room for wider range of VSC sector providers in the locality and in particular, some of the larger national providers.

5.3.3 In so far as there is weight in the argument presented by one participant that safeguarding practice can often seem as if it is "*built around the home rather than the street*," or that the City Council Review of Mr Banfield's circumstances focussed more on housing than safeguarding, then these arguments pose a challenge for all concerned in reflecting on personalised responses. It invites partners to broaden thinking still further about what safeguarding means for people who sleep rough. It challenges us to think about whether or not our approach has become too narrow and focussed on those who live in accommodation or not seeing that "*safeguarding is everybody's business*" and can be applied in any sector, including housing. It suggests, perhaps, that we may have ceded too much to approaches which imply that the person's freedom to live in the way they choose is used as a determinative factor in the practitioner-person relationship and analysis. Or it may imply that partners believe that safeguarding is only for adult social care and not for all sectors. This perspective links to a reflection of one contributor to this thematic SAR process, that one of the challenges faced by partners appears to be that no single agency can act as the "agency of last resort" for all individuals who sleep rough. A newly energised countywide shared narrative gives an opportunity to strengthen specific shared approaches. This SAR gives an opportunity to re-energise messages and practice in its follow-up action plans to promote consistent understandings and practice.

5.3.4 A very good WSAB document *"Using Professional Judgements in Safeguarding Adults - Guidance for Professionals*" aims to communicate the way in which safeguarding decisions might be made. Such documents are useful. When it is next reviewed for update, it may help to extend the content as appropriate to include references to rough sleepers and safeguarding taking into account the final actions agreed following this SAR. The aim would be to consolidate the move from care management to strengths-based approaches where conversations, not necessarily services, are the main focus between practitioners and people.

5.3.5 With regard to the Mental Capacity Act 2005 (MCA,) there is considerable expertise available in the locality on its detail. In practice, the wider safeguarding community has been reminded by a leading adult safeguarding and mental capacity expert, Professor Michael Preston-Shoot, that it has become something of a pattern in SARs that MCA decision-making often underplay the significance of the "executive function" of a person in a way which gives it more prominence alongside the entitlement of the person to make "unwise decisions." [62] This is about "decisional capacity" as set alongside "executive capacity" where executive function loss is about difficulties in" *understanding, retaining, using and weighing information in the moment, thus affecting problem-solving, enacting a decision at the appropriate point*." [63] This is a hard balance to strike, certainly. Appealing to "executive function" may be seen as a more risk averse approach in decision-making [64] in safeguarding practice with people who sleep rough. If it is embraced more fully, then it may be hard to see what a worker would

actually do in terms of securing support / service options in response if a wider range of accommodation is not available. On the other hand, use of the "unwise decisions" principle, allows practitioners to discontinue contact with an apparent rationale for doing so. Either of these may be the correct course of action and balance will be exercised by decision-makers in the context.

5.3.6 Whichever perspective is taken, WSAB partners can use the opportunity of forthcoming changes in the MCA to deepen understanding in its learning and development provision of how the MCA applies specifically to people who "sleep rough" including in relation to the "executive function."

5.3.7 With regard to the Mental Health Act (MHA) 1983, although it is understood that the use of the Act applies to the very specific circumstances linked to the assessment of mental health based on presentation at a given point in time, partners may wish to reflect on and amend policy as needed, to ensure that Section 7 Guardianship is explored as a possible solution in those limited circumstances for anyone who is compulsorily admitted to hospital for any reason and is also a rough sleeper. Again, service availability would have to reflect the need assumed in such circumstances where this available tool might be used. As suggested, no one can have intended that the programme to ensure people with long-standing mental health needs can live in community settings outside of long-stay institutions could result in people with those needs living on the streets. This is another example of a challenge faced by many beyond the bounds of Worcestershire.

5.3.8 Anecdotally, the Independent Reviewer was told of a circumstance where a referral to social care from homelessness services was questioned on the basis that the person concerned had "no fixed abode." This discussion can be used as an opportunity to challenge our aspirations in ensuring a person-centred care and health system. Interestingly, through the SAR process, awareness of bank activity to create bank accounts to help people who have "no fixed abode" [65] is an example of what can - and perhaps should - be done to ensure a person-centred rather than an address-focussed, response.

5.3.9 In reflecting on the use of required legislation and good practice amongst colleagues responding to the same person sleeping rough in the local community, there may be an opportunity for partners to model even more effective joint working. For example, the requirement of Housing Authorities to create "Personal Housing Plans" [66] with the person who is homeless are understandably focussed on a person's housing needs. However, housing partners noted that often the awarding of a tenancy to someone who has been sleeping rough is only a step on a journey. Longer term support is often required to support a person to sustain a tenancy. In this perspective, housing work is seen as more than "bricks and mortar." Alongside this commitment, partners in adult social care are responding to the same person to support them as the law and guidance from the Care Act and local aspiration allows. Partners may wish to ask if they can integrate their processes even more effectively so that the person experiencing the support does not "feel the join." This has been a long-held aspiration of many parts of public services. Now, perhaps, is the time for partners in Worcestershire to re-double their commitment to this in the experience of people sleeping rough.

5.3.10 Amongst factors which secure more co-ordinated relationship between social care and housing legislation to improve support and services delivery might also be:

- Learning and development – it is unclear to what extent all agencies share delivery of safeguarding training. To do so may assist their wish to ensure a more commonly agreed understanding of what safeguarding is and how to is applied in a range of settings. It would be important to ensure that this is open to all, including any sub-contracting arrangements.
- Service design – the area is well placed to build on its sense of localities to ensure that teams operate in increasingly joined-up ways, building on the personal relationships developed at the local level. Partners will be well placed to know the extent to which this needs to become more consistent across the whole county.
- Contracting / Grant-giving – where local voluntary and community organisation contract with statutory partners or receive conditional grant-funding for activities, then

this also provides an opportunity to secure co-ordination with commissioners / grant-givers on safeguarding practice for people who sleep rough.

- Communications and engagement – there are examples of success within the county from which all areas might learn to develop a single method of engaging with the public to promote their co-ordination with the approach adopted. A whole-county approach to social marketing around the theme of rough sleepers is recommended.

**5.4** ***TOR4 Identifying any other specific themes in the experience of those who are the subject of the SAR such as experience of debt, family support, cause / symptom issues or similar which might have an impact on learning from this thematic review overall.***

5.4.1 The biographies of the people whose experience is the subject of this SAR outline their experience and provides insight into the extent of the specific themes envisaged in TOR4. These factors all impact on safeguarding of individuals concerned to varying degrees.

5.4.2 All those who are the subjects of this SAR were / are male. Other identity characteristics which may be significant are that in relation to ethnic or national origin, as far as is known, four of the individuals were of a white British origin, one was Caribbean and one from Poland. The age ranges at the time of death of those included as subjects of this SAR were three in their forties (Mr Boczarski, 40; Mr Sparrey, 47; and Mr Frisby, 49; and one, Mr Jones, in his fifties aged 55.) The person who is alive, Mr Ridell, is 53. Mr. Banfield was 74.

5.4.3 Whilst engaging with people "on the street", the Independent Reviewer and Safeguarding Board Manager met one woman who slept rough in the locality – Amanda. It became clear that her experience had included encountering the risks of sexual exploitation. We understood that local police services also monitored her welfare along with the Outreach service. Actual or attempted sexual exploitation could be a feature of experience for a male and an instance of that was referred to by one person but it was not mentioned with regard to the experience of the five people who are subjects of the SAR. The fact that no woman was a subject of this SAR does not mean that there is not learning from a woman's perspective. Partners may wish to assure themselves that specific activity supporting women who sleep rough in the area is all that it can be.

5.4.4 Rental debt was a feature in the experience of most of the people included in the group who are subjects of the SAR. Ways of responding to this seemed to be well thought through and detailed procedures / check-and-balances seemed to be in place. The arrangements for debt management included the possible outcome of eviction where again, detailed procedures with checks and balances appeared to be in place. However, there was specific learning about succession arrangements in the event of a tenant's death as outlined above in the biography of Mr. Jones. It may be that post-eviction arrangements could be strengthened in the context of overall information sharing between partners assuming that a person may be more likely to sleep rough when they have been evicted. The implementation of the Universal Credit system was mentioned by a number of participants as a challenge in creating immediate financial issues for individuals due to the time taken to process applications. No one from the Department for Work and Pensions was involved in this stage of the SAR. It may be that wider partnerships in the locality would provide a helpful route for all concerned to do what they can about this system in the interest of people in Worcestershire more generally and those sleeping rough in particular. The WSAB may wish to share the SAR report with the DWP and seek feedback on work on the implications of the Universal Credit system.

5.4.5 Two of the men concerned who are the subjects of this SAR ended their own lives by hanging. Hanging accounts for 52% of suicides in Worcestershire according to the Worcestershire HWBB *Suicide Prevention Plan 2018-2021*. [67] The Plan does not seem to include direct reference to people who sleep rough or the homeless. It may be inferred, however, by the references to vulnerability. Partners may wish to consider if any specific steps to supporting people who sleep rough to prevent suicide are needed to enhance this aspect of the support offered.

5.4.6 Experience of bereavement of partners was a factor in the experience of four of the men. To what extent this affected each individual and any connection to their subsequent experience of rough sleeping and associated issues of safeguarding is perhaps impossible to tell. Nevertheless, stereotypically, men are often characterised as being less able or willing to express feelings. This can then be understood as negative for the man concerned and perhaps the source of the development of a problem for them. It is not unthinkable that these four individuals found themselves reacting to their experience of loss in way which led to some neglect of themselves as their experience of sleeping rough developed. There are already a number of initiatives in Worcestershire [68] aimed at supporting people in their experience of bereavement. These services may be open to people who sleep rough but there does not appear to be anything specific on the website referenced. Partners will consider if something more targeted might be developed perhaps linking to reflection of the possible greater contribution of the Psychology Service to this theme.

5.4.7 One of the people included as subjects of this SAR, Mr Boczarski, had arrived in the UK from another EU country some years ago. In the course of the SAR, it became clear that people who become rough sleepers after moving to the UK can face challenges in returning to their country of origin - if they would want that - due to funding of the journey. That is, it appears that in circumstances encountered by people who sleep rough, EU states (including the UK) do not pay for their nationals to return home if they cannot afford do so. This may be one area where the locality might be able to create greater use of local philanthropy to support individuals who sleep rough in a variety of ways including the funding of journey back to a country of origin if a return home if agreed as the best course of action.

5.4.8 The factor in Mr Banfield's experience of his apparent "transitory" behaviour is also a relevant characteristic in this context. It is acknowledged that it can be hard for public agencies to know who is in their areas. Participants mentioned that often people who were rough sleepers themselves could be positive in their care for one another and drawing attention to services anything that concerned them about someone else who was sleeping rough. Changes in national practice guidance now make it a requirement for partners to know who is in their areas so information sharing arrangements are critical to making this a reality. Local services report responding to people who are "passing through."

5.4.9 The childhood experience of Mr. Frisby and Mr Sparrey is perhaps consistent with the overall approach embraced in the ACE's framework applied in the locality. It reminds us of the challenge involved in ensuring that all children can have a positive childhood so that they are able to meet challenges of adulthood as well as they can. Much work is dedicated to this now and perhaps there was no casual relation for Mr Frisby or Mr Sparrey in their childhood experience and that for them as adults. However, it is not unlike that of many others which are reported [69] and so give us pause for thought as we work to avoid a repeat of anything similar in the lives of others.

5.4.10 A further factor to which contributors drew attention in the experience of rough sleepers was effectively one of tenancy sustainment. Participants noted that in the journey away from rough sleeping, acquiring a tenancy is only a start. The challenge is more than having a roof over your head, it was said, as it can be lonely having your own accommodation. Clearly, a lot of work already goes into tenancy sustainment across the county. It would appear that the issue would be one about the extent to which all concerned can work well together and perhaps in new ways to support people for whom rough sleeping has been a significant experience in their exit from rough sleeping.

5.4.11 A final more general point relates to the potential which the "Housing First" model [70] might offer in safeguarding people who have sleeping rough. Again, there is local experience of success within the county where a demonstrable difference has been made in one District Council area where the number of rough sleepers at the time of the review had been eliminated to zero. Colleagues in other areas are building on this experience and will be able to learn in a way which suits their local arrangements. An important aspect of establishing the success of the initiative has been actively working to counter any discrimination against people who sleep rough in support and service provision. This is also something which could be taken up in a renewed communication campaign.

### *5.5 TOR5 Specific consideration to the issues of self-neglect as a Care Act 2014 category of safeguarding links to issues for rough sleepers.*

5.5.1 The issues of self-neglect are to be connected to the wider reflection of multi-agency working addressed in Section 5.1 to some extent. That wider reflection is not repeated in this section, therefore.

5.5.2 However, amongst other resources, a helpful one for WSAB in terms of wider evidence on the theme of safeguarding and rough sleeping will be the work of Martineau *et al* (2019.) [71] A number of issues are identified there from wider learning which echo and inform local analysis presented in this Report. In particular, they note that the danger *of "...high levels of risk (becoming) normalised, meaning that practitioners (find) it difficult to make a realistic assessment of risk over time…"* [72] is present in work with people who sleep rough. This observation appears important given the historical fact that there have always been people who have lived transient lives as noted earlier cf. para. 4.5. However, in the context of recent national policies on welfare and housing, it does seem that levels of homelessness and rough sleeping have increased cf. para. 4.7. This means, arguably, that a different response is required in our current context. The fact of people sleeping rough and their condition in life appearing to be, or being, normalised in society alongside ways of thinking and practising which can create barriers, intended or not. Seeing the world in a different way supported by an agreed local narrative and practise framework will help maximise the possibility of success in achieving the local aspirations.

5.5.3 It is understood that changing our minds and practices is not an easy process. An instance of this relates to the issue of the place given to motivation on the part of any individual in general and those who sleep rough and / or misuse substances in particular. This came up a number of times in discussions. Much support and services in the locality is based on the idea that it is imperative to secure the motivation of the individual if progress to a new stage in life in which rough sleeping is no longer practised is secured. Again, it follows that there is increased possibility of better safeguarding in this environment. Finding the right service and support pattern which is flexible enough for all concerned is a real challenge, it is acknowledged but a further challenge to our thinking through the SAR has been to ask that if "(*rough) sleeping*" (presumably / usually at night) is the problem, why do we appear to focus on day time services?

5.5.4 But what kind of support and services would be provided for people who are not "ready," do not have the required motivation and which would result in better safeguarding? Anecdotally, in the SAR we heard of an initiative in Brisbane, Australia, where the local area had made the premises of a sheltered car park available to rough sleepers at night.[73] There is a similar unconditionality in this approach as in the Housing First model but partners may feel that their Social Welfare Emergency Procedures (SWEP) processes do something similar. Nevertheless, these are important models to reflect on as they address the issue which many in the locality seem to face which is working with the person at the point where motivation cannot be secured. There may be further learning from the response to the COVD-19 challenge in the locality, too, which post-dated the Independent Reviewer's discussions. There may be learning from "Wet House / Dry House" models in response to people needing to change the way in which they consume / use alcohol when applied to those who sleep rough. This approach has been around for a while [74] and is the basis of some approaches to drug rehabilitation i.e. a period of use of a replacement for the problematic substance is assumed on a transition route to living without the substance. It is understood that Worcestershire has used such provision previously.

5.5.5 These ideas are significant for Worcestershire in reflecting on the challenge of self-neglect in the experience of people who are rough sleeping. Self-neglect has become the focus of a growing research literature and practice guidance [75] in response to perceived or actual increased occurrence. In relation to people who sleep rough, by any ordinary definition of the phrase "self- neglect," it can be argued that sleeping rough can be seen as a characteristic of

it. It would follow, therefore, that if rough sleeping behaviour is a form of self-neglect then it is a cause for concern and action in terms of wellbeing and possibly as one of the categories of abuse identified in the Care Act guidance. With regard to people who sleep rough, it is sometimes argued that they are example of people who "make choices and decisions that others think of as self-neglect" as stated in the WSAB Self-Neglect Guidance. This may be the case but alongside it we will want to be assured that no other factors are affecting the MCA assessment such as the absence of choice of resources at the point of assessment or the use of "unwise choices" as a kind of a get-out clause in an understandably complex situation. It is accepted that, as stated in the Guidance, "*If the person does not want any safeguarding action to be taken, it may be reasonable not to intervene further, as long as no-one else is at risk; their 'vital interests' are not compromised – that is, there is no immediate risk of death or major harm; all decisions are fully explained and recorded; other agencies have been informed and involved as necessary…It is necessary to balance respect for autonomy and self-determination against a duty of care and promotion of dignity."* [76]

5.5.6 The WSAB Self-Neglect Guidance is very thorough and evidence based. It is consistent with national best practice. [77] Rough Sleeping is included as an example of self-neglect in responses to the questions "*When Should Professionals Act?"* as one of five areas of *"threshold for professional intervention in self-neglect situations - Living Environment ... Rough sleeping in adverse weather conditions."* [78] The Guidance is due for updating in 2020. Updating may provide an opportunity to add guidance on the reasoning of Professor Preston-Shoot (cf. para. 5.3.4) of the significance of the role of "executive function" in the MCA assessment. It may also help practitioners to provide a couple of case studies of the MCA being applied in a scenario where rough sleeping is a feature.

## 6.0 STRENGTHS IN PRACTICE - GOOD PRACTICE EXAMPLES

6.1 Good guidance, as noted at para 5.5.6, by itself is not enough, however. It is accepted that a strong framework to which all contributors – including the public – feel engaged and committed, is required as well. There are many aspects of this in the Worcestershire area and it is important to acknowledged those in the spirit of the strengths-based approach taken in this SAR.

6.2 It should be noted that emphasizing strengths does not mean that there is no conflict between partners in working towards their aims. Indeed, the presence of some conflict is normal and healthy, especially when all concerned are committed to positive outcomes for the people sleeping rough who they are concerned about. There is evidence of such robust relationships within the area.

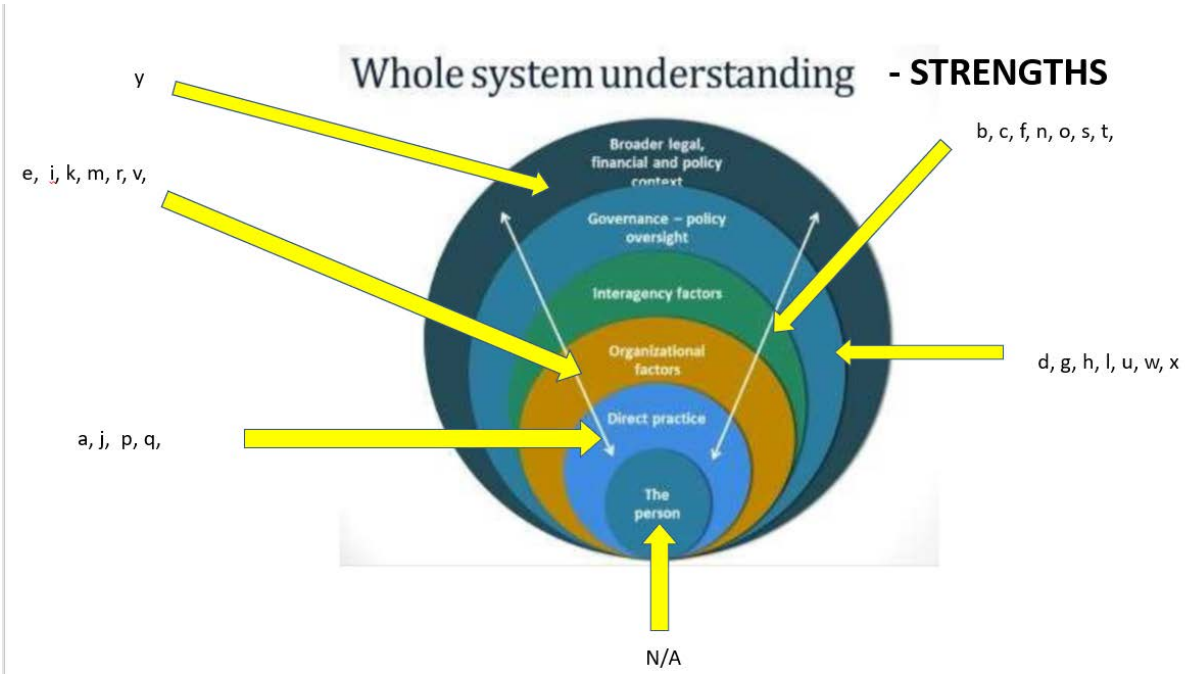
6.3 However, if conflict becomes a destructive process then energy to change can be undermined. The experience of partners responding to the COVID-19 scenario has demonstrated what can be positively achieved for people who sleep rough. The influence of the wider national commitment to resources and strategic direction are acknowledged as significant contributors in creating local success.

6.4 Summarising some of the strengths which have been found, therefore include:

a) Lots of very knowledgeable, committed and competent people working to support and safeguard rough sleepers
b) Colleagues holding one another in high esteem, appreciating the efforts which one another make
c) Commitment to information sharing played out in increasingly effective "Local Intelligence Groups" (noted as "brilliant" by one contributor) and "Blue Light Forum" alongside
d) routine monitoring ("snapshot" counts) of numbers of rough sleepers and "housing jigsaw"
e) Services established on good knowledge / evidence base – use of ACE's, psychologically-informed environments, etc.
f) Availability of resources within the locality to support re-settlement of those people sleeping rough who have nothing
g) Use of formal post-incident review mechanisms to reflect and learn from experience across a range of agencies

h) Recognition of need in the locality to create shared approach / narrative for the next stages of development
i) Positive service developments such as the Housing First approach being used and extended; or "Somewhere Safe to Stay"
j) Flexibility to people in their situations shown by Social Workers / Psychiatrist visiting the rough sleeper *in situ*
k) Established "concern for welfare" process by the Police
l) Support from Business / Traders in Worcester – examples of good cooperation and concern for people sleeping rough
m) What was described as "brilliant" GP coverage for rough sleepers in Worcester and evidence of really flexible responses in other areas e.g. ensuring correspondence through surgery
n) SWEP arrangements are thoughtful
o) Homeless Health Group and hub
p) Person-centred focus shown in working with "relapse"
q) Embracing of a "compassionate persistence" or "elastic tolerance" [79] approach
r) Some good examples of support for staff – counselling available if needed in some organisations
s) No Wrong Door approach …. One Day One Conversation (ODOC) approach
t) Use of Complex Case meetings
u) Learning from other related SARs
v) Specific services such as "Crisis Café" in Redditch
w) Effective community engagement on the issue of rough sleeping in one of the Districts
x) Policies are thorough including with a review date for updating e.g. the WSAB Self Neglect Guidance, due for updating in 2020
y) Overall response to the COVID-19 scenario

6.5 These strengths can also be presented in a graphical way using the model of "whole systems understanding" developed by Michael Preston-Shoot to indicate the spread of strengths across all aspects of the local system identified in this SAR.




## 7.0 RECOMMENDATIONS

7.1 In public policy literature, the idea of what are called "wicked issues" is used to refer to those very complex situations which require extensive co-ordination amongst many agencies and

local communities. The issues and challenges for the WSAB partners and the local community can be seen as an example of such a "wicked" issue cf. paras. 5.0.2**.**

7.2 In agreeing that the experience of the five men who were subject to this SAR and taking into account the Worcester City Council Review, WSAB partners wanted to learn from collective experience from every point of view with safeguarding as a focus. In this way, the SAR can be a springboard for the next steps to be taken to develop the support and services offered to people who sleep rough and may need to be safeguarded. The recommendations are kept to a smaller number of high-level issues which can be applied in Worcestershire and built into existing workplans and arrangements.

7.3 It is important that it is as clear as possible about lead responsibility for given recommendations. A suggested accountable nominee to lead the Recommendation from the point of Report final approval is indicated in **bold, italicised text in square brackets, thus: [ *ABC* ]** At the beginning of each recommendation, the WSAB sub-group / relevant single organisation is also highlighted for the action recommended.

**7.4** The Preston-Shoot model used above at para. 6.5 is also used at the end of the Recommendations section to show the Recommendations in a graphical way. Similarly, it indicates the way in which the recommendations cover aspects from all aspects of the local system identified in this SAR.

**TOR1 Understanding the multi-agency and public responses made in respect of the men who are the subject of this SAR and how we might be more likely to help prevent the deaths of adults sleeping rough in Worcestershire through developed coordination and engagement across relevant boundaries / sectors further as needed,**

1. ***P&QA to draft a letter to be sent from Derek Benson and review response with regard to*** considering whether or not some developments to current leadership arrangements might enhance the shared approach to rough sleepers and safeguarding e.g.
   - **(a)** Using a nominated local or other independent person "Champion" model for the overall work of pulling partners together to create a shared narrative / doctrine including agreed approach to safeguarding and rough sleepers and associated action plans achieved through the relevant "Rough Sleepers" group ***[Worcestershire Strategic Housing Partnership - WSHP]***
   - (b) assess with Elected Members if there is more that their contribution might add e.g. through designating an Elected Member Lead on "Rough Sleeper" theme ***[CX's of County, City and District Councils]***
   - (c) assessing if public health leadership / perspective might strengthen strategic arrangements which impact on safeguarding ***[DPH & team with WSHP]***

2. ***P&QA to draft a letter to be sent from Derek Benson and review response with regard to*** contributing to the shared narrative:
   a. with due regard to local District-level variation, agree and deliver a consistent county-wide process o**f** engagement with local communities and businesses to co-produce a shared approach to people who sleep rough and other street-based behaviours to include specific engagement with small-providers such as soup kitchens to be part of a wider-community-led approach ***[WSHP lead group on Rough Sleeping]***
   b. Use contract / grant-aid arrangements and engagement to influence voluntary small-scale including volunteer led community groups such as street cafes providers as part of whole system ***[Commissioners – all public services [Relevant lead group on Rough Sleeping]***
   c. ensure volunteers are part of this initiative ***[Relevant lead group on Rough Sleeping]***

3. ***P&QA to draft a letter to be sent from Derek Benson and review response with a***im of influencing WSHP in building on current achievements to update design of a whole county approach to people who sleep rough, taking account of any need for local variation, built on

local practitioner / public meetings to make sure that local multi-agency / community relationships / teams are built and sustained with a clear "lead officer" role allocated.
***[WSHP relevant lead group on Rough Sleeping]***

4. **For the LDP&C to** consider how shared approaches to safeguarding and MCA learning and development might promote better understanding of partner's contributions to safeguarding people who sleep rough.
***[WSAB]***

***5. P&QA to draft a letter to be sent from Derek Benson and review response with a***im of developing a shared narrative, by considering if there is more development possible to promote a shared data base for all organisations across the county to ensure that information is shared and enabling transition for rough sleepers using different services.
***[WSHP relevant lead group on Rough Sleeping]***

**TOR2 Considering the impact of physical or mental impairment or illness, including substance dependency and dual diagnosis on the risks experienced by adults who are rough sleepers and the service response to those issues.**

6. ***P&QA to draft a letter to be sent from Derek Benson and review response with regard to*** Mental Health re:

a. For commissioners to review their arrangements for extending the detail and extent of activity for people who sleep rough and suicide in the Suicide Prevention Strategy embracing a developed approach for mental health services as part of multi-agency arrangements including Psychology Service.
***[PH with the CCG and WHCT Psychology Service]***

b. For commissioners to review their arrangements and develop a more specific focus for post-bereavement support for men who sleep rough e.g. by post-bereavement services engaging with relevant rough sleeping operational groups to ensure that they know when a bereavement has occurred.
***[CCG & PH]***

8. ***P&QA to draft a letter to be sent from Derek Benson and review response with a***im of continuing efforts to establish wider range of innovative accommodation provision as well as services from larger / national VSC sector providers, replicated across the whole county and embracing new models responding to current challenges e.g. "wet houses," resources from philanthropists and the "Housing First" model.
***[WSHP]***

**TOR3 Reflecting on learning about any relationship between the safeguarding and assessment duties of the Care Act 2014 and safeguarding good practice such as Making Safeguarding Personal (MSP,) other relevant legislation (e.g. the Mental Health Act 1983 as amended, the Mental Capacity Act 2005 and specific housing legislation) and the experience of rough sleepers.**

9. ***P&QA to draft a letter to be sent from Derek Benson and review response with a***im of ensuring that the safeguarding of adults who sleep rough is explicitly stated by the service aims of the current Homelessness and Rough Sleeping Strategy and incorporating any newly developed service arrangements
***[WSHP with / through relevant lead group on Rough Sleeping]***

10. ***P&QA to draft a letter to be sent from Derek Benson and review response with a***im of asking agencies to work together to consider how the balance / compromise of specialism and generalist can be established in and between relevant groups including:

- each Primary Care Network to consider the provision of a nominated GP Lead for people who are sleeping rough. (Ref 5.2.5)
***[WCCG/PCNs]***
- housing lead in safeguarding hubs through shared RSL role.
***[RSL's with WSHP with / through relevant lead group on Rough Sleeping]***

11. **For LDP&C to** ensure with regard to MCA that issues connected to "executive function" are incorporated and possible implications made clear for practitioners, including Case Studies in Rough Sleepers Strategy and in Self-Neglect Policy
***[WSAB & WSHP with / through relevant lead group on Rough Sleeping]***

12. **For LDP&C to** consider how Section 7 Guardianship might be used to good effect to support those people who have been rough sleeping when being discharged from mental health hospital wards.
***[WHCT and WSAB Self-Neglect Policy]***

13. ***P&QA to draft a letter to be sent from Derek Benson and review response re c***onfirming practical arrangements for the WSAB area for the appropriate review of the deaths of people who sleep rough.
***[WSAB & WSHP]***

**TOR4 Identifying any other specific themes in the experience of those who are the subject of the SAR such as experience of debt, family support, cause / symptom issues or similar which might have an impact on learning from this thematic review overall**.

14. ***P&QA to draft a letter to be sent from Derek Benson and review response re the way a***n agreed new shared model for approach to rough sleeping can be the basis to create, deliver and maintain a Communications Strategy to support shared approaches with the public
***[WSAB & WSHP with / through the Rough Sleeping Task and Finish Group and with WCC Communications Team and partners from all public sector Comms Teams]***

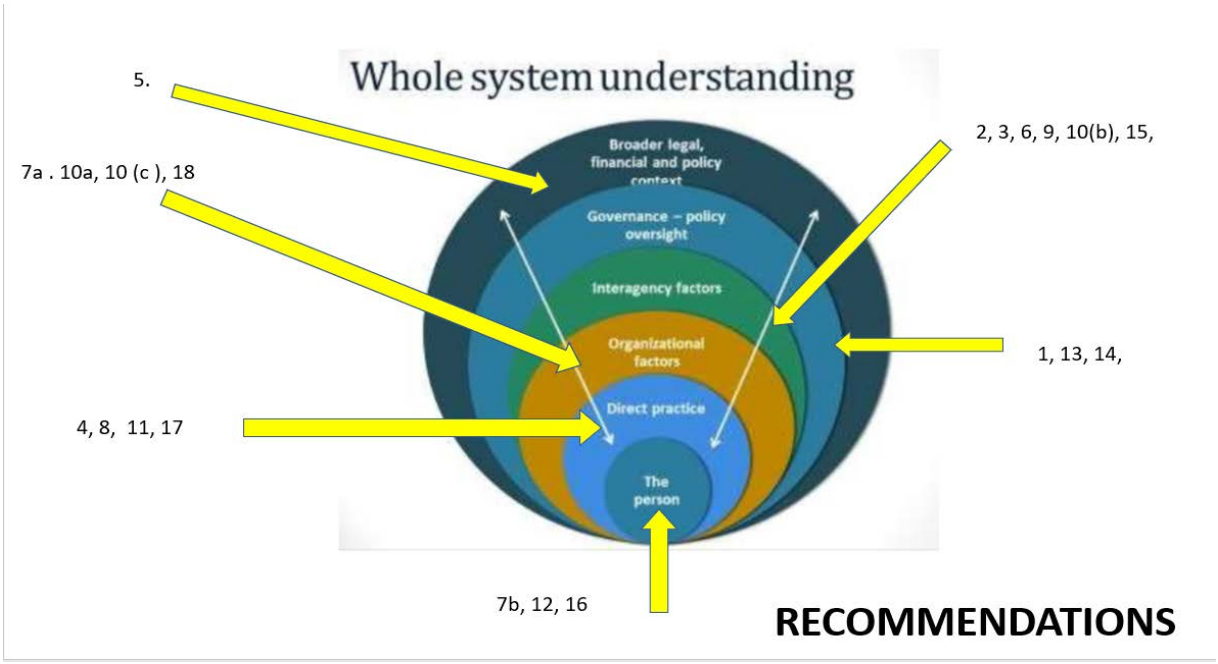
15. ***P&QA to draft a letter to be sent from Derek Benson and review response with the a***im of sharing the outcome of this SAR with the DWP and discuss local arrangements for Universal Credit with a view to seeking to improve experience of people needing it.
***[WSAB & WSHP with / through the lead group on Rough Sleeping Task together with DWP]***

16. ***P&QA to draft a letter to be sent from Derek Benson and review response with a***im of requesting that at an appropriate time, a strategic review of the needs of women who are sleeping rough with regard to safeguarding in the light of current support is undertaken.
**[WHSP]**

**TOR5 Specific consideration to the issues of self-neglect as a Care Act 2014 category of safeguarding links to issues for rough sleepers.**

17. **For LDP&C,** as part of the planned 2020 update and review of the WSAB Multi-Agency Self-Neglect Guidance, develop more material (including case studies) relating to people who sleep rough and self-neglect specifically based on agreed direction for next steps in multi-agency working as a framework for practice.
**[WSAB]**

18. The Acute Hospital Homelessness Liaison Pathway Officer in partnership with others to consider to what extent wider learning in relation to the "Homeless Patients Pathway" can be utilised to improve the experiences /outcomes of people sleeping rough.
***[WAHT]***




**APPENDICES**

**APPENDIX 1** PPP prepared for the Stakeholder Event scheduled for 28/03/2020

02a 2020 03 28 LEARNING EVENT The

**APPENDIX 2** PPP and Notes from WSAB Stakeholder Event at Warndon Community Centre 7th November 2019

2019 11 07 STAKEHOLDER EVENT

Notes from Thematic Review Stakeholders I

**APPENDIX 3** LGA Safeguarding and Homelessness Event, Birmingham, 25th September 2019

Safeguarding and Homelessness - Birmi

**APPENDIX 4** **Some other resources**

*All-Party Parliamentary Group for Ending Homelessness Rapidly responding to homelessness – a look at migrant homelessness, youth homelessness and rapid rehousing models* July 2018 at: https://www.scie-socialcareonline.org.uk/rapidly-responding-to-homelessness-a-look-at-migrant-

homelessness-youth-homelessness-and-rapid-rehousing-models/r/a110f00000THgKKAA1 *accessed 27/04/2020*

*Dying on the streets – the case for acting quickly* – St Mungo's at https://www.mungos.org/app/uploads/2018/06/Dying-on-the-Streets-Report.pdf *accessed 27/04/2020*

Personality disorder and rough sleeping - https://www.mentalhealthtoday.co.uk/blog/inequality/rough-sleeping-and-personality-disorders-a-dual-diagnosis-of-exclusion *accessed 27/04/2020*

**NICE Evidence**

Rough sleeping + personality disorder
https://www.evidence.nhs.uk/search?from=01%2F01%2F2010&to=12%2F12%2F2019&q=%22rough+sleeping%22+%22personality+disorder%22
homeless + personality disorder
https://www.evidence.nhs.uk/search?from=01%2F01%2F2010&to=12%2F12%2F2019&q=homeless+%22personality+disorder%22
Rough sleeping + mental health
https://www.evidence.nhs.uk/search?from=01%2F01%2F2010&to=12%2F12%2F2019&q=%22rough+sleeping%22+%22mental+health%22

## APPENDIX 5 - THE INDEPENDENT REVIEWER

The Independent Reviewer has nearly 35 years relevant experience mainly in public sector social care. This included membership of a senior leadership team of a joint social care and housing local authority directorate. Other relevant experience specifically on safeguarding included chairing a Local Safeguarding Adults Board, operational and strategic lead for safeguarding in a Council; learning and development delivery relating to safeguarding; and direct supervision of safeguarding practice. The Independent Reviewer has also conducted Safeguarding Adults Reviews.

## ENDNOTES

[1] https://www.worcesternews.co.uk/news/18341733.coronavirus-danger-get-rough-sleepers-off-worcester-streets-right-now/ *accessed 06/04/2020*
[2] Cf. https://www.worcester.gov.uk/news/recommendations-from-rough-sleeper-death-review-have-been-put-into-practice *accessed 07/04/2020*
*https://www.worcesternews.co.uk/news/16242788.opportunities-missed-to-keep-cardon-banfield-off-the-streets-report-says/ accessed 07/04/2020*
*https://www.worcesternews.co.uk/news/14804151.the-cause-of-cardon-banfields-death-will-remain-a-mystery/ accessed 07/04/2020* and followed-up in 2019 at:
http://committee.worcester.gov.uk/documents/s46327/Rough%20Sleeper%20Death%20Review%20301019.pdf *accessed 20/04/2020*
[3] Source: http://www.worcestershire.gov.uk/wsab *accessed 09/04/2020*
[4] Source: https://www.safeguardingworcestershire.org.uk/wsab/sars/ *accessed 27/04/2020*
[5] *Care and Support Statutory Guidance* para 14.168 updated 26 October 2018 at https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance *accessed 26/10/19*
[6] Source: https://www.scie.org.uk/children/safeguarding/case-reviews/quality-markers/ *accessed 09/04/19*
[7] Source: https://www.scie.org.uk/safeguarding/adults/practice/sharing-information#sixprinciples *accessed 09/04/19*
[8] See Stephen Martineau, Michelle Cornes, Jill Manthorpe, Bruno Ornelas, James Fuller (2019) *Safeguarding, homelessness and rough sleeping: An analysis of Safeguarding Adults Reviews* Sept 2019 NIHR Policy Research Unit in Health and Social Care Workforce The Policy Institute King's College London at:

https://kclpure.kcl.ac.uk/portal/files/116649790/SARs_and_Homelessness_HSCWRU_Report_2019.pdf pp/ 8-9 *accessed 21/04/2020*

[9] It is known that it came to light after the WCC Review that Mr Banfield had living relatives at the time of the following newspaper report cf. https://www.dailymail.co.uk/news/article-4989632/amp/Saint-Vincent-family-s-long-lost-relative-died-tent.html *accessed 07/04/2020*

[10] Report: *Independent review into the death of an individual sleeping rough - Larry* (name changed) July 2018 c/o Worcester City Council

[11] *Op. cit.* No. 3

[12] Cf. Concerning (1) Mr Paul (Jobey) Sparrey - https://www.bbc.co.uk/news/uk-england-hereford-worcester-48312908 *accessed 09/04/2020*; (2) Mr Remigiusz Bozarski - https://www.worcesternews.co.uk/news/17845497.bus-shelter-dwelling-homeless-man-remigiusz-boczarski-took-life-inquest-hears/ *accessed 09/04/2020* and (3) Mr Cardon Banfield - https://www.worcesternews.co.uk/news/15602102.coroner-confirms-extensive-efforts-were-made-to-trace-family-of-cardon-banfield-after-he-was-found-dead-in-a-tent/ *accessed 09/04/2020*

[13] Cf https://www.worcesternews.co.uk/news/17749941.campaigners-question-rough-sleeper-left-living-39-amongst-rats-litter-39-long/ *accessed 06/04/2020*

[14] *Op. cit.* No 10.

[15] Homeless Link (2017) Taking action following the death of someone sleeping rough: https://www.homeless.org.uk/sites/default/files/site-attachments/Taking%20action%20after%20someone%20dies%20June2017.pdf *accessed 08/04/2020*

[16] Whilst not a direct feature of this SAR, how migrants are welcomed in an area might perhaps link to safeguarding. Oxford, for example, established a Migrants Champion role which is something which could be developed with a safeguarding link, perhaps cf. https://www.itv.com/news/meridian/2019-08-07/oxford-s-first-migrant-champion-to-help-newcomers-integrate-into-city/ *accessed 22/04/2020*

[17] *Op. cit.* No. 13.2

[18] Cf. https://www.bbc.co.uk/news/uk-england-hereford-worcester-48312908 *accessed 14/04/2020*

[19] *Individual Review into the death of a person sleeping rough C – May 2018* at: http://www.healthwatchworcestershire.co.uk/wp-content/uploads/2018/07/Independent-Review-C-FINAL-160518.pdf *accessed 27/04/2020*

[20] Cf. https://www.gov.uk/government/publications/the-rough-sleeping-strategy *accessed 27/04/2020*

[21] Cf. Glasser, Irene and Bridgman, Rae (1999) *Braving the Street: The Anthropology of Homelessness* Public Issues in Anthropological Perspective Berghahn Books. Also at: https://www.jstor.org/stable/j.ctt9qcqrk *accessed 27/04/2020*

[22] Kelly-Irving, Michelle and Delpierre, Cyrille *A Critique of the Adverse Childhood Experiences Framework in Epidemiology and Public Health: Uses and Misuses* in Social Policy and Society Vol. 18, Issue 3 July 2019 pp. 445-456. Also at: https://www.cambridge.org/core/journals/social-policy-and-society/article/critique-of-the-adverse-childhood-experiences-framework-in-epidemiology-and-public-health-uses-and-misuses/9D5EFAD918AAA52C947AD28C2CBA46EC *accessed 27/04/2020*

[23] *Op. cit.* No. 9

[24] Cf. Care and support statutory guidance Updated 2 March 2020 para 14.7 at https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1 *accessed 05/06/2020*

[25] 2019 LGA *Making decisions on the duty to carry out Safeguarding Adults enquiries Suggested framework to support practice, reporting and recording* 2019 LGA *Making decisions on the duty to carry out Safeguarding Adults enquiries Suggested framework to support practice, reporting and recording* at https://www.local.gov.uk/sites/default/files/documents/25.130%20Making%20Decisions%20on%20the%20duty_06%20WEB.pdf *accessed 05/06/2020*

[26] Cf. https://en.wikipedia.org/wiki/Vagrancy_Act_1824 *accessed 07/04/2020*

[27] (1) Ravenhill, Megan Honor (2003) *The Culture of Homelessness: An ethnographic study* PhD thesis, London School of Economics and Political Science (United Kingdom). At http://etheses.lse.ac.uk/2665/ *accessed 07/04/2020* A

(2) Cllr Sharon Thompson ( Birmingham City Council) states that *"The homeless community is a community – same things happen there as in any community."* At LGA Event on Safeguarding and Homelessness, September 2019 cf **Appendix 3**

[28] Information from Haringey Council in a presentation at the LGA Event on Safeguarding and Homelessness, September 2019 held at the Studios, Cannon Street, Birmingham cf. **Appendix 3**

[29] Information from Stephen Gabriel, Head of Housing and Communities, Malvern Hills and Wychavon District Council – shared at the Thematic SAR Stakeholder Event, Warndon Community Centre, 7th November 2019 cf. **Appendix 2.** It is acknowledged that this figure is anecdotal.

[30] At: https://www.kingsfund.org.uk/blog/2020/02/health-care-services-support-people-sleep-rough *accessed 07/04/2020*

[31] cf. https://www.worcesternews.co.uk/news/17538421.editors-view-when-homeless-people-refuse-to-accept-help-what-can-you-do/ *accessed 22/04/2020*

[32] At: http://www.legislation.gov.uk/ukpga/2017/13/contents/enacted *accessed 07/04/2020*

[33] Cf. https://www.gov.uk/government/publications/the-rough-sleeping-strategy *accessed 15/04/2020*

[34] For example https://www.independent.co.uk/news/uk/home-news/universal-credit-benefits-impact-income-welfare-ifs-report-a8882806.html *accessed 07/04/2020*

[35] At: https://www.streetlink.org.uk/ *accessed 22/04/2020*

[36] At, for example: https://www.wyreforestdc.gov.uk/media/4725558/Worcestershire-Homelessness-and-Rough-Sleeping-Strategy-2019-22-v2-KB-.pdf *accessed 15/04/2020*

[37] *Op. cit*. No. 21

[38] Appendix 3

[39] Cf. Martineau *et al op. cit.* No. 9

[40] See, for example:
(1) 6, Perri; Leat, Diana; Seltzer, Kimberley; and Stoker, Gerry (2002*) Towards Holistic Governance – the New Reform Agenda* pp. 34 ff. Palgrave; and
(2) Juliette Alban-Metcalfe & Beverly Alimo-Metcalfe Integrative leadership, partnership working and wicked problems: a conceptual analysis *The International Journal of Leadership in Public Services* Volume 6 Issue 3 September 2010

[41] Cf. https://www.apse.org.uk/apse/index.cfm/news/articles/2020/working-together-to-end-rough-sleeping/ *accessed 15/04/2020*

[42] Annabel Davidson Knight, Toby Lowe, Marion Brossard, Julie Wilson (2017) *A Whole New World: Funding and Commissioning in Complexity* at https://collaboratecic.com/a-whole-new-world-funding-and-commissioning-in-complexity-12b6bdc2abd8 *accessed 27/04/2020*

[43] Appendix 3

[44] *Ibid.*

[45] cf. https://www.gov.uk/government/news/housing-secretary-james-brokenshire-awards-funding-to-reduce-rough-sleeping *accessed 22/04/2020*

[46] Cf. https://www.homeless.org.uk/sites/default/files/site-attachments/Real%20Change%20Alternative%20Giving%20Toolkit.pdf *accessed 27/04/2020*

[47] See how CRISIS include this within their approach, for example at: https://www.crisis.org.uk/get-involved/philanthropy/ *accessed 22/04/2020*

[48] Cf. Martineau *et al op. cit.* No. 9 pp. 8/9

[49] Cf. Martineau *et al op. cit.* No. 9 p.8

[50] Cf. West Berkshire Healthwatch 2018 Homelessness and Rough Sleepers Report at https://www.healthwatchwestberks.org.uk/wp-content/uploads/2018/02/Healthwatch-West-Berkshire-Homeless-Rough-Sleeper-Report-2018.pdf p.4 *accessed 27/04/2020*

[51] Cf. *Homelessness guidance for Mental Health Professionals - Making the most of your support* Homeless Link May 2018 at https://www.homeless.org.uk/sites/default/files/site-attachments/Homelessness%20guidance%20for%20mental%20health%20professionals%20June18.pdf accessed 27/04/2020

[52] BETH WATTS, SUZANNE FITZPATRICK, AND SARAH JOHNSEN Controlling Homeless People? Power, Interventionism and Legitimacy *Journal of Social Policy.(2018),47,2,235–252*

[53] *Community Mental Health Framework for Adults and Older Adults at https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/ accessed 28/04/2020*

[54] Juahar, Sandeep (2014) *One Patient, Too Many Doctors: The Terrible Expense of Overspecialization* at https://time.com/3138561/specialist-doctors-high-cost/ *accessed 16/04/2020*

[55] Britnell, Mark *The role of the 'specialist' in healthcare* in Clinical Medicine (Lond). 2011 Aug; 11(4): 329–331 at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5873739/ accessed 16/04/2020.

[56] Cf. Homeless Healthcare Team https://www.solent.nhs.uk/our-services/services-listings/homeless-healthcare-team/ *accessed 20/04/2020*
[57] Cf. https://www.swbh.nhs.uk/services/homeless-team/ *accessed 16/04/2020*
[58] Cf. https://www.swbh.nhs.uk/dr-muninder-lotay-clinical-lead-homeless-patient-pathway/ *accessed 16/04/2020*
[59] Cf. https://www.charityjob.co.uk/jobs/crisis-uk/clinical-psychologist-x-11/662391 *accessed 16/04/2020*
[60] Cf. *Homelessness guidance for Mental Health Professionals - Making the most of your support* The Innovation and Good Practice Team in Homeless Link May 2018 at: file:///C:/Users/capacity4care/Documents/ZZ%20AA%20JOBS/A%20COMMISSIONS/005%20TAX%20YEAR%202020%2021/02%202020%2003ff%20WSAB%20THEMATIC/Homelessness%20guidance%20for%20mental%20health%20professionals%20June18.pdf *accessed 15/04/2020*
[61] *Op. cit.* No. 42
[62] Professor Michael Preston-Shoot at the *LGA Safeguarding and Homelessness Event* September 2019 at **Appendix 3**
[63] Cf. *Working with adults who self-neglect: best practice evidence from research and reviews* Michael Preston-Shoot (researcher with Suzy Braye and David Orr) Brent December 2018 at https://www.brent.gov.uk/media/16412026/brent-2018-self-neglect-presentation.pdf slide 26, *accessed 27/04/2020*
[64] Cf. practitioners discussion at end of Hardy, Ruth *Hoarding and mental capacity: key points for social workers 12 March 2018 at:* https://www.communitycare.co.uk/2018/03/12/hoarding-mental-capacity-key-points-social-workers/ *accessed 16/04/2020*
[65] See, for example, https://www.hsbc.co.uk/togetherwethrive/ *accessed 28/-4/2020*
[66] *Homeless Code of Guidance for Local Authorities (updated 2019)* ch. 11 at: https://www.gov.uk/guidance/homelessness-code-of-guidance-for-local-authorities/chapter-11-assessments-and-personalised-plans *accessed 24/04/2020*
[67] At: https://worcestershire.moderngov.co.uk/documents/s15483/10%20Suicide%20Prevention%20Plan%20draft%20090218.pdf *accessed 17/04/2020*
[68] At: https://www.bereavementsupportworcestershire.org.uk/useful-links/ *accessed 17/04/2020*
[69] For example, see Tickle, Louise We are failing children in care – and they are dying on our streets *The Guardian* 11/11/19 at : https://www.theguardian.com/cities/2019/nov/11/we-are-failing-children-in-care-and-they-are-dying-on-our-streets *accessed 21/04/2020*
[70] See https://hfe.homeless.org.uk/sites/default/files/attachments/Making%20Housing%20First%20Effective.pdf accessed 17/04/2020
[71] Cf. Martineau *et al op. cit.* No. 9
[72] Cf. Martineau *et al op. cit.* No. 9 p.5
[73] See https://www.brisbanetimes.com.au/national/queensland/car-parks-transformed-into-pop-up-accommodation-for-homeless-people-20190927-p52vgt.html *accessed 17/04/2020*
[74] See Maureen Crane and Anthony M. Warnes (2003) W*et Day Centres in the United Kingdom: A Research Report and Manual Commissioned by The King's Fund and Homelessness Directorate* Sheffield Institute for Studies on Ageing University of Sheffield at http://www.dldocs.stir.ac.uk/documents/wetcentre.pdf *accessed 17/04/2020*
[75] Cf. for example, https://www.scie.org.uk/self-neglect/at-a-glance *accessed 17/04/2020*
[76] *WORCESTERSHIRE SAFEGUARDING ADULTS BOARD MULTI-AGENCY SELF NEGLECT GUIDANCE* 2017, p.12
[77] *Op cit.* No. 58 slide 5, *accessed 27/04/2020*
[78] *Ibid*. p.6
[79] *Op. cit.* No 57-p.17

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