Safeguarding Adults Review
‘PETER’

Overview Report
September 2022

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1. Introduction

1.1 Surrey Safeguarding Adults Board ['SSAB'] agreed to commission this Safeguarding Adult Review ['SAR'], after a referral from Surrey Heath Borough Council, following the death of an adult with care and support needs, who fell from a train platform. For the purposes of anonymity and at the request of his family he is known within this review as 'Peter'. The SSAB believed the case met the mandatory criteria under s44 Care Act 2014 for a review, given what was known about the risks of harm to Peter and believed that this case might offer important opportunities to better understand how partners could work together in the future to prevent harm to other adults at risk in similar circumstances. Peter was a 50-year-old white, British male. In 1999, following a road traffic accident, his leg was amputated below the knee. In 2011, Peter had suffered a skull fracture and had a subarachnoid haemorrhage. An assault, in 2014, required neurosurgical drainage procedure. Since that assault he experienced epileptic seizures and for the remainder of his life he required medication to prevent these. In 2017 he suffered a further traumatic subdural Hematoma, requiring surgery. He did not always remember to take his medication or prioritise his physical health needs, including care of his stump resulting in numerous pressure sores and infections which impacted on his mobility.

1.2 Peter had a long history of alcohol abuse which started at about the age of 14 years old, when he would drink with a family member and friends. He continued drinking over the years and by April 2018 an assessment by I-access staff indicated Peter was likely alcohol dependent.[1] He reported a history of experiencing significant withdrawal tremors, including seizures and blackouts due to alcohol misuse. He was described by staff within The Hope Hub who knew him well as a '*lovable rogue*'. When not drinking heavily, he was polite, thoughtful, proud and intensely shy. He did not find it easy to ask for, or accept, that he needed assistance. They also commented that he regularly displayed aggressive and reckless behaviours when inebriated; often this resulted in criminal charges or medical care. His extensive forensic history dated back to 1999 with multiple convictions and prison sentences. Most related to offences committed whilst under the influence of alcohol. He was known to police forces in London and across the Southeast and had a range of convictions from threatening abusive behaviour to fraud, theft, and physical assaults. Police records also indicate he was the victim of assaults (including with injury) and theft. Peter had also come into contact with the police, mental health and NHS emergency department staff between 2010 and 2017 as a consequence of having made several suicide attempts, all under the influence of alcohol.[2]

1.3 He described his family as an important protective factor in his life. He had previously been married and had three adult children. His daughter explained that, prior to his accident, he had been a capable dad, cooking for the family, house proud and taking care of his presentation. He also valued contact with his mother and gravitated to the area where his family lived in the hope of seeing them. His family and professionals who knew him well spoke of Peter's stated desire to get well and of his sadness (and theirs) that he was unable to manage his addiction.

1.4 Peter was also deeply affected by his partner's death. Practitioners and his family commented that after this Peter seemed lost; he ceased to take care of his basic needs and his drinking escalated. Unable to succeed to her tenancy, he started rough sleeping and was often found sleeping by her grave. From this time, he became well known to services, including to Surrey Heath Borough Council's [SHBC'] housing and Surrey County Council's ['SCC'] social care departments, Police and Probation. His needs were discussed at multi-agency risk panels

[1] According to records reviewed by the SABP Trust's SI author, he completed a Severity Alcohol Dependence Questionnaire (SADQ) scoring 27 (16-30 indicates moderate dependence)

[2] In 2010 he attempted to cut his throat, in 2013 he expressed suicidal thoughts but did not remember doing so later when he was not intoxicated. In 2017 he tried to throw himself under a train and was detained under s136 Mental Health Act but later found to have capacity and insight into the risks when he was intoxicated.

(CHaRMM[3] and Surrey Adults Matter[4]), he also received support from The Hope Hub charity. At his death, he had been out of prison for two days and accommodated by the Surrey Heath Borough Council's Housing team in Datchet.

1.5 The reviewers wish to express sincere condolences to all members of Peter's family for their loss and thank them for contributing so generously to the review. We are also grateful to the professionals who worked with Peter for sharing their insight into his experiences so honestly. The efforts they and his family made to support him and try to keep him safe were apparent and it was equally clear how distressed they were at his death.

2. Scope of Review

Purpose of a Safeguarding Adult Review

2.1 Prior to the commissioning of this review several investigations into the circumstances leading up to Peter's death had already been completed.[5] At the time of writing this report, Peter's Inquest has not been completed. The reviewers have, however, had sight of a number of witness statements prepared for the Inquest and a draft report completed by the Prisons and Probation Ombudsman.

2.2 The purpose of having a SAR is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died; its purpose is to:

- establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults;
- review the effectiveness of procedures (both multi-agency and individual organisations);
- inform and improve local interagency practice by acting on learning (developing best practice); &
- prepare a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

2.3 There is a strong focus in this report on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to help and protect Peter from harm.

Involvement of Peter's family

2.4 The reviewer spoke with Peter's daughter who shared information about his personality and life journey, as well as her experience (given the care she had for him) and the impact for her of his needs and the circumstances surrounding his death. His daughter wished to commend the work of staff, particularly from The Hope Hub, explained that the practical help and care they provided '*gave him extra years'*. She also raised concerns that, although it seemed obvious to the family that following surgery in 2017 Peter's cognitive functioning had deteriorated significantly, this was not recognised by professionals. Specifically, she believed he should have been more regularly assessed to ascertain whether he had developed Korsakoff Syndrome or a similar neurological condition. The reviewers and SAB partners remain committed to supporting the family's involvement and will invite their comments on this report before publication.

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[3] 'CHaRMM', which stands for Community Harm and Risk Management Meetings is the forum in Surrey for implementing powers introduced by the Anti-social behaviour, Crime and Policing Act 2014. This is a multi-agency forum, which shares information to and agree actions to reduce the negative impact that problem individuals and families have on Surrey's communities through their anti-social behaviour.

[4] Surrey Adults Matter is the name used locally for a new approach to improve lives of adults with severe multiple disadvantages, adopting the national programme (supported by a coalition of national charities including Clinks and Homeless link) 'making every adult matter'. More information is available at: http://www.meam.org.uk/the-meam-approach/ [accessed 02.07.22].

[5] This included investigations by the Rail investigation accident branch, the Office of Rail and Road and British Transport Police's design out crime unit. Those investigations have been notified to the coroner and do not form part of this review.

Themes

2.5 The review covers the period from November 2019, (when Peter was assessed by Surrey Council's Adult Social Care department as at risk of exploitation and in need of care and support to prevent harm arising from self-neglect) until his death in October 2021. The SSAB prioritised the following themes for illumination through the SAR:

- Given Peter's history, how well did partners understand their organisational duties; did they work together and with him to implement effective plans to reduce risks including through the Make Every Adult Matter Approach?
- How effective and well-coordinated was care planning at key points of transition such as hospital discharge and prison release, were continuity of care obligations understood and applied when he was placed out of area?
- How effective was the multi-agency response in recognising and responding to prevent an escalation of Peter's mental health and risk of self-harm/ self-neglect?

Methodology

2.6 The SAB commissioned independent reviewers to conduct a SAR using the Social Care Institute for Excellence Learning Together methodology and tools from the SAR In Rapid Time method. The learning produced through a SAR concerns 'systems findings'. Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to proactively safeguard, within and between agencies.

2.7 A full list of the documents disclosed and considered as part of this review is set out within appendix A, however, the following agencies provided documentation to support the SAR:

- British Transport Police
- HMP Highdown[6]
- Prison and Probation Ombudsman
- Probation Service
- Surrey Adults Matters
- Surrey Borders Mental Health NHS Trust
- Surrey Clinical Commissioning Group
- Surrey County Council's Adult Social Care Localities team and Prison Social Care team
- Surrey Heath Housing Needs team
- Surrey Police
- The Hope Hub

2.8 Multi-agency learning events took place, both with front-line practitioners who worked with Peter and the leaders who oversaw the services involved in supporting them.

3. Narrative Chronology

3.1 Prior to the period under review, concerns regarding the risks to Peter by his drinking and behaviours were well understood. In January 2019 he was referred to CHaRMM, because of high levels of anti-social behaviour reports and because he was at risk of exploitation within his accommodation. He had reported allowing people to stay at his address, as he either felt sorry for them (because he knew how difficult rough sleeping was) or intimidated by visitors and unable to prevent them accessing his flat to use or deal drugs. The police, recognising his vulnerability to exploitation by gangs operating 'county lines', secured a partial closure order prohibiting anyone

[6] Although chronologies for the final period in prison were provided by the Forward Trust and HMP staff, his medical notes were not made available by CNWL NHS Trust (who provided medical services within the Prison) to this review, because of the ongoing Coronial process.

apart from Peter, his support workers and his daughters from accessing the flat. Peter was also supported by staff from The Hope Hub to try to prevent him losing his tenancy.

3.2 Despite these efforts Peter continued to allow people to use his flat and continued to exhibit high levels of anti-social behaviour when inebriated. In November 2019, whilst Peter was in prison, an eviction order from his tenancy was executed. He was also assessed, by social workers work in the in-reach Prison Team within Surrey County Council as having care and support needs. This assessment concluded that whilst he could manage his day to day needs within context of prison environment because of the structure of that environment and the forced abstinence from alcohol, he would have eligible care needs when in the community, especially in relation to managing and maintaining nutrition, personal hygiene, managing his toileting needs, being appropriately clothed, maintaining a habitable home and safely using his home as well as developing and maintaining family relationships or using community facilities. The social worker conducting the assessment reported, following several meetings, that '*[Peter] is vulnerable due to his physical disability, acquired brain injury and ongoing alcohol use… without a structure [Peter] would be at risk of severe neglect and given his history of alcohol misuse he would be very vulnerable with the number of physical health issues he has. I would recommend on release he will benefit from supported accommodation with a clear routine and structure in place.'* The report also highlighted Peter '*continues to struggle and retain information after he has had meetings, he admits he struggles with his memory. … regarding his finances, he agreed he struggles and then he has to borrow off his mum or daughter or has to go without food. We spoke about appointeeship and whether we could support him with his finances, [Peter] did not object to this.*'[7]

3.3 In December 2019 he was assessed by a forensic consultant psychiatrist to ascertain if he had a mental disorder and capacity to comply with a Criminal Behaviour Order (CBO). The psychiatrist concluded that neurodevelopmental disorders were highly unlikely, but found that Peter did not have capacity to comply with the CBO at that time due to alcohol dependence.

3.4 On his release from prison on the 10.01.20 he was referred by his Probation officer to Surrey Adult Matters ['SAM'], part of the 'Make Every Adult Matter' programme. The SAM a multi-agency group of professionals who regularly meet, adopting a 'Team around the Person' ['TAP'] process, to offer holistic assessment and support for individuals with complex needs. SAM also have a strategic Steering Board[8] which reviews data and emerging issues to assist in future commissioning and service delivery at both local level and through central government. The project piloted a trauma informed outreach service for SAM clients in partnership with several homeless charities, including The Hope Hub. Professionals responsible for care pathways retain their involvement and responsibilities but work together in a more uniformed way, with the client at the heart of the process. Peter was accepted onto the SAM programme on the 23.02.20, he was also accommodated by SHBC on the 24.02.20.[9] Thereafter the TAP met usually every 6 weeks to action plan together. These meetings were usually attended by the SAM lead, his support worker from The Hope Hub, his Probation officer, Social Worker, Housing Options worker and, when he was engaging with the service, the I-access worker.

3.5 By April 2020 the Pandemic had led to the first lockdown resulting in significant and swift changes to the delivery of statutory services. Peter had been recalled to prison and was detained in HMP Winchester. He was supported whilst in Prison to safely manage his alcohol withdrawal

[7] Taken from the assessment dated 14.11.19

[8] The SSAB's Board manager attends SAM Steering Board

[9] He was originally offered an appointment by SHBC's housing team on his release from prison but did not attend. He subsequently declined two further offers by the housing team to accommodate him. He was found emergency nightly paid accommodation as soon as he attended their offices and applied for assistance.

symptoms, he engaged with substance misuse services who provided in reach support within the Prison. During discussions with the reviewer, practitioners reviewing the case notes commented on the pro-active work done within the prison health team to engage with Peter and ensure information was passed, prior to his subsequent release, to the TAP. On the 07.05.20 at a TAP meeting, it was understood that he would be released without accommodation, so a plan was agreed for him to attend The Hope Hub and for SHBC's Housing Options team to find emergency, nightly paid accommodation. I-access and Adult Social Care offered ongoing support to address his alcohol dependency and lack of life skills.

3.6 A further Care Act needs assessment was completed on the 26.06.20 which concurred with findings that Peter was '*vulnerable to exploitation when in the community. [Peter] would like supported accommodation as struggles with management of day-to-day responsibilities*… [Peter] *'self neglects and does not seek medical support particularly for care for his stump… wears an illfitting prosthetic'*.[10] The assessment identified needs in respect of personal hygiene (he needed OT equipment to assist him shower), managing nutrition (including inability to purchase food as he had been banned from local shops), needed prompting to maintain a habitable home and use his home safely, managing personal relationships, engaging in work, learning or volunteering, and that he was without capacity to manage his finances (so referred to the deputyship team though it is noted he '*feels able to manage his own financial affairs*'). The TAP agreed a care plan for support to '*wrap around his existing accommodation*'[11] but the specifics of how this was to be achieved were vague. For example, he was not identified as part of the 'everyone in' cohort.[11] He was accommodated on the 01.04.20 following an escalation through SAM which resulted in an intervention by SCC's Adult Social Care Director. However, this placement quickly broke down, because Peter was clear he did not wish to reside within that placement, refusing to engage with the support offered and because of inappropriate behaviour by him towards other residents. He was subsequently returned to prison and on release accommodated by SHBC's housing needs team under their 'relief duties'.[12] It wasn't clear, thereafter, who within the TAP should lead on securing appropriate supported accommodation beyond the temporary relief period. Though the Housing Needs worker made it clear they would be unable to offer longer-term support. His social worker reported she had made (albeit unsuccessful) attempts to identify suitable providers[13] and raised the lack of suitable options with her line manager. The care plan also relied heavily on Peter's compliance to accept and actively engage with the support offered and on The Hope Hub staff to provide daily support either within their centre or via assertive outreach staff to maintain his personal hygiene and nutrition. There was no reference within the care plan to a contingency if another subsequent lockdown was announced or if social distancing requirements meant Peter could not access The Hope Hub or their staff were prevented from visiting him. Nor did the action plan indicate the legal framework practitioners should apply to provide the structured, protective care Peter responded well to.

3.7 By September 2020 the housing department advised the TAP that their duties to provide accommodation for the relief period would shortly end and that, because of how Peter had lost his last settled accommodation, he would then likely be found to be intentionally homeless meaning that all duties to accommodate him under Housing Act 1996 would cease. Peter also reported two

[10] Taken from the needs assessment dated 26.06.20 [11]
Taken from the TAP meeting minutes

[11] This was an additional scheme funded by central government during the Covid Pandemic to ensure rough sleepers were offered accommodation that would enable them to comply with strict social distancing laws. SHBC and SCC had agreed alternative pathways to accommodate Peter, via a social care placement, so it wasn't necessary to accommodate him under this scheme.

[12] Section 189B of the Housing Act 1996, as amended by the Homelessness Reduction Act 2017 requires local authorities to 'provide relief' to anyone experiencing homelessness for 56 days.

[13] In conversations with the reviewers, his social worker explained she had contacted all providers on SHBC's database (114 providers), but had not received a response from any agreeing to assist. She explained this was because, in the main, their providers were set up to provide domiciliary support for older people. She also approached both the usual supported accommodation providers commissioned by adult social care in the area Peter wished to live, by August 2020 both confirmed they would not accommodate Peter as his needs were too high and because of his forensic history.

serious assaults, but on both occasions was unable to provide statements to police so they were unable to progress investigations. Towards the end of that month SCC's Adult Social Care localities team completed an assessment of his capacity and confirmed he did not have capacity to manage a tenancy.

3.8 In October Peter's Probation officer confirmed he had been closed to their service. Peter had also reported to I-access he no longer needed their assistance, so both services withdrew from the TAP, though his I-access worker indicated Peter could re-refer when he was ready to accept support. In October, November and December Peter was taken by police (twice from rail platforms) to A&E for assessment under the Mental Health Act 1983 as he had expressed suicidal ideation to police officers whilst under the influence of alcohol. He was also taken to A&E over concerns that he had a suspected heart attack. Within TAP meetings minutes questions were posed as to whether Peter was exhibiting symptoms of an Acquired Brian injury or Korsakoff syndrome. Peter contacted A&E and mental health services in December, explaining he felt suicidal. These prompted a further TAP meeting and a formal 'best interest meeting' to determine what (and how) to put in place support for him if appropriate accommodation was identified. On the 16.12.20 the TAP agreed SCC's ASC would make an application to the Court of Protection to seek relevant permissions (given his lack of capacity) to sign a private tenancy on his behalf so that wrap around support could be provided within that setting.

3.9 During this period, he was assessed by Hospital Psychiatric Liaison Services (PLS) and an approved mental health professional (AMHP). These assessments took place, in line with guidance in the Mental Health Act 1983 ['MHA'] Code of Practice, once Peter has had an opportunity to sober up. By which time he consistently reported no suicidal thoughts or intent and was assessed to have capacity to decide his care and treatment.[14]

3.10 Following this decision that he had capacity, a s42 safeguarding enquiry risk assessment plan (dated 24.12.20) noted:

> '[*Peter] has had capacity assessments for finances, maintaining a tenancy and care and support needs and lacks capacity to make decisions in all three areas, however these are currently being re- assessed in line with the mental capacity act as [Peter's] capacity clearly fluctuates depending on how much alcohol he has consumed. [Peter] recently demonstrated he had capacity regarding his decision to engage in offending behaviour, therefore it is not currently clear whether [Peter] has capacity regarding his care and support needs and his self-neglecting behaviour. [Peter] is alcohol dependant and we know that increased alcohol use contributes to the level of neglect [Peter] presents with*.' This concluded he was '*at risk of abuse and neglect in relation to unwise decision around care and support needs, also being exploited by other individuals in his housing complex due to how he manages and withdraws finances, an area that he also has mental capacity*.'

3.11 Subsequent capacity assessments over the next six months carried out by his social worker[16] in respect of his ability to decide care and support needs, manage financial affairs and a tenancy all concluded he was making capacitated but unwise decisions. There is evidence within correspondence that others within the TAP did not agree with the findings of these assessments, but practitioners reported they felt unable to challenge those findings or the implications this had for his care plan given the social worker's knowledge and experience.

3.12 In early 2021 risks posed by his insecure housing and high level of need appeared to be escalating. The police reported they had renewed concerns regarding his risk of cuckooing, he also

[14] For example, an assessment completed on the 21.12.20 whilst he was at the Abraham Cowley Unit. [16] An experienced AMHP and with support from her team manager.

reported in early February he had been beaten up twice that week. SHBC's housing team reported they continued to make strenuous efforts to secure nightly paid accommodation within Surrey, securing B&B accommodation in Woking on the 15.02.21. In March 2021 the TAP explored opportunities for Peter to access additional support regarding his addiction but noted he could not access rehabilitation as he had not engaged with group work. Likewise, the minutes noted that his social worker recognised he required support to develop life skills but stated it was '*not possible to provide this currently'* even though, by this time, he was now residing in Surrey. The Hope Hub were, therefore, the only service providing 'wrap around support'. Throughout this period care planning discussions at the TAP meetings were staled awaiting confirmation regarding his capacity to sign a tenancy, manage his finances and consent to care and treatment plans. In addition, an assessment the social worker had completed in January 2021 confirming Peter had eligible needs had not been 'signed off' by senior managers. TAP members were therefore still awaiting clarification from social care whether they would assume responsibility for arranging accommodation and/ or apply to the Court of Protection for deputyship on behalf of Peter. By May 2021 his drinking had increased significantly, and the TAP were sufficiently concerned to conduct an outreach visit. They found Peter intoxicated at a railway and supported him to return to his mother's home that evening.

3.13 In June 2021 he was evicted from the nightly paid B&B as, despite clear warnings he could not let people stay in his room, he breached this condition. He was also informed by Housing needs that they were 'minded' to find him intentionally homeless and that their duty to accommodate him would therefore shortly end. During this period, he resumed rough sleeping, staying in a tent in a car park. He continued to access The Hope Hub daily for food, clothing and help with managing his appointments. His social worker also completed a further assessment of his needs, concluding that he no longer had eligible social care needs. Peter attended the TAP meeting for the first time on the 30.06.21, he then completed a common referral form for supported living accommodation in early July. His social worker confirmed, first during a TAP meeting and subsequently by email dated 08.07.21, that she was closing his case but offering further support in the future is it was needed.

3.14 In early August he was accommodated by SHBC's housing team in supported accommodation, but lost this after a violent incident less than two weeks into his stay. He was subsequently charged with assault and criminal damage. On his arrest for criminal damage, he was referred to the Criminal Justice Liaison and Diversion Service ['CJLDS']. Although referred to this service previously, he had refused their input or been unable to complete assessments.[15] His vulnerabilities were recorded as physical health (amputee, epilepsy), mental health, unemployed (though he declared he did not want to work due to his disability) and alcohol dependence. His risk to self was identified as medium, staff also noted a risk of accidental harm and deterioration in his physical health given level of alcohol dependency. They had recorded within their assessment '*no evidence of any acute mental illness*' and noted he had advised them he had no thoughts or intent of self-harm, so his overall risk was assessed as low. The CJLDS staff discussed with Peter available support and gave contact details for Samaritans, i-access, CALM, Crisis Line and SANE. He was also provided with psychoeducation regarding physical and mental health, medication, the impact of long-term alcohol use on memory, as well as other effects of alcohol on the body. A plan was made for a referral to an Outreach Team and to liaise with his GP regarding an ulcer on his leg.

[15] Peter was referred to CJLDS in January 2021; May 2021; July 2021 and three times in August 2021. In January his assessment could not be completed by CJLDS because of his level of intoxication and in May because the referral was received at the end of working hours. The CJLDS explained that if a person cannot be assessed by them during their working hours due to intoxication or referral being received towards the end of the working hours the referral would be taken over by the Custody Health Care Professional such as: a paramedic, nurse, or a doctor. Therefore, the Custody were advised to contact the mental health professional in case of any concerns, and to provide a self-referral leaflet. In May 2021 it was also noted that S was open to i-access and the service was updated appropriately. In July 2021 and 7th August 2021 S declined vulnerability assessments. On 7th August 2021 the reason given by S was that he was receiving support from i-access.

3.15 Peter returned to living in the car park and was reportedly assaulted (receiving a head injury) in early September 2021. He subsequently made a fresh application as homeless, and SHBC Housing Options team arranged night paid emergency accommodation in Datchet pending medical enquiries.

3.16 On 13.09.21 his suspended sentence[16] was activated and he was returned to HMP Highdown. On arrival he was assessed by the clinical nurse lead in reception and found to be intoxicated; he was prescribed Pabrinex for 3 days and Thiamine. A risk of fitting was identified (due to history of epilepsy) so he was placed in the healthcare unit. He was also referred to the Brief Alcohol Intervention Service. He was not referred by the healthcare unit to the SCC's Prison Cocial Care team.

3.17 By the 16.09.21 he was noted to be disorientated, sweaty, confused and paranoid with presentations suggestive of delirium tremors. He was transferred to St. Helier's hospital for treatment. On admission he was assessed by the medical team (and later reviewed by the Liaison Psychiatry Team). A CT scan recorded no acute issues. He was reported to be aggressive and verbally abuse to prison staff, he removed a cannula (resulting in some loss of blood) and attempted, unsuccessfully, to remove his handcuffs. He was prescribed diazepam, so following his return to Prison on the 21.09.21, his detox plan was extended to continue with the hospital prescribing. The following week (27.09.21) he met with the Forward Trust's wellbeing and recovery practitioner, having declined offers to refer for psycho-social support, he was given harm minimisation advice. At some point during this period, he was seen by a psychiatrist who questioned if Peter had presentations which might indicate Korsakoff syndrome. It was reported verbally to this review that a subsequent GP review refuted this. Prison staff reported[17] Peter remained agitated and delusional throughout his stay, including damaging a light, repeated using the emergency call button unnecessarily despite warnings and verbal abuse of officers and nursing staff. He also refused to return a razor blade and, because this requires a search, had to be restrained by staff. His behaviours resulted in 14 separate negative behaviour warnings and, by the 04.10.21, he was placed on '3 officer unlock'.

3.18 During the practitioner event, the members of the TAP commented that this was a very marked change in Peter's presentations and commented that neither prison or healthcare staff had notified them of this change, or that a possible diagnosis of Korsakoff had been suggested. Throughout his period of incarceration, his 'TAP' continued to meet. There is evidence within the minutes of forward planning for his release, the housing option worker confirm the relief duty will be triggered meaning that they would find him emergency, nightly paid accommodation but that this would be out of area. Staff from The Hope Hub checked to ensure his DWP claim would remain active. The TAP did not believe there would be sufficient time to secure a review of his needs from SCC's Prison Social Care team if they sent a 'community' referral, but they did attempt to contact the Healthcare unit to ascertain why he had been placed there and discuss his on-going needs. They reported that they were unable to get information from unit staff. A subsequent meeting on 12.10.21 revised plans, but staff were not aware of actual date of release, only that it was imminent. When contacted to be made aware (on the 13.10.21) he would likely be released on the 15.10.21 Peter's probation officer commented to prison staff that, given his behavioural issues, it would have greatly assisted to have had more notification and to have been provided with details of any change in need or presentation of behavioural issues whilst he had been in Highdown. There is then evidence of extensive multi-agency communications to ensure that emergency accommodation was available to Peter of his release and that practical arrangements were made to ensure he could comply with duties to meet with his probation worker, obtain travel warrants, food and clothing supplies from The Hope Hub. The TAP Chair was going to escalate the lack of available

[16] Received in July 2021- 6 month suspended sentence and £185 fine for failing to appear in court.
[17] Taken from the Chronology prepared by the Forward Trust and HMP Highdown for this review

accommodation options for Peter to the next SAM Steering Board, so that additional funding or agreement could be secured to explore accommodation options such as 'wet hostels'. It was proposed to consider these in more detail at the next meeting scheduled for the 27.10.21.

3.19 Peter was reported to be more settled on the 13.10.21. On the 15.10.21 staff at the medical unit gave him a discharge summary, but this was not passed to his community GP or members of the TAP. Peter attended The Hope Hub on the 15.10.21 as arranged. He was also seen by an outreach worker from The Hope Hub later that day who noted he was inebriated, low in mood and unhappy about having to travel to Datchet for his accommodation. He was given credit for his mobile phone, supported to stay with his mother that evening and then to travel the next day.

4. Analysis of Agencies' Actions

Given Peter's history, how well did partners understand their organisational duties; did they work together and with him to implement effective plans to reduce risks including through the Make Every Adult Matter Approach?

4.1 Peter's vulnerabilities were recognised. Practitioners and his family were aware that his alcohol dependency increased the risks that his physical and mental health would deteriorate, that he would be unlikely to comply with tenancy conditions and likely to encounter criminal justice agencies, both as a perpetrator and victim of crime. Equally, TAP minutes evidence agencies understood the need to secure suitable accommodation for Peter, in the reasonable belief that once this was in place longer-term goals to improve his health and wellbeing were more achievable.

4.2 Practitioners also recognised that, given the wide-reaching ramifications of his alcohol dependency, it would be beneficial for statutory services to work collectively to understand both his needs and his ability to meet those needs or protect himself from harm (including through selfneglect). He was, consequently, one of the first cohort to be accepted onto the SAM. The SAM quickly identified most of the relevant agencies to be involved in his 'TAP'. The approach taken was designed as a rights-based, systems approach and consideration was given to duties owed to assess him in respect of his social care needs, provide emergency accommodation, provide support to prevent reoffending and, if he accepted support to address his alcohol dependency, ease a path so specialist addiction support would quickly be available to him. Consideration was also given by the TAP to Peter's capacity, in line with the Mental Capacity Act 2005, to understand the risks that his homelessness, offending behaviour and drinking posed.

4.3 The Mental Capacity Act 2005 ['MCA'] and associated code of practice is predicated on an assumption of capacity (unless there is evidence to the contrary). Capacity must also be determined in an issue and time specific manner. Practitioners should not judge someone to be incapacitated because their decisions appear unwise and should make any necessary adjustments to assessment processes to enable a person to understand information pertinent to the issue. The MCA applies across private and public frameworks for the delivery of any care and treatment, it is intended to strengthen system wide rights-based approaches and protect against unnecessary interference in our autonomy.

4.4 We know from extensive research[18] that ascertaining a person's agency in complex situations can be extremely difficult, particularly where there is strong evidence of fluctuating capacity (often associated with alcohol dependency) or a divergence between how an adult 'performs' during an assessment process and how they execute decisions in real life situations.

[18] See, for example, Martineau and Manthorpe [2020] 'Safeguarding adults reviews and homelessness: making the connections' Journal of Adult Protection, 22,4, `81-197 and Martineau, S. J., Cornes, M., Manthorpe, J., Ornelas, B., & Fuller, J. (2019). *Safeguarding, homelessness and rough sleeping: An analysis of Safeguarding Adults Reviews*. London: NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London.

Within their practical guide for practitioners. Ward and Preston-Shoot[19] list the physical and emotional conditions most dependent drinkers display to challenge the idea that alcohol dependency is a self-determined choice. They remind practitioners that NICE guidance[22] advises assessments of capacity should consider observations of the person's ability to execute decisions in real life situations. This highlights the situational aspect of decision making. NICE advises where there is evidence (e.g. from previous case history) that outside of an assessment environment the person is not able to understand or weigh up information to enact a decision, this should be thoroughly explored and could trigger further duties to ensure an adult is safe from abuse or exploitation.

4.5 Practitioners and senior leaders across agencies, including those involved in this review, express concern that the subjective nature of capacity assessments often obscures statutory welfare responsibilities. They warn that assessing capacity where addiction (and therefore fluctuating capacity) is a significant factor adds layers of complexity across a range of statutory duties that it not always well understood, inadvertently impacting on organisational duties to respond to identified safeguarding concerns and as such requires skilled, multi-agency involvement and agreement. This is explored in more detail within the analysis for the third theme.

4.6 Karl Mason[20] highlights that, whilst responsibilities under s42 Care Act 2014 to work collectively to address safeguarding risks is relatively new, it conceals shadows still present in wider welfare policy frameworks that influence how practitioners interpret their organisational duties. He identified three dominant ways of framing partner agencies' responses, namely:

- 'sin talk' which empathises the person's responsibility for their situation leading to punitive state response, e.g. the requirement under the Housing Act 1996 to consider if a person is intentionally homeless and, if so, determine they are ineligible for on-going support;
- 'sick talk' which focuses on the person's vulnerability and promotes treatment or welfare responses, e.g. the approach adopted by the Homelessness Reduction and Care Acts; and
- 'systems talk' which underlines a rights-based approach, e.g 'Housing first' and, more recently, the 'everyone in' approach to rough sleepers adopted during the Pandemic.

4.7 Practitioners reported to this review how different approaches to Peter's vulnerability and limitations to statutory legal powers (which are directly attributable to different legislative eligibility criteria that practitioners must apply) frustrated a shared understanding of Peter's needs, causing discord when planning his care. This is a common feature in SARs involving homelessness. In response, the LGA have recommend SABs adopt a model of effective practice.[21] This was developed from thematic analyses of safeguarding adult reviews on self-neglect, housing and alcohol abuse. We have structured our analysis according to the four domains identified within this model, namely:

- Direct practice with individuals which is person-centered, provides a thorough understanding of needs and risks taking into account the impact of trauma and adverse experiences;
- Multi-agency, multi-disciplinary team around the person so that services work together to provide integrated care, information is shared and cases coordinated to utilise powers under all relevant legal frameworks;
- Organisational network surrounding the TAP providing supervision to promote reflection and analysis of case management, access to specialist legal, safeguarding, mental capacity and

[19] Ward and Preston-Shoot [2021] '*How to use legal powers to safeguard highly vulnerable dependent drinkers*' for Alcohol Change UK, available at https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf [22] NICE (2018) *Decision Making and Mental Capacity*. London: National Institute for Health and Clinical Excellence.

[20] '*Adult Safeguarding and Homelessness, Understanding Good Practice*' [2022] Jessica Kingsley publishers

[21] Michael Preston Shoot, 'Adult Safeguarding and Homelessness: A briefing on positive practice [2021] LGA

mental health advice and developing commissioning to respond to needs for those experiencing multiple exclusion homelessness;
- Clear governance to promote locally agreed processes and procedures, monitor effectiveness of provision and that can hold partners to account for practice standards.

Direct practice to understand needs

4.8 As set out above SCC's Prison Social Care social worker recognised, in November 2019, Peter managed his care needs despite his disability within a prison environment, attributing this to the prison regime and enforced abstinence. She advised Peter would need considerable help to meet these needs once released; that he would benefit from a similar structured environment and support to manage his finances to prevent exploitation. In December 2019, he was found to lack capacity to adhere to a Criminal Behaviour Order because of his alcohol dependency. This decision was motivated, correctly, to prevent criminalising Peter for actions when he could not reliably process information or execute decisions freely. Both these demonstrate practitioners applying MCA principles to promote a treatment and welfare responses ('sick talk').

4.9 In line with this finding, throughout the review period Peter often failed to comply with his accommodation providers' reasonable behavioural expectations. Consequently, he lost this, for example the residential placement funded by social care in April 2020 and the supported living placement secured by SHBC in August 2021. Because questions had been raised about his ability to manage a tenancy due to his dependency, SHBC continued to exercise powers to provide alternative accommodation recognising that, without this, he would likely be at high risk of abuse and neglect ('system talk'). SHBC's housing option team only changed their position and notified Peter he was intentionally homeless, following confirmation in June 2021, that he had capacity to manage a tenancy. Even so, they agreed to use legal powers[22] to provide emergency accommodation on his release from prison on the 15.10.21. Throughout the period, however, they were also acutely aware that the nightly accommodation in B&B out of their area was unsuitable in the long-term, given Peter's disability and his desire to remain close to his family and support network in Camberley.[23] In December 2020 TAP members proposed, and SCC's social worker agreed to seek legal support to apply to the Court of Protection to obtain deputyship for Peter so that they could sign a private tenancy on his behalf, this was not pursued once it was determined he had capacity. It should be noted, however, that SCC could have exercised powers under s8 Care Act to provide accommodation-based care. There is often a misapprehension that accommodationbased care is limited to care homes or other residential care, however, as defined in the Care Act, this is whatever accommodation is required to meet the person's assessed eligible needs.

4.10 Staff from The Hope Hub explained that as they got to know Peter, they realised he knew what to say to practitioners to deliberately mask the extent of his inability. They confirmed he relied on their service for food, clean clothing, for travel warrants and credit for his mobile[24] as well as to remind him of appointments and read his post. The locality team social worker's initial needs assessment concurred with this view and the previous care act assessment that he was eligible for social care due to an inability to manage basic needs in the community. As set out above, during the review period the extent of Peter's daily alcohol consumption varied and with this, so too did his ability to engage with TAP support offered. However, staff from The Hope Hub explained that Peter usually responded well to their

[22] Under s189B Housing Act 1996
[23] Demonstrated by discussions reported within the TAP minutes and at the practitioner events for this review.
[24] This was despite receiving his full benefit entitlement. He could not explain how he had spent his money, leading practitioners to believe this was being taken from him by other dependent drinkers.

support. They credited him with helping them to shape their life skills programme, reporting that he was very clear about what help he needed to move towards independence. For example, he engaged well with a peer programme to improve his literacy and numeracy; they commented on the pride he took in learning his timetables. Practitioners also remarked that, on the occasions that his needs were better managed, and he appeared to be reducing his daily alcohol consumption, services would then withdraw, or he would disengage with support (e.g. with I-access offer) resulting in a cyclical risk pattern.

4.11 Throughout the period the risks associated with Peter's poor money management and exploitation remained unresolved. Practitioners reported that SCC's deputyship team were unsure they could make an application to the Court of Protection, but once he was assessed as having capacity returned the referral. It does not appear that there was any further exploration of alternatives power, such as if DWP appointeeship might have managed the risk of exploitation more effectively.

4.12 Peter's physical health also required frequent attention during this period. Family members and practitioners spoke of the impact that his poor self-care had on his stump and that the resulting pain impaired his mobility and mood significantly. The Hope Hub confirmed they received a good response from the community matron whenever they requested assistance to reduce risks of infections or pressure sores. However, it does not appear from the minutes of meetings or correspondence that his GP took an active role in the TAP to coordinate his health or advise those providing daily support.

Team around the Person to coordinate care

4.13 It is understood that following his referral to the localities social care team in January 2020, Peter was allocated a social worker with previous experience as an AMHP so that she could assess if he displayed signs of cognitive impairment because of a possible acquired brain injuries ['ABI']. It remains unclear why Peter's case was not referred to the specialist mental health and addiction social care team, but practitioners speculated this may have been because Peter had not given consent to that referral or because there are long waiting lists for that team.

4.14 Prior to the review period Peter had attended an appointment with a Consultant Neurologist at Frimley Health NHS Trust who had access to his medical records, including attendances at numerous A&E following seizures or head injuries. It is understood that throughout the review period he remained in the care of the epilepsy team at Frimley Hospital, albeit with sporadic engagement. So, it is unclear why their involvement (or the involvement of his GP) in complex assessments of his capacity was not sought. Hospital staff explained Peter would often leave A&E or become aggressive so be required to leave, making it very difficult to complete full investigations. However, they highlight that CT scans were completed on a few occasions and did not show any obvious signs of brain injury. Surrey also has an integrated health team which (had Peter been referred) could have enabled a multi-disciplinary review of his presentations and consideration for referrals to investigate concerns regarding Peter's presentations under the Young Onset Dementia or delirium pathways.

4.15 Initially his locality social worker concluded he lacked capacity to sign a tenancy. The impact of that assessment on effective care planning is considered further below. She reported to this review that as she got to know Peter, she adjusted her view of his capacity (and, in line with MCA principles, the timing of assessments to a suitable time in the day when he would not be inebriated). Subsequent capacity assessments were reportedly conducted over several sessions to test Peter's recollection of previous discussions. In

determining his capacity regarding offending behaviours, she explored the cyclical nature of his offending and felt he fully understood the increased risks posed by his drinking. Likewise, she was aware that his money management undoubtedly put him at increased risk of exploitation, but he had explained to her that he deliberately withdrew all the available money in his account to prevent collections of court fines and thereby maximise his ability to buy alcohol. He had explained he knew this was risky- as he would be more likely to get the money stolen and further prison terms for non-payment, but prioritised alcohol over those risks. His social worker believed this demonstrated capacitated, but unwise decision making. In 2019 the psychologist had taken a different view of the impact of his addiction and resultant fluctuating capacity in respect of his behaviours, demonstrating the subjective nature of capacity assessments. But it is important to note that her approach was consistent with case law.[25]

4.16 Conversely, the decision in June 2021 that Peter was no longer eligible for social care support despite an apparent increase in his needs and no change in the ongoing safeguarding risks that his self-neglect and alcohol dependency posed to his physical and mental health, understandably confused other members of the TAP. Contrary to the legal duties Peter was not provided with clear explanations of this decision in writing. SCC have since confirmed they agreed with staff from The Hope Hub for them to report the assessment findings to him directly, mindful of his literacy issues. The localities assistant team manager also met with Peter to ensure he was aware of the outcome. It remains difficult to understand the rationale for this change of position, which begs the question, how would it be feasible for The Hope Hub to explain this decision to Peter. It is possible that staff within SCC's social care department, including senior leaders, conflated their assessment function [s9 Care Act] with the duty to determine eligible needs and ascertain whether the adult wants the local authority to meet those needs [s13(3)(b) Care Act]. This is considered in more detail later because it shines a light on the strength of the organisational network supporting the TAP.

4.17 Within the TAP, this change in social care's position led to conflict with other practitioners who felt Peter's assertions that he would cope were accepted on face value whereas evidence they put forward to the contrary[26] was given insufficient weight. It is clear from communication records and TAP minutes that practitioners feared conclusions that Peter had capacity (by SCC's social care department and mental health services in December 2020) were to enable services to justify withdrawing or withholding support. Mason[30] identifies that the '*stretching of safeguarding responses to homelessness has not elided the powerful and persistent discourse of 'sin talk*'. He points to empirical research[27] which has identified the conditionality of social care responses, perhaps necessitated by chronic resource issues, which results in agencies normalising risk or look for ways in which individuals fall outside of their eligibility criteria. This conclusion is also supported by findings with the NIHR funded 'communities of practice' research.[28]

4.18 Throughout the case records there are examples given of assertive outreach and flexibility by practitioners to ensure that they were able to assess Peter at a time that would

[25] In *London Borough of Tower Hamlets v PB* [2020] EWCOP 34 Mr Justice Hayden held that (i) the fact PB seriously overestimated his ability to keep his alcohol use under control was not enough to establish a lack of capacity; (ii) not every addict in some degree of denial can be regarded as incapacitous; and (iii) the requirement to be able to understand the "reasonably foreseeable consequences" of a particular decision does not mean that the relevant person must accept the professions' view that they will not be able to control their drinking.

[26] They gave examples of Peter overstating his abilities when interviewed by the DWP for personal independence payments and how their respectful challenge or further probing uncovered the true nature of his needs. [30] Op Cit. at p34

[27] Whiteford and Simpson 2015, p.130; Cornes et al. 2011; Mason et al. 2018

[28] Harris, J. (Ed.) (2022). *Safeguarding Responses to Homelessness and Self-Neglect Communities of Practice Report: Key messages emerging from conversations in research study sites*. NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London. https://doi.org/10.18742/pub01- 075

improve his engagement. It is understood that involving the adult directly with the action plan and inviting them to meetings was not originally within the terms of reference of the SAM. TAP members explained that they now try to maximise an adult's opportunities to speak directly to the TAP and co-produce the action plan. It is notable however that, despite Peter articulating clearly that his family were an important protection factor in his life and giving health staff permission to discuss his health needs and treatment plans, they were not invited to TAP meetings or kept informed of plans.

Organisational Network to support the team around the person

4.19 The purpose of a model that requires robust supervision and management oversight of frontline decision making as well as access to specialist legal advice is to ensure that local processes and policies are used effectively to enable statutory obligations to be met. Crucially, in Peter's case it does not appear the TAP or the Organisational network understood the implications that decisions regarding his capacity would have for multi-agency care planning. This is considered in more detail within the analysis of the third theme.

4.20 In addition, the use of Housing Act powers to accommodate Peter out of area also thwarted a system approach because, as his TAP explained, it proved impossible to arrange for alternative social care input when he was out of borough, particularly if those placements were intended to be temporary.[29] This is considered in more detail within the analysis of the second theme.

4.21 Concerns regarding the complexity of the capacity and needs assessments and challenges in finding suitable accommodation-based care were escalated by his social worker to her senior leaders within SCC. There is evidence of oversight of her assessment, and she confirmed she was offered assurance that senior managers were aware of Peter's case and would 'hold the risk'. However, reflecting during a conversation with the reviewer one senior manager felt that in addition to staff support, strategic leaders should offer practical system led solutions to the challenges of meeting needs associated with addiction, poor mental or physical health and homelessness. From an adult social care perspective, they highlighted that this would require staff with particular skills as this is not the usual presentation of need for a locality team and needs would unlikely be met through the usual reablement or residential care services. They also suggested that it would be helpful if Terms of Reference for multi-agency approaches such as CHaRMM and SAM included clear guidance for agencies (especially those invited to be part of any TAP) on when to escalate cases to senior leaders' from across the statutory and provider sector organisations to intervene and find resolution.

4.22 Other members of the TAP and senior leaders commented, however, that they had not considered escalating this case for a shared, multi-agency senior overview or dispute resolution as they relied on the expertise of practitioners attending the TAP meeting. Instead, their focus moved to seeking to resolve the impasse by identifying alternative accommodation options that might work for Peter, e.g. a wet hostel in Southampton.

Governance

4.23 As detailed below, there has been a number of important improvements to practice and newly commissioned services since Peter's death. This demonstrates the positive impact the 'Make Every Adult Matter' and SAM approach is having in Surrey. The SSAB's Board Manager's attendance at the SAM Steering Board is good practice as it enables emerging issues or themes from case work to be viewed through a safeguarding lens.

[29] The duty to provide support to under s189B is limited to 56 days.

However, given the overarching responsibility to take action to safeguard an adult at risk and the complexity of legal powers to fulfil that function is most acutely felt at operational level, SSAB and partner agencies may wish to reflect on how to use that information to improve practice across the wider workforce and whether existing reporting arrangements for the SAM conform to the governance expectations set out by the LGA in their practice briefing on safeguarding and homelessness.

System finding

4.24 Regular attendees at the TAP recognised Peter's vulnerabilities. Their attempts to support him were frustrated by limitations on legal powers to compel Peter to comply with support offered, his ability to consistently engage with service expectations and a lack of commission services to offer accommodation-based support to compliment the support offered by The Hope Hub.

4.25 A lack of clarity in escalation routes for multi-agency senior managers to resolve disputes between practitioners or review cases where action plans were not having any noticeable positive impact, led to conflict and services withdrawing support when Peter's needs and the risks he faced were unchanged. The organisational network requires strengthening as does legal literacy with regards to the implications of a person's capacity on different statutory duties. Oversight of multiagency risk management, particularly where significant safeguarding concerns have been raised should include regular reports on emerging themes or lessons learnt to the SSAB and clear processes for disseminating changes to services/ practice back to frontline staff.

How effective and well-coordinated was care planning at key points of transition such as hospital discharges and prison release, were continuity of care obligations understood and applied when he was placed out of area?

4.26 There are specific duties within Care Act of cooperation between Local Authorities (social care and housing), NHS and Prisons so they work at strategic and operational level to promote wellbeing, prevent the escalation of needs, improve quality of care and safeguard adults with care and support needs.[30] The Care and Support guidance advises local authorities to agree and apply local protocols to ensure continuity of care.

4.27 During the review timeframe Peter attended A&E on a number of occasions, but was only admitted into hospital once, this was to St. Helier's between 18-21.09.21. On his return to HMP Highdown he and prison staff were provided with a discharge summary, enabling the healthcare unit to continue his treatment safely. This was good practice and in-line with expectations. Practitioners reported that it was difficult to offer consistent care to Peter within A&E, including when taken by police because he posed a risk to himself, as he was usually intoxicated and aggressive. On more than one occasion he was reported to have left A&E against medical advice, because of waiting times. To mitigate risks staff spoke with his daughter and alerted her to his non-attendance or selfdischarge. As detailed above, they did not contact any members of his TAP which likely made it more difficult to ensure continuity of care and cooperation regarding his care plan.

4.28 In respect of continuity of care for offenders, Care and Support Guidance advised local authorities should:

- have processes for identifying people in custodial settings who are likely to have or to develop care and support needs. Guidance highlights that reception screening and health

[30] S3, 6-7, 23-24, 76, 39-41 Care Act, accompanying regulations and Care and Support Guidance, DHSC [revised June 22], with regard to chapters 14, 17, 20-21.

assessments are key opportunities to establish whether an individual has been receiving care and support before entering custody.

- aim to conduct assessments of those who appear to have care and support needs promptly following receipt of the referral from managers of custodial settings, the prison's health providers and any self-referrals. Guidance also reminds practitioners that the enduring duty to assess [s11(2) Care Act] also applies to prisoners.
- provide information to prisons about adults with eligible needs going into prison.

4.29 Local authorities are also responsible for continuity of care for offenders coming into their area on release from prison. Early engagement in the resettlement plan is advised both by the Care and Support guidance and instructions from the National Offender Management Service which states prisons must "*inform local authorities and their providers of decisions to move or release prisoners to enable a local authority to meet its duties for continuity of care…it is good practice to ensure early involvement of all agencies in resettlement planning"*.[31]

4.30 Peter benefitted from good cooperation and clear processes for continuity of care on two out of the three times he was incarcerated during the review timeframe. He was assessed promptly when first detained in HMP Highdown in 2019, ensuring he was provided with necessary adaptions to assist him to manage his disability whilst in prison and that social care and probation staff were aware of his needs on release. Again, when detained in HMP Winchester in 2020, the local Prison Social Care team ensured he could access support to address his dependency both during his incarceration and on release. As a result of those interventions and the sharing of information between prison, in-reach teams and services in the community, Peter was able to engage with appropriate support on his release. For example, he consented to his probation officer referring him to SAM following the release in January 2020 and, after his release in May continued to work with iaccess to reduce his drinking, including starting group sessions within a relapse programme in August 2020.

4.31 This good practice was not replicated on his final prison stay. Whilst this review had limited information from the healthcare unit, there is evidence that he was assessed at reception, his needs were recognised to be of sufficient risk that he was admitted to the healthcare unit.[32] Practitioners from The Hope Hub reported making attempts to speak with prison and unit staff, including at the request of his mother who was concerned as she hadn't heard from him. SCC's Prison Social Care team reported they often receive referrals from HMP Highdown's healthcare unit and had a good working relationship with unit staff. They confirmed that their service is well known throughout the prison; it is well advertised with posters in all parts of the prison and within the unit, resulting in frequent peer and self-referrals. The social worker also attends ward rounds when requested. Unfortunately, they did not receive a referral for Peter on this occasion. It is also understood that the risk assessment was not completed for Peter, even though this was a mandatory requirement and he had displayed behaviours that required a '3 man unlock'. Furthermore, whilst limited information was given to Peter's probation officer shortly before his release, this was not in accordance with the expected standards for early engagement with local authorities. Prison staff also did not comply with their duty to refer to SHBC's Housing Options team [s213B Housing Act] in respect of his likely homelessness on release. These were missed opportunities, had a referral been made, Peter would likely have been assessed by the same

[31] Adult social care: PSI 03/2016, PI 06/2016: Section 8

[32] This service was managed by CNWL foundation trust who were commissioned to provide mental health and primary care services. Prisoners are monitored by a GP attached to the unit, nursing staff at band 7 level and health care assistants. At the time of writing this report is it understood that the

Prison Social Care social worker who had conducted the first needs assessment in 2019. Both her and the localities social worker were of the view that the clear change in his behaviours would likely have resulted in a reassessment of his needs and a review of his eligibility for social care and decision-making capacity. The Prison Social Care social worker clarified that the short length of his sentence would not have prevented her from completing an assessment, even if the referral had come from community-based practitioners (e.g. The Hope Hub staff) as the duty was to undertake these whenever there was an appearance of need and to do the assessment promptly.

4.32 During conversations practitioners queried whether the numerous case recording systems for offenders may have impeded cooperation. They explained there was different systems for prison staff, probation, the Prison Social Care team and that the unit may also have had different systems for nursing staff and the GP. The Hope hub staff also queried whether the lack of cooperation was because they were not viewed as 'professionals' because they do not work for a statutory body. It is also possible that, because the duty to cooperate is between the local authority and prison staff there was confusion about how much could be shared with staff from the voluntary/ charity sector. Although not explicitly identified as an issue in this case, misconceptions around the impact of data protection and the GDPR also commonly create barriers. The SAM coordinator explained that, following Peter's death, they now invite HMP Highdown staff to be part of the TAP. Practitioners queried if the protocol between the local authority and mental health in-patient providers to ensure patients are not discharge to 'no fixed abode' could be replicated with prisons? If SSAB or their partners are interested in exploring this, they may find it useful to review the preliminary findings from research into the out of hospital care models.[37]

4.33 Another sphere where local authorities are required to co-operate and ensure continuity of care is when a person with care needs is moving to another area or if their needs cross over more than one local authority statutory welfare duty (e.g. children and adult social care department, social care and housing or public health). In regard to complex needs, local authorities are required to have in place '*arrangements to ensure co-operation between their officers, particularly between housing and social care, given that housing and suitability of living accommodation play a significant role in supporting a person to meet their needs and can help to delay that person's deterioration'*[38] The Make Every Adult Matter programme (and particularly the SAM approach) would meet this standard, particularly if the recommendation made in this report are implemented.

4.34 The importance of inter-departmental cooperation (and a proper understanding of the interface between Housing Act and Care Act duties to accommodate) was particularly pertinent for Peter because the over-reliance on the Housing Options team to arrange accommodation confounded responsibilities regarding continuity of his social care when placed out of borough. For

health care unit has been decommissioned. HMP Highdown has changed status from a category B to Category C prison and it is understood that very few category C prisons would have a healthcare unit. Instead, this facility will be repurposed to provide support to offenders with additional needs. [37] More information is available at: https://www.kcl.ac.uk/research/oohcm-evaluation [38] 15.24 Care and Support guidance

much of the review period, despite acknowledging Peter was eligible for social care, SCC were unable to provide statutory support as social care providers commissioned by them would not agree to work in other areas. At the time social care providers faced significant workforce issues because of the Pandemic. SCC's social care team reported that attempts they made to negotiate with providers in other areas proved fruitless as they either did not have capacity within their workforce to take on new clients or they were unwilling to take Peter onto their caseload because of his forensic history and complex needs.

4.35 Practitioners explained that SHBC are not the only local authority to rely heavily on nightly paid emergency accommodation in or around Slough to meet duties under the Housing Act. They commended Slough social care staff for sharing information about social care providers in their area and understood why Slough staff may not have felt able to take on statutory responsibility for meeting his needs under the Care Act. Not only would this put considerable strain on their financial resources unfairly, but it was also clear the Peter did not wish to move out of area. As such, the placements were always understood to be temporary whilst SCC found more suitable accommodation in line with their statutory obligations. To mitigate the risks of an imperfect care plan, the TAP put in place practical assistance (including travel warrants) so that he could travel frequently and access hub support. Officers from the British Transport Police appreciated their provision of travel warrants, explaining that decisions regarding prosecution for fare evasion are a matter for the train companies, who may not always consider someone's vulnerabilities in that decision.

Systems finding

4.36 Surrey partner agencies have established protocols for co-operation, including the SAM approach and there is evidence of good practice between the local authority and partner agencies, but this is not consistent or firmly embedded. In addition, the duties to ensure continuity of care for adults moving between hospital, prison and different local authority service or across geographical boundaries are not well understood and the pathways to secure these smooth transitions are not always easy to access, or challenge when obstacles arise.

4.37 Currently the local multi-agency safeguarding policy includes an aspiration to reach agreement with prisons on how they can provide assurances to the SAB[33] regarding safeguarding functions but is silent on continuity of care duties. Although policy framework for prisons mirrors the statutory Care and Support guidance, the prison framework is non-statutory and therefore only advisory. There is, however, an inter-agency escalation policy and the SSAB has an active prison liaison group which focuses on pertinent safeguarding issues for prisons. All 5 prisons in the area have representation on that group.

4.38 The overreliance on temporary, emergency powers to accommodate Peter under the Housing Act complicated the delivery of social care support and masked the duty to meet his eligible social care needs. This could have been overcome with a broader understanding of the legal framework for commissioning accommodation-based care under the Care Act 2014 and a broader understanding of the continuity of care obligations.

How effective was the multi-agency response in recognising and responding to prevent an escalation of Peter's mental health and risk of self-harm/ self-neglect?

4.39 Section 1 of the Care Act requires the local authority to promote an individual's wellbeing whenever it is carrying out any care and support function. Section 2 obligates local authorities to provide services or take other steps it considers will prevent or delay the development by adults in its area of needs for care and support. An early response to emerging harm is essential to stop risks from escalating. But, where an adult with care and support needs has experience or is at risk of abuse or neglect, s.42 of the Care Act 2014 requires that each local authority must make enquiries. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom. Equally, there is recognition within national guidance on safeguarding responsibilities and within the local guidance that a safeguarding enquiry is not a substitution for a

[33] 27.2 Surrey SAB Adult Safeguarding Policy and Procedures 2018.

care plan. This is reinforced within the Surrey Adults Matters approach, which requires practitioners to work collaboratively, taking into account all they can reasonably be expected to know, to establish a clear picture of need and risk and, using their existing legal powers and operational responsibilities, create a shared plan to mitigate known risks. However, an empowering approach such as Surrey Adults matter must be backed by resource and effective leadership, where disputes are swiftly resolved and creative solutions progressed with appropriate urgency.

4.40 The legislative framework to support those with an appearance of care and support needs and experiencing homelessness is very complex, but it is designed to ensure that agencies with statutory responsibilities carry out their functions in partnership to prevent needs escalating. Statutory criteria must be approached as fluid and facilitative, as opposed to creating artificial barriers. The roll-out of Integrated Care Systems is intended as an ideal opportunity to outcome these barriers between agencies. Crucially, in Peter's case it does not appear the TAP or the Organisational network fully understood the implications that decisions regarding his capacity would have for multi-agency care planning. The time required for the locality social worker to develop trusted relationships with Peter to undertake and then review those assessment, and for senior managers to have oversight and sign off her needs and capacity assessments caused uncertainty and delay to care planning processes. Since this time improvements to the TAP minutes form ensures it is easier for the SAM to capture information regarding emerging themes, including delays or inaction. It should be noted that this review is not critical of, nor do we dispute decisions regarding Peter's capacity. However, we believe it will assist SSAB and partner agencies to set out the practical impact those findings had on the multi-disciplinary care planning process.

4.41 For example, the conclusion that Peter lacked capacity to comply with a CBO constrained a systems approach to Peter's care planning by eliminating a legal power that would have enabled the Courts to impose the structured regime he was assessed as needing in the community. In a similar way, probation officers confirmed that they could not set licence conditions that he abstain from alcohol or require him to engage with I-access support. An important aspect of deciding licence conditions is the person's capacity to understand and comply with these.[34] In October 2021 this might have been possible, but his probation officer understandably prioritised securing him accommodation for the weekend over discussing with him (and therefore assessing his capacity to comply with) additional licence conditions regarding his alcohol dependency. Probation staff confirmed that the nature of his offence meant he did not meet the criteria to be accommodated on release into approved premises[41], a regime that would have restricted his freedom and required he engage in meaningful activity, work on his offending-based behaviour and attend relevant treatment or intervention programmes. Had this been an option, staff could also have requested regular blood testing to ensure abstinence or at least monitor the ongoing impact on his physical health.

4.42 As set out above, GP and/or specialist health involvement in Peter's TAP could have triggered medical processes to examine if his cognition was deteriorating due to physical causes. Equally, because Frimley NHS staff had consent from Peter to contact his daughter to discuss his health and treatment options, this should have also made it easier to get a more rounded picture of the deterioration in his cognitive abilities from his family and The Hope Hub staff who knew him well.

It would inevitably have made it easier for information to be shared during his detention in September-October 2021 between the prison healthcare unit and TAP members so that more was known collectively about the significant change in his presentation during his final prison stay. This could, in turn, have then enabled reconsideration of his mental health and/or capacity thereby

[34] Licence conditions policy framework, available at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1090775/licence-conditions-policy-framework.pdf [41] Approved premises offer an enhanced level of public protection in the community and are used primarily for high and very high risk of serious harm individuals released on licence from custody. This is typically following serious violence and/or sexual offences. Practitioners also explained that, during the Covid Pandemic (due to the legal requirement for social isolation) bedspaces within approved premises decrease by half, making it much less likely that any discretion would be applied, or providers would accept people who were not high risk, but difficult to manage.

unlocking possible alternative legal powers to provide restrictive care under the MHA or Deprivation of Liberty Safeguards [‘DOLS’].

4.43 Given the similarities between Peter’s presentations and those reported in *London Borough of Tower Hamlets v PB* [2020], it is our view that the Court of Protection may not have upheld any decision to authorise a breach of his right to liberty under the DOLS framework, even if they were satisfied that he lacked capacity regarding his residence and care. As Jackson J confirmed in *Wye Valley NHS Trust v B* [2015] best interests considerations under s4 MCA are *”not an academic issue, but a necessary protection for the rights of people with disabilities. As the Act and the European Convention make clear, a conclusion that a person lacks decision-making capacity is not an ‘off-switch’ for his rights and freedoms.’* Peter would likely have required wide controls on his freedoms to ensure he did not drink and to enable him to engage effectively with I-access. The proportionality of such restrictions would have to be weighed against the positive and negative impact these would have on Peter’s wellbeing. Anyone authorising a deprivation of liberty would need to be satisfied that harm caused by imposing restrictions against his wishes, were outweighed by the benefits. It is understood that, within Surrey, I-access have been commissioned to provide support solely to people willing to engage. Practitioners explained, during conversations with the reviewer, that the requirement for someone to want to engage is based on empirical research which demonstrates compulsion is rarely an effective motivator to secure rehabilitation in respect of alcohol dependency.

4.44 Similarly, the Mental Health Act expressly excludes compulsory detention for assessment or treatment solely on the grounds of alcohol dependency. If someone has a disorder of the mind related to alcohol use, for example alcohol-related brain damage, acute confusion, severe depression or psychosis, it is possible to use legal powers under the MHA. But as Preston Shoot and Ward make clear *'this will not be, and should not be, a simple or frequent option. It will generally require considerable multi-agency discussion to demonstrate the need for this route*.’[35] Again it is a legal requirement for practitioners using MHA powers to pursue the least restrictive option. As such, it is likely that practitioners would have needed to have explored alternative accommodation-based support before deciding that it was necessary and proportionate to use powers under the MHA to compel Peter to accept support for his dependency and resulting poor mental health.

4.45 Given the lack of powers under any legal framework to compel Peter to accept support to address his alcohol dependency, it is not unreasonable that the TAP relied on residual legal powers to offer support to address his care and accommodation needs, albeit aware that they would be unable to replicate the structured regime of prison he responded well to. Initially the social worker’s finding that he lacked capacity to manage a tenancy may have been influenced by the forensic psychiatrist’s views as well as SCC’s statutory duty to promote wellbeing [s1 Care Act] and possibly to avoid negative consequences for Peter that would flow from a finding that he had lost previous accommodation through intentional actions. Again, this is an example of the prevalence of a ‘sick talk’/ welfare approach. Despite good intentions, this too impeded a ‘system approach’ as the implications of this decision meant ongoing reliance on the temporary relief duty[36] to address his homelessness.

[35] Op Cit, p9
[36] s189B Housing Act 1996

4.46 Local authority social care and housing teams are required to work collaboratively to respond to and prevent homelessness at both a strategic and operational level.[37] Often this results in housing staff taking the lead to address issues of homelessness because local authorities are barred from meeting needs via Care Act powers if those needs can be met under the Housing Act.[45] However, this prohibition falls away if someone does not have sufficient capacity to make an application for housing.[38] Instead there is an expectation that accommodation will be provided alongside any social care support whenever an adult requires an element of external assistance, i.e. they have a need for care and support. The need for care and support is interpreted as a need to be 'looked after'.[39] As a rule of thumb, the act of looking after should be of such a nature that the individual would still require this intervention even if they were wealthy. The duty to provide accommodation-based care and support shift to the Care Act (rather than the Housing Act) if there were things that the adult could not be expected to do for themselves and it wouldn't be reasonably practicable to provide support without the provision of accommodation.[40] In *R (SG) v Haringey LBC* [2015] the Court confirmed '*in most cases the matter is best left to the good judgment and common sense of the local authority … accommodation-related care and attention means care and attention of a sort which is normally provided in the home or will be "effectively useless" if the claimant has no home*.' There is no expectation that those provided with accommodation-based care must have needs requiring a CQC registered, residential care setting. In fact, the legal duty dictating how care needs can be met is worded widely to enable local authorities to provide '*accommodation in a care home or in premises of some other type'*.[41]

4.47 The decision, in June 2021, that Peter did not have eligible social care needs remains, objectively, difficult to reconcile with the previous assessments and reports from other members of the TAP about escalating concerns during this period. Whilst, arguably he may have not accepted support other than from The Hope Hub, (because, even if an alternative service had been commissioned by SCC's social care department, any provider would unlikely be able to quickly replicate their trusted and skilled response), the muddling of the duty to identify needs [s9 Care Act] with considerations of whether he wanted needs met [s13(3) Care Act], meant alternative proposals were not put to him to consider. In practical terms it also left a sizable gap in commissioned services for adults who, even with skilled daily input from community-based services, remain at high risk because of alcohol dependency or who, like Peter, cannot realistically access necessary daily support because they are accommodated out of borough.

4.48 Practitioners reported that since Peter's death a new service 'Changing Futures Programme' has been commissioned to provide enhanced wrap around support in supported housing provision. There are now 7 different providers offering this service across Surrey. In addition, SAM leaders have been working with the Police and Crime Commissioner to explore accommodation pathways for people, like Peter, who are 'hard to house' because of their offending history and ongoing drug or alcohol dependencies. They explained that the cohort of individuals supported under SAM has grown from 25 when Peter was referred to 90. Of these, approximately 40 fit the brief for the 'hard to house' pilot, including people assessed as MAPPA, level 2 risk because they pose a risk to others.

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[37] S182 Housing Act 1996 and chapter 8 of the Homelessness Code of Guidance available at: https://assets.publishing.service.gov.uk/media/5ef9d8613a6f4023cf12fc67/current_Homelessness_Code_of_Guidance.pdf [45] s23 Care Act 2014

[38] *R v LB Tower Hamlets, ex p Begum* (1993)

[39] "*Looking after means doing something for the person being cared for which he cannot or should not be expected to do for himself: it might be household tasks which an old person can no longer perform or can only perform with great difficulty; it might be protection from risks which a mentally disabled person cannot perceive; it might be personal care, such as feeding, washing or toileting. This is not an exhaustive list. The provision of medical care is expressly excluded… if there is a present need for some sort of care, then obviously the authorities must be empowered to intervene before it becomes a great deal worse*." Lady Hale in *R (M) v Slough* [2008]

[40] *In SL v Westminster* [2013] the Supreme Court confirmed that where the needs for care and support is not available otherwise than through the provision of accommodation (i.e. affected both by the nature and location of accommodation) it would be for the local authority to provide under their social care duties (if the person was ineligible under the Housing Act).

[41] s8 Care Act 2014

Again, this is a county wide project working closely with probation to target those at risk of prison release with no fixed abode.

4.49 The overreliance on SHBC's housing needs team to meet Peter's need for accommodationbased care had wider ramifications for his care planning, because the lack of their own housing stock meant Peter was always placed out of the Surrey Heath area in nightly paid B&B accommodation. This was particularly challenging after his release from prison in May 2020 until his death as the 'everyone in scheme'[42] inevitably placed significant strain on available beds and council resources across the country. Where a duty to accommodate arises under the Housing Act, local authorities must consider suitability of the offer with reference to the adult's needs arising from illness or impairment. Equally this requires consideration of whether the location of accommodation is suitable, given their circumstances. For offers to be suitable, they should address practicalities regarding how the adult will access other necessary support. In respect of those in receipt of medical or psychological treatment, it is crucial to consider any established therapeutic relationships and the impact of any disruption.[51] In conversation with the reviewer, Hobe hub staff, members of the TAP and his daughter highlighted the practical difficulties for Peter when he was placed in emergency B&B accommodation as these were rarely designed with accessibility for those with physical disabilities or mobility issues in mind. Peter would often have to climb stairs, or mobilise long distances for toilet facilities, meaning that he would not take his prosthetic leg off at night, increasing the risk of pressure sores and infection. Given the exceptional pressures placed on services during the Pandemic, SHBC should be commended for the efforts their Housing team staff to secure accommodation that minimised risks to Peter. The nightly paid accommodation in Woking was on the ground floor. In addition, they frequently negotiated with providers on Peter's behalf who then demonstrated leniency, despite his repeated breaches of rules.

4.50 It is understood that SHBC's Housing Options team recently secured funding for a 'housing led project' to provide accommodation for 4 people with complex needs following a 'housing first' model which international studies indicate produces exceptional housing retention outcomes (around 80%)[43]. The support will be provided to those who would not normally be eligible under the Housing Act (for example, because they have been deemed intentionally homeless), but they must be able to demonstrate they have capacity to manage a tenancy. Whilst these new services will undoubtedly provide the right response for some individuals, it is arguable that Peter (and consequently those in a similar position to him now) would not have been able to benefit because of the reasonable concern that he may not have capacity to manage a tenancy. Therefore, it would be advisable to explore if SCC's social care teams could use their s8 Care Act powers to commission similar accommodation for adults with care and support needs who, because of alcohol dependency or cognitive decline linked to this, would likely struggle to maintain accommodation.

4.51 Peter had commented to a number of professionals how the daily struggle was impacting on his mood and motivation. It was well understood that, because of his prosthetic limb he found it painful to walk long distances and this too impacted on his mental wellbeing. On a number of occasions practitioners had concerns regarding his mental health and the risk he posed to himself when very low in mood and inebriated. Despite this, perhaps because he denied suicidal ideation when assessed for compulsory detention under the MHA or because of the placements out of area, he was not referred for any community based mental health support. Instead, The Hope Hub[53] and his GP (with whom he had very little contact) to manage this need.

[42] The DHSC and MH,C&LG policy to ensure all those at risk of rough sleeping were accommodated during the Pandemic [51] *Nzolameso v City of Westminster* (2015)

[43] Crisis' report '*Ending Rough Sleeping: What works*?' https://www.crisis.org.uk/media/238368/ending_rough_sleeping_what_works_2017.pdf

[53] The Hope Hub's team consisted of a mental health case worker funded through the Better Care fund.

Systems finding

4.52 The current SAM approach encourages a system focused, rights-based approach to multiagency assessment and care planning. During the review period this was in its infancy and faced additional, extraordinary challenges due to the Pandemic. Changes made since the review period to the SAM approach should result in greater involvement of the adult with care planning and more accountability for agencies to complete actions in a timely manner.

4.53 However, capacity assessments for adults with fluctuating capacity linked to addiction are highly complex and require those with expertise in the impacts of addiction on executive functioning. Ideally, this would be undertaken by a multi-disciplinary team enabling longitudinal consideration so that deteriorating conditions are also more easily recognised. Greater involvement of his GP and/or consultant neurologist within the TAP should have triggered a referral to the Integrated Care Team and enabled joint assessments of the extent of his cognitive impairments and any underlying causes of his inability. The essential role of health in regard to wellbeing is reinforced by the statutory identification of ICBs as one of the three safeguarding statutory partners within SABs. This is similarly crucial in operational decision making and therefore, where health practitioners do not have the resources to commit to shared assessments, particularly in the context of complex comorbidities where the underlying cause has not been established, health practitioners should provide advice for the TAP.

4.54 There is a gap in services to support the mental health of adults, particularly those with an established addiction, who are not yet in crisis such that they pose an immediate risk to themselves or others, but may be unwilling/unable to commit to rehabilitation and abstinence. It was well understood by his TAP that it was unrealistic to expect that his poor mental health could be addressed through his GP alone. Peter struggled to keep regular appointments and, as many health services moved on-line in response to threats posed by the Pandemic, he was also digitally excluded. This also made it extremely unlikely that he would have been able to make use of psychological therapies, provided through an IAPT programme.[44] The TAP, his family and staff at The Hope Hub tried hard to provide reassurance and motivation to him. When he was offered a referral for psycho-social support (in September 2021) he refused this, but those who knew him well explained that (perhaps because of pride or because he was so shy) this was often his initial response. He, and they, needed for this offer to remain open and, even if he didn't directly work with such a service, those caring about him would have benefitted from advice and support to assist them to monitor his mental wellbeing and alert his GP or others as soon as they had concerns regarding the danger he may pose to himself.

5. Recommendations Emerging from this Review

Recommendation 1: The SAM provide guidance for members of a TAP to include:

- guidance on the inclusion in TAP meetings of the adult, their carer or people important to them
- guidance on the inclusion of health professionals within the TAP, particularly for those where there are concerns regarding ABI or cognitive decline associated with long-term substance misuse/ alcohol dependency;
- guidance on when it would be appropriate for partner agencies to request (and share with the TAP) medical or legal expertise in respect of an adult's capacity to make decisions especially if this is regarding care, treatment or residence;
- an escalation process to the SAM Steering Board that requires the swift involvement of a multiagency senior leaders (and budget holders) in resolving disputes or reviewing entrenched cases;

[44] https://www.england.nhs.uk/mental-health/adults/iapt/integrating-mental-health-therapy-into-primary-care/

- how the SSAB and SAM Steering Board will report emerging themes or safeguarding issues to the Health and Wellbeing Board, including issues arising from lack of resource, disputes or complaints and how the SSAB and Steering Board will disseminate key learning or system improvements back to frontline staff.

Recommendation 2: The SSAB firstly seek assurance that relevant partners have delivered training or developing materials alongside relevant partners in line with the LGA's briefing on best practice for safeguarding and homelessness and Alcohol Change UK's briefing on legal powers so that misapprehensions regarding legal duties and powers are understood and applied correctly in Surrey. More importantly, SSAB should seek assurance that the impact of this has been tested, e.g. through audit activity to ensure improvements in legal literacy can be evidenced specifically in the context of addiction, how it impacts on capacity and statutory duties, including the duty to promote wellbeing [s1 Care Act], assess needs and that this is an enduring duty [s9 and 11(2) Care Act 2014] and the separate obligations that flow from eligibility [s13 Care Act].

Recommendation 3: SSAB work with partners from prison, probation and prison-based health providers to develop protocols for the sharing of information and referral pathways. This should include specific requirements to work with any members of a TAP, including third sector staff because they are working with/ on behalf of the local authority to provide support to those with complex care needs. It should also specify what information should be passed to prisons to assist in the early identification of offenders with care and support needs and facilitate early engagement with both SCC's Prison Social Care team and locality adult social care teams.

Recommendation 4: SSAB should prioritise, in collaboration with their liaison group and national leads, how best to ensure that prison and community-based services have robust information sharing and discharge processes so information about an offender's health is promptly transferred, both at the start of their detention (from community to prison) and on their release (from prison to community). Presently, because GP services for prisoners sit outside NHS primary care contract and there is no mechanism for prisoners to register for community GPs until after release, it is difficult to ensure continuity of healthcare. SSAB should consider raising this issue via the National SAB chairs' escalation processes to the Ministry of Justice and Department for Health and Social Care to resolve.

Recommendation 5: SSAB should seek assurance that partner agencies have trained their staff, including those who will be involved in any TAP, commissioning and brokerage staff on the expectations regarding continuity of care. Partner agencies should also demonstrate that training has resulted in an improvement in practice, particularly in the identification of the relevant legal framework under which the accommodation-based care is to be delivered and that TAP care plans articulate clearly who is accountable for key actions and within what timeframe.

Recommendation 6: Health, public health and social care commissioners should review data and thematic reports from the SAM to explore the gaps in mental health support available for those at high risk due to addiction. They should report to the SSAB if an early intervention model, aligned to the Make Every Adult Matter and SAM approach, could work with a TAP to provide therapy and monitoring of a person's mental health to reduce the risks associated with experiences of multiple exclusion homelessness and dependency.

Recommendation 7: The SSAB should also seek assurance from SCC and the ICB that services commissioned to provide specialist mental health and addiction support are available to provide advice to SAM and any TAP, that the role of the Health Integrated Care Team is promoted more widely across partner agencies and agencies are committed to commissioning sufficient local accommodation-based support in line with the strategic need in the area, facilitating access for those who would be eligible under health or social care legislation, including the preventative duties.

6. Glossary

ABI	Acquired Brain Injury
ACS	Adult Social Care
ADASS	Association of Directors of Adult Social Services
AMHP	Approved Mental Health Professional
CHaRMM	Community Harm and Risk Management Meetings
CMHT	Community Mental Health Team
CJLDS	Criminal Justice Liaison and Diversion Service
DWP	Department for Work and Pensions
ECHR	European Convention on Human Rights
GDPR	General Data Protection Regulation
ICB	Integrated Care Board (replacing the Clinical Commissioning Group)
NICE	National Institute for Health and Care Excellence
MAPPA	Multi-agency public protection arrangements
PLS	Psychiatric Liaison Services
SAR	Safeguarding Adult Review
SHBC	Surrey Health Borough Council
SAB	Safeguarding Adults Board
SAM	Surrey Adults Matter
SCC	Surrey County Council
TAP	Team Around the Person

Appendix A: List of documents reviewed

Item	Description	Dated
1	NOMS Care assessment policy	2016 and 2021
2	Coroner Bundle- PM and medical	
3	Police and accident investigation reports of incident	various
4	Surrey and Borders Partnership NHS Trust Serious Incident Review	15.02.21
5	Psychiatric report	27.12.19
6	The Hope Hub Report to the Coroner and chronology/ communication log	20.05.22
7	NPS letter setting out their concerns regarding his care and support needs/ vulnerabilities	12.07.18
8	Acceptable Behaviour Contract between Peter and Surrey Partnership	21.01.19

9	Capacity Assessments in relation to: • Managing a tenancy (ASC- found lacked capacity) • Decide care and support needs (AMHP- found had capacity) • Engage in offending behaviour (ASC- found had capacity) • Decide care and support needs (ASC- found had capacity) • Manage financial affairs (ASC- found capacious but unwise decisions) • Managing a tenancy (ASC- found had capacity)	 22.09.20 21.12.20 08.01.21 12.03.21 (c.) 27.04.21 08.06.21
10	NOMS Care Act assessment (completed whilst 'Peter' in MHP Highdown)	14.11.19
11	Surrey Adult Matters referral form (Peter accepted onto programme from 23.03.20)	13.02.20
12	Active Residential Services incident form re Peter missing	11.04.20
13	TAP minutes (monthly meetings between SAM chair (JS), NPS(PM) , ASC(EH), The Hope hub(CS), Surrey Heath BC housing (CJ) detailing multi-agency action plan to address Peter's needs and seek to mitigate safeguarding risks	05.05.20, 26.05.20 24.06.20,04.08.20, 03.09.20, 11.09.20, 27.10.20, 17.11.20, 05.02.21, 03.03.21, 07.04.21, 30.06.21, 14.09.21, 12.10.21.
14	Needs assessment and eligibility decision by Surrey Adult Social care	26.06.20
15	Peter's personal housing plan	17.07.20
16	Risk assessment plan	24.12.20
17	Needs assessment and eligibility decision by Surrey Adult Social care	06.01.21
18	Emailed police report raising concerns that Peter was being exploited and his home (in London Rd) was cuckooed for county lines in January 2019.	13.01.21
19	Copies of email correspondence between Surrey Heath localities team, Surrey Health integrated care team, The Hope Hub, Surrey CC (Public health) and housing service manager to discuss, then escalate decision making regarding suitability and funding of accommodation options for Peter, including during the 'everyone in' policy timeframe during the review period.	Various
20	Surrey Adult Matters case notes (51 pages)	15.04.20- 19.10.21
21	Notes from meeting with The Hope Hub and Peter	07.05.21
22	'Minded' decision by Housing Solutions re intentionally homeless	07.06.21
23	Common Referral for supported accommodation	02.07-15.07.21
24	Chronologies completed by: 1. HMP Highdown 2. Forward trust	
25	Summary of Involvement completed by:	
	1. Adult Social Care 2. Surrey Adult Matters 3. SABP 4. St Heliers and Epsom NHS Trust 5. Frimley Health NHS Trust 6. Probation Service	