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**Safeguarding Adults Review (SAR)**

**Subject: John (Adult N)**

**Final Overview Report**

**SAR Independent Author: Richard Proctor**

*This Safeguarding Adults Review would not have been possible to undertake without the co-operation and information supplied by those agencies who provided care and support for John. This contributed significantly to the production of the final report and helped to identify recommendations for improvement.*

*This report reflects the combined views of the SAR Panel who have invested their time, commitment, and expertise throughout this process. The input and professional support provided by the Nottinghamshire Safeguarding Adults Board Manager and Safeguarding Adults officer was invaluable throughout this process.*

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1. **Introduction**

**1.1 Statutory Framework**

Section 44 of The Care Act 2014 states that the Safeguarding Adults Board must arrange for there to be a review of a case involving.

a) an adult in its area with care and support needs (whether the local authority was meeting any of those needs)

b) if there is reasonable concern about how the Board, or members of it or other persons with relevant functions worked together to safeguard the adult and

c) the Safeguarding Adults Board knows or suspects the adult has experienced serious abuse or neglect and there is concern how the partner agencies have worked together to protect the individual.

The decision to undertake a Safeguarding Adult Review (SAR) in relation to this case was made by the Independent Chair of the Nottinghamshire Safeguarding Adults Board on the 20th July 2022, whom after considering the circumstances of the case was satisfied that the criteria to undertake such a review was met.

The timeline period for the review to consider was identified as the 10th April 2021 to the 11th October 2021.

**2. Service Involvement**

The review was informed by information provided by the following agencies.

* Bassetlaw District Council (BDC)
* Framework Street Outreach Team (SOT)
* Nottinghamshire Healthcare NHS Trust (NHNT)
* Nottinghamshire Police (NP)
* Change Grow Live (CGL)
* Doncaster and Bassetlaw Teaching Hospitals Teaching Trust (DBTH)
* NHS Nottingham and Nottinghamshire Integrated Care Board (ICB)
* East Midlands Ambulance Service (EMAS)
* Hope Community Services

**3. Pen Picture of John.**

John had many challenges in his life with regards to his mental health and was reportedly addicted to alcohol. He was found on occasions “rough sleeping” and experienced periods of homelessness.

Despite several attempts to engage with members of John’s family so as to enable the Independent Reviewer and Author to gain a greater understanding of John as a person, it could not be achieved. The following personal description of John is one provided from the perspective of a practitioner who supported him during the time period of this SAR.

***“John reported being alcohol dependant since the age of 15 years something he described as normal in his family life. John had been homeless for the majority of his life but dreamed of having his own home one day.***

***He was passionate about many subjects including football and had a love for gardening and aspired eventually to work as a gardener.***

***John reported being a father and would describe how proud he was of his children. This unfortunately on occasions was associated with personal regret, where he felt he had let his children down.***

***He was a lovable rogue with an infectious laugh with the capacity to enjoy a joke.***

***He struggled with managing his finances and whenever he returned to the streets, he appeared to be more vulnerable than other rough sleepers and was assaulted on several occasions.”***

**4. Summary of significant events**

**4.1** On the 10th April 2021 John attended an appointment with his General Practitioner (GP). John explained he had recently returned to the area after spending time away. He explained to the GP that he recently suffered a relapse in relation to the use of alcohol but felt to be now in a stable position. He was referred by the GP to the local drug and alcohol support and advice service Change Grow Live (CGL). The GP prescribed Pregabalin medication for John’s condition of Epilepsy.

[Pregabalin: medicine to treat epilepsy and anxiety - NHS (www.nhs.uk)](https://www.nhs.uk/medicines/pregabalin/)

**4.2** On the 7th May 2021 CGL received John’s referral. CGL were unsuccessful in contacting John when there was no response after calling him by telephone.

**4.3** On the17th May 2021John became a resident at the Hope Community Services Hostel. Hope Community Services are a homelessness charity and are regulated by the Charity Commission. The overview of the charity provided to the Charity Commission includes its activities as supporting individuals who are or in danger of becoming homeless by providing accessible emergency accommodation and “move on” supported accommodation.

In accordance with the hostels operating procedures John was subject to a risk assessment completed by the hostel staff. The risk assessment assessed 13 different risk issue areas. John scored as medium risk in relation to substance misuse, suicide, and mental health. The other 10 assessed issues which included tenancy, John scored as low risk.

A support action plan was also completed by hostel staff which sought to address support for John in relation to the issues of housing, physical and mental health, employment, and substance misuse.

Upon admission to the hostel John was requested to adhere to the Hope Community Services Acceptable Behaviour Contract. This detailed many conditions of his residence at the premises including a condition not to bring alcohol or illegal substances onto the premises. John duly read and signed this contract.

**4.4** On the18th May 2021 John returned to the hostel where he was found concealing a bottle of cider in his jacket. The cider was confiscated, and he received a warning from the hostel staff regarding his behaviour.

**4.5** On the 20th May 2021 John following his move to the hostel registered with the local GP practice. John was not seen by the GP but was prescribed the following medication in relation to his current health issues. Pregabalin for Epilepsy, Sertraline for Depression, Thiamine and Vitamin B in support of his Alcohol Abuse.

[Sertraline: an antidepressant medicine - NHS (www.nhs.uk)](https://www.nhs.uk/medicines/sertraline/)

[Thiamine: a medicine for vitamin B1 (or thiamine) deficiency - NHS (www.nhs.uk)](https://www.nhs.uk/medicines/thiamine-vitamin-b1/)

**4.6** On the25th May 2021 John informed hostel staff that he was struggling with alcohol issues and was advised to call CGL to arrange an appointment.

**4.7** On the 27th May 2021 John informed his hostel key worker that he had missed an appointment with CGL and wished to stop drinking alcohol. He reported to be struggling with past trauma issues but refused to elaborate any further as to what these issues were. John agreed to work with CGL in relation to his substance misuse issues and was informed should he require counselling he should inform the hostel staff of his willingness to do so.

**4.8** On the 2nd June 2021 following the discovery of alcohol and used alcohol cans in John’s room he received a warning from the hostel staff regarding his behaviour. The hostel operates a three-warning policy which if residents do not adhere to, places their continued residence at risk.

**4.9** On the 7th June 2021 John had a meeting with his hostel key worker. The key worker set goals for John to complete a housing application form and to arrange an appointment with his GP so he may be referred for support from a Community Psychiatric Nurse.

**4.10** On the 15th June 2021 John attended CGL and undertook a comprehensive assessment, which after completion he reported wanting to become alcohol free. A severity of alcohol dependency test was completed. John’s score of 46 suggested he had severe alcohol dependency. A plan was made to arrange a nurse led alcohol assessment.

[How to screen | Diagnosis | Alcohol - problem drinking | CKS | NICE](https://cks.nice.org.uk/topics/alcohol-problem-drinking/diagnosis/how-to-screen/)

**4.11** On the 19th June 2021 John arrived back at the hostel after 9pm. This resulted in John being refused entry to the hostel. The hostel rules dictate that residents have to return to the hostel before 9pm or risk being refused accommodation. John returned to the hostel the following day and resumed his stay at the premises.

**4.12** On the 24th June 2021 CGL made telephone contact with John. John reported having no reduction in his alcohol use. Despite numerous appointment reminders sent by CGL following this contact, John failed to attend a pre-planned nurse led alcohol assessment.

**4.13** Onthe morning of the 6th July 2021 John was found rough sleeping in a shop doorway by a Framework Street Outreach (SOT) worker. SOT work to support homeless people “sleeping rough” and work in partnership with agencies such as the police and health to monitor and respond to people in crisis. John reported to the worker not staying at the hostel the previous night, as he had been helping a homeless person and had missed his curfew at the hostel. He informed the worker that he could return to the hostel that morning. The worker provided John with a card detailing how to access support from SOT should it be required.

John returned to the hostel where he participated in a focus group. During the session he became irate and was asked to leave the session. Later owing to his behaviour he was asked to leave the hostel with another resident.

Shortly after leaving the hostel John was arrested by Nottinghamshire Police (NP), for assault. This following an incident in a nearby car park. Enquiries identified that John and the assault victim were both under the influence of alcohol at the time of the incident. Following John’s arrest, he fully admitted the offence and as a result received a police caution sanction, following the victim declining to register a complaint. As a result of John being under the influence of alcohol at the time of the offence, he was referred by NP to the Nottinghamshire Healthcare NHS Trust Liaison and Diversion Team, which is a service that operates in NP custody suites. This team aim to identify a person’s vulnerabilities at the earliest point of the criminal justice system and share relevant information with the justice agencies. Where appropriate they refer people into relevant services, supporting them through the referral process. John reported to the Liaison and Diversion Team that he had a mental health illness, that he was an alcoholic and was currently homeless. John reported recognising a need to manage his alcohol addiction and a requirement to engage with his CGL worker. In response the Liaison and Diversion Team provided John with information regarding how to contact mental health crisis and accessing housing support.

**4.14** On the 7th July 2021 John returned to the hostel and was assessed by staff back into the service. It was explained by staff that if he ever he found himself in a similar situation that had led to his arrest the previous day, he should avoid any confrontation and not to take matters into his own hands.

**4.15** On the 9th July 2021 earlier that day John arrived back at the hostel apparently under the influence of alcohol and was observed by hostel staff to be stumbling around his room. Staff asked him to leave the premises and return at 9pm so he could be reassessed. This he duly did and was permitted back into the premises.

**4.16** On the 10th July 2021 following the discovery by hostel staff of John’s roommate bringing alcohol into the hostel, John became involved in a verbal altercation with staff and displayed verbal aggression towards them. Consequently, staff asked John to leave the hostel until the 12th July 2021 owing to his continued breaches of hostel policy. There is no information provided to inform the SAR that identifies where John slept following this exclusion from the hostel.

**4.17** On the 12th July 2021 John returned to the hostel and no further issues of concern were identified for a period of time with John engaging well at the hostel with his key worker sessions.

**4.18** On the 22nd July 2021 John attended a face-to-face appointment with his CGL recovery coordinator. John disclosed consuming approximately 60 units of alcohol on a daily basis. John discussed with the coordinator potential alcohol detoxification options and was advised to commence recording his alcohol consumption in a diary and reduce his alcohol intake. Despite the request by the CGL recovery coordinator for John to provide records of his alcohol consumption, these were not provided.

**4.19** On the 26th July 2021 John attended CGL where he undertook blood born virus screening. The CGL recovery coordinator discussed with John the prospect of attending alcohol workshops and he expressed an interest in attending.

[Hepatitis signs, treatment and staying safe | Change Grow Live](https://www.changegrowlive.org/advice-info/find-advice-info/health-and-wellbeing/hepatitis)

**4.20** On the 28th July 2021 John failed to attend his prearranged appointment with his CGL recovery coordinator. The CGL recovery coordinator made several attempts to contact John by telephone over the next following days but was unable to establish contact.

**4.21** On the 4th August 2021 the CGL recovery coordinator contacted the hostel and spoke with a member of staff. The hostel staff member reported that John had reduced his alcohol intake but that it was suspected had started using Synthetic Cannabinoids often referred to as “Black Mamba or Spice.” The CGL recovery coordinator requested they inform John of their availability for a face-to-face appointment the following day, but John failed to attend.

[Drug licensing factsheet: cannabis, CBD and other cannabinoids - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/cannabis-cbd-and-other-cannabinoids-drug-licensing-factsheet/drug-licensing-factsheet-cannabis-cbd-and-other-cannabinoids)

**4.22** On the 11th August 2021 John attended a face-to-face appointment at CGL and an alcohol screening test was undertaken, where it was apparent John was under the influence of alcohol. The alcohol screening test utilising a breathalyser machine demonstrated that at that time John had 131 microgrammes of alcohol per 100 millilitres of his breath. John reported having consumed approximately 30 units of alcohol that morning prior to his appointment. The recovery coordinator advised John should try to reduce his alcohol intake and complete a consumption diary, so CGL may explore detoxification options.

**4.23** On the18th August 2021 John attended a face-to-face appointment with the CGL nurse, to complete an alcohol assessment. John reported having no suicidal ideation or previous episodes of self-harm. John expressed a desire to explore an inpatient alcohol detoxification programme and was advised he would require having blood tests undertaken by his GP. Consequently, CGL contacted John’s GP by letter requesting the blood tests to be taken from John.

**4.24** On the 24th August 2021 EMAS and NP were called to attend a “move on” property owned and managed by the hostel provider. It was reported that John and another male had overdosed after suspectedly taking unknown substances. John was conveyed by EMAS to the Doncaster and Bassetlaw Hospital (DBTH) emergency department and was observed by hospital staff to be initially unresponsive. It was recorded by DBTH that John may have injected heroin, cocaine, and consumed alcohol. The drug Naloxone was administered which is a drug often used to rapidly reverse an opioid overdose. John regained consciousness and once his treatment was completed, he was subsequently discharged from the hospital. Following his discharge from hospital the hostel would not permit John to access the hostel until the following day, owing to their assessment of the seriousness of the incident that had occurred.

[What We Do - Hope Community Service (hopeservices.org.uk)](https://hopeservices.org.uk/what-we-do/)

[Naloxone hydrochloride | Drugs | BNF | NICE](https://bnf.nice.org.uk/drugs/naloxone-hydrochloride/)

**4.25** On the 25th August 2021 John returned to the hostel and was found by hostel staff to be heavily under the influence of alcohol. This breached his tenancy agreement with the hostel, and he was refused access to the accommodation. He was asked to return the following day so he may be reassessed. Additionally on this date CGL contacted the hostel and requested they inform John of the date of his next face to face appointment. The hostel staff shared information with CGL regarding the events of John’s suspected overdose as detailed at **4.24*.***

**4.26** On the 26th August 2021 John returned to the hostel and was reassessed back into the service. He was advised his behaviour was unacceptable and would not be tolerated.

**4.27** On the 27th August 2021 following unsuccessful attempts made by the GP to contact John via the hostel to enable a medication review to be undertaken, John’s medications were reduced to weekly prescriptions.

**4.28** On the 1st September 2021 John failed to attend a face-to-face appointment with the CGL recovery coordinator.

**4.29** On the 8th September 2021 John attended a face-to-face appointment with the CGL recovery coordinator.TheCGL recovery coordinator undertook a risk review with John who reported his recent overdose as detailed at **4.24** was accidental after using another person’s needle to inject himself with the drug Heroin. The issue of harm reduction was discussed with John, and it was suggested by the CGL recovery coordinator John should undertake a blood born virus test. John reported to be consuming daily between 22 and 67 units of alcohol subject to whatever finance he had available. He also reported continuing to use Synthetic Cannabinoids. The CGL recovery coordinator discussed alcohol reduction with John and requested he complete an alcohol diary.

Additionally on this date following unsuccessful attempts to contact John, the GP suspended the prescribing of all his medications.

**4.30** On the 14th September 2021 owing to John’s behaviour at the hostel John was evicted from the hostel premises. This owing to a culmination of issues including the incident as detailed at **4.24,** being abusive to staff, having a female guest in his room and suspicions that he was using “black mamba” a synthetic cannabinoid.

**4.31** On the 15thSeptember 2021 John failed to attend a face-to-face pre-arranged appointment with the CGL recovery coordinator. The recovery coordinator contacted the hostel who informed them that John had been evicted as he had failed to keep up with his rent payments. Later this date John arrived at the CGL premises and was seen by the CGL recovery coordinator. John informed the coordinator that he was now sleeping rough and was consuming approximately 60 units of alcohol per day. A subsequent face to face meeting was arranged to take place on the 21st September 2021. The coordinator advised they would arrange a referral for him to the local food bank.

**4.32** On the16th September 2021 East Midlands Ambulance Service (EMAS) received a 999-emergency call regarding a report that John was unconscious with blue lips and was lying against the wall of a shop after taking the drug Heroin. The call was categorised as a Priority 1 (most urgent) and EMAS arrived within three minutes of the call. The ambulance crew in attendance were informed John had taken an injection of the drug heroin together with three friends and had fallen unconscious. One of these friends had consequently injected John with Naloxone. The ambulance crew provided John with oxygen where he regained consciousness and was able to provide his details to the ambulance staff. Medical observations were taken by the ambulance staff and an Electrocardiogram (ECG) identified no specific concerns at that time. The ambulance staff advised John to attend hospital, but he refused. The ambulance staff undertook a Mental Capacity assessment and deemed that as John was able to retain the information, weigh up the risks and communicate his decision, he was deemed to have mental capacity regarding his care and treatment. One of John’s friends agreed they would care for him, and John was advised by the ambulance staff that should his condition worsen, he should call 999 once more. No safeguarding referral was raised by EMAS, and no information was shared with John’s GP as EMAS were unable to find John’s patient details on the Personal Demographics Service NHS electronic database.

[Mental Capacity Act Code of Practice - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice)

**4.33** On the21st September 2021 John failed to attend his prearranged face to face appointment with the CGL recovery coordinator.

**4.34** On the 22nd September 2021 John made an unscheduled attendance at the CGL offices and was seen by the CGL recovery coordinator. John was apparently under the influence of alcohol at that time. He was advised by the coordinator to visit the local authority, so he may complete an accommodation application, owing to being homeless.

**4.35** On the 23rd September 2021 John presented as a homeless person at the Bassetlaw District Council offices. It was recorded that John was under the influence of alcohol at the time. A telephone triage assessment was undertaken where John reported having previously resided at the hostel and had been asked to leave owing to non-payment of his service charges. He explained that he was now “sleeping rough”in the town centre doorways and that residing at the hostel had affected his mental health.

**4.36** On the 24th September 2021 John was discovered by an SOT worker “sleeping rough” on the street. John discussed with the worker his previous stay at the hostel and wanting to stay somewhere that could provide more support for him. He reported working with CGL and was advised to contact them so he may be referred to a local independent housing association, who specialise in shared housing for single people. The worker advised John, they would provide him with a mobile telephone, to enable SOT to contact him if he required support.

**4.37** On the 28th September 2021 John made an unscheduled visit to CGL where he reported to the recovery coordinator witnessing an assault during the night and after intervening being assaulted himself. Despite the coordinator suggesting to John, he should seek some medical attention he declined. John during the visit reported still misusing Synthetic Cannabinoidsthough had reduced his daily unit intake of alcohol. In an attempt to aid John with his housing needs the coordinator contacted a local housing project to explore potential accommodation options.

Additionally on this date the officer from Bassetlaw District Council dealing with John’s homelessness issues contacted his mother who explained she was unable to accommodate him owing to a lack of capacity in her home. The officer additionally contacted the hostel provider who explained that John may return if he paid his outstanding service fees. In an attempt to locate John, the housing officer contacted SOT and asked if they could assist in locating John, so they may contact him. No contact was established and consequently on the 30th September 2021 John’s case was closed by Bassetlaw District Council.

**4.38** On the 5th October 2021 John was located by an SOT worker “sleeping rough” in a shop doorway. It was recorded by the worker that John was shivering and wet from the previous night. The worker provided John with a new sleeping bag and some food. John reported having contacted the council in relation to his accommodation issues and the worker arranged to meet him the following day to provide him with a mobile telephone and complete referral paperwork for a local housing provider.

**4.39** On the 6th October 2021 the SOT worker met with John as arranged where they provided him with a mobile telephone. Together they completed the referral paperwork for the local housing provider, which the SOT worker forwarded by email to the provider.

Additionally on this date SOT contacted CGL to inform them that John would be unable to attend his next face to face appointment as he had a housing application appointment.

**4.40** On the 7th October 2021 the SOT worker attempted to contact John by telephone to attend an appointment at the local housing provider so he may be assessed for suitability, but SOT were unable to contact him.

**4.41** On the 8th October 2021 John was located by the SOT worker who arranged for a taxi to transport him to the local housing provider. Following his attendance, it was agreed following an assessment that John would be able to stay at the accommodation once he had been paid his benefits which could be used to pay for the cost of his residence. It was reported that John was happy with this decision. Prior to leaving him the SOT worker purchased warm food for John and informed him they would contact him the following week.

**4.42** On the 9th October 2021 John was found collapsed and unresponsive in the local bus station, after apparently consuming synthetic cannabinoids. John had suffered a cardiac arrest and was conveyed by ambulance to the local acute hospital. Despite interventions provided at the scene and further treatment provided at the hospital John did not regain consciousness and died on the 11th October 2021 after sustaining irreversible brain damage as a result of a cardiac arrest. A subsequent coroner investigation following his death concluded that John’s death was drug related.

**5. Methodology**

SAR methodology is non- prescriptive within the Care Act with the overall aims that the review is conducted wherever possible in a timely and proportionate manner.

The chosen methodology to undertake this SAR was a blended approach of action learning with a more in-depth analysis of agency involvement. This option is characterised by reflective/action learning approaches, which does not seek to apportion blame, but identify both areas of good practice and those for improvement.

This is achieved via close collaborative partnership working, including those practitioners involved at the time, as well as key family members.

The process undertaken was as follows.

**5.1 Panel Membership**

A Safeguarding Adult Review (SAR) panel was established consisting of senior managers from lead agencies with no previous involvement in the case to support the progression of the SAR. These individuals were identified to have authority to effect change in their own agency and have the appropriate level of professional knowledge to support the SAR.

Nottinghamshire Safeguarding Adults Board have commissioned the Independent Reviewer and Author of the SAR to produce an independent report. This individual was not involved in the delivery of identified services; line management for any service or any individual mentioned within the report. They are a former senior police officer experienced in undertaking SARs on a national basis.

The author and panel agreed terms of reference as detailed below to guide and direct the review. They undertook responsibility to look openly and critically at individual and agency practice; to identify whether this SAR indicates changes could and should be made to practice and if so, how these changes will be brought about.

In this case, agencies involved in supporting John produced chronologies in relation to the agreed timeline, which were shared with the independent reviewer and author. Following receipt of this information and analysis of the content, the Author requested agencies complete a Single Agency Reflection Template containing eleven pertinent questions for agencies to answer in relation to the case. (See Appendix 1.)

**5.2 Terms of Reference**

The purpose of the review is to consider:

* How effectively did agencies work to safeguard the individual in light of the known risks, and was there evidence to suggest that agencies shared a common understanding of risk?
* Did his eviction result in appropriate action being taken to safeguard John and did concerns leading up to the individual’s death receive an appropriate and effective response from agencies?
* Was there effective co-ordination of the individual’s care and support needs throughout the scoping period?
* Were there policies and procedures in place to support practitioners, if so, was there due regard to these? Were they effective and is there a need for any review or amendment?
* Were there areas of good practice?

**5.3 Family Involvement**

It was identified as a priority for the panel to allow family members to have a voice in helping to shape and inform this review. However, multiple attempts made to engage with family members proved unsuccessful.

**5.4 Action Learning Event.**

This event took place on the 19th July 2023 involving multi-agency staff from several agencies involved in providing care and support for John. The agencies in attendance were CGL, SOT, Bassetlaw District Council Housing, ICB, Hope Community Services and Ashfield District Council Rough Sleeper Coordinator. Also in attendance were staff from Nottinghamshire Safeguarding Adults Board (NSAB)

The key objectives of the event were established as,

* To consider what worked well?
* What could we have done better?
* What are our recommendations for improvement?

The event was focussed on what were considered the significant events that featured during the timeline of the SAR.

**5.4.1 The first area of focus featured upon the eviction event.**

It was identified by participants that Hope had undertaken a risk assessment when John was accepted as a resident at the hostel. Hope owing to changes in personnel felt unable to comment on multi-agency involvement at the time the assessment was completed. However, they identified since this case they have taken action to improve the quality of information they receive to inform the risk assessment by seeking information from agencies involved in providing support to the person including Bassetlaw District Council and Framework. Hope discussed the challenges they sometimes encounter in obtaining information from their clients, but in an attempt to overcome this allocate a support worker as in John’s case to build trust with the person with the aim they become more open and transparent regarding their care and support needs so appropriate referrals can be made for support from other agencies. NSAB proposed that the board undertake a multi-agency audit to consider the current risk assessment process undertaken by Hope so they may consider multi-agency working and information sharing.

The lack of local specialist supported accommodation for homeless people with alcohol and substance misuse issues was discussed and the housing representative identified that they receive many referrals for accommodation from people with multiple complex needs but that there is a lack of accommodation where “wrap around” support can be provided to manage their multiple needs.

**What worked well?**

It was identified that Bassetlaw District Council housing did manage to secure an agreement for John to return to the hostel, but it did not happen as John could not be contacted. It was identified that the Rough Sleepers Panel is a forum where cases such as John’s may be brought so as to identify what support the individual needs and which agency will have responsibility to lead the work.

**What could we have done better?**

It was identified when it became apparent John was to be evicted, communication could have been improved through notifications being made to agencies already supporting him through establishing agency single points of contact. It was felt a pre-eviction protocol should be established and it was agreed that the Rough Sleeper Coordinator would work with Hope to develop such a protocol. Following this event such a protocol has now been developed and the Rough Sleeper Coordinator is working closely with the Local Authority and non-commissioned accommodation providers to promote and expand the use of the protocol across all housing benefit exempt providers in the Bassetlaw District Council area.

Framework reported having a fund known as a “Personal Budget” available to them which could have been used to support John in securing him accommodation. However, SOT identified this budget was limited, and due to high demand could not always be used for everyone but was an option that was not explored.

**What are our recommendations for improvement?**

**Recommendation 1.**

**The Rough Sleeper Coordinator should promote the establishment of the pre-eviction protocol to all housing exempt accommodation providers to ensure they understand the process, embed it in practice and ensure that relevant agencies are notified of the residents planned eviction, instigating referrals to the Rough Sleeper Action Group and Vulnerable Persons Panel meetings.**

**Recommendation 2.**

**Nottinghamshire Safeguarding Adults Board SAB should work with housing exempt accommodation providers, to audit their risk assessment process with the aim of promoting multi-agency working, and information sharing, that result in the establishment of support plans that mitigate or manage the risks posed to the individual.**

**Recommendation 3.**

**Framework Street Outreach should raise awareness within its organisation of the availability of the “Personal Budget” and how workers may access it, to support homeless individuals with accommodation needs.**

**5.4.2 The second area of focus featured upon the response to the eviction event.**

The issue of Bassetlaw District Council Housing being unable to contact John following eviction was discussed. Housing reported that whilst they will attempt to establish contact through working with other agencies, owing to the demands on their services makes this challenging.

The issue of John disengaging with his GP resulting in his prescription allocation being suspended was also highlighted as another example of John disengaging with services.

It was noted that no Safeguarding Concerns were ever raised and whether his case would have even met the criteria for a Care Act Section 42 enquiry to be undertaken. It was identified Nottinghamshire Safeguarding Adults Board have an established “Safeguarding Adults at Risk Referral Pathway” which does not replace the guidance of when to raise a Safeguarding Concern as per the Care Act 2014 but provides referral pathways for practitioners to consider utilising in response to concerns for the safety and welfare of individuals in a range of different scenarios. It does not however currently include referral pathways for homelessness or rough sleeping.

[Nottinghamshire Safeguarding Adults Board](https://nsab.nottinghamshire.gov.uk/media/rgsl2rln/referralpathwaysguidanceadultsatrisk.pdf)

It was identified that in some areas of England, local authorities have designated resources to coordinate activity and provide support to individuals living in similar circumstance to John by creating a “Team around the Adult.” It was confirmed by attendees that no such arrangement existed in Nottinghamshire but that the “Making Every Adult Matter” approach has been adopted locally. This approach aims to help local areas design and deliver better coordinated services for people experiencing multiple disadvantages.

[Home - MEAM](http://meam.org.uk/)

It was recognised that in cases such as this one the value of early multiagency meetings being held to share information and assess risk could not be understated.

The issue of the assessment of mental capacity undertaken by EMAS following John suffering a suspected overdose was raised and the conclusion drawn of John being deemed to have mental capacity was queried and whether Johns executive function may have been impaired at that time. Executive function is an umbrella term used to describe a set of mental skills that are controlled by the frontal lobes of the brain which can be affected by alcohol and drug misuse. Whilst Nottinghamshire Safeguarding Adults Board have several established practitioner toolkits and guidance in relation to the application of the Mental Capacity Act 2005, it was identified it does not have guidance for practitioners regarding the identification and response to individuals who may lack executive functioning.

[Recommendations | Decision-making and mental capacity | Guidance | NICE](https://www.nice.org.uk/guidance/ng108/chapter/recommendations#executive-dysfunction)

**What worked well?**

It was considered that the support provided by SOT in providing John with a mobile phone and arranging transport to appointments was good practice. The multiagency working that occurred between CGL, Bassetlaw District Council and FOS in attempting to secure John accommodation was identified as good practice.

**What could we have done better?**

It was identified there was an occasion where John could not access the hostel owing to a curfew being in existence at the hostel. It was highlighted by Hope that whilst such a curfew does exist if there were reasonable explanations as to why a resident was late returning to the hostel for example if they had been receiving treatment at hospital then they would be allowed back into the premises. It was considered that curfews may be difficult for some individuals to conform with owing to the complex issues they often faced.

**What are our recommendations for improvement?**

**Recommendation 4.**

**Nottinghamshire Safeguarding Adults Board should update its “Safeguarding Adults at Risk” Referral Pathway to include Referral Pathways to advise practitioners how to respond to Homelessness and Rough Sleeping and work with Nottinghamshire Adult Social Care to ensure future guidance they produce reflects the same referral pathways.**

**Recommendation 5.**

**Nottinghamshire Safeguarding Adults Board should seek assurance from its statutory partner agencies that their existing Mental Capacity Act training incorporates reference to the consideration of executive impairment and that Nottinghamshire Safeguarding Adults Board produces a 7-minute briefing on executive impairment and promoted to partners through its communication strategy.**

**5.5 Documentary Review**

* Relevant agencies provided chronologies of service involvement within the identified timeline.
* The chronologies were used to create a multi-agency chronology.
* Single Agency Reflection/Learning Template.
* The Care Act 2014.
* Mental Capacity Act 2005.
* Equality Act 2010.
* Housing Act 1996.

**6. Analysis**

**6.1** **How effectively did agencies work to safeguard the individual in light of the known risks, and was there evidence to suggest that agencies shared a common understanding of risk?**

**6.1.1** As detailed at **4.3** when John took up residency at the hostel, a risk assessment was undertaken by hostel staff. Guidance provided by the hostel provider requires staff when completing risk assessments to discuss with the individual their involvement with other agencies and consider receiving completed risk assessments completed by other agencies. The risk assessment completed with John detailed several areas for consideration including substance misuse and tenancy issues. When the areas of consideration were assessed the risk of tenancy issues was scored as low and medium risk in relation to substance misuse.

The information used to inform the risk assessment was provided by John and in response a support plan was developed the SAR assumes to assist the hostel in mitigating or managing the risks identified in the risk assessment. In relation to the risk of tenancy, the risk assessment stated there was no reported history of concerns regarding tenancy. This was contrary to the information provided to inform the SAR that demonstrated that John had been homeless for periods of time throughout his life. It was recommended within the support plan that John should register with the local authority housing department the SAR assumes to enable John to apply for housing assistance as per Part 7 of the Housing Act 1996 together with engaging well at the hostel so he may be considered for one of their “move on” properties. The plan detailed that this action would be completed by John and the support worker.

In relation to substance misuse, it was identified in the support plan that John should attend his appointments with CGL, and this action completed by John and the CGL workers. There was nothing recorded as to who the single point of contact at CGL would be, or evidence subject to John’s consent of establishing other single agency points of contact, so should risks change or escalate, additional support for John could be considered. There was no evidence also of the risk assessment or support plan being reviewed in light of changing or escalating risks, for example the reported overdose event detailed at **4.24.**

The SAR identifies this as a missed opportunity for the hostel to arrange a multi-agency meeting, so specific agency points of contact could be established, and information being shared by agencies to inform the risk assessment and lead to the development of a multi-agency risk management plan. The Nottinghamshire Safeguarding Adults Board 2022-2025 details its intent to develop a Prevention strategy on four focus areas one of which is “Rough Sleeping”. The SAR identifies this as an opportunity for Nottinghamshire Safeguarding Adults Board to promote the value of holding multi-agency meetings when dealing with cases of Rough Sleeping and Homelessness so multi-agency information can be shared leading to the development of multi-agency risk management plans.

[nsabstrategicplan.pdf (nottinghamshire.gov.uk)](https://nsab.nottinghamshire.gov.uk/media/yrhpdupa/nsabstrategicplan.pdf)

**Recommendation 6.**

**Nottinghamshire Safeguarding Adults Board through the development of their prevention strategy should promote the value of holding multi-agency meetings to share information and develop multi-agency risk management plans to manage or mitigate the risks posed to Adults “Rough Sleeping and experiencing Homelessness.”**

**6.1.2** As detailed at **4.35** when John presented at the Bassetlaw District Council offices declaring himself as homeless, the housing worker contacted the hostel in an attempt to reduce the risks posed to him through being homeless. They discussed the option of the council paying John’s outstanding rent arrears with the hostel but as they were unable to contact John, this option was not pursued.

**6.1.3** Asdetailed at **4.32** EMAS attended a report of John being unconscious following a Heroin overdose event. EMAS provided treatment, and John regained consciousness. Following medical observations, the EMAS staff in attendance recommended that it would be in John’s best interests to attend hospital although John declined to do so. The EMAS staff assessed that John had the mental capacity to make the decision not to attend hospital in relation to his care and treatment. The issue of John’s executive function potentially being impaired at that time was considered by practitioners at the action learning event leading to the generation of actions detailed within **Recommendation 5.** NICE guidance also promotes the assessment of executive capacity. It recommends that assessment should include real world observation of a person’s functioning and decision-making ability, with a subsequent discussion to assess whether someone can use and weigh information and understand concerns about risks to their wellbeing.

In July 2022 EMAS established a new referral pathway with substance misuse services in Nottinghamshire to enable EMAS staff to raise a referral with substance misuse services to support the patient in relation to their illicit drug use. The establishment of such a referral pathway the SAR identifies as good practice.

**6.1.4** As detailed at **4.1** and **4.5** John was registered with two GP practices where John was prescribed medications though never seen face to face by a General Practitioner (GP) during the timeline of the SAR. Following reports of John overdosing as detailed at **4.24** the GP made attempts via the hostel provider to arrange a medication review in line with NICE guidance. NICE guidance recommends a structured medication review should take place for people who have long term conditions or who take multiple medicines with the aim of optimising the impact of medicines, minimising the number of medication related problems, and reducing waste. No contact could be made with John resulting in the medication review not taking place. Consequently, Johns prescribing regime was halted by the GP surgery. There is no evidence to indicate how John’s medication needs would be met following the halting of his prescribing regime.

The General Medical Council advise that medication should only be prescribed when a practitioner has adequate knowledge of the patient’s health and that they are satisfied that the medicines prescribed serve the patient’s needs.

[1 Recommendations | Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes | Guidance | NICE](https://www.nice.org.uk/guidance/ng5/chapter/1-Recommendations#medication-review)

[Good practice in prescribing and managing medicines and devices (gmc-uk.org)](https://www.gmc-uk.org/-/media/documents/prescribing-guidance-updated-english-20210405_pdf-85260533.pdf)

**6.1.5** As detailed at **4.13** following his arrest and subsequent detention in police custody NP identified that John may have substance misuse issues. In response John was referred to the Nottinghamshire Healthcare NHS Trust Liaison and Diversion Team, which is a service who operate in NP custody suites. This team aim to identify a person’s vulnerabilities at the earliest point of the criminal justice system and share relevant information with the justice agencies. Where appropriate they refer people into relevant services, supporting them through the referral process. John reported having mental health problems, being an alcoholic and being currently homeless. John acknowledged a requirement to manage his alcohol addiction and engage with his CGL worker. The Liaison and Diversion Team provided John with information regarding mental health crisis contact and access to housing. The provision of the Liaison and Diversion Team operating within NP custody suites the SAR identifies as good practice.

**6.1.6** As detailed at **4.24** following John’s suspected drug overdose and his attendance at the DBTH emergency department when questioned by medical staff at the hospital John denied regular drug misuse and subsequently consent for John to be referred to the local Drug and Liaison was not obtained.

**6.1.7** As detailed at **4.1** John was referred by the GP toCGL due to concerns regarding his alcohol use. As detailed at **4.10** John expressed a desire to be alcohol free and tests undertaken by CGL indicated he may have severe alcohol dependency. CGL established a plan with John to undertake a nurse led alcohol assessment. As detailed at **4.22** John undertook an alcohol screening test and disclosed consuming 30 units of alcohol that morning. The NHS recommend that to keep health risks low individuals should not consume more than 14 units of alcohol on a weekly basis and the risks of excessive alcohol consumption were identified by CGL. As detailed at **4.23** when John expressed a desire to explore an inpatient alcohol detoxification programme CGL wrote to his GP requesting blood tests to be taken, so this option may progress. Owing to John’s apparent disengagement with his GP practice, the blood samples were not taken and the option of exploring an alcohol detoxification programme did not progress further.

**6.1.8** The Care Act 2014 identifies an **“**Adult at Risk” as a person who has care and support needs, is experiencing or at risk of abuse or neglect and as a result of those care and support needs is unable to protect themselves from abuse or neglect or the risk of it. In Nottinghamshire the Multi Agency Adult Safeguarding Procedures identify that where concerns exist that an “Adult at Risk” has been abused or neglected, is being abused or neglected, or is at risk of being abused or neglected, then with the consent of the individual a safeguarding concern should be raised to the local authority who under Section 42 of the Care Act 2014 would undertake whatever enquiries were necessary to safeguard the individual. The SAR has established that no safeguarding concerns relating to John were ever raised to the local authority. The SAR assumes this owing to the issues he presented with when considered by agencies did not meet the criteria for such an enquiry to be undertaken. Whilst the SAR does not seek to challenge the decision of agencies not raising a safeguarding concern, the SAR has identified an apparent absence of multiagency working and information sharing taking place in this case which if had occurred may have assisted in managing the risks posed to John, owing to the complex issues he presented with.

The SAR has been informed whilst not in existence at the time of this SAR timeline a Vulnerable Persons Partnership Meeting (VPPM) is now established in the Bassetlaw District Council area and operates in conjunction with the Rough Sleepers Action Group. The VPPM Terms of Reference state it is accountable for assessing and addressing the vulnerability of individuals referred to it by partners across Bassetlaw. The Terms of Reference define a person as “vulnerable” if they need special care, support, or protection because of age, disability, or risk of abuse or neglect. The case criteria details that support which may be required includes safeguarding, mental and physical health, substance misuse and housing. Member organisations include Bassetlaw District Council, CGL, SOT, Hope Community Services and NP, all agencies who were involved with John during the timeline of this SAR. Had the VPPM been established during the timeline of this SAR John’s case may have been considered in this forum, resulting in multiagency information being shared leading to a multi-agency risk management plan being established.

The VPPM Terms or Reference identify the meeting will not replace or duplicate the remit and responsibility of the Multi-Agency Safeguarding Hub which is the single point of contact for all professionals to report safeguarding concerns. However, considering the criteria of the cases likely to be considered at the VPPM it is the SAR’s anticipation these will often be complex cases which if not managed appropriately with the appropriate interventions applied may lead to the individuals being exposed to risk. The VPPM Terms or Reference do not clearly evidence the governance or accountability arrangements for the meeting, how strategic oversight is provided and the reporting mechanisms in existence.

**Recommendation 7.**

**Nottinghamshire Safeguarding Adults Board should commission a county wide review of the approach to the Vulnerable Persons panels and review the Vulnerable Persons Partnership Meeting Terms of Reference to establish appropriate strategic oversight, governance, and accountability arrangements.**

**6.2 Did his eviction result in appropriate action being taken to safeguard John and did concerns leading up to the individual’s death receive an appropriate and effective response from agencies?**

**6.2.1** As detailed at **4.3** when John became a resident at the hostel, he read and signed an Acceptable Behaviour Contract. In doing so John agreed to adhere to hostel policies, which included not to consume or bring alcohol and illegal substances onto the premises.

The support plan completed by the hostel detailed that John had been an alcoholic since he was 15 years old, equating to approximately 29 years of alcohol dependency. As detailed at **4.10** a severity of alcohol dependency test conducted by CGL suggested that John had severe alcohol dependency. When the hostel staff completed John’s risk assessment there was no information recorded or within the subsequent support plan that John may use illegal substances though incidents that occurred during the timeline of the SAR including at **4.21** and **4.24** indicated that he was.

Owing to a culmination of issues regarding John’s behaviour at the hostel which included suspicions that he was using illegal substances and previous breaches of his acceptable behaviour contract including as detailed at **4.8** the discovery of alcohol in his room, John was evicted from the hostel and subsequently returned to “rough sleeping.”

Considering, the challenges John faced in relation to alcohol dependency and substance misuse issues, his capability in adhering to the conditions of a zero-tolerance policy of alcohol and substance misuse imposed by the hostel the SAR views as unrealistic, where without the provision at the hostel of specialist drug and alcohol support, made his eventual eviction and return to “rough sleeping” apparently inevitable.

The Bassetlaw District Council Homeless and Rough Sleeping prevention strategy was published in response to Section 1 of the Homeless Act 2002. This set a requirement for Local Authorities to publish a strategy based on a review of homelessness in their area. The council’s strategy identifies “Working to end rough sleeping in Bassetlaw” as its first priority. Whilst the strategy makes several commitments to support the delivery of its priorities it does not address the lack of specialist commissioned supported accommodation for homeless people with drug and alcohol issues.

[Homeless and rough sleeping prevention strategy | Bassetlaw District Counc…](https://www.bassetlaw.gov.uk/housing-services/homeless-and-rough-sleeping-prevention-strategy/)

The Nottinghamshire Director of Public Health annual report for 2023 seeks to raise awareness of the challenges facing people with lived experience of severe multiple disadvantage together with recommending that organisations with responsibility for housing should collaborate to develop joined up, sustainable, long -term housing solutions which include appropriate support for people with experience of severe multiple disadvantage.

[director-of-public-health-annual-report-2023.pdf (nottinghamshire.gov.uk)](https://www.nottinghamshire.gov.uk/media/yppb3mtg/director-of-public-health-annual-report-2023.pdf)

**Recommendation 8.**

**Nottinghamshire Safeguarding Adult’s Board should endorse the co-produced recommendations in the Nottinghamshire Director of Public Health annual report for 2023 particularly recommendation 1, that organisations with responsibility for housing should collaborate to develop joined up, sustainable, long-term housing solutions which include appropriate support for people with experience of severe multiple disadvantage.**

**6.2.2** As detailed at **4.32** EMAS attended an emergency call following a report of John suffering a drug overdose. EMAS staff provided medical support for John who regained consciousness. John was advised by EMAS staff that he should attend hospital, but he refused. EMAS staff in attendance undertook a mental capacity assessment, and deemed John had mental capacity to make the decision to refuse further treatment. No information was shared by EMAS with John’s GP regarding this event as it transpired that John’s patient details could not be found on the Personal Demographics Service NHS electronic database. EMAS have since identified a system issue where data already held may self-populate. As learning from this SAR when patient’s records cannot be found on the Personal Demographics Service NHS electronic database there is now an expectation that EMAS staff will manually complete the information should similar circumstances occur. The learning from this event has been cascaded to all emergency staff.

[Personal Demographics Service - NHS Digital](https://digital.nhs.uk/services/personal-demographics-service)

**6.2.3** As detailed at **4.36** SOTprovided supportfor John following his eviction from the hostel. This support included when found wet and cold after “sleeping rough,” an SOT worker provided him with a new sleeping bag and food. Additionally, they provided John him with a mobile phone so they could maintain contact with him. The provision of the mobile phone to maintain contact, the SAR identifies as good practice. Further support provided by SOT included a supporting John to complete housing referral paperwork, liaising with CGL when John was unable to attend an appointment and arranging transport to the local housing provider so future accommodation provision may be considered.

**6.2.4** As detailed at **4.34** following John’s eviction from the hostelhe presented as homeless at the BDC. Part 7 of the Housing Act 1996 enables a person to apply to a local housing authority for housing assistance and if the authority has reason to believe the individual may be homeless or threatened with homelessness it must make enquiries to determine whether they are eligible for assistance. Following John’s attendance, the local authority in an attempt to find him accommodation contacted his mother who was unable to accommodate him. They additionally contacted Hope Hostel who informed the local authority that he may return to the premises if he paid outstanding serving fees. The local authority housing officer attempted to establish contact with John via the SOT worker to explore this option but as no contact could be established, the local authority closed John’s case.

[Homelessness code of guidance for local authorities - Overview of the homelessness legislation - Guidance - GOV.UK (www.gov.uk)](https://www.gov.uk/guidance/homelessness-code-of-guidance-for-local-authorities/overview-of-the-homelessness-legislation)

**6.3 Was there effective co-ordination of the individual’s care and support needs throughout the scoping period?**

**6.3.1** As detailed at **4.3** whenJohn became a resident at the hostel, a support action plan was completed. The support plan which was used by the hostel to help manage the risks identified in the risk assessment detailed John requiring support with housing, physical and mental health, finances, employment, and substance misuse. The support plan identified actions that required undertaking by John and his hostel support worker. There is no evidence to demonstrate how the plan was used to coordinate John’s care and support, shared with partner agencies, or updated and reviewed in relation the escalation of risk. The Social Care Institute for Excellence identify that to manage risk effectively it is important to have clear monitoring and reviewing systems in place together with sharing the plan with relevant agencies. The issues in relation to the support plan should be addressed through the implementation of **Recommendation 2.**

[Risk assessment process and key points to risk identification in virtual interactions | SCIE](https://www.scie.org.uk/care-providers/coronavirus-covid-19/social-workers/risk-identification)

**6.3.2** As detailed at **4.29** when the GP surgery was unable to contact John so a medication review could be undertaken,John’s prescription medications were suspended. The General Medical Council advise that medication should only be prescribed when a practitioner has adequate knowledge of the patient’s health and that they are satisfied that the medicines prescribed serve the patient’s needs. There is no evidence to indicate how John’s medication needs were met following the suspension of his prescriptions. The GP practice did contact the hostel to seek John’s whereabouts which proved unsuccessful, and no other enquiries were made by the GP practice, to contact him.

**6.3.3** Whilst the SAR acknowledges attempts were made by both the GP Practice and BDC to contact John, these were apparently limited, and other opportunities were not explored by making enquiries with other agencies who supported John up to the time of his death. This displayed an apparent lack of “professional curiosity,” which is an often-highlighted area of learning identified in SARs nationally. Professional curiosity when applied enables practitioners to feel confident to question and challenge the information they receive, identify concerns, and make connections to enable a greater understanding of a person’s situation. NSAB already has established guidance regarding the application of professional curiosity in adult safeguarding practice. Drawing upon learning from this case this guidance should be promoted to partner agencies and through its assurance activities NSAB should check to ensure the requirement to apply “professional curiosity” is embedded in agency safeguarding adult training.

[Professional curiosity in safeguarding adults - Social Care Online (scie-socialcareonline.org.uk)](https://www.scie-socialcareonline.org.uk/professional-curiosity-in-safeguarding-adults/r/a116f00000UuRRKAA3)

**Recommendation 9.**

**Drawing upon learning form this case Nottinghamshire Safeguarding Adults Board should promote its Professional Curiosity guidance with partner agencies and through its assurance activities ensure the requirement to apply professional curiosity is embedded in agency safeguarding adult training.**

**6.4 Were there policies and procedures in place to support practitioners, if so, was there due regard to these? Were they effective and is there a need for any review or amendment?**

**6.4.1** As detailed at **4.3** when John become a resident at the hostel, he was required to adhere to an Acceptable Behaviour Contract. This placed upon him certain restrictions including a condition not to bring alcohol or illegal substances onto the premises. Following several alleged breaches of this contract he was evicted from the premises and returned to rough sleeping. Hope is a homeless charity and are regulated by the Charity Commission. Hope hostel is nonregulated in relation to registration or compliance with the Care Quality Commission regulations and the SAR understands is classed as “exempt accommodation” in relation to certain Housing Benefit provisions. Exempt accommodation is shared housing that is not funded or commissioned by the local authority and often used as accommodation for people with very few other housing options such as offenders recently released from prison, migrants, and rough sleepers where a small element of care, support and supervision is provided, which are reflected in the operating features of the hostel where John stayed. By the very nature of the services provided by the hostel it is reasonable to assume several of its residents will have complex needs and could be vulnerable if not provided with an appropriate level of care and support. This raises concerns regarding the under regulation of such premises. The Supported Housing (Regulatory oversight) Bill is currently progressing through the House of Commons, owing to national concerns regarding the regulation of such premises where the Bill seeks to introduce local authority oversight and enforcement powers in relation to supported exempt accommodation.

[CBP-9668.pdf (parliament.uk)](https://researchbriefings.files.parliament.uk/documents/CBP-9668/CBP-9668.pdf#:~:text=Bob%20Blackman%20MP%20drew%20sixth%20place%20in%20the,second%20reading%20took%20place%20on%2018%20November%202022.)

**Recommendation 10.**

**Nottinghamshire Safeguarding Adults Board should work in partnership with Nottinghamshire County Council Public Health to review supported exempt housing arrangements in Nottinghamshire, to identify risks and opportunities to influence changes to policy at a local and national level.**

**6.5 Were there areas of good practice?**

**6.5.1**. There were several areas of Good Practice identified during the timeline of this SAR including,

* The support provided by SOT in providing John with a mobile phone so they could maintain contact and arranging transport to enable him to attend appointments.
* The establishment of a referral pathway to substance misuse services for EMAS staff to refer patients directly for support.
* The provision of Liaison and Diversion Teams hosted in the Nottinghamshire Police custody suites to enable individuals within the criminal justice system to be referred for support into relevant services.
* The multiagency working that occurred between CGL, Bassetlaw District Council and FOS in attempting to secure John accommodation.

**6.6 Equality and Diversity Considerations**

The Equality Act 2010 protects people from discrimination in society owing to the protected characteristics they may display as described in the Act. One of the identified protected characteristics is disability.

John reportedly had both physical and mental health issues and may have been considered to have a Disability if it had a substantial and long-term impact on his ability to carry out normal day to day activities.

The SAR has been unable to identify any evidence to indicate that John did not receive the appropriate level of care and support from agencies owing to this potential protected characteristic.

**7. RECOMMENDATIONS.**

**Recommendation 1.**

**The Rough Sleeper Coordinator should promote the establishment of the pre-eviction protocol to all housing exempt accommodation providers to ensure they understand the process, embed it in practice and ensure that relevant agencies are notified of the residents planned eviction, instigating referrals to the Rough Sleeper Action Group and Vulnerable Persons Panel meetings.**

**Recommendation 2.**

**Nottinghamshire Safeguarding Adults Board SAB should work with housing exempt accommodation providers, to audit their risk assessment process with the aim of promoting multi-agency working, and information sharing, that result in the establishment of support plans that mitigate or manage the risks posed to the individual.**

**Recommendation 3.**

**Framework Street Outreach should raise awareness within its organisation of the availability of the “Personal Budget” and how workers may access it, to support homeless individuals with accommodation needs.**

**Recommendation 4.**

**Nottinghamshire Safeguarding Adults Board should update its “Safeguarding Adults at Risk” Referral Pathway to include Referral Pathways to advise practitioners how to respond to Homelessness and Rough Sleeping and work with Nottinghamshire Adult Social Care to ensure future guidance they produce reflects the same referral pathways.**

**Recommendation 5.**

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**Recommendation 9.**

**Drawing upon learning form this case Nottinghamshire Safeguarding Adults Board should promote its Professional Curiosity guidance with partner agencies and through its assurance activities ensure the requirement to apply professional curiosity is embedded in agency safeguarding adult training.**

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