BIRMINGHAM SAFEGUARDING ADULTS BOARD

"Safeguarding is everybody's business"

Multi-Agency Learning Review

Overview Report

In respect of Adult 4

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Acknowledgements

The Panel would like to express their sincere condolences to Adult 4's family and many friends.

Members of the review panel offer their thanks to all those who have assisted with this review including the authors of the Individual Management Reviews and the professional support from the Board.

1 Introduction

1.1 Confidentiality

1.1.1 In order to protect the identity of all individuals featured within the review, all names have been anonymised and the deceased will be referred to as 'Adult 4'.

1.2 Summary of the circumstances leading to the review

1.2.1 This multi-agency learning review was commissioned by Birmingham Safeguarding Adults Board (BSAB) concerning the circumstances leading to the death of Adult 4, who died whilst homeless in Birmingham in January 2019.

1.3 Process and Methodology

1.3.1 The Care Act 2014 states that a Safeguarding Adults Board (SAB) must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR) A referral was made for the BSAB to consider a SAR for Adult 4. The SAR Sub-Group of the BSAB made a decision that the referral did not meet the criteria for a SAR and this was ratified by the Independent Chair of the Board. However, a decision was made that the BSAB would conduct a Learning Review as there was no other review mechanism available in the city. The review looked towards learning how agencies could work together differently to obtain better outcomes for homeless people.

1.3.2 The review was steered by an independent lead reviewer and multi-agency review panel whose membership consisted of senior managers and designated professionals from the key statutory agencies, each of whom were independent of the case.

1.3.3 The review applied a methodology comprising of a panel and Individual Management Reports from agencies, and sought to analyse these individual and multi-agency responses according to the principles of *Making Safeguarding Personal* and the six core safeguarding principles:

- **Empowerment:** people being supported and encouraged to make their own decisions and informed consent.
- **Prevention:** it is better to take action before harm occurs.
- **Proportionality:** the least intrusive response appropriate to the risk presented.
- **Protection:** support and representation for those in greatest need.
- **Partnership:** local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability:** and transparency in safeguarding practice (ADASS & LGA, 2018)

1.3.4 It was recognised that family and friends can offer an important perspective that agencies might not hold, and the panel took steps to ensure their involvement and their contributions were incorporated into the review wherever possible

1.3.5 The review focussed on the period between March 2018, when Adult 4 referred himself to substance misuse services, until his death in January 2019. The panel also considered information outside of this timeframe for contextual purposes. In particular, the review considered the need to consider the immediate period following Adult 4's release from prison in August 2017.

2 Adult 4's Background

2.1 Adult 4 was 31 years of age when he died. He had been known to services since childhood and had a long history of mental illness, self-harm, drug and alcohol misuse, and drug-related offending behaviour. As a young adult he received a diagnosis of having a personality disorder with depressive symptoms and substance misuse would feature in later psychotic episodes. He also had chronic health concerns including Human Immunodeficiency Viruses (HIV), Hepatitis C, and HIV associated Nephropathy.

2.2 Adult 4 had been mostly rough sleeping, sofa surfing and living in direct access hostels since at least 2015 and had been actively involved in begging and anti-social behaviour throughout this time. Whilst he was often observed to be vulnerable, he was also known, at times, to become extremely agitated, aggressive and cause concern to the general public who encountered him - particularly when he expressed suicidal thoughts. During these periods of distress, he was either under the influence of substances or expressing symptoms of mental ill-health, or both. When in a distressed state, he often put himself or others at risk. He also admitted that he was fearful of authority as well as of buildings which he wanted to get in and out of very quickly.

3 Summary of Key Episodes

3.0 Adult 4 had near daily contact with an extensive range of agencies and it would therefore not be feasible to provide a full chronology of these contacts. However, the following events are considered by the independent reviewer and panel to represent the significant events as well as provide some indication of the complexity and scale of services provided:

3.1 Summer 2017

3.1.1 On Adult 4's release from prison after a short period of detention for possession of cannabis, he went on to receive a broad range of criminal justice, health, substance misuse, housing and anti-social behaviour services. He often encountered a number of these services each day and developed a particularly positive relationship with the Advanced Nurse Practitioner from the Health Xchange, a GP service for homeless people. The Homeless Community Mental Health Service engaged with him briefly before he disengaged.

3.1.2 Soon after leaving prison, he became reluctant to take the anti-psychotic medication which he was being prescribed as he felt that it interacted with spice and mamba and was responsible for his aggressive outbursts.

3.2 Spring and Summer 2018

3.2.1 Accommodation was provided to Adult 4 in Washington Court, a large hostel for homeless people in Birmingham City Centre which provides 24-hour supported accommodation in single room units with meals provided communally. After a short period of feeling better, he soon disengaged with the services provided and began self-harming, missing appointments for his HIV Treatment and left the accommodation

3.2.2 After leaving and whilst homeless, he went on to decline an offer of specialist accommodation at the Multiple Needs Unit and his mental health and self-harm deteriorated. Adult 4 went on to both attempt and threaten to hang himself, each time denying that he was suicidal when questioned. A Mental Health Act assessment found no evidence of acute mental illness, although they lacked some important information from primary care services about the fluctuations in his health. Thereafter, he declined an emergency medical assessment with Change Grow Live (CGL) who were unable to engage with him again after this and closed his case.

3.3 Winter 2018

3.3.1 Over coming months, Adult 4 increasingly withdrew from services. His physical health and self-neglect became more and more concerning. He appeared unwell, dishevelled, walked around the streets in his pyjama bottoms and became aggressive when approached by services. A wide range of agencies continued to try to assist Adult 4:

- by providing multi-agency support and treatment for his HIV,
- by encouraging him to receive wider medical treatment,
- by encouraging him to access the winter shelters which were available to him,
- by providing him with food parcels and clothing,
- by helping him to access his welfare benefits,
- by taking him to hospital or to attend the local mental health drop-in services,
- by referring him to Adult Social Care (but they wrongly did not believe that they could provide assessment or services without him having an address),
- by moving him on when he was found breaching his Criminal Behaviour Order, and/or
- by pursuing additional civil orders to require him to engage with support and take-up accommodation, and for a mental health assessment to be undertaken if he breached the order.

3.3.2 Agencies struggled to engage Adult 4 and he declined most services. Although he was admitted to City Hospital with an acute kidney injury shortly before his death, he was repeatedly absent from the ward and went on to leave the hospital without notifying anyone and before his risks had been fully explained to him. These risks

were passed on to the Health Xchange the next day and Adult 4 was located but again declined medical treatment and refused to return to hospital.

3.4 January 2019: the day of his death

3.4.1 Three days after Adult 4 had left hospital, the ambulance service was called to attend to him in the city centre and found him perilously unwell. He was continuing to take illicit drugs and, despite significant attempts by the attending clinicians, he constantly refused any observations or treatment and refused to be taken to hospital. His friends stated that this was his usual response to ambulance staff and, having considered that Adult 4 had capacity to make the decision to decline treatment, ambulance staff gave advice to Adult 4's friends to call back if required and made sure that they had a mobile phone with which to do so. They advised both Adult 4 and his friends that he would die without medical treatment.

3.4.2 Six hours later that day, a second 999 was received for an ambulance to attend to Adult 4 who was in cardiac arrest. Full advanced lifesaving treatment was commenced, and a second crew and care team, including a doctor assisted with treatment, but Adult 4 was declared dead. An inquest was later held which determined the principle cause of death to be a heroin overdose, and that a contributory cause was pneumonia.

4 Key Themes

4.0 Over the period assessed within this review, it has been evident that a large number of practitioners from key agencies were pro-actively working together to meet their collective concerns for Adult 4's safety and well-being. Their involvement has been considered in detail by the review panel, good practice recognised. The recommendations made for improving individual services are reported separately. The following themes were recognised as applying to most agencies' approaches to Adult 4:

4.1 Understanding Adult 4's Risks and Needs

4.1.1 Adult 4 was considered by the review panel to be experiencing multiple exclusion homelessness. This term is increasingly used to describe how individuals may face barriers to services based upon their multiple needs, intersecting disadvantage and by the manner in which agencies are organised, often providing services in relative silos (Cornes et al., 2011; JRF, 2018, Mason, 2017). A key finding from research is how frequently the roots of many people's experiences of multiple exclusion homelessness in adulthood lies within very troubled childhoods, characterised by multiple trauma, distress and exclusion (McDonagh, 2011). This did indeed appear to be the case for Adult 4. Significantly, research has found that this group face considerably higher rates of disease, injury and premature mortality than the general population (Luchenski, 2018; Aldridge, 2018).

4.1.2 In the main, Adult 4's multiple needs were well understood by professionals within this context, although there appeared some question concerning his mental health. Adult 4 had various historic diagnoses but had not been subject to any prolonged assessment as mental health services engagement with him was sporadic.

4.2 Traumatic Brain Injury

4.2.1 It was questioned whether Adult 4 had experienced Traumatic Brain Injury. Although this was not recorded or diagnosed at the time, Adult 4 was considered to fit the profile of someone who had been susceptible to acquiring one, particularly as it was known that he had been subject to assaults whilst rough sleeping; experienced prolonged substance misuse and hypoxia at times of drug overdose.

4.2.2 A recent systematic review and meta-analysis has identified that more than half of homeless people experience Traumatic Brain Injury which was associated with increased risk of suicide, poorer self-reported physical and mental health, and heightened criminal offending (Stubbs et al, 2019). Indeed, the lifetime prevalence of moderate or severe Traumatic Brain Injury is nearly ten-times higher for homeless people than estimates in the general population but rarely considered by agencies as a cause or consequence of their homelessness (Corrigan et al., 2018)

4.2.3 In Adult 4's case, his multiple exclusion homelessness appeared to have been attributed by agencies to his adverse childhood experiences, his mental ill-health and his substance use. However, there was no indication that agencies had considered the possibility or screened for Traumatic Brain Injury, or that this type of screening was commonplace.

Recommendation 1: Traumatic Brain Injury
Birmingham City Council Neighbourhood's Directorate should ensure that Traumatic Brain Injury is factored into the city's homeless pathways and practice for assessment and support of homeless individuals in such a way that does not over-medicalise the issue

4.3 Normalisation, minimisation and crisis responses

4.3.1 The review questioned whether there was any evidence that practitioners were normalising the risks that Adult 4 faced as a homeless person with multiple needs. In the main, it was evident that practitioners were taking very seriously and working hard to respond to Adult 4's needs in ways which would be described as person-centred: "being human, compassionately persistent, open and transparent, respectful, listening, giving time and commitment" (LGA, 2020:18). However, there were a few instances of professionals referring to the 'lifestyle choices' that Adult 4 was seen to be making and that he was 'placing himself at risk' indicating a failure to apply a trauma-informed approach based on an understanding of what has happened for him to be in these circumstances. Person-centred work requires practitioners to reflect upon their pre-judgements, prejudices and unconscious bias, particularly in respect of substance misuse.

4.3.2 For other practitioners, the sheer scale of their near daily interventions with Adult 4 meant that they were often responding to an incident or crisis. Although there was good evidence that agencies pooled resources and information, it was not always evident that at times of crisis they were applying a structured approach to assessing Adult 4's needs, risks, capacity and entitlements.

4.3.3 Many agencies referred to Adult 4's lack of engagement. Wherever possible, this review has sought to reframe this assessment by considering how agencies had

themselves been unable to engage with him. Turning responsibility around in this way is an important ingredient when considering agencies' own responsibility to work differently to support and engage with those on the margins of society.

Recommendation 2: Trauma Informed[1]/Psychologically Informed Environments Approaches[2] - Commissioned Services
Birmingham City Council Commissioners to seek assurance that commissioned services supporting homeless people are delivering interventions applying the Trauma Informed and/or Psychologically Informed Environments (PIE) approaches. Where a learning need is identified, commissioners to ensure that this has been addressed.

Recommendation 3: Trauma Informed/Psychologically Informed Environments Approaches - Commissioned Services
Birmingham City Council Neighbourhood's Directorate should ensure that there is an expectation that all services provided through the multi-agency homeless pathway are delivered through Trauma Informed and/or Psychologically Informed Environments (PIE) - approaches in ways which extend beyond crisis intervention and with a clear escalation framework should services not meet this expectation.

4.4 Statutory Assessments

4.4.1 Although practitioners were evidently working hard to respond to Adult 4's needs, such as finding him accommodation, food and clothing, treatment for his substance misuse, mental and physical conditions and referrals for safeguarding, it was not always apparent that his entitlement to statutory assessments was being considered. In particular there was an absence of referrals for a statutory homeless assessment under the Housing Act 1996 and Homelessness Reduction Act 2017 to determine whether the local authority had a duty to secure accommodation for him. There was also an absence of referrals for an assessment under section 9, Care Act 2014 which should be done when it appears that a person may have care and support needs.

4.4.2 During Adult 4's final year, the Homelessness Reduction Act 2017 came into force. The Act has introduced a duty on certain public authorities to refer service users who they think may be homeless or threatened with homelessness to their local housing authority. Agencies with this duty including NHS hospitals, emergency health care providers, social care, probation services and prisons, who now have a statutory duty to contribute to the prevention of homelessness.

[1] Further information on the Trauma Informed Practice approach can be found at: https://www.hee.nhs.uk/our-work/mental-health/new-roles-mental-health/social-workers/developments-whole-system-approaches-support-trauma-care

[2] Further information on the Psychologically Informed Environments approach can be found at: https://eprints.soton.ac.uk/340022/1/Good%2520practice%2520guide%2520-%2520%2520Psychologically%2520informed%2520services%2520for%2520homeless%2520people%2520.pdf

Recommendation 4: Legal Literacy on Homelessness
Birmingham City Council Neighbourhood's Directorate to ensure that front-line practitioners have a basic understanding of the legal rights of multiply excluded homeless people.

Recommendation 5: Homelessness Duties
Birmingham City Council Neighbourhood's Directorate to gain assurance from relevant partner agencies that they are competent in their duty to refer individuals that are homeless to the local authority, in compliance with the Homeless Reduction Act 2017, and that they are working collaboratively with shared values with other agencies to prevent homelessness.

4.5 Self-Neglect and the Safeguarding System

4.5.1 Although multiple agencies were already involved with Adult 4, he had not been subject to assessments under the Care Act 2014 of either his care and support needs (section 9) or his safeguarding risks (section 42) and a formally co-ordinated response that could have followed if the assessment justified it. Indeed, national Safeguarding Adult Reviews have questioned how well understood self-neglect in relation to substance misuse and adult safeguarding (NIHR, 2018).

4.5.2 Practitioners were justified, at times, in predicting barriers to raising safeguarding concerns, as the response from Adult Social Care was indeed lacking when concerns were raised. Social workers and their supervisors wrongly assumed that an assessment could not be undertaken because Adult 4 was rough sleeping and have rectified this misunderstanding. However, in Adult 4's final months, it was not always clear that due consideration had been given to his escalating self-neglect. There is no single definition of self-neglect, but it may be seen as an adults' inability or unwillingness to care for themselves or their immediate living environment (Birmingham Safeguarding Adults Board, 2017).

4.5.3 Whilst practitioners generally displayed great concern for Adult 4, they often appeared to lack awareness of what to do when Adult 4 appeared to be making a capacitated decision to refuse support.

> ***"A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support."*** **(Care Act Statutory Guidance 14:17)**
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> **)**

4.5.4 Greater awareness of the complex and nuanced decision-making that is needed around self-neglect and safeguarding would benefit all agencies. This requires a greater awareness of the criteria for statutory safeguarding assessment under section 42, Care Act 2014 and, in order to secure an appropriate response, referring agencies need to be clear about how they considered the criteria was being met at the point of referral. For those homeless people who self-neglect and who do not meet the criteria, a co-ordinated response is still needed, and a revised pathway has since been put in place.

4.6 Substance Misuse, Fluctuating and Executive Capacity

4.6.1 Akin to many individuals who experience multiple exclusion homelessness, Adult 4's mental capacity appeared to have fluctuated. He often presented coherently and appeared to have executive capacity to make decisions, but he did not always then act in accordance with his stated intentions. At other times, his capacity appeared to fluctuate on a daily basis, influenced by intoxication, withdrawal from substances, mental health and his pressing need to acquire drugs. It was also indicated that, at times, and as his health deteriorated, he may not have capacity to make specific decisions, particularly in respect of his self-neglect, and capacity assessments should have taken place.

4.6.2 When Adult 4 was refusing treatment, it was not always clear how practitioners were making the assessment of his capacity and whether they were considering the organic, behavioural and social factors which may have impacted upon his mental capacity, including his history of trauma, potential for traumatic brain injury, prolonged substance misuse and mental ill-health.

4.6.3 There is no doubt that assessing capacity for individuals experiencing substance misuse and multiple exclusion homelessness is challenging for practitioners, particularly at times of an individual's fluctuating capacity (Martineau et al., 2019). It has been argued that there is a need for a common set of protocols and tools for services working directly with multiply excluded homeless people in order to guide the need to balance capacity, best interest, autonomy and self-determination with a duty of care to this particular group of people (Pathway, 2017; NIHR, 2019).

4.7 Harm Reduction Approach

4.7.1 Adult 4 had received harm reduction advice on his drug use and safer injecting. In the context of substance misuse, harm reduction interventions aim to change risky behaviour, including the risks of blood-borne viruses, overdoses and other harms associated with injecting drug use, without necessarily focusing on or requiring a reduction in drug use. Examples include needle and syringe programmes, psychosocial and behavioural interventions designed to reduce risk and supervised drug consumption facilities and, generally, multicomponent interventions have been found to be more effective than standalone interventions (Luchenski, 2018).

4.7.2 However, the review heard that multi-component harm reduction facilities that include needle exchange in the city centre have since reduced. Recent Public Health England data has shown that the number of people who inject drugs and report adequate needle and syringe provision is sub-optimal with less than half of those surveyed indicating adequate provision for their needs (Public Health England, 2018). Indeed, at the time of writing, there have been reports of an HIV outbreak in Birmingham and the West Midlands (BBC, 2020).

Recommendation 6: Harm Reduction
Birmingham City Council Public Health to ensure that there are adequate community harm reduction facilities for substance misuse services in Birmingham and provide assurance to the Health and Well-Being Board.

4.8 Dual Diagnosis

4.8.1 Adult 4 experienced the co-existence of mental illness with substance misuse, known as 'dual diagnosis', throughout the period covered by this review. Dual diagnosis refers to the negative impact of drug or alcohol use on individuals who experience mental health difficulties, and it is recognised that they are more likely to disengage from services (NCCMH, 2016). It has been considered that Adult 4's mental illness had warranted a referral to secondary mental health services, at least at times, and therefore dual diagnosis considerations were needed.

4.8.2 In Birmingham, the *Dual Diagnosis Referral and Treatment Pathway Guidance (version 3)* was instigated to enable mental health and substance misuse services to work together in a philosophy of shared care and integrated treatment and to ensure that service users have access to services that are best placed to meet their needs (supplementary Joint Working Protocol, 2015). Had the protocol been instigated in this case, then the lead agency would have been identified, joint working arrangements and joint assessments put in place, and Adult 4 would not have been discharged from either service without joint agency consideration, notwithstanding the ongoing challenge of Adult 4's disengagement.

4.8.3 The review heard how the introduction of a single integrated contract for substance misuse services in 2015 created some disruption in how mental health services and substance misuse services worked together in the early years of the contract. Recommissioning had changed the approach required to a psychologically focussed model. It was argued that Adult 4 was unable to engage at this psychological level and whilst a trauma informed model was needed, he also needed his basic needs to be met first through long-term assertive outreach. Nonetheless, working relationships between the two organisations have strengthened in recent times and under the most recent commissioning of the Rough Sleepers Initiative, a qualified mental health nurse has been recruited as part of the outreach team which may be seen to strengthen partnership working across dual diagnosis.

Recommendation 7: Dual Diagnosis Pathway
Birmingham City Council Public Health to seek assurance that the dual diagnosis pathway has been strengthened to ensure strategic and operational collaboration between relevant agencies.

Recommendation 8: Dual Diagnosis Pathway in the Substance Misuse Strategy
Birmingham City Council Public Health to ensure that the Substance Misuse Strategy establishes a baseline expectation for required multi-agency responses to dual diagnosis and outcomes to be delivered.

4.9 Working Together

4.9.1 There is no doubt that, at the time, Birmingham's agencies and commissioning landscape was well advanced in its dedicated response to rough sleepers. We have seen that the Health Xchange provided a unique, dedicated, multi-disciplinary, primary care outreach service. Birmingham also benefited from a dedicated community mental health team for homeless people; dedicated outreach substance misuse services; anti-social behaviour officers working with homeless

people; voluntary organisations providing a key worker, no wrong door approach; specialist supported housing for people with multiple needs, and a multi-agency task focussed Street Intervention Team. Moreover, the hospital which serves the city centre had its own dedicated homeless team and has pathways in place to meet its responsibilities under the Homelessness Reduction Act. Credit must therefore be given to the great strides that had been taken by agencies working towards operating as a 'system' in the delivery of joined-up services to Birmingham's population of rough sleepers.

4.9.2 However, and despite attempts to co-ordinate the multi-agency response to Adult 4 through the Street Intervention Team, agencies appeared at times to operate as a discrete collection of services, and a sense of diffused responsibility appeared to have emerged.

4.10 Street Intervention Model

4.10.1 Adult 4 was discussed regularly at multi-agency Street Intervention Team meetings which gathered together professionals from the range of agencies providing services to those involved in street culture activities and rough sleeping. The model emerged as a result of the increasing numbers of street homeless and lacked protocols and procedures, particularly around agency accountability, conflict management and escalation. As a result, there was no concrete mechanism for intervention planning and risk management or agreement about who was to be the lead professional for Adult 4.

4.11 Responding to Multiple Exclusion Homelessness

4.11.1 Research has concluded that there is a need for a different type of service to address multiple exclusion homelessness than that traditionally offered: support that is open-ended, person-centred, persistent, flexible, and co-ordinated (Cornes et al., 2011b). Indeed, such qualities are wholly consistent with Making Safeguarding Personal:

> ***"Making Safeguarding Personal means it should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety."*** **(Care and Support Statutory Guidance 14.15)**

4.11.2 Although Birmingham Changing Futures Programme was funded by the National Lottery to provide this type of personalised support to individuals facing multiple needs in Birmingham during the period considered in this review, the lead worker did not appear distinguishable from the wide range of practitioners already actively involved. Other practitioners could equally have picked up the mantle of lead professional, such as in probation services whilst Adult 4 was under supervision, or within the integrated contract for substance misuse services held by Change Grow Live, but were unable to meaningfully engage him.

4.12 Changing Service Landscape: Rough Sleeper Service Pathways

4.12.1 The *Rough Sleeping Service Pathways and Core Accommodation & Support Offer* (January 2020) has sought to address these shortfalls. These new pathways

formalise the response to multiply excluded homeless people through the introduction of the Community Navigator role alongside a Rough Sleeper Manager from the City Council to co-ordinate responses thereafter. The new model commissions an outreach service, and pathways also include: daily tasking; weekly multi-agency team meetings; rapid prescribing; a nurse; a community psychiatric nurse; social work; multi-disciplinary clinical decision-making and a rapid rehousing pathway within the principles of Housing First.

4.12.2 However, given that there appeared to have been some degree of diffused responsibility in the delivery and co-ordination in Adult 4's case, it is recommended that some assurance is provided that the new model of working has positive outcomes for the future. The review went on to hear how certain agencies, such as ambulance services, had not been connected into the homeless pathways and there was also a need to ensure that all front-line services were within scope to connect to the new pathway.

Recommendation: 9: Rough Sleeper Service Pathways
Birmingham City Council Neighbourhood's Directorate to ensure that all relevant services are effectively connected into the Rough Sleeper Service Pathway.

Recommendation: 10: Rough Sleeper Toolkit
Birmingham City Council Neighbourhood's Directorate to consider adoption, or adaptation for local purpose, of the screening tools and guidance contained within Pathway's *Mental health service interventions for people who sleep rough (3rd edition).*[3]

4.13 Interface of Support and Enforcement

4.13.1 As a result of their positive intent not to criminalise Adult 4, the police and local authority anti-social behaviour enforcement officers did not pursue him in respect of breaches of a Criminal Behaviour Order. However, it was recognised that civil and criminal enforcement, as well as post-sentence licence conditions within periods of supervision by probation service, can be used to both enable and require those in substance misuse or mental health treatment to access and engage with those treatments.

4.13.2 There is no doubt that balancing enforcement with support is a challenge for agencies, but it is certainly one that needs to be done within a considered multi-agency response to a structured plan to address the needs and risks that individuals may face.

4.13.3 Much of this report has referred to balance: balancing autonomy and risk; balancing crisis responses with structure and formality. However, this balancing of enforcement with support itself could be seen as contradictory to our duty to promote autonomy, choice and control. BSAB's Risk Enablement Guidance, which was published after Adult 4's death, is all about achieving balance between an individual's wellbeing and risk and serves as an important reminder of the principles that must underpin our approaches at such times of challenge.

[3] Available at https://www.homeless.org.uk/sites/default/files/site-attachments/Mental%20Health%20Interventions%20for%20People%20Who%20Sleep%20Rough%20-%20v2.pdf

4.14 Informal Support

4.14.1 Birmingham is served by a range of religious and community organisations providing informal support and the provision of basic needs (such as food, clothing and bedding) to homeless people within the city centre; Adult 4 was well known to many of these. It has not been within the scope of this review to consider their involvement in this case. The purpose of reviews within the context of adult safeguarding is to promote learning and improve agency practice rather than undertake a wider investigation. It is understood that Birmingham City Council are continuing to work with community groups and faith groups and other mutual aid networks to link them into the broader service offer for rough sleepers.

4.14.2 It was drawn to the review's attention that harrowing filming of Adult 4 and other vulnerable people had been uploaded onto the internet. The panel considered that this activity should be discouraged, particularly where the individual's capacity to consent to the filming has not been established.

5 Conclusion

5.1 This review has considered the tragedy of Adult 4's death whilst he was rough-sleeping on the streets of Birmingham in January 2019. This multi-agency review explored whether agencies could have done more, or acted differently, in order to protect Adult 4 from harm and better meet his needs.

5.2 There was no doubt that practitioners from a wide range of agencies had concerns for Adult 4 and were doing their best to engage with him and enable him to access support and healthcare, many on a near daily basis. The review found good examples of key practitioners going 'that extra mile' to build trusting relationships with Adult 4 and maximise the options that were available and practitioners were clearly working with other agencies in newer partnerships focussing on street homelessness. Whilst agencies could not force someone into treatment where there was no legal basis to do so, it was not apparent that there was a structured and formalised approach to collectively address Adult 4's needs and the risks that he faced. At times this led to a dispersed responsibility and there was a need to ensure that case management and leadership was rooted in Adult 4's statutory rights to assessments.

5.3 More than shortcomings for agencies, the review has highlighted the complex and nuanced decision making that is needed when considering mental capacity and safeguarding, and balancing the wellbeing and risks faced by multiply excluded homeless individuals experiencing problematic substance misuse. Recommendations have therefore focussed more on the need for specific guidance to help front-line practitioners in their future responses whilst at the same time, embracing the sentiment of the government's Rough Sleeping Strategy:

> ***"It is not acceptable that in our prosperous society vulnerable people sleep on our streets. We have a duty to support these people, to make sure that they have suitable, safe and stable accommodation. We need to make sure that they have access to the privileges that so many of us take for granted in our day to day lives, including access to healthcare, mental health and substance misuse support, and access to benefits. We must make sure that in***

the future, no one ever has to sleep rough again" (Ministry of Housing, Communities and Local Government, 2018c)

Recommendation 11: Homeless Mortality Reviews
Birmingham City Council Neighbourhood's Directorate should consider implementing a homeless mortality review process to ensure that deaths are reviewed in the future.

6 Recommendations

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Birmingham City Council Neighbourhood's Directorate should consider implementing a homeless mortality review process to ensure that deaths are reviewed in the future.

There are also individual agency recommendations identified by agencies through their Individual Agency Management Report (IMR) which were presented to the review. The learning for each individual organisation and their recommendations are available in a separate document.

[4] Available at https://www.homeless.org.uk/sites/default/files/site-attachments/Mental%20Health%20Interventions%20for%20People%20Who%20Sleep%20Rough%20-%20v2.pdf

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Acronyms

ADASS: Association of Directors of Adult Social Services
AMHP: Approved Mental Health Professional
APN: Advanced Nurse Practitioner
BCC: Birmingham City Council
BID: Business Improvement District
BSMHFT: Birmingham and Solihull Mental Health Trust
CCG: Clinical Commissioning Group
CPN: Community Psychiatric Nurse
CRC: Community Rehabilitation Company
DWP: Department of Work and Pensions
GP: General Practitioner
LGA: Local Government Association
HIV: human immunodeficiency viruses
IMR: Individual Agency Management Report
IV: Intravenous
IVDU: Intravenous drug user
MCA: Mental Capacity Act
NIHR: National Institute for Health Research
SAB: Safeguarding Adult Board
SAR: Safeguarding Adult Review
SWMCRC: Staffordshire and West Midlands Community Rehabilitation Company

Glossary

Approved Mental Health Professional: a social worker or other professional approved by a local authority to carry out a variety of functions under the Mental Health Act.

Best interests: any decisions made, or anything done, for a person who lacks capacity to make specific decisions must be in the person's best interests.

Care Clusters: a framework for planning and organising mental health services and the care and support that can be provided for individuals. In mental health there are 21 clusters that cover a range of diagnosis and needs. Each person will be assessed based on their symptoms and individual need.

Care Passport: documents currently used by some health services for people with learning disabilities. A document that provides immediate and important information for doctors, nurses and administrative staff for people who might need hospital admissions or assessments.

Crack: cocaine smoked from small rocks.

Dual Diagnosis: refers to individuals with severe mental illness who misuse substances.

Health Xchange - primary care service for homeless people in the Birmingham area provided by Birmingham and Solihull Mental Health Foundation Trust. A full general practice service to those who are homeless or vulnerably housed who aged 16 and over and not pregnant. Including nurse clinics providing a range of services such as blood tests, prescribing, chronic disease management, sexual health, hepatitis & HIV testing, and naloxone. Access to mental health support with two community psychiatric nurses available who are able to assess and triage mental health issues, including referral to secondary mental health. Referral into the practice's own counsellor and psychotherapist.

Homeless Community Mental Health Team: this community mental health team is the statutory mental health NHS service in Birmingham and Solihull for people who are homeless and experiencing mental health problems. The service includes patients that are not registered with a GP.

Housing First: a housing programme designed to provide open-ended support to long-term and recurrently homeless people who have high support needs

Mamba/Black Mamba: synthetic cannabinoids.

Mental Health Act 1983 (amended 2007): a law mainly about the compulsory care and treatment of people with mental health problems:

- Section 2 - admission for assessment (or for assessment followed by treatment)
- Section 3 - admission for treatment
- Section 4 - admission for assessment in case of emergency
- Section 136 - gives the police the power to remove a person from a public place when they appear to be suffering from a mental disorder and take them to a place of safety. The person will be deemed by the police to be in immediate need of care and control as their behaviour is of concern.

Mental Health Act Assessment: the process of examining or interviewing a person to decide whether an application for detention or guardianship should be made.

Psychologically Informed Environments: this strengths-based model of practice, endorsed by the Ministry of Housing, Communities and Local Government, recognises that clients with challenging behaviour have particular support needs, often arising from earlier trauma and abuse. As part of this approach, they will be working within a broadly therapeutic framework, enabling them to develop clear and suitably consistent responses to clients who may be chaotic and distressed and who have learned not to trust.

Smack: heroin.

Spice: synthetic cannabinoids.

Street Triage: a multi-agency service in Birmingham comprising of a mental health nurse, paramedic and police officer together in one vehicle responding to 999 calls, where it is believed people need immediate mental health support.

Traumatic Brain Injury: damage to the brain that occurs after birth.

Trauma Informed Practice: a strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for everyone, and that creates opportunities for survivors to rebuild a sense of control and empowerment alongside inclusive services. Trauma Informed Practice forms part of the NHS Long Term Plan and NHS Mental Health Mental Health Implementation Plan, amongst others.

BIRMINGHAM SAFEGUARDING ADULTS BOARD

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