BIRMINGHAM SAFEGUARDING ADULTS BOARD

"Safeguarding is everybody's business"

Individual Agency Learning and Recommendations

In respect of Adult 4

(This document should be read in conjunction with the Overview report for Adult 4)

Contents

Individual Agency Learning and Recommendations

1. During the review for Adult 4, each agency involved was requested to carry out an Independent Management Review (IMR) which reflected upon the services that they provided. The agencies presented and discussed their analysis with the review panel along with their individual agency recommendation that their Independent Reviewer identified.

2. Below are the key learning and relevant individual agency recommendation as identified by their internal Independent Reviewer, taken from the IMR reports for the major organisations that were involved in the review. The recommendations have led to the creation of action plans by the agencies, which are updated by the respective agencies.

3. The recommendations in this document relate to individual agencies. The overview report contains wider partnership recommendations.

Health and Social Care Agencies:

Birmingham and Solihull Mental Health Trust

4. Birmingham and Solihull Mental Health (NHS) Foundation Trust provided both primary and secondary care services to Adult 4. The Trust managed primary care services through the Health Xchange. Secondary care services were provided through the Homeless Community Mental Health Team, Street Triage and the Place of Safety where a Mental Health Act Assessment was undertaken. The Trust considered their responses from each of these services within the context of Multiple Exclusion Homelessness (MEH) and recognised Adult 4's experience of mental ill health, physical ill health and substance misuse.

Birmingham Health Xchange

5. Birmingham Health Xchange provides a dedicated primary care service for local homeless and vulnerably housed people consisting of GPs, specialist outreach nursing, nurse clinics, a counsellor, a psychotherapist and two community psychiatric nurses linking with the community mental health teams. Weekly multi-disciplinary meetings provided information sharing across the team. This bespoke primary care service for homeless people was considered to be a unique provision for homeless people which sought to remove the barriers that homeless people face in accessing healthcare.

6. It was evident that the outreach nurse and community psychiatric nurse had worked tirelessly to build trusting therapeutic relationships with Adult 4 and addressed both his medical and practical needs. Adult 4 clearly saw the outreach nurse, in particular, as his go-to professional when he needed help. Unfortunately, the outreach nurse was on sickness leave when Adult 4's physical health deteriorated significantly in the last months of his life and that

level of outreach provision could not be backfilled, although another nurse covered some of her duties.

7. The weekly multi-disciplinary meetings shared information rather than formally planned care or interventions as formal care planning is not an expected core function of primary care. Safeguarding was not routinely considered at these meetings, but this requirement has since been put into place.

8. The Trust reflected that there were times when information was not shared between the hospital based psychiatric liaison services and the community based mental health teams. The Trust has committed to liaise with A&E departments and Psychiatric Liaison Services to improve their identification of the registered GP for homeless people using the Health Xchange in order to strengthen information sharing in the future.

9. At the time of Adult 4's engagement with the Health Xchange, it had been judged by the Care Quality Commission to be 'inadequate' overall. Since this time, it has made the necessary improvements and is now judged to be an 'outstanding' practice.

Homeless Community Mental Health Team

10. The period of care, following Adult 4's release from prison in 2017, was distinct in being the only period when the Homeless Community Mental Health Team (CMHT), as secondary mental health providers, were able to briefly engage with Adult 4.

11. The Homeless CMHT had a lower threshold for accepting referrals and greater flexibility in its method of operating than other community health teams. However, at the time, they were unable to provide the level of outreach to assess individuals on the street. This outreach component has since been added to the Homeless CMHT offer, and Community Psychiatric Nurses (CPNs) and psychiatrists are now able to assess individuals on the street where needed.

Place of Safety

12. When Adult 4 was detained[1] and taken to the Trust's Place of Safety, he was assessed under the Mental Health Act. Unfortunately, the wealth of previous concerns about Adult 4's mental health, which had been recorded near daily by the outreach nurse, was not available. Had the records been available, the low level of engagement with other services may have influenced the assessment by identifying the need for direct contact between agencies, as Adult 1 was unlikely to instigate that contact himself. As a result, the Trust has made a recommendation for itself to explore if there is any option to surface any information from EMIS (database) onto Rio (database) or develop another way

1.

[1] He was detained under Section 136 Mental Health Act 1983

of entering key information on Rio to enable the sharing of information in such instances.

Across Mental Health Services

13. Although consideration had been given to safeguarding referrals at the Street Intervention Team meetings, no practitioner from the Trust made a safeguarding referral in respect of Adult 4's self-neglect. Practitioners anticipated that a referral would not be accepted for a variety of reasons at different times, including not being able to locate him and not meeting the threshold. No consideration appeared to be given to escalating the issue, although the Trust has its own internal procedures for escalating safeguarding concerns. There was also a sense of normalising risk because of the level of complex needs in a large number of service users. As a result, the Trust has committed the Homeless Xchange and Homeless Community Mental Health Team to make adult safeguarding referrals when needed and to consider the dispute resolution process to challenge disagreements where referrals do not meet current thresholds.

14. Adult 4 often appeared coherent, but his presentation suggested that he had fluctuating capacity at times and there was no reported evidence that Adult 4's capacity had been assessed by the Trust as part of his overall care and support plan. Consideration was not given to the Dual Diagnosis Pathway and few practitioners were aware of the policy and pathway. The Trust has therefore committed to review the application of the Dual Diagnosis Referral and Treatment Pathway Guidance in all service areas.

15. Nonetheless, the significance of Adult 4's relationship with the outreach nurse should be highlighted. It was evident that the outreach nurse did much to keep Adult 4 safe and to 'get alongside' him in such a way as removed many of the barriers to his accessing support and he clearly valued this therapeutic relationship until his mental health deteriorated at the very time that the outreach nurse herself became unavailable through sickness.

16. In order to strengthen their responses overall, the Trust has committed to reviewing the suitability of using the toolkit 'Mental Health Services for Rough Sleepers' (Pathway, 2014)[2] which provides a set of screening tools and practice guidance. The Trust is also considering the development of an integrated care record which could share records between health and social care providers for vulnerable individuals including those with current experience of multiple excluded homelessness.

1.

[2] This second edition, updated with the Care Act, is available at https://www.homeless.org.uk/our-work/resources/guidance-on-mental-capacity-act

Recommendations 1: Birmingham and Solihull Mental Health NHS Foundation Trust to review the application of the Dual Diagnosis Referral/Treatment Pathway Guidance in all service areas. This will require a corresponding Change Grow Live review of this guidance and partnership working.

Recommendations 2: Birmingham and Solihull Mental Health NHS Foundation Trust to review the current dual diagnosis policy to ensure the dual diagnosis guidance is a key feature to ensure effective joint working between Change Grow Live, and Birmingham and Solihull Mental Health NHS Foundation Trust.

Recommendations 3: The Homeless Xchange to review the suitability of using the 'Rough Sleeper' toolkit and the use of a care passport for people with current experience of MEH.

Recommendations 4: The Homeless Xchange and Homeless Community Mental Health Team to make adult safeguarding referrals when required and use the dispute resolution process to challenge disagreements about referrals meeting thresholds.

Recommendations 5: Birmingham and Solihull Mental Health NHS Foundation Trust to explore if there is any option to "surface" any information from EMIS onto RiO or develop another way of entering key information onto RiO to enable the sharing of information in instances like Mental Health Act assessments.

Recommendations 6: The Health Exchange to liaise with A&E departments and Psychiatric Liaison Service to improve identification of the registered GP of some homeless people being the Health Xchange.

Recommendations 7: The Health Xchange to consider how cover for sickness absence is managed by the service to enable adequate provision for vulnerable services users.

Recommendations 8: Birmingham and Solihull Mental Health NHS Foundation Trust to ensure any new mental health service offer to people with experience of MEH includes street outreach and assessment by CPNs and psychiatrists.

Birmingham Health Xchange General Practice

17. The GP element of the service is commissioned through Birmingham and Solihull CCG, and GPs were provided on a locum basis from Cape Hill Medical Centre. Cape Hill Medical Centre is accredited as a 'Safe Surgery' through Doctors of the World. Doctors of the World seeks to empower NHS staff to provide healthcare for everyone in their community. They provide resources and training to support doctors, nurses and administrative staff to better

understand the barriers that prevent people, including homeless people, from accessing healthcare, empowering them to advocate on behalf of excluded patients.

18. The CCG has considered that the primary care service needed to have:

- addressed the inconsistency of having a series of locum GPs servicing the Health Xchange and introduced a new contract for Cape Hill Medical Centre to provide clinical leadership and GP services at the Health Xchange, with a lead GP providing a consistent presence at the practice;
- monitored Adult 4's mental health more closely and recorded missed appointments. They have therefore required that a clear DNA policy be developed and implemented, and re-circulated guidance on the protocols regarding self-neglect provided by Birmingham Safeguarding Adult Board;
- had greater oversight of the discharge letters received from ambulance services and hospitals concerning mental health and self-harm and committed to strengthening their oversight and monitoring of safeguarding activity through the contracting monitoring process. This to be done by their Designated Safeguarding Team who are not usually part of that process;
- considered harm reduction advice concerning Adult 4's disclosures of his sharing of needles. This advice would be expected to be provide by the HIV clinic, but it was known that Adult 4 was rarely attending this clinic;
- considered how Adult 4's homelessness was being addressed and committed to raise awareness of GPs about the homeless pathway; and
- that greater monitoring of the services was required and committed to monitoring and assurance around the future quality of the service, which is now rated as 'outstanding' by the Care Quality Commission.

Recommendations 1: Birmingham and Solihull CCG designated team to have oversight and monitoring of safeguarding activity for the Primary Care Service provided to Birmingham Health Xchange, through the contracting monitoring process.

Recommendations 2: Birmingham Health Xchange primary care services to ensure appropriate health advice is given and ensure timely signposting for patients who disclose they are sharing needles.

Recommendations 3: Birmingham Health Xchange primary care services to ensure a clear DNA policy is developed and implemented to ensure missed appointments are followed, where appropriate, at the next available appointment with the Birmingham Health X change service.

University Hospitals Birmingham

19. Adult 4 sought treatment for HIV from the HIV Team in March 2018 following several years without treatment and medication. His treatment plan and wider needs were systematically reviewed by a multi-disciplinary team over coming months and included a wide range of responses including social work and

referrals to other specialities, notably nephrology and hepatology. Guidelines were followed when he disengaged from the service and the police called when he left in an agitated stated. The team's overall response reflected that staff had worked hard to support Adult 4 and to try to keep him engaged. When this was not successful and they were no longer able to contact him, they escalated their professional and social concerns to external agencies, leaving it open for him to be seen should he return to hospital. The Trust reflected that they need to:

- record an individual's mental capacity and behaviour, although in this case, Adult 4 was understood to have had mental capacity to make decisions;
- record whether assessments take into account a history of suicidal thoughts;
- record whether concerns over self-neglect need acting upon; and
- take action to ensure that when patients do not comply with prescribed treatment plans, that they are empowered to make their own decisions by being provided with clear information as to the risk and benefits, that all options are explored and that risk is assessed and mitigated as far as possible, in keeping with Risk Enablement Guidance (BSAB, 2019).

Recommendations 1: University Hospital Birmingham to ensure that when patients do not comply with prescribed treatment plans, that they are empowered to make their own decision (even if felt to be unwise) by being provided with clear information as to the risk and benefits, that all options are explored and that risk is assessed and mitigated as far as possible.

Recommendations 2: University Hospital Birmingham to ensure learning from the review is shared with staff across the organisation.

Recommendations 3: University Hospital Birmingham to ensure qualified staff within the HIV teams receive level 3 safeguarding adults training.

Sandwell and West Birmingham NHS Hospital Trust

20. Adult 4 was admitted to City Hospital four days before his death. Whilst treating him, it was evident that staff assessed his risks and responded to Adult 4's wishes concerning his treatment. They also liaised effectively with the neighbouring Queen Elizabeth Hospital to enable his transfer to the specialist unit. It was noted that staff had made a referral to their homeless services and had planned to refer to substance misuse services before Adult 4 left the hospital without warning. The Trust has a its own homeless team and a robust referral pathway to support compliance with the Homeless Reduction Act 2017, which was seen as good practice.

21. The Trust reflected that their physician had not had a chance to make an assessment of Adult 4's mental capacity before he left the hospital and it was not until the following afternoon that actions were taken to liaise with the Health Xchange and mental health services in the hope of returning Adult 4 to hospital.

As a result, the Trust has committed to raise awareness of the Mental Capacity Act, safeguarding and self-discharge procedures. It proposes to design bespoke training on these areas, which will be mandatory for all qualified staff, and auditing their impact upon compliance with the Mental Capacity Act, safeguarding, self-discharge and escalation procedures.

Recommendations 1: Sandwell and West Birmingham Hospital Trust to raise Awareness of Mental Capacity Act and Safeguarding Escalation.

West Midlands Ambulance Service NHS Foundation Trust

22. West Midlands Ambulance Service (WMAS) responded to seven calls for assistance during the period in question. No clinician had more than one contact with Adult 4 and the full extent of his situation and needs was not known to WMAS. In the main, Adult 4 was reluctant to share inform or engage with ambulance staff and he was frequently rude and aggressive towards them. However, ambulance staff took time to engage with him and calm him and, on a number of occasions, he went on to explain that his behaviour was his frustration at being detained when he wanted to go about his day.

23. There was good evidence prior to the day of the death, that ambulance staff had liaised well with other agencies on the scene, pooled resources and information and given due consideration to Adult 4's wider needs.

24. The last occasion in which Adult 4 declined assistance was on the morning of his death. Adult 4 was so obviously unwell that the crew were very concerned and did not want to leave him. They were aware that Adult 4 was HIV, Hepatitis C positive and schizophrenic. They worked hard to engage with him and worked alongside his friends to communicate and encourage him. Whilst they made an assessment of his mental capacity to refuse treatment, it was recognised that the crew had missed a significant opportunity to involve the Mental Health Triage Car, the Street Intervention Team or the police in his care, treatment and protection. They had considered contacting the police but did not consider that there was a legal basis for them to attend to someone who had the capacity to refuse treatment. The service was not familiar with multi-agency responses to rough sleeping in the area at the time and has therefore made a recommendation to contribute to securing a service pathway for referring homeless people.

25. A Serious Incident Investigation was undertaken following this incident and concluded that this ambulance crew needed further training on the principles of the Mental Capacity Act 2005 and 'best interest' decisions. Moreover, since this incident, the Trust has strengthened their guidance to staff concerning the need to record the rationale for their decisions about capacity and the importance of documentation.

Recommendation 1: West Midlands Ambulance Service to look at how they can engage with the Rough Sleeping Service Pathway and or Street intervention Team, or the Local Authority.

Birmingham City Council Adult Social Care

26. Adult Social Care reflected upon the various services calls for service within the following areas and considered that:

- a call made by a member of the public to the Emergency Duty had warranted further follow-up and communication with other agencies who were known to be involved at the time;
- a Mental Health Act Assessment did not give due consideration to the ongoing risk of mental health deterioration due to substance misuse and address this in the resulting plan. Neither did the Approved Mental Health Practitioner appear to consider the need to follow-up with the wide range of agencies identified;
- a social worker and their supervisor incorrectly understood that Adult 4's homeless status was a barrier to receiving a response from their service. As a result, the social worker did not assess his needs or undertake the level of enquiry expected for an assessment under the Care Act 2014 and that which was instructed by the duty worker;
- there was a missed opportunity for practitioners to fulfil their duty to refer under the Homelessness Reduction Act;
- there was a lack of awareness of the existence of social workers based at the HIV Clinic who would have been available for advice; and
- the complexity of large organisations was noted, and Adult Social Care is in the process of sharing information and pathways to each of the specialist teams, such as the HIV Team, across its services.

27. It was reflected that, in general, staff appeared to believe that partner agencies were better placed to support rough sleepers, despite their multiple and inter-related needs, although it was not clear what partner agencies expected of their service. It was further recognised that the skill sets developed by social work teams had tended to be around home visits and there appeared to be a lack of confidence around engagement with rough sleepers and creativity in considering how to approach this work with partner agencies. As a result, the service has committed to raising the capacity of staff to be able to be accessible to rough sleepers and respond effectively, from a trauma informed perspective and in partnership with other agencies. Moreover, the service has committed to provide training and guidance to social work teams on their duty to refer under the Homelessness Reduction Act.

28. Finally, the response by one social worker in describing Adult 4's circumstances as a 'chosen lifestyle' was found to be of concern. These matters of practice will be taken up specifically with the individual members of

staff concerned as this type of minimisation and judgement was not considered to be more widespread amongst staff.

Recommendation 1: Birmingham City Council Adult Social Care to provide information to all Adult Social Care staff on our duty to refer under the Homelessness Reduction Act 2017.

Recommendation 2: Birmingham City Council Adult Social Care to undertake myth-busting workshops with staff around rough sleepers. To include raising awareness of trauma, our partner agencies and considerations when assessing needs and undertaking safeguarding enquiries.

Recommendation 3: Birmingham City Council Adult Social Care to discuss increasing the accessibility of their service to include the development of "touch-down points/hubs" in the community, and the value of a "trusted assessor" in the homeless outreach team.

Recommendation 4: Birmingham City Council Adult Social Care to develop more effective working relationships with partners and to contribute to complex case MDTs.

Change Grow Live

29. Adult 4 had been known to Change Grow Live (CGL) since 2015 and had ten separate treatment periods since that time, although his engagement with the service was sporadic. At times they would see him daily, but they described their engagement as often superficial as Adult 4 rarely wanted to engage. Beyond this, CGL's homeless team were involved in providing him support; attended the multi-agency case meetings with the Street Intervention Team; and held multi-disciplinary case conferences to formulate a plan around his homelessness, drug use and mental health issues.

30. CGL reflected on their involvement that they lacked a plan to manage the risks of non-engagement; lacked exploration of Adult 4's apparent paranoia around certain medication; should have explored further Adult 4's decisions to decline treatment, as well as assessed his capacity to make those decisions each time. CGL have therefore made a recommendation to require a risk management plan at the start of treatment to include an assessment of previous dis-engagement and plans to mitigate this. Practitioners appeared to be managing crises more than delivering trauma informed, psycho-social interventions, particularly as they were well aware of his history of abuse and neglect. Since this time, CGL have introduced training for all staff on trauma-informed practice

31. However, there was some evidence that mental health pathways were not well understood and CGL have made a recommendation for themselves to strengthen how mental health pathways are understood by staff.

32. In addition, CGL's role in relation to other agencies was not always clear and their potential role as lead professional for Adult 4 did not appear to have been explored. CGL would normally become the lead professional if a service user

did not have any identified mental health concerns that would require the Care Programme Approach, which Adult 4 did not. Although CGL had experienced difficulty in maintaining engagement with Adult 4, their homeless team had the experience of working with hard-to-reach populations and had the resources to meet Adult 4's needs. Despite them being well placed to be the lead professional for Adult 4, they recognised that they were not in a position to leave cases open indefinitely and were able to demonstrate a robust process for attempting to re-engage an individual.

Recommendation 1: Change Grow Live - When a service user represents into treatment, staff to explore the reasons behind previous disengagement and to put actions into place to mitigate, as far as possible, to ensure continued engagement.

Recommendation 2: Change Grow Live to work with mental health services to ensure that there are effective pathways in place to support service users with substance misuse and mental health concerns.

Recommendation 3: Change Grow Live to ensure staff across the service are competent in their knowledge of mental capacity and the impact this may have on a service user's ability to engage.

Midland Heart

33. Rough Sleepers Outreach Team within Midland Heart engaged regularly with Adult 4 from 2015 onward, although his non-attendance at appointments was frequent and when accommodation was sought for him, he would generally dis-engage at the point of access and decline offers of accommodation. Nevertheless, various options of supported accommodation, provision for individuals with multiple needs and private rented accommodation were offered at various times in order to prevent further rough sleeping.

34. Reflecting on their services, Midland Heart considered that:

- they were often flexible in offering to complete assessments on outreach, enable direct routes of access to specialist accommodation and keep accommodation open to him for extended periods of time, which was seen as good practice;
- highlighted by a delay in raising a safeguarding concern and lack of adherence to internal safeguarding processes, they have committed to strengthen their response to safeguarding and to review their safeguarding procedures; and
- they had over-looked the local authority's statutory housing duty, particularly following the introduction of the Homelessness Reduction Act in October 2018. As a result, they have committed to addressing their internal procedures to ensure that all relevant homeless cases are referred to the local authority for consideration of their homeless duty.

Recommendation 1: Midland Heart to strengthen the Midland Heart Safeguarding Procedure

Shelter and Birmingham Changing Futures Programme

35. Within Birmingham Changing Futures Together, Shelter managed a Lead Worker who was to support adults experiencing homelessness, substance misuse, mental health difficulties and who were at risk of reoffending.

36. The Lead Worker identified Adult 4 as having housing, physical and mental health needs and referred Adult 4 to the local authority following concerns over his self-harm. However, they reflected that:

- no action had been taken in regard of his self-neglect or suicidal ideation and further records in respect of any mental health support were lacking - they have now committed to build staff knowledge and skills around adult safeguarding, Mental Capacity Act, and self-neglect;
- the Lead Worker had difficulty engaging fully with Adult 4;
- case notes and action plans lacked detail;
- plans to address his housing needs through housing options were not clear, and he was not supported by them to make a homeless application; and
- they lacked a third-party protocol to regulate information sharing with other agencies.

37. As a result, Shelter have committed to recommendations to address these shortcomings and to ensure consistency and quality of their approach through undertake a training needs analysis for their caseworkers; a review of internal policies, procedures and a case audit.

38. During his last weeks of life, Adult 4 was using the Shelter office to contact the Department of Work and Pensions and resolve his benefit situation. He became frustrated during the call. Since this time the Department of Work and Pensions has provided a service through the Shelter offices and this is seen as good practice and a pro-active response to addressing the needs of rough sleepers.

Recommendation 1: Shelter to assess the training needs of staff and scope out what casework management training is available.

Recommendation 2: Shelter to undertake review of internal policies, procedures and templates to ensure they are fit for purpose.

Recommendation 3: Shelter to undertake a case mapping exercise for shared learning.

Recommendation 4: Shelter to review their Information Sharing Protocol.

Trident Reach

39. Adult 4 stayed at Washington Court between April and August 2018, having been referred by Changing Futures and, after an initial assessment, they often experienced difficulties in engaging with him despite their attempts to be flexible in the way that support was offered. They considered:

    - that greater liaison and joint working should have been held with other agencies, particularly when they identified that Adult 4 was self-harming and his disengagement risked him losing his room; and
    - that there were shortcomings in their record keeping, particularly in respect of 'next steps' that were agreed to maintain engagement with Adult 4 and recommendations have been made in each of these regards.

40. As a result of recent commissioning by the City Council, Trident Reach's involvement in homeless services has been extended. The new service commissioned from them promotes a 'community navigator' role, with support workers taking the lead in co-ordinating multi-agency collaborative approaches to supporting each individual. Moreover, the organisation has recently been involved in developing a multi-agency template for Hospital Passports and Health Action Plans for people experiencing homelessness. These could accompany a person at the point of hospital admission and aid hospital staff in understanding that individual's particular needs, wishes and preferences; help breakdown any actual or perceived barriers in accessing and maintaining patient care; reduce the risk of self-discharge or exclusion from hospital services. Further consideration of more recent developments in the multi-agency service landscape will follow.

Recommendation 1: Trident Reach to ensure that their staff utilise their agencies on-line case management system 'In-Form'.

Recommendation 2: Trident Reach Staff to adopt a community navigator role.

Recommendation 3: Trident Reach to ensure all service users who return to service during an abandonment procedure undertake a re-engagement discussion.

Recommendation 4: Trident Reach to pilot Hospital Passports and Health Action Plans for individuals experiencing homelessness.

Criminal Justice and Enforcement Agencies:

West Midlands Police

41. West Midlands Police had a longstanding neighbourhood policing team in Birmingham City Centre, and police officers were therefore able to familiarise themselves with the increasing number of homeless people who were rough sleeping in the area. Indeed, Adult 4 was well known to the police as a Persistent Prolific Offender and, as such, he was regularly encountered by the police through both stop and search, through the enforcement of a Criminal Behaviour Order and through undertaking safe and well checks when alerted by other agencies. In total, police officers undertaking stop and search, recorded his location 132 times.

42. Within this high level of contact, the police noted numerous examples of good practice: often providing an immediate response when Adult 4 was at risk; providing the highest level of observation and care whilst he was in custody; providing safe and well checks; collaborating with other agencies and responding to members of the public who were concerned for his welfare.

43. Despite the high demand for their response, the police found no indication that the risks that Adult 4 faced had been downplayed or normalised. However, the Force recognised that vulnerable adult referrals were not always made; threats of suicide were not always followed up with other agencies and their Partnership Unit not always deployed to make referrals. The review heard how the Force has since introduced a new policy to guide their responses to adults with care and support needs as well as a new Vulnerability Referral Form available on their force-issued mobile devices to enable them to refer a vulnerable person for support from partner agencies directly at the scene. They will also be reinforcing their expectations of officers in responding to self-neglect.

There were no recommendations set for the West Midlands Police

Staffordshire and West Midlands Community Rehabilitation Company

44. The Community Rehabilitation Company (SWMCRC) managed Adult 4's release from prison after a short period in custody in July 2017. This included post sentence supervision for twelve months until July 2018. During this time, Adult 4 attended supervision as required, but it was reflected that little in the way of rehabilitative work was completed as a result of the 'chaotic' nature of his life at that time.

45. SWMCRC recognised that Adult 4 had maintained contact throughout his licence period and therefore did not breach the conditions of his licence where further concerns would have been raised. However:

    - the resettlement plan undertaken prior to his release from prison was inadequate, lacked management oversight and did not form part of Adult

4's supervision in the community. His changing addresses were not verified; his chaotic lifestyle and risk not assessed, and the dedicated Housing and Welfare Teams not utilised to assist with benefits and secure accommodation;

- professional curiosity was lacking in respect of Adult 4's mental health issues and ongoing an absence of liaison and collaboration with mental health services or other agencies; and
- his circumstances were taken at face value and he was not therefore managed in a way that was true to his circumstances and would have benefited from having a case discussion with the manager.

46. A recent inspection report identified some of the shortcomings evident in this case, including excessive workloads; a concentration on maintaining attendance rather than focussing on the factors influencing offending and risk; lack of multi-agency liaison (HMIP, 2018). Much work has been undertaken since this time to strengthen the approach to adult safeguarding and risk, and in response to this review and the inspection report, SWMCRC have made the following recommendations:

- Refresher training on adult safeguarding for responsible officers and Improved and increased attendance at both internal and external safeguarding briefings/training across wider workforce.
- Actions to improve levels of professional curiosity when managing complex/vulnerable cases, particularly concerning the utilisation of specialist teams such as the Housing and Welfare Teams and utilisation of conditions of licence for attendance at both substance misuse and mental health services.
- Improved communication between Community Offender Managers and Through the Gate Resettlement case workers, strengthening release planning and follow-through into the community.

Recommendation 1: Staffordshire & West Midlands Community Rehabilitation Company Responsible Officer to attend adult safeguarding refresher training (internal and external).

Recommendation 2: Staffordshire & West Midlands Community Rehabilitation Company to work towards Improved levels of professional curiosity when managing complex/vulnerable cases for their staff.

Recommendation 3: Staffordshire & West Midlands Community Rehabilitation Company to Improve/increase attendance at both internal and external safeguarding briefings/training across wider workforce

Recommendation 4: Staffordshire & West Midlands Community Rehabilitation Company to work towards Improved communication between Community Offender Managers and Through the Gate Resettlement case workers.

HMP Birmingham

47. Adult 4 was only in custody in HMP Birmingham for two weeks in July 2017. Inter-disciplinary staff ensured that he received his usual anti-psychotic medication and he was referred to both substance misuse services and probation. Whilst no concerns were noted, the government has, since this date intended to introduce an "accommodation on release" performance indicator to be jointly owned by prisons and probation services (Ministry of Housing, Communities and Local Government, 2018 c).

There were no recommendations set for HMP Birmingham.

Birmingham City Council Street Intervention Team

48. The role of the Street Intervention Team was to provide a multi-agency approach to supporting members of the street community and rough sleepers. This has included, where necessary, taking action against individuals who are perceived to be acting in an anti-social manner and begging aggressively. The multi-agency team met daily at the start of the day and shared a common database that recorded contact details for all agencies working with an individual. The particular role of the City Council within this team was to co-ordinate multi-agency meetings, enable Adult 4's engagement with other agencies and to take enforcement action on anti-social behaviour as required.

49. The ASB Enforcement Officer spoke with Adult 4 on a very regular basis and prioritised Adult 4's needs in the face of pressure to take action against him for his anti-social behaviour. It was considered at the time that having a further order would not necessarily impact upon Adult 4's behaviour, and they concentrated on supporting the existing Criminal Behaviour Order. Nonetheless, it was reflected that the officer lacked training in safeguarding and homelessness and relied upon decisions being made by others in the multi-agency team around referrals. A recommendation has therefore been made to ensure that all local authority staff working within the Street Intervention Team receive regular training on trauma informed practice, adult safeguarding, self-neglect and mental capacity. They have also recognised the need to strengthen their supervision and management in respect of safeguarding functions. Expectations of detailed case recording by City Council officers involved in the team has also been formalised as this was found to be lacking.

Recommendation 4: Birmingham City Council Street Intervention Team to strengthen the capacity of staff to identify and respond to adults with multiple needs.

Department of Work and Pensions (DWP)

50. Adult 4 had passed the Work Personal Capacity Assessment for Employment and Support Allowance. In view of his assessed support needs, he was therefore not required to attend meetings with a work coach at Jobcentre Plus

and had all contact by telephone. His benefits were disrupted at times when he did not notify of a change of address but reinstated swiftly when support workers contacted them. During the Christmas period, Adult 4 experienced problems with the split payments and he was offered a short-term benefit advance and food bank, and the local Jobcentre Plus offices were alerted to the need to provide the advance should he present in person at any office.

51. Significantly, since this time, the DWP has introduced a permanent homeless outreach worker based at St Basil's, Shelter and SIFA on a daily basis. The service also now attends Birmingham's Rough Sleeper Taskforce and questions around homelessness and vulnerability are now systematically asked at the start of every new claim. Each of these are recognised as a good practice response.

There were no recommendations set for the Department of Work and Pensions

BIRMINGHAM SAFEGUARDING ADULTS BOARD

"Safeguarding is everybody's business"

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