BIRMINGHAM SAFEGUARDING ADULTS BOARD

"Safeguarding is everybody's business"

Safeguarding Adult Review Report
Stephen

Acronyms

ACAP: Adult and Communities Access Point
ACE: Adverse Childhood Experience
ARDB: Alcohol Related Brain Damage
BCC: Birmingham City Council
BCHC: Birmingham Community Healthcare NHS Trust
BSAB: Birmingham Safeguarding Adults Board
BSMHTF: Birmingham and Solihull Mental Health Foundation Trust
CCG: Clinical Commissioning Group
CGL: Change Grow Live
CIWA: Clinical Institute Withdrawal Assessment for Alcohol
CMHT: Community Mental Health Team
CPN: Community Psychiatric Nurse
CRC: Community Rehabilitation Company
CT: Computerised Tomography [scan]
DART: Drug and Alcohol Recovery Team
DHR: Domestic Homicide Review
DVT: Deep Vein Thrombosis
ED: Emergency Department
EPR: Electronic Patient Records
GP: General Practitioner
HMP: Her Majesty's Prison Birmingham
HRA: Homeless Reduction Act 2017
iCAT: Intelligence Common Assessment Tool
IMR: Individual Management Review
LA: Local Authority
LWPM: Lead Worker Peer Mentor Scheme
MAPPA: Multi-agency Public Protection Arrangement
MCA: Mental Capacity Act
MDT: Multi-Disciplinary Team
NICE: National Institute for Health and Care Excellence
PIE: Physical, Intellectual, Emotional Training
PIPs: Personal Independence Payments
PPU: Public Protection Unit
RSI: Rough Sleeper Initiative
SAB: Safeguarding Adults Board
SAP: Supporting Adult Panel
SAR: Safeguarding Adults Review
SCR: Safeguarding Child Review
SIT: Street Intervention Team
WM: West Midlands
WMP: West Midlands Police

Acknowledgements

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. The panel particularly wishes to thank members of Stephen's family for their contributions.

The family representative has read the report prior to publication and expressed:

"It is beyond my wildest dreams everyone was so helpful and compassionate regarding Stephen including the resources and time being put into this review including the support from the board support team. I would like to thank all the services in particular the Washington Court Support worker for their hard work"

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1 Background to the Safeguarding Adults Review

The Birmingham Safeguarding Adults Board (BSAB) has a statutory duty to arrange a Safeguarding Adults Review (SAR) where:

- An adult with care and support needs has died and the Safeguarding Adult's Board (SAB) knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and there is reasonable cause for concern about how the Board, its members or others, worked together to safeguard the adult.

- A SAB can also carry out a review when the statutory criteria for a review is not met for an adult with care and support needs. A SAR is a multi-agency review carried out to determine what agencies involved could have done differently that could have prevented harm or death from taking place. The aim is not to apportion blame - it is to promote effective learning and improvement to prevent future death or harm occurring, and to improve how agencies work together towards achieving positive outcomes for adults and their families.

2 Decision to Conduct Safeguarding Adults Review

The SAR Sub-group of the BSAB Executive Board considered this case against the SAR criteria and concluded the case did not meet the statutory criteria for a SAR, however decided to follow its discretionary power to still carry out a review. The Independent Chair of the BSAB ratified this decision. It was decided to commission someone independent to carry out the review.

3 Methodology for the SAR Learning Review

The Care Act 2014 Statutory Guidance states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. There is no set statutory model which has to be used for SARs.

The methodology for this review was based mainly on Reflective Practice Sessions - the original participants in the case reviewed identified aspects of the case (as part of a reflective practice session chaired by the independent reviewer/author). Due to the review taking place sometime after Stephen's death and the scoping period that was reviewed, some of the actual key front-line staff were no longer available, therefore their organisation sent appropriate representation to participate in the Reflective Practice Session.

The Review adopted the following steps:

- A SARs Panel was set up to oversee and manage the review. An independent reviewer/author was commissioned to carry out the review, and a Chair identified for the SAR (see section 5.1 and 5.2 for details of the SAR panel).

- Key agencies involved provided a chronology which detailed their

agency's involvement in the case in the timelines identified. The agencies also provided summaries of any key learning they identified from their chronologies, as well as identifying any key staff who worked with Stephen who could be invited to the reflective practice sessions.

- A series of small themed reflective practice sessions with key staff who were involved directly with the Stephen were held. Where staff were no longer working for their organisation, the organisation was asked to send an appropriate representative.
- A larger reflective practice discussion then took place. bringing the smaller groups together as one to identify collective learning.
- The independent author was also able to speak to other relevant individuals if they were identified through the review.
- The author and representative from the BSAB met with the family representative.
- The independent author wrote the Overview Report, which was overseen by the SARs panel.

4 Involvement of Family and Friends

The independent reviewer had the opportunity to speak with a member of Stephen's family. They described Stephen's family life and the experiences that shaped his later years. Although they had little contact with Stephen in the last ten years of his life, they did hold telephone conversations with him in the last few months before his death. The SAR panel were grateful for the family contribution.

5 Terms of Reference and Key Lines of Enquiry

The SAR was required to address the following:

- What happened?
- What were the relevant agency policies and procedural guidance at the time, and were these followed by the professionals involved?

This would lead:

- To identify whether any errors or problematic practice occurred and/or what could have been done differently.
- Why these errors or problematic practice occurred, and/or why things were not done differently.
- Were there significant weaknesses in, or gaps, between the agencies policies?
- Were all appropriate professional/agencies involved at the time?

- Was communication effective between the parties involved?

- To what extent were professionals aware of, and influenced by, the wishes of the vulnerable person and their carers?

In addition, the following Key Lines of Enquiries will be looked into as part of the review, taking into account the below:

- Was there any system learning in regard to Stephen's accommodation needs?

- What were the issues that led to Stephen sleeping on the street as opposed to the accommodation provided, and what could have been done differently?

- Was the right support put in place both pre and post-prison, considering his needs for care and support, housing, self-neglect and mental health?

5.1 The SAR Panel

The panel members have identified where (if at all) they may have been involved in Stephen's case. Their involvement was reviewed by the BSAB and was not considered to in anyway hinder their impartiality and ability to participate in the review as a panel member.

The panel had representation at a senior level from the following agencies:

- Birmingham and Solihull Clinical Commissioning Group (CCG)
- Birmingham Community Healthcare Foundation Trust (BCHC)
- Birmingham and Solihull Mental Health Foundation Trust (BSMHFT)
- Adult Social Care, Birmingham City Council (BCC)
- Commissioning Partnership Insight and Prevention, BCC
- Neighbourhoods Directorate, BCC
- Public Health - BCC
- National Probation Service
- West Midlands Police (WMP)
- Her Majesty's Prison (HMP) Birmingham
- BSAB Business Board Manager
- BSAB Safeguarding Project Officer
- Independent Reviewer and Report Author

5.2 The Independent Reviewer and Report Author

The independent reviewer and report author, Simon Hill is a retired WMP Officer who served for a number of years on the Public Protection Unit (PPU), investigating both child and adult protection cases. For five years he was responsible for the Review Team contributing to Individual Management Reviews (IMR), SARs, Safeguarding Child Reviews (SCR) and Domestic Homicide Reviews (DHR).

He has conducted numerous DHRs and SARs around the West Midlands (WM) region in the last seven years. He regularly presents learning from SARs

and DHRs at events held by safeguarding partnerships as well as facilitating multi-disciplinary workshops. For the last four years he has provided level III adult and child safeguarding training for CCGs, Hospitals and Mental Health Trusts.

He has had no involvement with any of the events and with the subject of the review and was no longer serving as a police officer during the period under review.

6 Themes for Reflective Learning Sessions

The reflective learning sessions were set up looking at the following areas:

6.1 Self-Neglect, Mental Health and Mental Capacity: the review considered the interrelation between Stephen's self-neglect, mental health and mental capacity

The SAR recognised during the scoping that consideration of self-neglect, mental capacity and mental health were overarching themes, relevant to all of the areas for themed learning sessions and formed part of each discussion:

- **I.** To what extent was Stephen's self-neglect addressed in a multi-agency approach?
- **II.** In the light of Stephen's complex mental health, alcohol abuse, memory issues and suspected Korsakoff's Syndrome, did your agency have a clear understanding of his capacity?
- **III.** Could further mental capacity assessments have been undertaken?
- **IV.** Assess whether any capacity assessment undertaken were appropriate and correctly recorded in line with the Mental Capacity Act (MCA) guidance.

6.2 Complex Health Needs: the review considered whether Stephen received appropriate and timely support in relation to his complex health needs

A consideration of the combined chronology and agency summaries made it clear that there was considerable evidence that Stephen's long-term misuse of alcohol and complex health needs were substantially increasing his vulnerability:

- **I.** To what extent was your agency aware of Stephen's complex health issues in including suspected Korsakoff's syndrome, peripheral neuropathy, cellulitis, Deep Vein Thrombosis (DVT) and alcohol dependency?
- **II.** What part did your agency play (if any) in addressing those needs?
- **III.** What understanding did your agency have of who else (if anybody) was addressing those needs?
- **IV.** To what extent were these issues taken into account in assessing the

risk to Stephen from self-neglect?

V. Stephen spent a period from November 2017 to January 2018 in Her Majesty's Prison (HMP) Birmingham where his complex health conditions required attention. Was a pre-release health assessment undertaken and if so, who was involved?

VI. Was there any attempt to register Stephen with a General Practitioner (GP) before release?

VII. Describe and detail any liaison with the services that would be supporting Stephen upon his release.

6.3 Housing: the review looked at the challenges experienced by professionals in finding suitable placements for Stephen pre-release and post release from prison in January 2018, taking into account his complex health presentation, self-neglect and offending history (MAPPA sex offender registration requirements.)

I. Were appropriate housing applications completed in this case? Identify the causes of any missed opportunities to find appropriate accommodation in this case.

II. What were the challenges faced in finding accommodation for Stephen?

III. What statutory duties exist to provide accommodation for an adult with the same complex needs and history as Stephen's (consider whether there have been changes in legislation and guidance since the period under review and describe their impact)?

IV. How could multi-agency working have been improved in relation to identifying suitable accommodation for Stephen?

V. What gaps in provision of suitable accommodation for adults with complex needs still exist? How could they be met in Birmingham?

6.4 Adult Social Care: the review considered the most recent assessments of need undertaken with Stephen to identify whether assessments of need identified how his complex mental and physical health needs were leading to self-neglect which impacted upon his eligibility for care and support

I. A needs assessment was conducted by a social worker in January 2018, during the period Stephen spent in prison. Should this assessment have been sufficient to identify Stephen's needs to agencies supporting him upon release? With whom was it shared (identifying contact with Adult Social Care community teams)?

II. The support worker at Trident Reach (Washington Court), made a further referral to Adult Social Care in January 2018 and a social worker assessed Stephen in February 2018 as not meeting the threshold for further support. Was this assessment informed by all of

the factors that could have affected his eligibility for support under the Care Act?

III. The February 2018 needs assessment was immediately challenged as incorrect by the referrer. The chronology would suggest that there was a considerable delay in addressing this concern (including case closure and re-opening). Can these delays be accounted for? Was the concern escalated correctly?

IV. Identify changes in the management or handling of referrals that have or could be made, to reduce the chance of such delays occurring in other cases.

V. Consider referrals received and assessments. Were they appropriate and did they conform to the WM Adult Safeguarding policy and procedures, and the requirements of the Care Act (2014)?

7 Stephen's Lived Experience

Stephen was a 65 year old man born in UK.

Stephen was divorced and had children, He was university educated and previously had a successful career.

Stephen suffered trauma from the suicide of his sibling and this led to him drinking and his mental health deteriorating. He later lost his job, his marriage came to an end, including less contact with his children. Some years on he lost his property and a large sum of money. This trauma is believed to have impacted on his drinking and mental health over time.

Stephen ended up in various accommodation, receiving criminal convictions including detention in prison.

Stephen was accommodated in Washington Court following release from prison in January 2018. Services were working towards providing appropriate long term accommodation and support to meet his needs. He had had a history of alcohol abuse and rough sleeping.

It would appear that Stephen slept on a public bench on the 4 July, where he was found collapsed the following morning. In spite of attempts by paramedics to revive him life was pronounced extinct. The Coroner recorded the death to be natural causes to be as a result of Hypertensive Heart Disease.

The former manager of the Street Intervention Team (SIT) described the reaction of her colleagues when they heard of Stephen's death; "…*they were incredibly fond of him and the day he died staff were more than upset. They made the effort to let other workers know because they knew they would be upset. It was more than that. He was somebody that people went the extra mile for on lots of occasions. It was testament to him that he could inspire that sort of affection."*

8 Stephen's Wellbeing

The SAR recognised that Stephen had complex medical conditions and vulnerabilities that impacted upon his emotional and physical wellbeing. Significantly, an almost uninterrupted 25-year history of alcohol abuse may well have led to both psychological and physiological damage.

The information gathered from the direct observations of professionals and from submitted chronologies describing Stephen's accompanying medical conditions would suggest that Stephen may well have developed a degree of ARBD or injury that would have impacted upon cognitive abilities and memory and mental capacity. There is little doubt that as a result of alcohol abuse alone, Stephen's mental capacity would have fluctuated, depending upon his level of inebriation.

In conversation with the independent reviewer, Stephen's family member confirmed that from around 2009 they had noted a cognitive impairment in Stephen. On several occasions in conversations, he appeared to have forgotten his father was dead. He would be confused about recent events and forget what had been discussed. Independent of the review,

Alcohol Related Brain Damage is not a progressive condition like dementia and if it is rapidly diagnosed, can be successfully treated - 75% of people with ARBD can make a slight, significant, or complete recovery[1]. This can only be achieved if a patient eschews alcohol and Stephen gave no indication that he was prepared to do that.

A prison psychiatrist, many years before the period under review, had identified that Stephen showed signs of Korsakoff's syndrome. This was never established as a confirmed diagnosis, although there were many signs in Stephen's behaviour and presentation that this could have been accurate. In prisons and hospitals, he was treated with medication intended to reverse the progress of Wernicke-Korsakoff's Syndrome.

It is quite possible that Stephen was experiencing some symptoms of Korsakoff's, although without a full diagnosis, it is hard to be sure to what degree. Korsakoff's Syndrome is one of the most serious forms of ARBD. It is a chronic neuropsychiatric condition caused by a Thiamine (Vitamin B1) deficiency. It is often found in individuals with long-term alcohol misuse, where they have neglected their nutrition. The symptoms include a form of dementia, memory loss and confusion, personality changes including apathy and depression and, in some cases, ataxia and balance issues (even when not drunk). They may experience confabulation or false memories where past memories are mixed up with current circumstances creating complicated events that never happened[2].

Frontal lobe damage, associated with ARBD can lead to impaired reasoning skills and difficulties with planning and understanding the implications of

[1] Smith & Hillman (1999) Management of Alcohol related Korsakoff's Syndrome

[2] **All in the Mind:** Meeting the Challenge of alcohol-related Brain Damage (Alcohol Change)

decisions (for example, whether or not to drink and how this could hinder or help recovery). It can impact on adapting and inhibiting behaviours leading to disruptive or inappropriate behaviours.

Stephen also suffered from Peripheral Neuropathy, damage to the peripheral nervous system. It can be caused by alcohol abuse and is linked to ARBD. It can affect motor nerves; movement, limb control and balance in the feet and be accompanied with pain and numbness. It can also affect autonomic nerves; sometimes it causes problems with bladder control leading to incontinence.

Stephen experienced DVT - blood clots in the arteries of the leg that can themselves cause Neuropathy. They can be linked to deficiencies in vitamin B1, causing blood vessels to leak and clot. He was also treated for Cellulitis; a bacterial infection of the skin often found in the lower legs. It is linked to self-neglect and is often experienced by rough sleepers

When in prison in 2017-18, Stephen was treated for Scabies, a highly infectious microscopic skin mite that causes rashes and severe itching. It is more common amongst the homeless and those who self-neglect than in the general population.

9 What did Stephen want? - informing Person-Centred Work.

When Stephen left prison in January 2018, he had explained to his prison social worker that he had a very positive experience in supported accommodation in Nechells that had allowed him independence, but support when he needed it. It was his preferred accommodation.

Washington Court Support Worker 1 who tried to find suitable accommodation when Stephen left prison, described how emotional he became when he was shown a potential accommodation he liked, and his subsequent disappointment when he was refused the property because of his offending history.

Washington Court Support Worker 1 felt that Stephen did want to reduce his dependence on alcohol but was not prepared to abstain from alcohol. Unfortunately, Stephen told the prison social worker *"…that in a choice between food or alcohol, alcohol always won*." He recognised the impact of low mood on his ability to function on a day-to-day basis and had stated a willingness to engage with mental health services even though early attempts were unsuccessful.

10 Key periods from the Chronology

10.1 January 2015 to November 2017

Stephen had served several prison sentences in the years prior to those being considered in the SAR. In July 2015, he was released again from prison and referred to Change, Grow, Live (CGL)[3] to continue the support relating to

[3] Change, Grow, Live (CGL) provide alcohol and substance misuse support in Birmingham

alcohol abuse that had commenced whilst he was in custody. He failed to attend two appointments and was discharged.

In January 2016, Birmingham Housing recorded a MAPPA risk assessment relating to Stephen which was to inform staff engaging with him: '*no lone females only visit in twos'.*

Released from a further custodial sentence that month, Stephen was placed in temporary accommodation in a Travel Lodge. The following month he took up a BCC tenancy, but in June 2016 was recalled to prison and lost the tenancy in August due to his behaviour. He had apparently been setting fires inside the premises and acting aggressively towards other elderly residents.

The SAR established that Stephen's risk assessment, combining sex offending and risk of violence had been reviewed by WMP Managing Sex Offenders and Violent Offenders officers in June 2016 and May 2017, and he had been assessed using the Thornton's Risk Matrix 2000[4] as a medium risk offender. This provided a combined score for risk of further offending. His sexual risk was deemed high, and his violence risk was considered to be low. He therefore had a combined score of medium risk of recidivism (risk of reoffending). A risk management plan had been completed and the overall risk was deemed to be medium risk (this sex offending risk assessment remained the same until April 2018 when his sex offender registration ended).

Although some agencies listed Stephen as a Schedule 1 Offender in their records (a statutory list of sexual and other offences that pose a risk to children), that terminology has been discontinued for over 15 years and such offenders are now identified as posing a *'risk to children'* in all child safeguarding procedures.[5] Stephen was never described as a Schedule 1 Offender by Probation or Community Rehabilitation Company (CRC) and was not considered to pose a risk to children.

Stephen had an established pattern of behaviours that led him to being arrested on several occasions between June 2016 and 2017 for failure to comply with the notification requirements of his sex offender registration that had commenced in 2011.

The WMP scoping document was clear that Stephen *'excused'* his repeated failures claiming at different times financial hardship, generalised confusion, memory loss and mobility issues. These reasons were not apparently given any credence and there is no evidence that his breaches were attributed to any medical conditions, even though those conditions continued to manifest themselves for the remainder of his life.

Stephen consequently spent a number of months in custody during this period. Re-released in June 2017, he again failed to attend scheduled alcohol support

[4] Risk Matrix 2000 (RM2000) is a statistically derived risk classification process intended for males aged at least 18 who have been convicted of a sex offence. At least one of these sexual offences should have been committed after the age of 16. It uses simple factual information about offenders' past history to divide them into categories that differ substantially in their rates of reconviction for sexual or other violent offences.

[5] West Midlands Child Protection Procedures 2.14

appointments with CGL.

Stephen was now homeless and mostly sleeping rough. In July 2017, he was admitted to Sandwell Hospital and appropriate paperwork was completed by the homeless team in preparation for discharge. He presented drunk with several conditions: Cellulitis, Atrial Fibrillation and suspected DVT. He was recognised as showing signs of Korsakoff's Syndrome, given appropriate medication and was treated for withdrawal from alcohol following an established protocol, Clinical Institute Withdrawal Assessment for Alcohol (CIWA)[6], but not referred to the alcohol team.

He was apparently repeatedly verbally aggressive with staff treating him and security were required to attend the ward. He was recorded by his doctor as explaining that urinary incontinence was a choice, because of his frustration linked to being convicted of indecent exposure when urinating in the street. There was no recorded Mental Capacity Assessment. Stephen self-discharged against medical advice. The Sandwell and West Birmingham Hospital NHS Trust IMR suggested that a safeguarding referral should have been made by the Emergency Department (ED) in these circumstances.

Two days later, Stephen was found rough sleeping in Birmingham City Centre by the SIT. At the end of the month, he was involved in a drunken altercation on the street with a security officer. He was arrested and found to be in possession of a collection of bladed and pointed implements and argued unsuccessfully they were work tools.

Stephen was entering a period, from July until being sent to prison in November, where his health worsened. He was suffering complications that led to a hospital admission for vascular surgery and for treatment for Ischaemia of the legs caused by Cellulitis, requiring treatment to femoral arteries.

He was frequently found drunk in the street and in September was taken to ED at Sandwell Hospital having been suspected of drinking his own urine. He had failed to keep sutures relating to his Cellulitis clean, but no self-neglect referrals were made.

In October, Stephen broke his left wrist as a result of a fall whilst drunk. Admitted again to Sandwell Hospital, the homelessness team identified the challenge of finding housing. He was noted to be a registered sex offender who had lost previous tenancies due to anti-social behaviour and arson. He was discharged to a *'friends'* address.

On the 1 November, Stephen was convicted in relation to the offensive weapons and his frequent disregard of court orders and was sentence to 6-

[6] The Clinical Institute Withdrawal Assessment for Alcohol, commonly abbreviated as CIWA or CIWA-Ar (revised version), is a 10-item scale used in the assessment and management of alcohol withdrawal

months imprisonment.

10.2 Stephen is sentenced to Prison from November 2017 to January 2018

On admission, Stephen underwent the appropriate medical assessment. It was apparently based upon self-disclosure and was not informed by transferred medical records since Stephen was apparently no longer registered with a GP. Stephen's old GP records would have been held centrally and could have been requested by the prison if required. He described being Bipolar and suffering Peripheral Neuropathy. He was recorded as having a diagnosis of Korsakoff's Syndrome and was consequently treated with Thiamine.

His CIWA score suggested mild symptoms of alcohol withdrawal, but Stephen reported 20 years of alcohol abuse and a daily alcohol intake of 50 units. He was placed under the Drug and Alcohol Recovery Team (DART). He also stated he had previously been an injecting drug user - it appears that Stephen declined further interventions in prison and there is no evidence that he was referred to CGL upon release.

He was recognised as being homeless and referred immediately to the CRC who would be responsible for identifying appropriate accommodation prior to release. He was also referred for a needs assessment by the prison social care team at a Complex Needs meeting on the 9 November.

Stephen was unkempt and in a poor physical condition, suffering from Scabies. He was consequently placed on a hospital ward. Initially he was recorded as verbally aggressive and refusing alcohol treatment. A week later, although he was more compliant, he was still not attending to personal hygiene and declined showers. His Social Work Needs Assessment indicated that he was fearful of showering because his mobility issues meant he was at risk of slipping. He was given support showering twice a week and this was assessed as the care and support he would need to maintain his personal hygiene.

Stephen was discharged from the hospital wing under Rule 45 (which meant he had no association with other prisoners *'in his own interests'* (commonly the case with sex offenders). Two weeks after entering prison, Stephen was recorded as urinating on his cell floor and defecating in a bin. Challenged over this behaviour, he was clear it related to mobility issues at night. It was however recorded that his poor hygiene was a *'behavioural choice'*. He was still suffering urinary incontinence and wetting his clothes throughout his time in prison.

On the 22 December, Stephen's release date was calculated as 30 January 2018. His Housing and Welfare Referral was started on the 9 January. In the subsequent days, the Resettlement Team and Probation started seeking approved premises for Stephen. The needs assessment from the social worker was shared with Probation and it confirmed he would need help with personal care and that mobility issues made a ground floor accommodation necessary.

The resettlement team approached at least three approved accommodation providers in the City, as well as commissioned supported accommodation but also non-supported exempted accommodation. They were met with the same response; either a lack of space or a refusal because of the complexity nature of Stephen's needs but also his offender history.

The resettlement team therefore sought to refer Stephen into the Lead Worker Peer Mentor Scheme (LWPM - *'Changing Futures'*) to provide support upon release. The SAR identified that at this time there was no way of monitoring referrals and applications in relation to a person with complex needs without follow-up calls and emails. This has been addressed and the new IT system (the Intelligence Common Assessment Tool (iCAT)) is an all-in-one database referral and case management tool for supporting clients with multiple complex needs.

The LWPM did not have capacity to take on Stephen, although they did begin to engage with him later (LWPM ended with the adoption of a Rough Sleeper Initiative, which will be described below).

Despite application to numerous housing providers, the resettlement team were struggling to find accommodation for Stephen as his release date approached. His combination of complex needs, his anti-social behaviour, and his sex offender status and convictions for arson, meant they were being met with repeated refusals from providers. The SAR considered if this difficulty was because of the unique complexities of Stephen's case, or whether this was a reflection of a failure on the part of commissioned providers to meet their responsibilities to accommodate homeless adults with complex needs (see *'Analysis: Homelessness and Rough Sleeping'*, section 13).

There was an attempt by Probation to organise a Homeless Team Assessment of Stephen in prison or over the phone, six days before release. This was apparently not practical.

At this point, the concern that no accommodation could be identified was escalated to the Commissioning Manager, Prevention at Adult Social Care. The probation team were told by Housing that because of his history, they could not accommodate Stephen either in the City or outside. They were asked not to present Stephen at the neighbourhood office on his release - this would be the normal procedure where a standard housing application (Housing Options) or homeless application was required. No explanation was apparently shared with Probation for this advice, however the neighbourhood directorate explained at the learning sessions that this was because of the MAPPA risk assessments which remained *'live'* on their system and had actually been reaffirmed by Probation themselves on the 24 January, prior to Stephen's release.

It was the view of the homeless team manager that the most suitable choice for Stephen would be residential care. Although there was evidence provided at a learning session that this was indeed explored with Adult Social Care and a suitable placement found, it was not pursued as an option.

The intervention of the service commissioner with the homeless team

manager meant, however, that on the day of Stephen’s release, several options were being explored in tandem:

- Fry Housing would interview Stephen upon release.
- If this option was unsuccessful, Stephen would be accepted at Washington Court (a hostel for adults at risk of homelessness) for one week with a package of support in line with his Prison Needs Assessment.
- A suitable BCC bungalow property had been identified that needed some preparation that Stephen could bid on through the Housing Options Pathway.

10.3 January 2018 to Stephen’s Death (July 2018)

Stephen was released on the 30 January and met at the gate by a police officer and a support worker from Midland Heart. After visiting probation, the assessment at Fry Housing was unsuccessful because of a misunderstanding that led them to believe Stephen was on day release only. Stephen consequently moved into Washington Court. It was to turn out to be his temporary home until his death five months later.

By the 31 January, Housing confirmed that Stephen no longer had the highest priority for the bungalow, and it was to be allocated to another applicant. Whilst this was shared with Midland Heart, Probation were unaware and informed the WMP MAPPA team of this proposed address. This led Police to state a few days later that the address was unsuitable due to the proximity of other sex offenders; a judgement with which Probation took issue. Probation would have had the final say as approval by the Police was not required, but agreement of all agencies is desirable. With hindsight, it can be seen that this difference of opinion was immaterial, since the property was no longer available.

The learning session established, through the helpful sharing of BCC’s electronic housing application records, that Stephen had had a *‘Part 6’* application opened on his behalf on the 30 January, where he was assessed as band 4: *‘Applicants aged 55 or over or disabled applicants seeking retirement or extra care housing’.* This is the standard route for housing applications and can be distinguished from the duties placed upon a Local Authority (LA) when a homelessness application is received.

It was established that this banding was changed two hours later to *‘no housing need’* because Stephen was accommodated, albeit temporarily, in Washington Court. As a consequence, the application was paused. This meant that although he remained homeless, he would not be offered any BCC properties until such point that he left Washington Court and reactivated his application. There is no evidence that Stephen, and significantly, Washington Court Support Worker 1 who would be working with him addressing his housing and other needs, were aware of this paused status in relation to Birmingham properties.

It was also established in discussions with Housing officers, that had a

homeless application been submitted, this could not have been paused in the same way. A homeless application would have been continued and his eligibility would have been assessed and accommodation offered for Stephen to consider. The learning related to housing applications is considered below.

The probation accommodation team continued to seek accommodation for Stephen in the first weeks of February, with no success.

It is an indication of how rapidly Stephen returned to abusing alcohol that he was taken into ED at the Queen Elizabeth Hospital after a fall on the 1 February. He was drunk, had pain in his shoulder and neck and was moved overnight to the emergency observations unit because of concerns around cardiac issues. Stephen was not registered with a GP, so no discharge letter was sent. No referral was made to alcohol services and Stephen was discharged to a *"…hostel in Moseley"*. This was poor practice and showed a lack of professional curiosity given Washington Court is not in Moseley. It was an indication of confusion and memory issues that were a recurrent feature of Stephen's presentation to professionals.

A critical part of his care required the reassessment of his needs for social care, which were currently being met on a very temporary basis by Washington Court staff. The reassessment was allocated to Social Worker 1 on the 4 February and took place on the 13 February. Only Social Worker 1 and Stephen were present. During a face-to-face Care Act section 9 needs assessment, an adult with care and support needs (which had been established in prison) must[7] be supported by their carer or any person nominated by that adult. Whilst not strictly his carer, Washington Court Support Worker 1 was well aware of Stephen's needs and therefore her absence was regrettable, since she could have helped to prevent a needs assessment based only upon Stephen's self-assessment of his needs and vulnerabilities, which it is reasonable to suggest was probably not accurate.

Social Worker 1 concluded that Stephen "…*did not meet the threshold for funded social care*". This contradicted the earlier needs assessment conducted in the prison. The reliability of the assessment and the factors contributing to it are considered below in section 15.

It is a measure of Stephen's issues around memory that two days after the needs assessment, he told probation he had had no contact yet from Adult Social Care.

Washington Court Support Worker 1 addressed Stephen's entitlement to Personal Independence Payments (PIPs) in February. This was good practice returning to Stephen the dignity that comes with some level of financial security.

[7] In the case of an adult with care and support needs, the LA must also involve any carer the person has (which may be more than one carer), and in all cases, the Authority must also involve any other person requested. 6.30 Care Act Guidance

Stephen, supported by Washington Court Support Worker 1, handed in registration forms to GP Practice 1 on the 20 February (It was almost another month before he had a first review with a GP Registrar). The next day Stephen could not remember the name or location of the practice when speaking to his probation officer.

Stephen remained incensed by his indecency conviction and his sex offender registration requirement. As late as February 2018 (two months before it expired) he was appealing the requirement through the court.

Stephen was finally reviewed by a Registrar GP on the 16 March, six weeks after his release from prison. The appointment was superficial and there was no structured consideration of Stephen's complex health needs until a further GP appointment 12 days later.

By March 2018, following referrals by the CRC Housing and Welfare Team, the LWPM were arranging to start engagement with Stephen. He did not attend his first appointment at Washington Court.

In March, Washington Court Support Worker 1 and Probation were repeatedly making calls to Social Worker 1 at Adult Social Care to put in place *'home help'*, oblivious to the fact that the assessment had concluded Stephen did not have care and support needs and was to be closed on the 28 March. The closure was supported by a comprehensive but unrealistic list of signposting suggestions. These were not shared with anyone who could assist Stephen, whose memory issues and self-neglect meant his engagement with the proposed steps was unlikely.

It was not until the 5 April that Washington Court Support Worker 1 discovered from Social Worker 1 the result of the first assessment. Social Worker 1 claimed he had assumed Stephen had moved on, but in view of the fact he was still at Washington Court, he undertook to reassess Stephen. The reassessment did not occur as promised and Washington Court Support Worker 1, after repeatedly chasing the re-assessment, was obliged to re-refer Stephen on the 22 May. Stephen was showing marked signs of physical and mental health deterioration. Washington Court Support Worker 1 had by then spent a long time calling and *'hanging on'* for Social Worker 1 where escalating her concerns through management may have prevented considerable frustration. The engagements with Adult Social Care are considered below in section 15.

Stephen's deterioration in April and May was recorded on several occasions by Probation when he missed appointments or turned up drunk but amiable. By mid-April, Stephen had been at Washington Court for more than 12 weeks, the maximum allowable stay at the hostel.

From January until his death, Stephen was attending ED increasingly frequently, and all of the admissions stemmed from concerned passers-by on the street. There does not appear to have been consistent identification of this as an indicator of increased risk across the professionals who were working with Stephen. These increasing signs of self-neglect in Stephen, shown also by alcohol abuse and lack of attention to his hygiene and self-care, were an

indication that a specific self-neglect safeguarding referral was required that focused upon his deteriorating physical and mental health. The absence of a multi-disciplinary meeting to consolidate each professional's awareness of the current compromised state of Stephen's wellbeing, will be addressed in section 12.1.

On the 15 May, Stephen was taken to City Hospital in relation to a DVT but was abusive to staff and asked to leave. Washington Court Support Worker 1 became aware of this instance and informed the GP.

Washington Court Support Worker 1's actions above prompted a GP appointment on the 25 May, where the memory loss issues, she was describing together with Stephen's deteriorating mood and self-care issues were identified as possibly due to Korsakoff's Syndrome. Stephen stated he was bipolar and had run out of prescribed Lithium on a recent trip to Portugal. There is no evidence that he was either still being prescribed Lithium or that he had been to Portugal in the months since his release from prison and it is suggested that this may be a further sign of his memory issues linked to alcohol and a possible false memory associated with Korsakoff's Syndrome. The GP referred Stephen for a psychiatric assessment in relation to Bipolar. In common with his initial first GP appointment, no plan to refer to alcohol services was discussed.

On the way to Washington Court from the GPs, Stephen revealed to Washington Court Support Worker 1 that he was being threatened and financially abuse by other residents at Washington Court and this was shared with Adult Social Care. It correctly became a focus for a Safeguarding enquiry which, whilst important, seemed to deflect attention away from the increasing risk from self-neglect and deteriorating health that were themselves every bit as urgent.

In June 2018, Stephen had a first meeting with the LWPM workers. The contact was positive, but it was to be the only session with the team before Stephen's death. Meanwhile Washington Court Support Worker 1 was now trying to get Adult Social Care to respond to the new referral of concerns around self-neglect and exploitation. She informed Probation of her concern that, due to racial abuse of staff (including her), Stephen was facing eviction. In addition, he was absenting himself from Washington Court due to fear of other residents.

On the 11 June, Stephen was taken to University Hospital Birmingham with pain related to the DVTs in his legs. He was drunk and aggressive and was required to leave the hospital. There was no attempt to refer to alcohol services. A discharge letter alerted the GP to the frequent attendance (12 in the last year), and the fact they were alcohol related. Stephen was asked to attend for a GP review which was good practice.

The Community Mental Health Team (CMHT) for Older People discussed Stephen at a Multi-Disciplinary Team (MDT) meeting on the 13 June and felt that available information suggested that Korsakoff's Syndrome was more likely than Bipolar.

On the 14 June, for the first time in many months, the SIT saw Stephen with a group of homeless people in Birmingham City Centre. On 16 June he was again taken University Hospital Birmingham having been found drunk and unconscious. He refused all Computerised Tomography (CT) scans.

On the 17 and 18 June Stephen reported to the police two assaults and a criminal damage to his property by another Washington Court resident.

The referral of the 22 May was finally investigated by Social Worker 2 on the 20 June. The delay to the enquiry had been caused in part by capacity issues, a problem explored at learning sessions and developed in section 13

On the 22 June, Stephen was again taken to City Hospital, having been found unresponsive in an alleyway. He had a bottle of alcohol and one that appeared to contain urine. During triage he was verbally and racially abusive to staff and there are no records available of any treatment offered.

On the 25 June, the CMHT attended Washington Court to start Stephen's assessment, but he failed to attend. They were briefed by a support worker (not Washington Court Support Worker 1) who provided information about Stephen that contained numerous factual inaccuracies around Stephen's health and offending history. This was borne out by Washington Court Support Worker 1 at learning events, who felt she had never received sufficiently accurate or detailed information about her client upon release from prison, including details of his arson and sexual offending.

Towards the end of the month, Washington Court Support Worker 1 was still trying to re-arrange a mental health assessment, and Stephen was reported as drunk on site and again racially abusive. There was an incident where she went to speak to Stephen and he lay on his bed apparently oblivious to the fact that his dressing gown was open, exposing his genitals. This could have been a deliberate provocation, but it could also be a sign of the lack of inhibition associated with Korsakoff's Dementia.

On the 28 June, Stephen was taken to University Hospital Birmingham from the street with breathing difficulties, and difficulty walking; he was given antibiotics and discharged home. Unfortunately, on the same day, the CMHT attended for the re-arranged appointment, but he was absent. Washington Court Support Worker 1 expressed concerns about Stephen's hygiene and self-care as Stephen had not had a shower since arrival and his room was now uninhabitable. After a discussion with Washington Court Support Worker 1, the nurse formed the view that there was neither evidence of psychosis nor a mental health issues and proposed to close the case (this was not endorsed by the CMHT who kept a watching brief).

Given that the assessment of Korsakoff's related Dementia required psychiatric expertise, it appears the team were forgetting the purpose of the GPs referral and the assessment of their earlier MDT. In any case, without face-to-face contact with Stephen, professionals were no closer to understanding the impact of a two decades of alcohol abuse upon his mental and physical health.

On the 4 July, Social Worker 3 assessed Stephen in relation to the risk of harm from other residents which appeared to have assumed more significance than the very real risk from self-neglect. Social Worker 3 stated Stephen had capacity, citing his ability to understand, weigh up, and communicate his desires (the understanding of issues around capacity and self-neglect, and the quality and recording of capacity assessments will be considered in section 12.1).

Social Worker 1 started a new Needs Assessment but based it around the information recorded in February. However, on this occasion he did see the need for a care package once Stephen was placed in proposed complex needs accommodation.

It would appear that Stephen chose to sleep on the street on the 4 July and was found early the next morning collapsed on a bench. In spite of attempts by paramedics to revive him, life was pronounced extinct.

11 Introduction to the Analysis

Stephen's lived experience reflected the challenges posed by the interface between Adult Social Care, Adult Safeguarding and Multiple Exclusion Homelessness. This SAR is the story of a man transitioning from rough sleeping who needed effective multi-agency support and who demonstrated sadly, at the end of his life, the strong *'traction'* of the street.

The SAR panel concluded that Stephen's experience of two or more years rough sleeping, punctuated by periods in custody, meant self-neglect had become entrenched and was impacting on a daily basis on his wellbeing. Whilst finding accommodation in January 2018 was justifiably a high priority, Stephen's self-neglect was also in urgent need of coordinated action. Although agencies shared information about Stephen reasonably effectively, the absence of multi-agency meetings, with risk assessment of the physical and mental health needs and impact of substance misuse, meant that self-neglect was neither central in professional's minds nor engaged with in a holistic way. There appears to remain a lack of confidence across many disciplines in identifying self-neglect and recognising how to organise and offer appropriate levels of person-centred support that assist vulnerable adults to help themselves.

Washington Court Support Worker 1 found herself distracted by the need to constantly challenge Adult Social Care to respond to their duties under the Care Act in relation to assessing care and support needs and investigating safeguarding concerns. The assessment and investigation processes in this case were flawed and took far too long.

Any consideration of self-neglect requires attention to mental capacity. The presumption of capacity or an apparent failure to appreciate the complexity of capacity assessments in cases of self-neglect was evident throughout this SAR. It remains too frequently the case that professionals use an individual's right to *'personal autonomy'* as a justification not to assess capacity in relation to self-neglect, even where there are numerous indicators that capacity may

be an issue. Where alcohol misuse and low mood are present, their impact upon mental capacity are frequently underestimated.

The SAR will summarise the current provision across the City for rough sleepers, whilst acknowledging that because Stephen was transitioning into accommodation he would, even under the improved provision of 2020, become the responsibility of other professionals, since outreach and engagement workers would need to keep their focus on adults still rough sleeping.

12 Analysis: Effective Practice in Relation to Self-Neglect and Mental Capacity

12.1 How was Self-Neglect addressed in this case?

'*Managing the balance between protecting adults from self-neglect against their right to self-determination is a serious challenge for public services. Balancing choice, control, independence and wellbeing calls for sensitive and carefully considered decision-making. Dismissing self-neglect as a 'lifestyle' choice is not an acceptable solution in a caring society*'[8]

A feature of this SAR was an absence of effective, joined up working relating to self-neglect. The BSAB Self-Neglect Guidance and Pathway[9] was introduced in May 2017. It was based around three key principles that this SAR would suggest, remain entirely relevant and appropriate. They apply to all persons who self-neglect, whether or not they are homeless (Multiple Exclusion Homelessness adds several high-risk elements):

- **Key Principle 1 -** Robust partnership working from the earliest practical stage.
- **Key Principle 2 -** Interventions should draw upon knowledge of the kinds of approaches that work best.
- **Key Principle 3 -** Agencies should place the adult at the centre of the plans to support them.

To achieve Key Principle 1, the pathway required an agency to refer a self-neglect concern to a monthly Supporting Adult Panel (SAP) where a lead agency and appropriate partners would be identified and actions relating to capacity, mental health, the Care Act section 9 needs assessments could be agreed. In complex cases or where the actions did not resolve a concern, the pathway required a Multi-Agency Strategy Meeting where the Self-Neglect Risk assessment document could be completed. In cases where agreed actions did not reduce risk, the pathway indicated section 42 Care Act safeguarding duties could be commenced. It appears from information

[8] **Adult Self-Neglect Best Practice Guidance:** Responding to self-neglect concerns and enquiries for adults with care and support needs in the West Midlands. 2.5-2.6

[9] Practice Guidance and Framework for responding to concerns about adults who self-neglect (including Hoarding behaviour) in Birmingham

provided to the panel that the SAPs never achieved the level of management of self-neglect suggested by the pathway.

It is difficult to assess with hindsight the extent to which this pathway had been embedded across the City in 2017 and 2018. It is however not unreasonable to assume that professionals and managers should have been aware of the relevance and appropriateness of this pathway in a case like Stephen's. It is regrettable that there is so little evidence of the pathway having any impact in this case.

As an apparent consequence, professionals spent many hours trying to support Stephen, and if asked, would have said he evidently self-neglected, but would probably have struggled to answer the question *"…so what are we doing about that?"* beyond describing their immediate tasks. They probably would not have known how their efforts fitted in with the whole, because there was little shared understanding of all of Stephen's needs and vulnerabilities, nor a shared risk assessment.

Had a small group made up from the CRC Housing and Welfare team, probation officers, Washington Court Support Worker 1, CGL, his GP, Adult Social Worker, LA Housing officer, SIT Worker met in a Multi-Agency Strategy meeting (a *'Team around the Person'* [10]), they could have addressed many of the key considerations around Stephen's self-neglect. It is argued by this SAR that not only would that have been more effective, but actually would have saved the time spent chasing updates or sharing concerns.

They would have discussed numerous issues and addressed the key principles; which are Stephen's priorities, and which will have the most positive impact on his engagement with professionals and foster trust? Do we understand the traumas in Stephen's life and the impact of them? If Stephen had a history of mental health vulnerabilities and had been previously sectioned, what is their impact now? Is 20 years of alcohol abuse and possible ARBD the cause of his confusion and memory loss and incontinence issues, that impact upon his dignity and self-esteem? Does Stephen understand the impact of alcohol on his health and if he wants to change course, does he understand his own deficiencies and have a strategy to overcome them? Are we confident in our capacity assessments in relation to the various decisions related to self-neglect; hygiene, self-care, keeping his accommodation habitable? Are we revisiting these assessments when mood is low, or alcohol is impacting upon Stephen's decision making? Do we understand whether there is a disconnect between Stephen's ability to articulate what needs to happen and his ability to put the theory into practice?

The Pathway stresses the importance of a person-centred approach and it was achieved in large measure by Washington Court Support Worker 1, who showed compassion and an understanding of Stephen's life and traumas and had formed a non-judgemental relationship. She tackled issues as they arose with determination and persistence. She gave Stephen time and respect even

[10] **Adult Safeguarding and Homelessness:** A briefing on positive practice LGA & ADASS Michael Preston-Shoot

when his frustrations and vulnerabilities led to behaviours which were aggressive or abusive. What was missing was a collective approach. Washington Court Support Worker 1 could have advocated for Stephen at the strategy meeting and together professionals could have identified something that could have motivated him and made engagement across other areas more likely (he had diverse interests and experiences that could have been rekindled through social prescribing or third sector groups, for example).

The absence of a clear plan with agreed actions and responsibilities and a review process was the reason that key issues: homelessness and housing, mental health, physical health, mental capacity, and care and support needs, remained largely unresolved during the period under review.

Stephen was taken into EDs in at least three hospitals in Birmingham having collapsed in the street drunk on numerous occasions. Section 15 will address whether the need to manage Stephen's case through Safeguarding procedures (section 42 Care Act) was recognised early enough, and whether the right safeguarding risks were identified. It does appear that this critical point in relation to self-neglect support needs clarification in Birmingham's reworked Self-neglect Guidance.

The SAR was informed at learning events that the SAPs had not been uniformly effective across the City and were no longer in place. At present the pathway remains visible on the BSAB website and this can only lead to confusion.

Key Learning in relation to self-neglect:

Learning Point: Where there are concerns relating to self-neglect, practitioners should carry out a multi-disciplinary identification of those needs, as well as identifying risk.

Learning Point: Capacity assessments should be considered in relation to each of those identified needs.

Learning Point: Practitioners should distinguish between *'micro'* and *'macro'* decisions in relation to self-neglect. This requires recognition that an adult may have capacity for decisions in relation to some element of their identified needs but may not have capacity in relation to the holistic impact of all the identified needs and vulnerabilities upon their wellbeing.

Learning Point: Practitioners should be mindful of the impact of anxiety or depression upon self-motivation.

Learning Point: Self-neglect can be a response to trauma and/or neuropsychological impairment.

Learning Point: Where there are alcohol-related concerns combined with self-neglect, practitioners should identify the impact alcohol abuse has upon capacity.

Learning Point: Multi-disciplinary meetings with an identified lead professional are always helpful in agreeing a support plan for self-neglect.

Learning Point: A safeguarding referral should be considered where an adult who self-neglects refuses all support, remains at a high risk of harm and, as a result of their refusal, is unable to protect themselves from the risk of self-neglect.

Learning Point: Capacity assessments should be considered in relation to each of those identified needs.

Recommendation 1: The Self-neglect Guidance is currently being re-drafted and it is recommended that where cases are complex, the guidance considers the use of multi-disciplinary meetings to bring agencies together, as well as identifying escalation processes when risk is high and there are difficulties in finding solutions to support and individual who is non-compliant.

Recommendation 2: Birmingham City Council's Neighbourhood Directorate to ensure that front-line practitioners working along the homeless pathway have a basic understanding of the legal rights of multiply excluded homeless people in relation to housing and homelessness legislation and the Mental Capacity Act, and ensuring that there is a robust case recording of assessments, support and engagement with homeless people.

12.2 How was Mental Capacity addressed in this case?

a. Whilst there is an assumption of capacity within the MCA, it should not be used as a reason not to assess capacity in cases where there are clear signs of self-neglect and concerns about self-care or acceptance of care and support. A duty of care was owed to Stephen to assess whether he had the mental capacity to understand the risks of his decisions and the impact they may have upon his safety and wellbeing. The SAR panel found reasons to be concerned that at key points, Stephen's ability to make critical decisions and understand their consequence, may have been in doubt and capacity assessments should have taken place.

b. Many of the key professionals that worked with Stephen would have had good reason to doubt Stephen's mental capacity. Twenty years of consistent alcohol abuse that continued, and indeed, appeared to worsen during the period under review, would suggest that his capacity probably fluctuated.

c. A study of alcohol-related SARs from 2017, conducted by Alcohol Change UK[11] pointed out the challenge of waiting (where possible) for a person to regain capacity, stating; *"…this is challenging if an individual continually moves in and out of capacity due to intoxication, or spends the majority of their waking hours intoxicated with some moments of lucidity"*.

d. The prison social worker stated at the learning session that he believed

[11] **Learning from Tragedies**: An analysis of alcohol-related SARS published in 2017 (July 2019)

when he saw Stephen, he was intelligent, articulate and had capacity. At that point (after several months of medication and structured abstinence and withdrawal) this seems a fair judgement. The chronology demonstrates that immediately upon release, Stephen returned to heavy drinking. Thereafter, capacity would once again be hard to assess.

e. Washington Court Support Worker 1 recognised that Stephen had poor memory and needed constant *'post-it'* prompts. The chronology describes just some of the missed appointments, forgotten names, places and details. Stephen also appeared to forget entire events. Washington Court Support Worker 1 felt that low mood impacted upon Stephen's decision making.

f. In a case of self-neglect where the assumption of capacity may be in doubt, and where a professional believes that a person does or does not have capacity, it is important to record how that view was reached.

g. Capacity is decision and time specific, so the tendency of professionals to declare that Stephen *'had capacity'* without identifying the decision being taken suggests a basic lack of understanding of capacity assessments. Any assessment of capacity relating to important or consequential decisions should be recorded in detail showing how a capacity assessment was carried out, the question(s) being asked, the range of choices open and the consequences of the choices.

h. The SAR was offered no evidence that across agencies they considered Stephen to have mental capacity, including in the assessments of Social Workers. There was no appropriate detailed recording of these assessments.

i. It is the independent reviewer/author's experience, derived from two year's training of frontline Health professionals on adult safeguarding and MCA, that many do not understand the level of proof required, stating that they *'need to be certain'* of lack of capacity rather than reasonably satisfied: *'the civil burden of proof'*. It is this basic legal misunderstanding, it is argued, that frequently inhibits professionals from questioning capacity.

j. Without an agreed plan for supporting Stephen, there was no apparent consideration of the complexity of capacity decisions in relation to self-neglect.

k. The SAR found no evidence of a clear understanding of complex capacity assessments and no compelling evidence that they had occurred. This would have required an appreciation of the macro and micro decisions relating to self-neglect and a distinction to be drawn between micro and macro decisions. Washington Court Support Worker 1 described how in relation to a micro decision, the application of creams to deal with Cellulitis and skin conditions, Stephen who wanted to relieve his discomfort, generally could carry a discussed plan into action with gentle prompts.

l. Capacity in relation to self-neglect, the macro decision, is never a one assessment process. It should be informed by a careful identification of

needs and risks, for example, whether Stephen could abstain from drinking and identify both the benefits of so doing and risks of continuing to drink. Could he identify the impact of failing to maintain hygiene and self-care, or of failing to keep his room safe and habitable, find ways of managing incontinence, know when to seek help for depression and anxiety?

m. Professionals needed to identify the specific decisions, maximise Stephen's ability to make those decisions and assess Stephen's subsequent ability to achieve his goals. This required an understanding of the part executive function plays in capacity assessments.

n. Stephen was articulate and intelligent, and this may have provided professionals with unjustified confidence in his capacity. Yet the ability to *'walk the talk'* to demonstrate the ability to carry plans into action requires a professional to watch for evidence of success, but also to watch for the risk of repeated mismatches. This is how capacity is established or refuted in complex cases. There was no evidence offered to the SAR that professionals demonstrated this level of understanding of mental capacity. When Stephen was described as having capacity, it may have been the case for micro decisions at a specific point in time and sobriety. It could not be said in relation to self-neglect in any generalised sense. That would have required identification of which parts of self-neglect Stephen could address and which he was accepting with capacity to leave as risks. It is this part of a patient *'slow burn'* person-centred approach that furnishes the small victories, the small steps taken, the negotiation of a safer life. Only then could professionals have said they were respecting Stephen's autonomy to make a lifestyle choice, rather than letting him suffer the unwanted consequences of life trauma and circumstances.

o. The learning event identified that many frontline professionals had no more than the most superficial understanding of mental capacity. Professionals from Probation, CRC Housing and Resettlement teams, support workers from homeless hostels, and complex need support workers stated they had received no MCA training. This is particularly concerning, because every professional working with people about whom there are concerns relating to capacity should be sufficiently trained to be confident in assessing their mental capacity and know when to seek expert guidance in more complex capacity decisions.

p. Without the adequate awareness of mental capacity, it seems many of the professionals supporting Stephen were unable to challenge or comment in relation to his capacity, because they were almost completely lacking in the necessary understanding.

Key Learning in relation to mental capacity:

Learning Point: Practitioners should record all steps taken before a capacity assessment, to maximise an adult's ability to make that choice.

Learning Point: In relation to capacity assessments, practitioners should ensure they have identified the decision to be made the choices, as well as the consequences of each choice, before starting to assess capacity.

Learning Point: Practitioners should note that, in relation to capacity assessments, the civil burden of proof applies; they need simply to be *'reasonably satisfied'* an adult has or does not have capacity (sometimes referred to as the *'51% rule'*).

Learning Point: The presumption of capacity should not be used as a reason not to assess capacity in relation to self-neglect, where there are clear indications that self-neglect is present.

Learning Point: Practitioners should ensure that the function test precedes the two-stage impairment test to avoid discrimination.

Learning Point: Practitioners should not record simply *'…person X had capacity'*. Capacity assessments should be recorded in sufficient detail to identify the nature of the decision and how the adult demonstrated understanding of those choices, as well as how they used or weighed the relevant information.

Learning Point: Where executive function[12] may be in doubt, practitioners should be aware that an adult may appear to be able to describe what they intend to do but be unable to carry those plans out in reality. Practitioners should therefore be alert to this possibility and look for these repeated *'disconnects'* before reaching an assessment.

Recommendation 3: National Probation Services, Community Rehabilitation Company, Trident and Shelter to ensure that their Birmingham workforce receive training on Mental Capacity Act and that these organisations consider Mental Capacity Act training for their workforce wider than the Birmingham area.

q. The Birmingham Self-Neglect Guidance, at section 10.3, addresses the order in which professionals carry out assessments for capacity, following the MCA Code of Practice, rather than the statute itself, with stage one being the identification of the impairment (the diagnostic test) followed by the function test. It is respectfully suggested that this is incorrect and that case law[13] is clear that the function test should precede the impairment test. It is suggested that this should be corrected in the redraft of the document.

[12] **Executive function**: A set of mental skills that include working memory, flexible thinking, and self-control. We use these skills every day to learn, work, and manage daily life. Trouble with **executive function** can make it hard to focus, follow directions, and handle emotions (among other things).

[13] See PC and NC v City of York Council [2013] EWCA Civ 478 at paragraph 58 and Kings College NHS Foundation Trust v C and V [2015] EWCOP 80 at paragraph 3

13 Analysis: Homelessness and Rough Sleeping

Stephen spent the period under review either rough sleeping, in prison, or (for the last five months) in a hostel for adults at risk of homelessness. He was typical of the growing demographic of people experiencing what is termed *'multiple exclusion homelessness'*. This form of extreme marginalisation is often linked to traumas in childhood or in adult life, loss of employment and status, divorce, separation, and family break up. It is also associated with experience of institutional care. Many rough sleepers experience the tri-morbidity of physical and mental ill-health and drug and/or alcohol misuse and premature mortality.[14]

Stephen had experienced all of these elements, which would by themselves have made finding accommodation upon his release from prison in January 2018 challenging, but should not have represented an intractable problem. Although some of Birmingham's commissioned, supported accommodation providers had capacity issues, most apparently refused Stephen because of his offending profile and his tenancy history. It was this offending profile that posed what was to prove an insurmountable challenge to the professionals from the CRC Housing and Welfare Team, Probation, BCC Housing and Washington Court Support Worker 1 working so hard to find suitable accommodation for Stephen.

Stephen's history meant that supported, commissioned accommodation was clearly the most suitable, but a LA tenancy obtained either by a Part 6[15] application or a homeless application with a support package was possible. Failing these, a supported exempted accommodation was described as a *'back burner'* option. All three could run in tandem and the chronology would suggest this was the approach taken, but with no success.

At 65 years old in May 2018, a remote possibility was that residential care (as suggested by the Homeless team manager) could have been identified, although a placement in care suitable for a person with Stephen's alcohol dependency and possible ARBD would have been very difficult to find. In any event, Stephen had never expressed a desire to go into residential care preferring supported accommodation.

At the Learning sessions, some professionals made the point that regardless of the range of options, in their view, the nature of Stephen's offending made him almost impossible to accommodate. There is some truth in this analysis. In a study by Homeless Link[16] of nearly 2,000 homelessness services concerning reasons for exclusion, 36% excluded for arson, and 25% for sexual

[14] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) **Multiple Exclusion Homelessness and Adult Social Care in England**: exploring the challenges through a researcher-practitioner partnership. Research, Policy and Planning, 33 (1), 3-14.

[15] Part 6 Housing Act 1996

[16] **Removing Barriers to Service**: A guide to inclusion for homeless people. Homeless link (service needs and provision) 2012

offences.

As a medium risk sex offender with an on-going registration requirement, this added the need for agreement from the police as to the suitability of proposed tenancies. Whilst this made the task more difficult, it would not (it is suggested) have proved impossible to overcome in the longer term. The City has provision for homeless persons convicted for sex offenders.

It was Stephen's conviction for arsons, linked to the fact that fire lighting had been one of the reasons for the loss of his Birmingham tenancy, that was repeatedly cited as grounds for refusal both in Birmingham and elsewhere. When the circumstances of the arsons are considered, they suggest possibly that they were offences committed because of the marginalised nature of Stephen's life linked to rough sleeping and financial insecurity; both occasions seem to have been motivated by a need to keep warm.

It was argued by some professionals that the arson risk posed by Stephen was possibly more perceived than actual and that the risk would have reduced and been manageable if Stephen had had suitable, properly maintained accommodation and financial security. Finding that suitable accommodation could have provided support workers with the opportunity to engage with *'compassion and persistence'*[17] to address the different strands of Stephen's self-neglect.

The argument continues that risk management needed to go beyond *'labels'* of sex offender and arsonist, to draw a more empathetic picture of Stephen and his needs as well as the risk he posed. It was felt that an over emphasis upon the offender *'labels'* used to try and secure the supported accommodation actually served to make a refusal more likely. Some participants at the learning event felt that direct approaches by professionals to known contacts within accommodation providers sometimes were more likely to be heard with a *'sympathetic ear'*.

It would still be necessary to overcome the argument that providers would not be insurable if they knowingly accepted tenants with a proven history of arson. However according to the Homeless Link study[18], '*it is very rare for insurance policies to have a specific condition that excludes those that have committed arson in the past. Most insurance policies state that staff must take all reasonable steps to prevent arson when accommodating or offering other services to an individual with a known arson conviction or pending arson investigation.*'

A bespoke risk management plan for a tenant with an arson conviction would have represented *'reasonable steps'.*

[17] **Michael Preston-Shoot**: Homelessness and Safeguarding Workshop. Birmingham, 29 September.2019

[18] **Removing Barriers to Service**: A guide to inclusion for homeless people. Homeless link (service needs and provision) 2012

Recommendation 4: Commissioners of supported accommodation in Birmingham include within commissioning services, descriptions and specifications that prevent exclusion ground where reasonable steps could be taken to remove the need for *'blanket bans'*.

The SAR discovered that Stephen's Part 6 application for a Birmingham LA tenancy was started and paused on the same day. It is clear that whilst a homeless application and a part 6 application would be considered under the same eligibility criteria and allocation scheme, the fact that a homeless application would have remained *'live'* even if Stephen was temporarily accommodated suggest that a homeless application should have been commenced in this case (and all cases where homelessness is a risk).

This consideration has to be viewed in the context of the Homelessness Reduction Act 2017 (HRA) which came into force on the 3 April 2018. Had a homeless application been started in January 2018, the Housing Act 1996 would have applied. If a homeless application had been started for Stephen after 3 April, the more robust Homelessness Duties under the HRA would have applied. It is probably unrealistic to expect support workers to have been aware so quickly of the impact of new legislation.

Under the HRA, the duty upon the LA lasts for eight weeks (prior to the HRA the duty lasted 28 days). Within that time, they must try to find suitable accommodation that will be available for six months (the relief duty). The LA must also create a personal housing plan with Stephen. If after that period, he remained at risk of homelessness, a decision must be communicated within 15 days.

In relation to Stephen, the LA would have a duty because of the priority need: '*You are vulnerable as a result of having served a custodial sentence'.*

If Stephen had been assessed as having made himself *'intentionally homeless'* the duty would only extend to temporary accommodation. In addition, the LA could argue that Stephen did not have a *'local connection'* and therefore the *'full duty'* would not apply.

Key Learning in relation to homelessness and rough sleeping:

Learning Point: Where a homeless person presents with convictions or an antecedent history that could lead service providers to invoke an exclusion, professional should ensure that they have clear, detailed information concerning those behaviours/convictions. This should include any known history or risk assessment that suggests the risk has been effectively managed, or the risk has been reduced.

Learning Point: Consider challenging refusals in relation to arson based upon alleged insurance requirements.

Learning Point: Avoid *'over playing'* the vulnerabilities.

Learning Point: Ask if there are reasonable steps that could be taken to circumvent exclusion.

Learning Point: Where a person is rough sleeping, or has been and is at risk of homelessness, a Homeless Application carried with it more duties upon the Local Authority than a Part 6 application and should be the default route into local housing.

Learning Point: Where someone who is homeless is given temporary accommodation, for example hostel accommodation, the workers supporting the person should ensure that there is a homeless application with the Council that is still live for the individual.

14 Analysis: Health

Stephen's mental and physical health vulnerabilities and the consequence of several years rough sleeping were very typical. As a study[19] of the health needs of rough sleepers recognised, *'many people who sleep rough have multiple, co-occurring and compounding needs, and the experience of rough sleeping is associated with tri-morbidity: the simultaneous combination of physical ill health, mental ill health and problematic drug or alcohol use'*.

Stephen's experience of health provision was almost entirely incident led, with admissions to hospitals after falls and accidents, or when he experienced problems like DVTs. In the years under review, whilst Stephen was rough sleeping, the only methodical and organised medical care he received was whilst in prison (where his prison health care followed the National Institute for Health and Care Excellence (NICE)[20] guidance) or when in hospital. It does not appear Stephen accessed Homeless Health Exchange, a city-centre primary care service aimed at the homeless and rough sleepers.

These hospital and prison admissions represented opportunities (albeit of short duration) for health professionals to address presenting problems, prioritise them with the patient and arrange continuity of care. The greatest challenge was ensuring that upon release from prison or hospital that continuity of care was achieved.

For one significant period, post release from prison (January 2018) and prior to his death, there was another opportunity to manage Stephen's physical and psychological health issues. Although technically homeless, Stephen was in Washington Court, supported by Washington Court Support Worker 1.

The SAR concluded that the majority of these opportunities were missed and chances to impact upon wellbeing was lost.

14.1 The Physical and Mental Health Impacts of Alcohol Misuse

Stephen's alcohol misuse was long standing, and the physical and

[19] **Delivering Health and Care for People who Sleep Rough**: Cream, Fenney et al The King's Fund Feb 2020

[20] **Physical Health of People in Prison NICE Guideline**: Published 2 November 2016 www.nice.org.uk/guidance/ng57

psychological conditions listed in section 8 above can reasonably be said to have been associated with that alcohol misuse and the physical impacts of rough sleeping and self-neglect. Prison sentences meant that for short periods he was assessed for alcohol withdrawal and treated with appropriate medication. He would have experienced periods of sobriety. In the chronology for the time period under review, Stephen was twice referred to alcohol services requesting upon release they engage with him and continue work commenced in prison. On both occasions he failed to attend arranged appointments and was discharged.

During his last prison sentence, although DART[21] were involved in his care, no substantial work was started in relation to Stephen's alcohol abuse, because he declined or forgot to attend appointments in prison, and he was not referred to alcohol services upon release.

Outreach workers from CGL and Shelter, with years of experience of dealing with substance misuse in the rough sleeper population, were in agreement at the learning event. Upon release, if an addict's first encounter was not with a Substance Misuse Worker, it would be with a drug dealer or a publican. Stephen's first inclination in the two days after release was to drink to such extent that he required ED hospitalisation.

The SAR recognised the strength of the argument that Prison In-Reach is the best way of ensuring an addicted prisoner develops positive engagement with services prior to release. Whilst this may be challenging to achieve where a prisoner like Stephen has a short sentence, it would remain an aspiration.

Recommendation 5: The SAR would recommend that Birmingham Public Health consider and explore the possibilities of prison in-reach for substance misuse.

Many years before the period under review, Stephen had been considered by a prison psychiatrist to have signs of Korsakoff's Syndrome. This information was shared upon admission to prisons or hospitals (via EDs) and he received Korsakoff's appropriate medicines. This was a short-term fix, but never a long-term solution. No assessment was ever completed to establish whether Stephen had Korsakoff's or some other form of ARBD even though his symptoms were so suggestive of ARBD.

Had this diagnosis been established, so many of Stephen's issues would have been explained and could have been treated. In relation to his last prison sentence, this proved one of the last opportunities to address ARBD. In reality, health professionals in prison treated the symptoms with drugs and continence aids but no longer-term plan to address the causes formed part of Stephen's health plan upon release.

Stephen also disclosed he believed he was Bipolar. Under the NICE guidance for prison healthcare, this should have prompted a mental health assessment. There is no evidence that this occurred so Stephen's mental health, like his

[21] Drug and Alcohol Recovery Team

alcohol abuse and possible ARBD, remained unaddressed.

In Stephen's case his history of mental health concerns and the low mood he experienced suggested the dual diagnosis, whilst Korsakoff's Dementia may not have fitted that dual diagnosis. It could be argued that with a prisoner who was homeless on arrival, the discharge care plan should identify chronic health conditions that needed to be addressed on release, especially if all the available records suggested they have been left undiagnosed for so long. This was a rare opportunity to address the health needs of a marginalised and excluded adult from a hard-to-reach group.

The health plan on discharge was unambitious but, in any event, could not be shared because the prison had nowhere to send it. As a homeless rough sleeper on sentence, no new address and no GP had been identified before discharge. Sharing the health plan with an ex-prisoner's GP is required by NICE guidance but seems particularly relevant for prisoners being released with the risk of homelessness. HMP Birmingham have undertaken to review their process in relation to registering prisoners with a GP, as well as identifying vulnerable prisoners not yet registered with a GP. Whilst integrated care records or care passports have been trialled in some areas and would help in such cases, they would ultimately require a national consensus to be effective and at present this is unlikely.

The SAR recognised that this case showed possible deficiencies in prison healthcare for rough sleepers and appeared to be another element of multiple exclusion homelessness.

Recommendation 6: HMP Birmingham review their release process in relation to the health needs of vulnerable prisoners at risk of multiple exclusion homelessness.

Getting Stephen registered with a GP on release was seen by Probation as problematic, because he had no birth certificate, but also because he did not apparently see it as a high priority (the CCG representative on the panel stressed professionals should be aware that ID documents are desirable but not essential[22]).

Pushed by Washington Court Support Worker 1, Stephen registered and was seen as a new patient by a GP registrar. The CCG chronology stated that the lack of coding in relation to safeguarding indicated the registrar *'failed to recognise the multiple factors making Stephen an adult at risk/vulnerable adult'*. The obvious link between heavy alcohol use and falls was not explored and no attempt was made to refer to alcohol services. This was a missed opportunity to start addressing complex health needs. On two further

[22] **Do I need a proof of address to register with my GP?**
Having proof of where you live helps but, NHS guidelines make clear that it is not necessary for you to have a proof of address when registering with a GP. This also applies if you are an asylum seeker, refugee, a homeless patient or an overseas visitor, whether lawfully in the UK or not

occasions, at a new patient check and a GP medication review. there were further missed opportunities when despite disclosing drinking well above safe limits, Stephen was not referred to alcohol services. He was not seen in primary care after May 2018.

Stephen was taken into hospital on numerous occasions in both Sandwell and Birmingham having collapsed drunk, suffering injuries or other health impacts. No evidence was offered to the SAR that Stephen was referred to hospital alcohol services, who could have referred him to CGL for support. This may have been because he was often aggressive and either asked to leave or self-discharged, however these were viewed by the SAR as further missed opportunities.

Recommendation 7: University Hospitals Birmingham NHS Trust and Sandwell & West Birmingham Hospital Trust should review their Emergency Departments admissions process to ensure that appropriate offers of referral are made when patients present with alcohol related conditions.

Stephen needed to be willing to address alcohol misuse and the SAR was told he said he wanted to reduce his consumption. The fact that he was never supported by alcohol services in the five months before his death is an example of why multi-agency strategy discussions are so necessary for entrenched self-neglect.

When Stephen was finally referred by his GP for psychiatric assessment for Bipolar, the referral went initially to the CMHT for the homeless before being passed to the older people team. It is suggested that as he transitioned from rough sleeping his needs remained more closely aligned to the homeless, and the more assertive outreach approach that BSMHFT encourage from the homeless team may have improved the chance of Stephen engaging.

15 Analysis: Stephen's Care and Support Needs and Adult Safeguarding

Stephen's care and support needs were identified in custody by the prison social worker, in line with duties under section 76 of the Care Act, but needed to be re-assessed in February 2018 in relation to provision of a care and support package whilst Stephen was in Washington Court, a homeless person hostel (that placement had started as strictly temporary, but under occupation rules of the hostel could only extend 12 weeks. Thereafter, if care and support needs were identified, a reassessment would be necessary in any permanent accommodation).

The needs assessment carried out in February 2018, that concluded Stephen did not meet eligibility criteria, was considered in the commentary to the adult social care chronology to have failed to justify why the threshold was not met. It incorrectly stated that care and support needs could be met by hostel staff and the presence of Washington Court Support Worker 1 in the assessment would have corrected this misunderstanding. In the view of the Head of Safeguarding for Adult Social Care, which was stated in the learning event, the assessment was simply wrong - with hindsight, Stephen did meet the eligibility

criteria due to physical or mental impairment and was unable to achieve two or more outcomes, and this was impacting significantly on his wellbeing.

The SAR identified that Social Worker 1 was fairly inexperienced and unfamiliar with the needs assessment which was a complex form (simplified since then to assist social workers to improve their needs assessments). Although supervised at an appropriate level, the first line manager simply endorsed Social Worker 1's decision rather than reviewing it.

There is no evidence that Stephen was given, at this point, a written explanation of the reasons he did not meet the eligibility criteria (a duty upon the LA under the Care Act). If he had, Washington Court Support Worker 1 would have been aware of the assessment, known what to challenge and would have been aware of his right to challenge the decision. If such notice was sent, it would probably have been on case closure - six weeks after the assessment. The SAR was satisfied closure at this point was inappropriate.

Recommendation 8: Birmingham City Council's Adult Social Care to look towards ensuring their systems for informing citizens of outcomes of needs assessments are communicated in a timely manner and includes information on how to challenge the outcome.

It is unfortunate that Washington Court Support Worker 1 did not escalate Stephen and her disagreement with the assessment appropriately, because the consequent delay in obtaining a re-assessment meant that between release from prison and his death (a period of five months), Stephen never received the care and support package to which he was entitled, and which may have reduced the impact upon his wellbeing caused by his deteriorating health.

Washington Court Support Worker 1 raised fresh concerns in late May 2018, that related to a significant decline in Stephen's self-care, mental health and his vulnerability to both physical and financial abuse by other residents of Washington Court. He was facing eviction from 10 July and Stephen was increasingly staying away from Washington Court due to fear of other residents. On the 17 and 18 June, he had reported to police being threatened and assaulted by another resident who also criminally damaged his television. Investigating officers made attempts to contact Stephen to progress the investigation with no success. It appeared that a combination of Stephen's untimely death and the imprisonment of the suspect for an unrelated matter led to the case being filed.

Two days later on the 20 June, the original safeguarding concerns were investigated and Social Worker 2, who spoke to Stephen, was made aware of the police reports (although Stephen made it clear he had not reported all of the financial abuse incidents because of his memory issues). She felt the concerns required a safeguarding investigation.

It is clear that Adult Social Care had missed the agreed timescales for concern decision making and safeguarding enquiries by a significant margin (seven days in total). This was then compounded by a further two-week delay. At the learning event, the Ladywood Constituency Team manager described the

team running with a backlog of 280 enquiries at that time. The Adult Social Care Safeguarding Lead described the unsatisfactory blockages in the process of accessing services *'multiple handoffs'*, that have been addressed by the restructuring described below.

The assessment of the safeguarding concerns took place with Stephen on the 4 July. There is no evidence that social workers had liaised with police about the status of the criminal investigation. Instead, they accepted without professional curiosity and a measure of over-optimism that Stephen was no longer fearful, even though he said he had been staying with a friend because of fear. He was apparently no longer at risk of financial abuse because '*he was no longer communicating with his neighbours or giving them money*'. The Adult Social Care chronology described this as a "…*simplistic view to take regarding ongoing risk. Stephen was a vulnerable adult with memory issues and a history of alcohol abuse…it was likely given his history and recent deterioration that abuse would occur again".* In the context of the safeguarding risks recorded, Stephen stated he was satisfied with the actions taken and agreed to closure. The full extent of the risk posed to Stephen by his vulnerability and deteriorating health had not however been properly identified as a safeguarding risk. His vulnerability to financial and physical abuse was one safeguarding concern, but not necessarily the most pressing given his deteriorating health.

It is possibly an indicator of Stephen's own perception of risk that he chose to sleep rough on the street the same night and passed away.

There had been a clear deterioration in Stephen's mental health, his physical health, hygiene and self-care. In the month before the safeguarding assessment there had been five separate admissions to Hospital EDs as a result of drunken falls or collapses in the street. Stephen was on the point of being evicted from the homeless hostel with no guarantee that he would be accepted into Midland Heart Complex Needs Services accommodation as proposed. Although the Social Workers intended to ask the GP to request a mental health assessment, they seemed unaware that this process had already been organised. Once more a needs assessment was proposed, five months after the original assessment.

The SAR panel felt that the adult social care professionals should have recognised that Stephen was at a level of risk that required a safeguarding plan in relation to self-neglect. The absence of a multi-disciplinary approach could have been addressed in a safeguarding plan, coordinating responses and reviewing the plan. With hindsight, it is unlikely that even if the social workers had recognised the need for a safeguarding plan, it would not have prevented Stephen sleeping rough and leading to his tragic death.

The identification of this increased risk may have been promoted if any of the Hospital ED teams involved with Stephen had submitted appropriate referrals of concern/safeguarding referrals in relation to Stephen's admissions. In the specific context of a patient apparently at risk of serious self-neglect, it could be argued self-discharge against medical advice or as a result of anti-social behaviour is further evidence of self-neglect. If the threshold for a

safeguarding referral in relation to self-neglect is a refusal of support and a high risk of harm, then it could be argued that threshold had been met. The Hospital chronologies offered no evidence that any referrals were made to Adult Social Care.

Recommendation 9: University Hospitals Birmingham NHS Trust and Sandwell & West Birmingham Hospital Trust to ensure their process for where a citizen self-discharges includes triggers for staff to consider self-neglect and referrals to appropriate services.

It is hard to avoid the conclusion that the involvement of Birmingham Adult Social Care had no perceptible positive impact upon either Stephen's care and support needs, wellbeing or his safeguarding. All accepted timescales were missed, needs assessments were incorrectly carried out and safeguarding not addressed entirely appropriately or in a timely fashion.

Recommendation 10: The Birmingham Safeguarding Adults Board to seek assurance from Birmingham City Council Adults Social Care that safeguarding concerns are being dealt with in a timely manner.

16 Service Improvements in Birmingham for Rough Sleepers

The SAR received assurance at the learning events that provision in Birmingham in relation to rough sleepers is now more co-ordinated and effective. The Strategic Lead for Rough Sleeping briefed the SAR independent reviewer/author and panel members, as well as frontline professionals involved in this case.

The Rough Sleeper Initiative (RSI) has seen a change of outreach provider and in February 2020 had halved the number of people sleeping rough to 52, the largest reduction in a core city in England. On the day of the combined learning event, in November 2020, that number stood at 25 citywide.

The Initiative now brings together the primary health provision for rough sleepers at Health Exchange, where Community Psychiatric Nurses (CPNs) offer drop-in mental health clinics for assessment of need. Some service users are signposted to support, some are given enhanced support by the Health Exchange's CPNs and some are referred on to secondary care through the Homeless CMHT. The Health Exchange has a part time psychotherapist who offers psychological support and therapy as well as Interpersonal Therapy for severe depression. The Mental Health Outreach team is supported by a psychologist, who can go out and assess mental health and capacity on the street with alcohol outreach provided by CGL at Washington Court and the Salvation Army by working in the City's hostels and directly with the homeless.

Around 8-9 agencies are involved in daily outreach following a morning tasking meeting, where individual cases are reviewed. A *WhatsApp* group keeps teams aware of developments or urgent cases. A write up of the day's tasks is shared across the teams. Each Monday the list of current and new rough sleepers is reviewed, and 2-3 complex cases will go to an MDT chaired by a manager from Health Exchange and attended by a liaison worker, funded

by RSI whose role is to ensure liaison between all the elements of the RSI and the social work community teams. She is able to explain and to provide a back-office function between the MDT and community teams, ensuring links are made between Adult Social Care and partners. The RSI agencies at the learning event gave testament to the effectiveness of this liaison worker. Her post is funded until March 2022 and the SAR would hope that her pivotal role in provision of services to rough sleepers is recognised as crucial and embedded in the City's funding plans.

Lancaster Street (the complex needs accommodation proposed for Stephen) has since been supplemented by additional provision at Holliday Road. Where an adult has mental health addiction and physical health problems these providers deliver whole wrap around support. It is to be hoped that the City now has sufficient capacity to meet the needs of adults with needs like Stephen's, because in 2018 his placement at Lancaster Street was not assured.

The SAR recognises that the positive approach of the Birmingham RSI and the weekly tasking meeting and multi-disciplinary approach will greatly assist those rough sleepers with unaddressed substance misuse issues and self-neglect.

It must be stressed that Stephen was transitioning from rough sleeping but was still in a homeless hostel and was never found a permanent accommodation. He could easily have slipped back to rough sleeping and had done so on several occasions in the last month of his life, including the day he died. The RSI cannot be expected to manage the many adults who find themselves in Stephen's transitory position although it will continue to work with individuals where it can to ensure support is provided by commissioned services.

It is therefore important that Birmingham's new self-neglect guidance recognises the different life experiences of adults who self-neglect. Some may be homeless, others transitioning from homelessness. The homeless pathways already identify self-neglect and the possibility of developing care and support needs. Not all adults who self-neglect will have care and support needs but may remain very vulnerable and supporting them is a complex challenge for agencies. The guidance should indicate how a multi-disciplinary approach can prevent an adult who self-neglects developing care and support needs. It is to be hoped the redrafted Birmingham self-neglect guidance reflects these challenges.

16.1 Trauma Informed Practice

Many rough sleepers have experienced Adverse Childhood Experiences (ACEs) and trauma in adult life that propelled them into homelessness and often self-neglect. They did not choose a lifestyle but reacted to changing circumstances.

The SAR was encouraged by the increasing number of outreach professionals working on the RSI who have had training on ACEs or have attended a three-day Physical, Intellectual, Emotional (PIE) training with reflective practice and

empathetic listening skills, promoting the principle that individuals should not have to need to repeat their story more than once. This is enhanced by Case Formulation meetings to reflect upon practice from an individualistic trauma informed level. It is to be hoped that as many frontline professionals as possible are provided with training relating to ACEs and trauma.

16.2 Multiple Exclusion Homelessness and Prison Release

The Birmingham City Council's (BCC) Neighbourhood Directorate recognised the challenges of finding suitable accommodation for people aged over 18 leaving prison or approved premises and have created an Offender Hub to break down barriers to accessing accommodation or support services by helping people gain/retain accommodation, improve health and wellbeing and reduce recidivism (the plan is to co-locate the services as soon as COVID restrictions allow).

Her Majesty's Prisons have also made efforts to ensure that the Resettlement Team provide prisoners with carefully planned timetables to meet appointments like re-housing assessments, and Probation, using an approach they call the *'Departure Lounge'*. Whilst in the past, mentoring schemes like LWPM were helpful, funding was variable and often short-lived, and this was also an issue with prison in-reach.

The adult social care RSI Liaison Worker aims to build liaison with the resettlement team to assist in picking up complex clients who are sentenced to prison, so that work continues on release to reduce the risk of recidivism.

To prevent homelessness on release, HMPs have funded a homelessness prevention team to provide short-term emergency accommodation, in hotels if necessary.

16.3 Community-Based Adult Social Care Provision

In September 2020, Adult Social Care re-organized and streamlined access. There are no longer duty teams or Adult and Communities Access Point (ACAP). Referrals go directly to constituency teams that will be dealing with cases and carrying out section 9 needs assessments. These teams have mental health expertise that would have been better placed to understand Stephen's mental health vulnerabilities. The teams have access to the Rio Electronic Patient Records (EPR) health record system and therefore could identify that the CMHT Older People team were involved.

A citywide safeguarding team takes on 80% of section 42 Care Act safeguarding referrals that should improve the response to cases that require a safeguarding response and safeguarding plan.

The Ladywood constituency team (covering Birmingham city-centre) and the safeguarding team are working to develop a consistent approach to rough sleepers who may have care and support needs building links with CGL and agencies working with RSI and the liaison worker described above will develop those links.

17 Conclusions

The SAR has recognised that in 2021, Birmingham's current RSI is better equipped to support homeless people like Stephen. It is to be hoped that funding is maintained so the improved provision can continue to have such a positive impact on the wellbeing of the homeless and on their transition to safe accommodation.

The recognition of need and multi-disciplinary approach to the homeless who self-neglect, appears to be in place and providing a more joined-up response to their needs. For the majority of the homeless who self-neglect, this is not a *'lifestyle choice'* and it is not appropriate to see it in this light. Most are reacting to their changing social and environmental factors.

The challenge of supporting adults who self-neglect (including the homeless) requires both Homeless Pathways and Adult Self-Neglect Guidance to be mindful of the complexity of self-neglect in relation to adults with care and support needs (like Stephen) and those that may not have care and support needs but are vulnerable, to ensure they do not develop care and support needs.

Senior leadership teams should take from this SAR the learning that their professionals working with adults who self-neglect need be confident with early multi-disciplinary work to identify needs and display a clear understanding of mental capacity in relation to self-neglect. These are the pre-requisites for reducing the harmful impacts of self-neglect.

18 Recommendations

Recommendation 1: The Self-neglect Guidance is currently being re-drafted and it is recommended that where cases are complex, the guidance considers the use of multi-disciplinary meetings to bring agencies together, as well as identifying escalation processes when risk is high and there are difficulties in finding solutions to support and individual who is non-compliant.

Recommendation 2: Birmingham City Council's Neighbourhood Directorate to ensure that front-line practitioners along the homeless pathway have a basic understanding of the legal rights of multiply excluded homeless people in relation to housing and homelessness legislation and the Mental Capacity Act, and ensuring that there is a robust case recording of assessments, support and engagement with homeless people.

Recommendation 3: National Probation Services, Community Rehabilitation Company, Trident and Shelter to ensure that their Birmingham workforce receive training on Mental Capacity Act and that these organisations consider Mental Capacity Act training for their workforce wider than the Birmingham area.

Recommendation 4: Commissioners of supported accommodation in Birmingham include within commissioning services, descriptions and specifications that prevent exclusion ground where reasonable steps could be taken to remove the need for *'blanket bans'*.

Recommendation 5: The SAR would recommend that Birmingham Public Health consider and explore the possibilities of prison in-reach for substance misuse.

Recommendation 6: HMP Birmingham review their release process in relation to the health needs of vulnerable prisoners at risk of multiple exclusion homelessness.

Recommendation 7: University Hospitals Birmingham NHS Trust and Sandwell & West Birmingham Hospital Trust should review their Emergency Departments admissions process to ensure that appropriate offers of referral are made when patients present with alcohol related conditions.

Recommendation 8: Birmingham City Council's Adult Social Care to look towards ensuring their systems for informing citizens of outcomes of needs assessments are communicated in a timely manner and includes information on how to challenge the outcome.

Recommendation 9: University Hospitals Birmingham NHS Trust and Sandwell & West Birmingham Hospital Trust to ensure their process for

where a citizen self-discharges includes triggers for staff to consider self-neglect and referrals to appropriate services.

Recommendation 10: The Birmingham Safeguarding Adults Board to seek assurance from Birmingham City Council Adults Social Care that safeguarding concerns are being dealt with in a timely manner.

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