Case Learning Summary: 'Paul' Safeguarding Adults Review

What is a Safeguarding Adults Review?

Safeguarding Adults Boards have a responsibility to ensure that organisations that work with adults at risk can learn from their own practice and that of others. When adults with care and support needs die or are seriously harmed in certain circumstances, the Care Act requires us to undertake a review. The Care Act also gives us the power to review other cases where there may be learning. The reviews help us learn from good practice and learn lessons from what went wrong, so that services and practice can be improved to reduce the risk of future harm.

Who was Paul?

Paul was a 51-year-old White British man who had served in the British Army for a period in the 1990s. Paul had an eleven-year-old daughter with his former partner and lived with his mother. He was a sociable person, well regarded by friends and family, and previously worked in security. He reported experiencing a number of mental health issues including anxiety, depression and PTSD, and disclosed he had been abused in the past.

What happened to Paul?

Paul lived with his mother but when she moved into sheltered housing in 2022 Paul became homeless. Paul engaged with a national charity, Helping Homeless Veterans UK (HHVUK), which helped Paul to arrange shared private rented accommodation and advised him to seek support from Portsmouth City Council (PCC) Housing Needs, Advice and Support (HNAS). HNAS did not progress Paul's application as he was not imminently at risk of becoming street homeless.

Paul's mental health deteriorated while living in the shared accommodation and HHVUK referred him to All Call Signs. All Call Signs are a local peer-to-peer support organisation set up by a veteran. Their staff have basic suicide awareness training but are not mental health professionals. Paul's mental health continued to worsen and there were a number of incidents involving the police, with Paul eventually being arrested and evicted from his accommodation.

HHVUK then accommodated Paul in a local hotel for a short period of time. Paul again engaged with HNAS and a housing assessment was completed but he was not assessed as being in 'priority need' for housing and was considered too high risk to house in the rough sleeping pathway accommodation. His mental health continued to deteriorate, and he engaged with his GP, the Rough Sleeping Hub, Police, 111 service and the Emergency Department reporting that he was experiencing suicidal thoughts. The day before Paul died, he was arrested for public order offences and later bailed. Paul was found by members of the public and later died in hospital.

Key Findings/Lessons

The review identified good practice in the relationships HHVUK and All Call Signs built with Paul. HHVUK provided him with accommodation and other financial support and encouraged him to seek help from other agencies. They made repeated attempts to advocate on his behalf.

Several agencies have also made improvements since Paul's death, including HNAS which now has additional resources to manage the increased demand and also has improved processes to identify, support and manage clients who are high-risk. HHVUK has an improved screening process for risk factors, and the Police have more resource and improved processes for mental health-related concerns.

However, the review also identified that:

- **Housing services were under-resourced at the time,** having experienced a sharp increase in demand. There were backlogs in answering emails, carrying out housing assessments, and long waits for callers to the phone line. HNAS did not assess Paul as being in 'priority need'. An appropriate assessment and with more information available should have identified this. **Paul's needs meant supported housing would have been appropriate** and a service may have been identified which would be able to accommodate him and manage his risks effectively.
- **Paul did not always disclose the extent of his mental health and substance misuse issues** (in common with many veterans). This made it difficult for agencies to assess vulnerability and risk effectively and provide appropriate support and services.
- **Agencies' IT systems did not make it clear that Paul was a veteran** even when it was known to the service. **Paul did not always identify as a veteran** and tell services this information. This meant he did not receive specialist veterans' mental health services that he would have been eligible for.
- Paul received a non-urgent rather than a crisis mental health appointment, due to confusion in referring and triaging. **As Paul had a mental health appointment pending, agencies did not assess it necessary to take more urgent action**.
- There was **no trigger for initiating the Multi Agency Risk Management (MARM) framework** for any agency, which would have provided a forum for the risks to be shared and mitigations to be identified to reduce the level of risk.
- The **voluntary sector organisations were not well linked in with statutory services** and were not clear on each other's roles.

Key Points for Learning & Reflection

- Are you and your team familiar with MARM and confident on how to use it to support multi agency working and risk management? Have you watched the MARM podcast and reviewed the MARM toolkit?
- Have you got a good understanding of the Armed Forces Covenant and what it means for your organisation? Do you ask clients if they are a member of the armed forces community, record this information, and are you aware of the support available to them? Consider doing the Armed Forces Covenant e-learning and/or spend some time getting to know more about referral pathways and what support is available locally.

Further information and useful resources

MARM Framework and toolkit (https://www.portsmouthsab.uk/procedures/)

Thematic Review Following the Deaths of Mr G, Mr H, Mr I and Mr J full report: (https://www.portsmouthsab.uk/scrs-2/)

Armed Forces Covenant e-learning (https://www.armedforcescovenant.gov.uk/localauthorities/learning-training-resources/)

Veterans' Gateway (https://www.veteransgateway.org.uk/)

Op COURAGE - NHS Mental Health service for veterans (https://www.nhs.uk/nhs-services/armed-forces-community/mental-health/veterans-reservists/)

Homelessness - 4LSAB Housing Practitioner Briefing (https://www.portsmouthsab.uk/wp-content/uploads/2022/07/Homelessness-4LSAB-housing-practioner-briefing-vFINAL-May-2022.pdf)

Managers are encouraged to explore the learning points in team meetings and supervisions. If you require further information about the case, please contact PSAB@portsmouthcc.gov.uk.