Portsmouth Safeguarding Adults Board

"Paul" Safeguarding Adults Review

What is a Safeguarding Adults Review?

The primary purpose of a Safeguarding Adult Review (SAR) is to draw out organisational learning about how the local agencies are working together, to support improvement.

Under section 44 of the Care Act 2014, Safeguarding Adults Boards must arrange a Safeguarding Adults Review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. They may arrange a Safeguarding Adults Review for other cases under section 44(4), for example where there is important learning to be identified.

The PSAB SAR subgroup considered the case referral for Paul on 26.10.22 and concluded that the above criteria had not been met. It was decided to carry out a discretionary review under section 44(4) of the Care Act.

The Care and Support Statutory Guidance states that SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again.

Who was Paul?

Paul was a 51-year-old White British man. He had limited involvement with agencies and served in the British Army for a period in the 1990s. Paul had a relationship with his ex-partner for four years and with whom he had an eleven-year-old daughter. Paul's relationship with his ex-partner broke down in 2015. Paul continued to live with his mother until she moved into sheltered housing in 2022. Paul was actively engaging with and receiving support from non-profit organisations for veterans such as Helping Homeless Veterans UK (a national charity) and All Call Signs (a local peer-to-peer support organisation set up by a veteran). Paul was a sociable person, well regarded by friends and family, and worked in security. Paul reported experiencing several mental health issues including anxiety, depression and Post-Traumatic Stress Disorder (PTSD), and disclosed he had been abused in the past.

Paul was described by his ex-partner as a bit 'manic' – up and down but he would bounce back quickly. She described his daughter as his world. Paul also left behind a 48-year-old sister.

Key Practice Episodes

- Paul periodically lived with his mother in Portsmouth for approximately twenty years. His mother was a Council tenant who moved into sheltered housing. This was a significant event that contributed to Paul becoming homeless in May 2022. Paul was told by his mother that he needed to look for alternative accommodation but he would not accept his mother's proposed move to sheltered accommodation. Paul gave up his employment prior to his mother's move on the basis that he considered this would prioritise his housing needs.
- Paul moved to the home address of his girlfriend's friend with his girlfriend. Their relationship lasted four and a half years. However, their relationship ended in May 2022 and living together then became untenable. Paul was offered a place in a hotel by a charity, Helping Homeless Veterans UK (HHVUK) and advised him to approach Portsmouth City Council (PCC) Housing Needs, Advice and Support (HNAS) before HHVUK sourced a private address in shared accommodation. HHVUK paid Paul's rent, deposit and provided furniture and food.
- Paul's housing application was not progressed because he was not considered to be imminently street homeless. Street homeless is the term used for those who routinely find themselves on the streets during the day and with nowhere to sleep at night. At that time and due to exceptional demand and staff resourcing challenges, HNAS were prioritising the assessment and support of customers presenting to the service who had actually become homeless. HHVUK made numerous attempts to contact HNAS but they were unable to get a response.
- During June / July 2022 HHVUK noticed a deterioration in Paul's mental health and consequently referred him to a non-profit organisation, "All Call Signs" who offer peer to peer support. "All Call Signs" staff have received some basic suicide alertness training but they are not mental health professionals. "All Call Signs" were never informed by Paul that he may have had thoughts of self-harm and his behaviours were considered to be alcohol related.
- During July and August 2022 Paul's mental health further declined. There were several incidents requiring police involvement - including domestic abuse incidents involving his ex-partner, and threats towards public house staff, who reported unpredictable behaviour and a declining mental state.
- On 8th August 2022 Paul was responsible for damaging the property he was living in. He voluntarily relinquished his tenancy and subsequently experienced homelessness. Paul was arrested for the damage and whilst in police custody he disclosed his previous suicide attempts. He was referred to, but was not seen by, the Hampshire Liaison and Diversion Service (HLDS). Paul was then temporarily housed at a hotel in Portsmouth by HHVUK and there was then a period of mental health decline.
- During August 2022 Paul engaged with the Rough Sleeping Hub in Portsmouth, PCC housing and his GP and he spoke about his worsening mental health.

- On 11th August 2022 Paul engaged with HNAS because HHVUK would only fund his stay at the hotel until the 15th August 2022 when he would once again be homeless. HNAS completed a housing assessment for Paul. He was assessed as not being in 'priority need', and was therefore referred to HNAS' commissioned rough sleeping services.[1] He was assessed for accommodation within the rough sleeping pathway but deemed to be too high risk to place in that service.
- On 12th August 2022 Paul presented at his GP surgery reporting that he was expressing suicidal thoughts. The GP referred him to the mental health crisis team. The referral stated that "he worked in the army, and he suffers with severe PTSD" however his military status was not recorded on his record. The referral was marked urgent for both the Crisis and Assessment to Intervention (A2i) team. The crisis team spoke to the GP that day and made an appointment with the A2i team for 1st September 2022. At about 02:00 hours on 15th August 2022 Paul called the Police reporting he was having suicidal thoughts but was open to speaking to mental health professionals. The call was transferred to the South Central Ambulance Service (SCAS). Paul later called the Police again at about 05:00 hours and reported he had spoken to SCAS and did not want the Police to attend. The 111 Mental Health Practitioner from Southern Health NHS Foundation Trust tried to call Paul back, but there was no answer so messages were left.
- On 1st September 2022 Paul visited the Emergency Department at Queen Alexandra Hospital after reporting suicidal thoughts and he was referred to the Southern Health Mental Health Liaison Team (MHLT) at the hospital. He was seen by the team who reported no immediate concerns of suicide and no evidence of an acute mental health need. MHLT contacted Solent NHS Trust Community Mental Health Team and asked them to continue to offer Paul support. While in hospital, he missed his A2i appointment.
- On 2nd September 2022 Paul was arrested by police for public order offences after initial concerns regarding alcohol and self-harm. Following investigation, he was bailed for Crown Prosecution Service advice on 3rd September 2022. He was recorded as homeless at the time of his release albeit he had stated an intention to speak with the HHVUK regarding his housing situation. Paul was provided with a train ticket to facilitate his travel back to Portsmouth. Paul was not seen in person by a HLDS practitioner whilst in custody but his records were screened remotely. He was assessed by the police as presenting with no thoughts of self-harm on his release.
- Paul was found by members of the public that night and later died in hospital.[2]

[1] The Housing Act 1996, Part 7 (as amended) sets out that local housing authorities must fulfil certain duties for people who are homeless and who are considered to be particularly vulnerable. The law sets out categories of people who may fulfil this "priority need" criteria.

[2] At the time of publication the inquest into Paul's death has not been held and therefore the cause of death has not yet been determined.

Review methodology

- Review of scoping information detailing each agency's involvement with Paul.
- Workshop on 28th March 2023 including pen picture of Paul and to explore strategic themes involving Portsmouth Hospitals University NHS Trust, Solent NHS Trust, Southern Health NHS Foundation Trust, Society of St James, Hampshire and Isle of Wight Constabulary, Portsmouth City Council Housing department, Hampshire and Isle of Wight Integrated Care Board and Helping Homeless Veterans UK.
- Themes included:
    1 Provision of housing and associated support for people with complex needs, including those who may pose a risk to others.
    2 How well agencies support people who may disengage from services, or who may not attend appointments, or who may not benefit from signposting to other services.
    3 How well veterans' organisations work together and with statutory agencies to support veterans
    4 Access to and quality of services for homeless veterans (and in particular primary care services).
    5 How effectively services take a whole family approach and support homeless people/homeless veterans to maintain healthy relationships,
    6 Consideration of how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management.
- Telephone conference with All Call Signs.
- Meeting to finalise recommendations.

- The author of this review is a Temporary Detective Chief Inspector employed within the Corporate Insights Directorate of Hampshire and Isle of Wight Constabulary as the head of the Serious Case Review Team. The author was also supported by a senior manager with Portsmouth City Council Adult Services. Neither person has had any involvement in the case under review and are independent for the purpose of conducting this review.

Involvement of family members

The reviewer has spoken with Paul's ex-partner who did provide a pen picture of Paul and his life to assist the panel when discussing events leading to his death. The reviewer has also spoken with Paul's father who declined to assist in the preparation of this report but does wish to be made aware when it is published. The author has also met with Paul's mother and aunt who have assisted this review.

Good Practice Identified

- HHVUK was responsive to Paul's request for their help and developed a good relationship with him. He said that he appreciated their advice and support. They 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.
- All Call Signs developed a good relationship with Paul and provided advice and support.

Changes made since Paul's death

- The Housing Needs, Advice & Support (HNAS) service has been provided with additional resources to manage demand and ensure enquiries are processed quickly. This includes a dedicated staff resource to assess "Duty to Refer" homeless referrals from other agencies, and a specialist homeless case officer for individuals at risk of rough sleeping.
- A team of officers delivered a targeted intervention successfully addressing the work backlog for the housing service.
- HNAS now initiates the Multi Agency Risk Management Framework (MARM) for high-risk clients who are difficult to accommodate and/or homeless, and has worked with its accommodation providers to explore how accommodation placements can be more easily secured for individuals assessed as presenting an increased risk.
- HHVUK now has more robust screening processes for client risk factors.
- The Police now have dedicated resource to review Mental Health related 'PPN1' reports and update care plans. There is a process in place to share Mental Health PPN1s with the person's GP even without consent if safeguarding risks warrant this, and a process in place to share PPN1s for homeless clients with Adult Social Care.

Learning

- Housing services did not fully consider the implications for Paul when the decision to move Paul's mother to sheltered housing was made. This was not a statutory obligation, but would be considered good practice.
- HNAS 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.
- 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.
- 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 Paul and manage his risks effectively.

- 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.
- There was confusion about the referral to Mental Health services, both in the referral and the triage, which meant that Paul received a non-urgent A2i appointment, rather than an urgent crisis response. This was contributed to by a recording error.
- Agencies experienced difficulties in contacting Paul which made it hard for them to engage with him.
- As Paul had a mental health appointment pending, agencies did not assess it necessary to take more urgent action.
- Agencies worked in silos and held information which was not shared to identify the picture of escalating risk.
- There was no trigger for a MARM 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. Assumptions were made that voluntary sector services would provide mental health and other support, without checks that this was happening, or that the organisations/individuals were able to provide this support.

Recommendations – multi agency

- Police and the local authority to explore information sharing mechanisms and governance to allow sharing of PPN1s for homeless clients.
- PSAB to seek assurances from all agencies that the MARM Framework is known and understood by all practitioners.
- PSAB to seek assurances from all agencies that a duty to refer under the Homelessness Reduction Act 2017 is being understood and being used by public authorities.
- Armed Forces Covenant - ensure systems are in place to identify veterans. Ensure staff understand the meaning of the Covenant. Improve awareness of veteran's services including Op Courage.
- Voluntary sector supporting veterans - promote better understanding and communication between statutory services and voluntary sector organisations including roles and responsibilities.

Recommendations – single agency

- PCC housing directorate to review its processes around supporting customers to transfer or downsize accommodation and the impact such a move may

have on other members of their household, so that the possible risk of those individuals becoming homeless is mitigated.

- HHVUK and All Call Signs to ensure they refer to statutory services where there are safeguarding concerns and that they are aware of local safeguarding/risk management protocols in the areas they operate in.
- Solent NHS Trust to review triage/recording processes to ensure practice is compliant with policy.

T/DCI Toby Elcock