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Safeguarding, homelessness and rough sleeping:

An analysis of Safeguarding Adults Reviews

Stephen Martineau, Michelle Cornes, Jill Manthorpe, Bruno Ornelas, James Fuller

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Summary

This report presents findings from an analysis of 14 Safeguarding Adults Reviews (SARs) where homelessness was a factor, and the results of a review of the literature relating to third sector and local authority policy and guidance on adult safeguarding and homelessness.

English local authorities have a duty under the Care Act 2014 (CA) to arrange a SAR where there is concern about the quality of joint working amongst local agencies in relation to an adult with care and support needs in its area, where that person is thought to have suffered abuse or neglect and has died as a result (or is still alive but is thought to have suffered serious abuse or neglect). The purpose of these reviews is not to apportion blame, but to learn lessons to improve practice. In our analysis of the 14 SARs we isolated five broad themes:

Co-operation, co-ordination and leadership

Within the local authority. Some SARs reported the lack of a lead agency or professional to co-ordinate care of individuals who were homeless. Complex cases were sometimes referred back and forth between agencies and there was a failure to give any feedback to professionals and agencies when they requested multi-agency support. Multi-agency meetings were sometimes marked by not having key people (such as housing staff) present or even invited. Failings of this kind sometimes led the person's situation to be responded to in crisis management mode.

Inter-authority co-operation. Some SARs highlighted the lack of (and difficulty surrounding) inter-authority notifications and the necessity for active outreach when the person moved between authorities. In one SAR, there was a dispute between three local authorities as to the person's ordinary residence, only resolved by a fourth taking up his care.

Being assessed

Housing Act 1996. Two SARs are critical of assessments under the Act: one because there was no formal assessment of the person's vulnerability and needs; the other questioned the outcome of the assessment.

Care and support needs. Some SARs report a failure to recognize care and support needs. There was some evidence to suggest a reluctance to see the person's needs as anything other than a housing matter. Two SARs reported a failure to make a needs assessment in the wake of a safeguarding referral, despite such needs being part of the picture.

Mental capacity assessments. Concern about practitioners' use of the Mental Capacity Act 2005 is a recurring theme, arising in relation to: points of transition (for example, as the person made an application for housing); fluctuating and executive capacity; where the person had capacity and was taking decisions considered unwise by others; and, the failure to recognize that coercion may have been in play.

Suitable accommodation provision

Concern was expressed by some SARs about insufficient provision of accommodation suitable for those who had a history of mental illness and those who had an alcohol dependency. This might be a 'wet' hostel (alcohol permitted) or extra care housing accommodation (care can be accessed on site). There was recognition in the SARs of the economic context that might be implicated here.

Hospital discharge

Two of the SARs were highly critical of the hospital discharge arrangements in their respective cases. Absence of co-ordination and care planning together with failures regarding assessment were associated in both cases with the person going to inappropriate accommodation (a homeless shelter and bed and breakfast accommodation).

Safeguarding

Six SARs record adult safeguarding referrals being made in respect of a homeless person; two of these gave rise to a section 42 CA enquiry.

Possible missed opportunities. These may have arisen because certain agencies (alcohol advice service; hostel staff) did not see it as part of their role to make referrals. Practitioners also reported lack of feedback on referrals that they had made.

Self-neglect. This was reported in eight of the 14 SARs. SARs described concern among practitioners about the relationship between alcohol dependency and self-neglect. In one SAR, three referrals for self-neglect did not give rise to a section 42 CA enquiry. In another, the SAR author found that practitioners did not understand that self-neglect could trigger such an enquiry.

Making Safeguarding Personal. Three SARs used Making Safeguarding Personal as an evaluative measure in relation to agency activity. Only one SAR found that the initiative had been implemented in the practice under review.

Lack of 'professional curiosity'. Some of these SARs express concern about what they call a lack of 'professional' or 'concerned' curiosity among professionals. This ranged from a lack of interest in the homeless person's 'story', to a failure to see patterns in the person's record that might have triggered a safeguarding alert. One SAR reported practitioners' speculation that curiosity may be inhibited by the legal and financial organisational risk that might come with real 'ownership' of a case.

Difficulties with engagement; normalising of risk; practitioner attitudes. Reported difficulties with engagement was common among these SARs, for a variety of reasons. Some SARs noted the danger that high levels of risk could become normalised, meaning that practitioners found it difficult to make a realistic assessment of risk over time. There was some evidence to suggest that practitioner attitudes about people with substance misuse problems might influence the way they had engaged with people.

Review of learning materials, local authority and third sector policy and guidance

We conducted a brief review of learning materials, and local authority policy and guidance that link safeguarding with homelessness. We included a non-statutory review where a person who was sleeping rough had died; we also examined third sector policy and guidance. We found very little material linking homelessness and adult safeguarding.

Conclusion

This analysis of a small number of SARs where homelessness was a factor found types of poor practice that are common to SARs in general. More specific to homelessness, there were reports of poor inter-authority co-operation, poor hospital discharge arrangements, and a lack of supported accommodation provision. There was some evidence of a reluctance to see the situation of individuals as a safeguarding matter (particularly in relation to self-neglect) and there was some evidence of a reluctance among agencies to see individuals' situations as other than a housing matter and to assess their care and support needs accordingly.

Introduction

There has been a significant rise in homelessness since 2010 in England, with rough sleeping, one of the most extreme forms of homelessness, rising by 169 per cent during this time (Fitzpatrick et al., 2018). In 2018, the Office for National Statistics (ONS) collated and published figures (for the first time) on the numbers of homeless deaths in England and Wales. It estimated that there had been 597 deaths of homeless people in England and Wales in 2017, an increase of 24% over the last five years. The mean age at death was 44 years for men, 42 years for women between 2013 and 2017. This compares with a mean age at death of 76 years for men and 81 years for women in the general population (ONS, 2018).

The extent of homelessness in England was described as 'a national crisis' by the House of Commons Committee of Public Accounts (2017: 3). In the same year the National Audit Office's (NAO) report on homelessness in England criticised the relevant government department (now the Ministry of Housing, Communities and Local Government: MHCLG) for the absence of an overarching cross-government strategy setting out the reduction in homelessness it was aiming to achieve (NAO, 2017).

The government published its *Rough Sleeping Strategy* for England in August 2018 (MHCLG, 2018b). This complemented the Homeless Reduction Act 2017 (HRA), in force since April 2018, which had amended Part VII of the Housing Act 1996, the core statutory provision relating to homelessness in England. The HRA extended assistance from housing authorities to all those affected by homelessness, not just those who have a 'priority need' under the 1996 Act. It also introduced an enhanced prevention duty, a new relief duty for those already homeless, and placed a duty on certain public authorities (NHS Trusts, for example) to refer to a housing authority people they think may be homeless or threatened with homelessness (MHCLG, 2018a).

In the *Rough Sleeping Strategy*, the Secretary of State expressed his commitment to halve rough sleeping by 2022 and end it completely by 2027 through a programme of prevention, intervention and recovery (MHCLG, 2018b). Milestones along the way included a further strategy for other forms of homelessness; a package of sector-led support for homelessness and rough sleeping developed with the Local Government Association, to be in place by summer 2019; and a review of the relevant legislation, to be completed by March 2020. The strategy also described Safeguarding Adults Reviews, the focus of this report, as 'powerful tools, which unfortunately are rarely used in the case of people who sleep rough' (MHCLG, 2018b: 31) and expressed a commitment to working with Safeguarding Adults Boards to ensure they are carried out, when the criteria in section 44 Care Act 2014 are met, with a view to learning lessons and improving services.

Safeguarding Adults Reviews (SARs) derive from one of the three main provisions in the Care Act 2014 (CA) relating to the safeguarding of adults at risk of abuse or neglect, the others being the duty to make enquiries under prescribed circumstances (section 42 CA) and the requirement for every local authority to establish a Safeguarding Adults Board (SAB; section 43 CA). The safeguarding provisions came into force in April 2015 and were accompanied by an illustrative, non-exhaustive guide to abuse and neglect in the statutory guidance to the CA (Department of Health & Social Care (DHSC), 2018). This makes clear that, in certain circumstances, 'neglect' in the CA encompasses self-neglect (DHSC, 2018: 14.17). The same document outlines the six principles that should underpin all adult safeguarding work, which should also be conducted in line with the approach embodied in the Making Safeguarding Personal initiative (i.e. 'person-led and outcome-focused', DHSC, 2018: 14.15).

Safeguarding Adults Reviews, which replaced non-statutory Adult Serious Case Reviews, relate to concerns about adults with care and support needs living in the local authority's area (covering other areas where relevant). They must be arranged when 'there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult' and the adult has died and the SAB 'knows or suspects that the death resulted from abuse or neglect'. The duty is also triggered where there is the same reasonable cause for concern around

joint working, but the adult is still alive, and 'the SAB knows or suspects that the adult has experienced serious abuse or neglect' (section 44 CA).

No eligibility criteria are applied in adult safeguarding with regard to the individual's care and support needs, nor is there a requirement that their needs are being met by the local authority for the duties of enquiry and of review to be triggered. However, in the case of SARs it may be that the section 44 CA criteria suggest to the SAB that commissioning a SAR is not required. This appeared to be the case described in Worcester City Council (2018) where a *non*-statutory review was decided upon because the adult's 'very limited involvement with services in Worcestershire' and the reportedly small amount of time he had spent in the county led the SAB to the belief that there had not been any 'lost opportunities for multi agency working' (Worcester City Council, 2018: 3). Likewise, one could envisage a case failing to meet the statutory criteria where a person who was homeless died and there was no evidence of abuse or neglect, including self-neglect. That said, section 44(4) CA allows for the commissioning of discretionary SARs of 'any other case involving an adult in its area with needs for care and support', and this is the case in two of the SARs reported in the present study (Isle of Wight, 2018; Lincolnshire, 2017).[1]

These statutory constraints should be borne in mind when considering the demands for reviews to take place that were made prior to the *Rough Sleeping Strategy*'s publication. The Mayor of London's *Rough Sleeping Plan of Action*, for example, called for the government to ensure that SABs undertake a SAR following the death of any rough sleeper (Mayor of London, 2018). The homeless charity, St Mungo's, called for multi-agency reviews to be conducted following the death of anyone sleeping rough, perhaps through a new requirement to carry out a SAR in all such cases (St Mungo's, 2018). These interventions came in the context of work by the Bureau of Investigative Journalism on the number of SARs being undertaken in relation to the deaths of homeless people (McClenaghan, 2018; see further in our methods section). SARs are not limited to circumstances where the person has died but more importantly, as outlined above, there may be occasions when the circumstances surrounding the person's death do not fall into the statutory adult safeguarding category.

In the following analysis of SARs, we employ the term Multiple Exclusion Homelessness (MEH) to reflect a recent reconceptualising of homelessness as a health and welfare concern and not just a state of 'rooflessness' (Maeseele et al., 2013). Homelessness is a complex phenomenon that covers a wide range of circumstances. The lived experience of homelessness can be 'transitional', intermittent, or 'chronic'. It can be seen to encompass the following circumstances: people sleeping rough, single homeless people living in emergency and temporary supported accommodation; statutorily homeless households who are seeking housing assistance from local authorities; and 'hidden homelessness' (e.g. 'sofa surfing') (Fitzpatrick et al., 2018). The use of the term MEH assists in negotiating one facet of this complexity, enabling us to record the overlap between homelessness and other kinds of social exclusion (Mason et al., 2017/18), as set out in the following definition:

> 'People have experienced MEH if they have been 'homeless' (including experience of temporary/unsuitable accommodation as well as sleeping rough) and have also experienced one or more of the following additional domains of deep social exclusion – 'institutional care' (prison, local authority care, psychiatric hospitals or wards); 'substance misuse' (drug problems, alcohol problems, abuse of solvents, glue or gas); or participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work).' (Fitzpatrick et al., 2011: 502-503.)

This report presents an analysis of 14 SARs where homelessness was a factor, and the results of a brief review of the literature relating to local authority and third sector policy and guidance on adult safeguarding and homelessness, together with a small number of learning materials. After a section on methods, the findings section presents in outline the characteristics of the cases contained in the SARs, and then reports the results of a thematic analysis of the SARs.

[1] In-text references to SARs in this report are to the Safeguarding Adults Boards concerned.

Methods

In the absence of mandatory reporting of Safeguarding Adults Reviews (SARs), in early 2019 we undertook a search for SARs where homelessness was a factor from a variety of sources. In light of the reported scarcity of SARs in this field, we did not want to apply overly restrictive criteria for inclusion. We included those SARs which recorded the individual as having been homeless, or threatened with homelessness, or sleeping rough at some time. We did not apply a definition of 'rough sleeping' or 'homelessness' (for example, the statutory definition of homelessness used in government statistics: MHCLG, 2018c), opting instead to include all SARs where these terms had been used by their authors.

In April 2019 we conducted internet searches for SARs, using the terms 'homeless' and 'rough sleeping' and variants of these, and searched the SAR library held by the Social Care Institute for Excellence (which includes our own earlier collation of Serious Case Reviews and SARs) for the same terms. In March 2019 the Department of Health and Social Care (DHSC) asked the Chairs of Safeguarding Adults Boards in England to send it any SARs where homelessness was a factor; we were given access to these. We also drew on data published by the Bureau of Investigative Journalism in August 2018. These data derive from the Bureau's Freedom of Information Act request of local authorities to impart how many SARs and Serious Case Reviews had been conducted in relation to homeless people since 2010 and the results of a 'scraping' search of the internet for the same material (Bureau of Investigative Journalism, 2018). Shortly before preparation of this report for publication we were sent a relevant SAR by the DHSC, published in June 2019, which we have analysed and included (Milton Keynes, 2019).

After the removal of duplicates and exclusions, where our criteria were not met, we entered data from the 14 SARs into an Excel spreadsheet (or data extraction table) and undertook a thematic analysis. We added new themes to this spreadsheet as they emerged and re-examined the SARs in an iterative process.

In addition, we undertook a brief review of local policy and guidance and of grey literature from organisations within the homelessness field, on homelessness and adult safeguarding. Also included were learning materials deriving from the SARs examined in this report, and one non-statutory review. We conducted searches of Social Care Online, the Social Care Institute for Excellence online database of social work and social care information, and internet searches. Searching for the terms *safeguarding* AND (*homeless* OR *rough sleep**) in all fields on Social Care Online produced 28 results. After screening for relevance, this produced three results. We conducted internet searches for the same terms and after the first 10 pages of results we had found eight relevant results. Combining these with results from the responses to the DHSC letter to Chairs of SABs in England and from earlier preparatory work we had, following deduplication, 23 results, which are reported on at the end of our findings section.

Finally, we asked James Fuller, peer researcher on this project who has lived experience of homelessness and employment experience in the voluntary sector supporting homeless people, to read this report and give his perspectives, which we reproduce here:

> 'Front line support workers – in third sector day centres caring for rough sleepers, for example, are perhaps the best placed service providers to make safeguarding referrals because of their detailed, holistic knowledge of their clients' circumstances, but are the least involved in the decision-making and implementation process. Certainly, the observation made here by LA housing staff that they felt excluded from joint meetings, because they are not regarded as 'professionals', resonates with day centre personnel. Indeed, there is some evidence that referrals from this source are treated with outright suspicion. In one instance, where we

attended a local authority-led crisis meeting (following the non-fatal stabbing of a client), it was made clear that day centres were perceived as 'using safeguarding as a sledge hammer to crack a nut', or (being 'emotionally-driven'), trying to circumvent due process on behalf of favoured clients. Such attitudes were prevalent among medical and other professional service providers in the recent past, although many now accept that support workers are an invaluable source of information, particularly in complex, multiple exclusion cases and work with them accordingly.

Meanwhile, observations about service provider fatigue and 'normalising' ways of living that should never be perceived as acceptable, may apply equally to seasoned support workers. Perhaps some 'scaling' is inevitable, given the common patterns of presentation that they see daily and the 'street' knowledge they acquire. Being professionally inquisitive is almost a prerequisite for effective working in this field (as is a degree of righteous indignation at the world's inequity). It is understandable if such attitudes create certain tensions, even mistrust, between support workers and statutory organisations.

Otherwise, third sector staff are acutely aware of the impact of austerity and hardening of attitudes towards the most excluded and disadvantaged members of society, as they deal with the consequences every day. In particular, the amount of people presenting at day centres with mental health issues, in addition to other problems, is rising exponentially. As specialist services and facilities are being decommissioned or becoming referral agencies, it is likely that support workers will invoke safeguarding measures more often. Nevertheless, for this to happen they will need to be given clear pathways and proper instructions on the 'when and how', instead of the opaque and distancing processes currently in place.

Support workers must remain non-judgemental in all instances, but some clarity and broad agreement over what is meant by 'impartial advice' in the context of care would be helpful. In the same way, a more considered definition of mental capacity as a test of a person meriting support should be developed. At present, passing this aspect of an assessment often appears to be an excuse for inaction for the reasons identified in this report. Support workers deal daily with the consequences of people repeatedly making poor (or 'dishonest') decisions, victims of coercion, domestic violence, drug and alcohol misuse, etc. Watching someone racing headlong towards sometimes fatal disaster necessarily impacts workers' views and behaviour. The relationships that support workers must build with their clients – based on trust, openness and empathy, allow a frankness that perhaps is not popular at present, but may be lifesaving. For the knowledge such contact produces to be wasted for political, economic, administrative or any other non-person centred reason is a travesty.' —James Fuller, 21 May 2019.

Findings

The SARs in outline

The 14 SARs under consideration covered a broad diversity of circumstance, ranging from a person who had experienced multiple episodes of rough sleeping (Newham, Islington, City and Hackney, and Lambeth, 2019, hereafter Newham et al., 2019) to another who had been served with a notice to quit (Haringey, 2017). Time periods under review by the SARs varied widely – from about two months (Solihull, 2016) to about seven years (Lincolnshire, 2017).

All of the SARs are in the public domain. Three are executive summaries (Lambeth, 2016; Nottingham and Nottinghamshire, 2017; Tower Hamlets, n.d.); the remaining eleven appear to be full reports. Of the 14 SARs, four review practice that took place wholly before the Care Act 2014 (CA) came into

force, i.e. pre-April 2015 (Brighton & Hove, 2017; Lincolnshire, 2017; Southwark, 2016; Tower Hamlets, n.d.).

Of the 14 SARs analysed in this report, 13 review individual cases, while one, Lincolnshire (2017), reviews the cases of 10 individuals. We have drawn from this latter SAR three individuals with reported episodes of homelessness. Hence, while we refer to 14 SARs, there are 16 individual cases under consideration here.

Among the 16 individuals, 14 were men; one was a woman; one was transgender. Mean age (of the nine cases where age is given) was 47 years. It is recorded in the SARs that seven of the 16 individuals had experienced rough sleeping. One had received a notice to quit his tenancy and was threatened with homelessness. The remainder were reported to have experienced episodes of homelessness.

Incidence of ill health, learning disability, and substance misuse across the 16 cases was as follows:

- Long-term mental health problem: 10
- Chronic physical ill health: 10
- Substance (including alcohol) misuse: 9
- Suspected or diagnosed learning disability: 5

Thirteen of the 16 individuals concerned meet the criteria for having experienced Multiple Exclusion Homelessness (MEH) because they had experienced episodes of homelessness as well as substance misuse or a custodial sentence or detention under the Mental Health Act 1983. It should be noted, though, the SARs do not use the term Multiple Exclusion Homelessness and may have omitted to record aspects of the individuals' life experience (for example, involvement in 'street culture activities' described in the MEH literature as including begging and street drinking: Fitzpatrick et al., 2011).

Ten SARs were commissioned because of a death that was known or suspected to have resulted from abuse or neglect; two SARs were commissioned because of serious abuse or neglect and the person was still alive (Newham et al., 2019; Nottingham and Nottinghamshire, 2017); the remaining two SARs were commissioned on a discretionary basis (Isle of Wight, 2018; Lincolnshire, 2017) under section 44(4) CA. Recorded incidence of actual/suspected abuse and/or neglect across the 16 individual cases was as follows:

- Physical abuse: 5
- Financial abuse: 6
- Modern slavery: 1
- Organisational abuse: 1
- Neglect: 5
- Self-neglect: 8

The record of homelessness of those individuals who are the focus of these SARs is summarised in Table 1.

Other forthcoming SARs associated with homelessness

As a result of the DHSC letter to the Chairs of SABs we were also informed about the following homelessness-related SARs that at the time of writing are ongoing, all described as thematic reviews: Leeds (by Neil Revely, reportedly starting, 3/19); Manchester; one being undertaken by Michael Preston-Shoot (reportedly in its early stages, 3/19); and one in Worcestershire (relating to the deaths of 3 homeless people; commissioning of the SAR awaiting sign-off, 3/19).

Table 1: Safeguarding Adults Reviews where homelessness was a factor

SAB (SAR publication date) Name (gender, age)	Mental and physical health	Record of homelessness	Cause of death (where relevant) Notes on safeguarding concerns
Brighton & Hove (2017) X (transgender, 59)	Personality Disorder. Episodes of self-harm. Detention under Mental Health Act 1983 (MHA). Possible learning disability	X was sleeping rough or living in bed & breakfast accommodation arranged by Kent County Council from 2012-2014, and then moved to Brighton where X was rough sleeping in April 2014. X was housed in temporary accommodation, but was sleeping rough again by July 2014, moving to a caravan where they died in December 2014. (*)	Coroner's verdict: 'misadventure to which self-neglect contributed' (page 5). X had reported being the victim of abuse.
Buckinghamshire (2017) Ms T (female, 34)	Paranoid schizophrenia. Detention under MHA. Chronic physical ill health.	Ms T had experienced an episode of homelessness in 2014. The mental health team assisted her in getting into a homeless shelter in summer 2014. Then she secured a more permanent tenancy with the local Housing Trust in August 2014.	Cause of death could not be established. Ms T was last seen in November 2015, but her body was found in an advanced state of decomposition three months later in 2016. Self-neglect a concern.
Essex (2019) Frank (male, 55)	Post-Traumatic Stress Disorder. Alcohol dependency. Chronic physical ill health.	Frank was homeless from September 2016 (when he lost his tenancy apparently because of his anti-social behaviour and drunkenness) until his death in March 2018. In this period, he was sleeping rough with temporary spells in hotels. From about August 2017 he was living in a car. He died in a hotel room provided by Harlow, under its cold weather provision. (*)	Cause of death: Multi-drug toxicity with a background of liver cirrhosis. There had been three referrals to Adult Safeguarding for self-neglect. He had suffered an assault in 2009. There was reported financial abuse.
Haringey (2017) Robert (male, 32)	Foetal Alcohol Syndrome. Possible learning disability. Low mood / depression following father's death.	Robert was not homeless, but he was not entitled to inherit his father's (local authority) tenancy. He was found not eligible for another tenancy on the basis that he was capable of independent living. Robert died (January 2016) in the home he had shared with his father on the day he received the eviction notice.	Inquest recorded an 'open verdict, with the cause of death asphyxiation by strangulation; further recording that Robert was full of sorrow about the death of his father and full of worry about his future.' (page 4)
Isle of Wight (2018) Howard (male, 53)	History of alcohol abuse (leading to multiple hospital admissions). Long-term heart condition. Double incontinence.	He became homeless (rough sleeping, sofa-surfing, homeless shelter) after a 'cuckooing' gang moved in on him, from at least April 2015. He was found dead in a bus shelter on the seafront, March 2017. (*)	Discretionary SAR (section 44(4) CA), apparently because it was not clear that the cause of his death was as a result of abuse or neglect. He was thought to have suffered financial and physical abuse. Self-neglect was a concern.
Lambeth (2016) Mr D (male, 75)	Mobility difficulties arising from an accident in 1960.	He had a tenancy in a bedsit but was spending his time at the house of a friend. Rent arrears led to his bedsit being repossessed shortly before Mr D's death in hospital (May 2015). His friend's house did not have electricity, or an effective running water supply (since 2009) and was in poor condition.	On admission to hospital he was found to be covered in faeces, lice, scabies and maggots. Numerous pressure ulcers. He died within a week of admission. Concern about self-neglect and neglect by his friend.

Lincolnshire (2017) David (male, 30s) Gerry (male, 30s) Stevie (male, 40s)	David: Schizophrenia. Personality Disorder. Drug abuse. Gerry: Personality Disorder; Psychosis. Drug abuse. Mild learning disability. Chronic physical ill health. Stevie: Schizophrenia. Drug abuse.	David was homeless on release from prison in 2009, followed by an erratic housing situation, including spells of homelessness. Gerry had periods of homelessness, once giving up a tenancy because he was fearful of going home. Stevie was rough sleeping in 2013 and then in temporary accommodation.	Discretionary SAR (section 44(4) CA). David, Gerry and Stevie were still alive, but had suffered at least a seven-year period (2007-14) of financial exploitation, physical and psychological abuse. Possible self-neglect.
Milton Keynes Safeguarding Board (2019) Adult B (male, 33)	Diagnosed with learning disability and autism for the first time, Nov 2015. Long-standing alcohol dependency. Substance misuse. Police records of mental disorder, self-harm, suicide risk.	He was in local authority care from age 12 to 21. He had local authority tenancies, ending in 2009 due to rent arrears and anti-social behaviour. He was taken in by an acquaintance in 2013 but was evicted because of his drinking. He was rough sleeping 'for more than ten years' (page 5). There were three attempts at rehabilitation (2010; 2014; 2015), none completed by him. He did not complete two applications to housing. From Jan 2016 till his death in Feb 2016 he was rough sleeping.	Cause of death while rough sleeping (Feb 2016) was hypothermia. Coroner calls for review because of apparent agency failings. Nov 2015: safeguarding alert raised by police in relation to financial abuse by other rough sleepers. Subsequent enquiry completed in Jan 2016.
Newham, Islington, City and Hackney, and Lambeth (2019) Yi (male, age not given)	Schizophrenia. Two brain injuries.	He bought his own home in 1999 but abandoned it (reason unknown) and started sleeping rough (2006). He was in sheltered accommodation 2013-15 but evicted because of rent arrears. In 2016 he was in temporary accommodation followed by emergency accommodation from which he was evicted (because of violent behaviour). An episode of rough sleeping was followed by admission to hospital (2017). Lambeth placed him in a nursing home.	The cause of his death in September 2018 was not connected to agency failings or abuse / neglect, so the SAR was undertaken because of 'serious harm' (page 3). Once he was in the nursing home a section 42 CA enquiry was initiated on grounds of neglect and acts of omission. Also signs of self-neglect; hoarding.
Nottingham and **Nottinghamshire** (2017) Adult C (male, 'young')	Possible mental ill health, learning disabilities and substance misuse problems.	SAR describes him as homeless, without further detail.	SAR relates to false imprisonment and assault in context of modern slavery, i.e. serious abuse, rather than death.
Solihull (2016) Mr S (male, age not given)	Anxiety and depression. Family reports of paranoia, suicide attempts, drug and alcohol abuse.	At the time of his hospital admission (following a suicide attempt) he was living with his parents. This followed a period of homelessness following a relationship breakdown. His body was found in woods close to the hospital, Sept 2015.	Cause of death: suicide contributed to by neglect. Neglect by hospital, where there had been a gap in his continuous supervision during which he left hospital.
Southwark (2016) Adult A (male, 45)	Schizo-affective disorder. History of being detained under MHA. Chronic physical ill health.	Since leaving his parental home in 2011, he had been housed in bed and breakfasts with at least one period of rough sleeping (following eviction for non-payment of rent). After being detained under MHA in May 2012, he was discharged and offered bed and breakfast accommodation, where he was found dead in September 2012. (*)	Cause of death: natural causes to which neglect contributed.
Tower Hamlets (n.d.) Mr K (male, late 60s)	Misused alcohol for some years. Health deteriorating rapidly since 2013.	He had lived alone in sheltered accommodation since 2008, having previously been homeless for some years. He died in late 2014 in his home.	He died after suffering serious burns in a fire in his home. Concerns about self-neglect.
Waltham Forest (2017) Andrew (male, 39)	Long-standing alcohol dependency, with alcohol related liver disease.	Andrew had lost his job and lost his tenancy, becoming homeless and moving to supported accommodation for the homeless for the year prior to his death in hospital in February 2016.	Cause of death: alcohol related liver disease. Concerns about self-neglect. Andrew had become increasingly reluctant to engage with services.

(*) Reported by the SAR as having spent time in prison. A custodial sentence, together with homelessness, is seen as a marker of Multiple Exclusion Homelessness (see our introduction).

Thematic analysis

We present here the main themes from our analysis under five broad headings: Co-operation, co-ordination and leadership; Being assessed; Suitable accommodation provision; Hospital discharge; and, Safeguarding. In the following, only in Isle of Wight (2018) is the real first name of the adult, Howard, used in the SAR; the remainder use pseudonyms or initials.

Co-operation, co-ordination and leadership

Reciprocal duties of co-operation between local authority departments and between the local authority and its 'relevant partners' (which include other local authorities, the police, and NHS bodies) are explained in the statutory guidance (DHSC, 2018: chapter 15) in accordance with sections 6 and 7 Care Act 2014 (CA). The Housing Act 1996 (section 213(1)) also sets out the duty of social services authorities to co-operate with local housing authorities.

Against the background of this general obligation to co-operate, the specific concern of SARs is to examine how agencies worked together to safeguard the adult who is the subject of the review. This section of our report highlights instances where the 'reasonable cause for concern' as to the quality of joint working (section 44(1) CA) was found to be borne out by the SAR, along with some of the apparent outcomes of this. It begins with multi-agency difficulties within the local authority and then moves on to inter-authority scenarios.

Poor multi-agency working within the local authority

In Newham et al. (2019) practitioners alluded to the challenges arising from the statutory framework outlined above:

> 'They understood the duty set out in s6-7 Care Act 2014 provided legal powers to enable cooperation, but were less confident about how to apply the legal framework in practice to secure cooperation across specialisms, organisations or geographical boundaries. They acknowledged the interface between health, social care and housing legislative duties are complex. Further complications arise because different terms are used within relevant legislation to determine responsibility for funding/commissioning treatment, care and support and/or housing. Interpreting those, alongside the individual's right to make decisions and any impact that tri-morbidity conditions could have on that ability, takes considerable skill!' (Newham et al., 2019: 4)

This SAR's first recommendation focused on the co-ordination of services within the local homelessness strategy to address safeguarding concerns. Practitioners reported that the 'case was not unique and spoke of individuals who "ping-pong" between services, because their conditions present considerable practical difficulties for services' (ibid., 4). Likewise, Brighton & Hove (2017) found that in the absence of a co-ordinated care pathway, 'the pattern that had developed of referring cases back and across agencies was not good practice and led to delay and a lack of leadership and co-ordination by statutory services' (Brighton & Hove, 2017: 31).

Other outcomes of poor leadership in relation to joint working included practitioners reporting 'fatigue if repeated requests for multi-agency support (under s42 Care Act or other risk management processes) appear to be ignored' (Newham et al., 2019: 4). Frontline practitioners could 'become overwhelmed, particularly as they will be dealing with large numbers of individuals at high risk of harm and with complex needs' (ibid.).

Another SAR reported that 'there did not seem to be a lead professional or agency coordinating care' (Essex, 2019: 20). Indeed, 'many agencies were not aware of the involvement of other agencies, and so could not coordinate care (and associated with this, the invitations to various multi-

agency meetings did not always lead to the most useful people being involved)' (ibid., 20). Although not explored in the SAR, the fact that housing and social services are the responsibility of different tiers of local government in Essex (district and county council, respectively) may have been a complicating factor.

In Lincolnshire (2017) local authority housing staff had difficulty in liaising with other statutory agencies and were not always invited to safeguarding strategy meetings. Though events examined in this SAR took place pre-CA, this was particularly troubling, given that abuse (intimidation and financial exploitation) was happening at the door and inside the homes of individuals, one of whom (Gerry) relinquished his tenancy because he had become scared; another (David) reporting that he was fearful of returning home. The SAR affirmed that the housing department was 'in a prime position to contribute a wealth of intelligence to multi-agency strategy meetings' (Lincolnshire, 2017: 61). Housing staff reflected that their failure to be invited to the meetings 'was because they were not viewed as "professionals"' (ibid., 60). The SAR author qualified this observation by suggesting that the limited number of strategy meetings may have had a part to play here.

The number and quality of adult safeguarding multi-agency meetings were also criticized in Isle of Wight (2018). The start date for the period under review in the case of Howard had been set in order to include a safeguarding strategy meeting in April 2015. At the time, Howard was living in a tent in woods. By the time he was found deceased in a bus shelter on the seafront by a member of the public in March 2017 there had been only three adult safeguarding multi-agency meetings. At none of these were all agencies involved present; at two of them neither the police nor housing officials were present. This was in the wider context of a case where there was a tendency (of which the SAR author is critical) for Adult Social Care to see Howard's situation solely in terms of homelessness and housing. The SAR author was unable to find any evidence 'that any agency was appointed as the lead agency, or any practitioner as the lead or key worker, responsible for co-ordinating information-sharing and monitoring implementation of the plan' (Isle of Wight, 2018: 17). While practitioners at a learning event suggested that, in light of the poor joint working, the housing department should be relocated either into Public Health or Adult Social Care, the SAR author identified the lack of a 'proactive cohesive and collaborative multi-agency risk management plan' as the central problem (ibid., 22). In the absence of this, Howard's situation was responded to in crisis management mode by single agencies: on occasion the Salvation Army provided hostel accommodation even though he was not abstaining from alcohol, because of the risk of death; at other times the police stepped in when health and social care agencies might have been better suited to the situation.

Inter-authority scenarios requiring good co-operation

Four of the SARs under review highlight challenges presented to local authorities by homeless individuals moving between areas, three in relation to maintaining contact and one where there was a dispute between authorities as to the ordinary residence of the individual concerned.

In the SAR jointly commissioned by Nottingham and Nottinghamshire (2017) the fact that Adult C moved across the City and County Council boundaries 'added to the fact that his health, housing and social care needs were never fully addressed' (Nottingham and Nottinghamshire, 2017: 4). No recommendations deriving from this observation were recorded in this executive summary of a case involving false imprisonment and assault in the context of modern slavery.

In Brighton & Hove (2017) X (who was transgender) had been the subject of a Vulnerable Adult at Risk alert in Kent because of their apparent vulnerability to abuse. The alert lapsed when X moved to Brighton. The SAR noted that there were no arrangements for notification of a person's move when

an alert is outstanding and acknowledged that this was a matter requiring further investigation, given the obvious difficulties involved of not necessarily knowing where the person has gone.

In Essex (2019), Frank's move from Uttlesford District Council (who had been working with Frank in relation to his housing) to Harlow was known by the authorities concerned. Harlow, however, which had received Frank's paperwork from Uttlesford did not process the case at least partly because Frank did not return a medical form, but also because of a lack of ties in the area. The SAR suggested that Frank's engagement could have been maintained through a more active outreach-based approach from Harlow (Essex, 2019).

Newham et al. (2019) is unusual in the context of the SARs under review in that it involved and was commissioned by four London SABs. Local Authority (LA) 1 (Newham) and LA 2 (Islington) disputed Yi's ordinary residence (this relating to one of the triggering criteria for the duty placed on LAs to meet an individual's care and support needs under section 18 CA) – a dispute that was not pursued because of expected legal costs. An extended extract from the SAR reveals a second dispute and that Yi was only ultimately assessed and taken care of by being taken to LA 4 (Lambeth):

> 'The dispute over responsibility reached an impasse on the 13.07.17 when staff drove him first to LA-2 and then to LA-3 [Hackney] offices to require assessment. In common with previous statutory interventions, staff did not share information known about his health and social care needs, mental capacity or likely presentations. For example, although he was accommodated for one night, hostel staff were not advised of his brain injury and wrongly assumed he was drunk. He was not assessed by either authority for on-going support.
>
> From 14.07.17 Yi slept rough, until on the 23.07.17 he was taken into St Thomas' hospital in a confused state. In line with their duties before discharge, hospital staff undertook an assessment of his need for continuing healthcare and identified that he would require nursing support on discharge. At this time he was appointed an advocate to support him during the assessment and care planning process undertaken by social care staff from fourth authority ['LA-4']. That authority subsequently accommodated in a nursing home and initiated a safeguarding enquiry under the category of "neglect and acts of omission". This review arose out of a recommendation from that enquiry.' (Newham et al., 2019: 3; footnotes removed)

The SAR makes no recommendation in respect of this narrative, although it does recommend a cost benefit analysis of 'preventative, person-centred interventions' in respect of health, housing, social care and criminal justice agencies (Newham et al., 2019: 7).

Being assessed

This second section of the findings focuses on those SARs which examine assessment under section 189 Housing Act 1996 (priority need); section 9 CA (care and support needs); and assessments under the Mental Capacity Act 2005. Adult safeguarding assessments are relevant here (at the interface with section 9 CA) but are considered later in the report under safeguarding.

Housing Act 1996

Five of the SARs report on the application of section 189 Housing Act 1996 which sets out the categories of people who have a 'priority need' for accommodation (new categories were added by *The Homelessness (Priority Need for Accommodation) (England) Order 2002*). In one (Southwark, 2016) the individual qualified under the statutory criteria associated with priority need assessments, though there was no suitable accommodation available (described in the section below on suitable accommodation provision). In two others, such applications were rejected: one because the person

was intentionally homeless (Brighton & Hove, 2017), the other because the person already owned a property (which he had abandoned for an unknown reason: Newham et al., 2019). In the latter case, the SAR was critical of the decision on the grounds that it did not involve a consideration of whether it was reasonable (given his disabilities and the condition of the property) to determine that he could occupy the property.

There is further criticism of decision making in relation to housing assessments in Haringey (2017) and Isle of Wight (2018). In Haringey (2017) Robert had recently lost his father and with this his right to remain in what had been their rented home. He was therefore threatened with eviction. The SAR found that a failure to meet with Robert face to face meant the housing assessment was working with poor quality information. In particular, there was no professional assessment of his vulnerability and needs, despite his sister emailing Homes for Haringey describing him as being 'almost suicidal' (Homes for Haringey subsequently acknowledged this should have prompted a safeguarding alert and a suspension of the eviction procedure: Haringey, 2017: 35). The SAR concluded:

> 'We do not have any direct evidence that Robert's death was linked to the Housing Panel decision although it may have been a contributory factor. The review acknowledges that Robert died on the same day as the eviction notice which was the outcome of the Housing Panel decision. He was reported by his friends to have attempted suicide before, but this was not known to agencies until after his death.' (Haringey, 2017: 29-30)

In Isle of Wight (2018) the author questioned the decision of housing officers that Howard did not have priority need:

> 'Overall, when Howard was known to have a serious heart condition and to have had seizures caused by excessive alcohol use, alongside increasing incontinence, it is hard to reconcile the decision that Howard was not vulnerable and in priority need with the physical and mental health problems with which he presented. Moreover, GPs and other professionals were clearly indicating how his homelessness was negatively impacting on his health and wellbeing.' (Isle of Wight, 2018: 21)

Needs assessments

The threshold for the duty to conduct a CA needs assessment is low (Clements, 2017), but nevertheless a number of these SARs tell of failings in meeting this duty. For example, Milton Keynes (2019) recounts that Adult B, who died sleeping rough at the age of 33, had been in local authority care between the ages of 12 and 21. He had a long-standing alcohol dependency and was subject to numerous hospital interventions due to alcoholic seizures, as well as numerous contacts with the ambulance service. He had also been arrested frequently, often due to breaches of his Antisocial Behaviour Order. Only diagnosed with autism and a learning disability in November 2015, Adult B died of hypothermia in February 2016 before he could be assessed or offered accommodation. The author concludes:

> 'You would think "how many more times?" should a person displaying such concerning behaviours and worrying health concerns have, before a professionals meeting is called to consider his case.' (Milton Keynes, 2019: 30)

Beyond this striking example of failure to recognize need, three aspects emerge when these SARs consider the approach to needs assessments by the local authorities concerned. First, there is the seeming reluctance to see the individual's situation as other than a housing matter. In Howard's case, notwithstanding a heart condition, a long history of alcohol abuse and double incontinence,

and having spent much of December 2016 in hospital, 'his situation [was] being primarily defined as a housing problem' (Isle of Wight, 2018: 27). In fact, no assessment of Howard under section 9 CA was conducted. In late December, '[t]he entry on the combined chronology from hospital social work records states that when it was suggested residential care may be provided his care needs "appear to have disappeared" and ASC [Adult Social Care] would therefore not be providing accommodation' (ibid., 12).

If Isle of Wight (2018) suggests inertia or a gate keeping attitude on the part of Adult Social Care, then in Brighton & Hove (2017) the author perceived a failing on the part of housing officials. While recognizing the referral of X to the Mental Health Social Worker for a community care assessment was the correct next step, once the finding of intentional homelessness had been made, the SAR states that this should have been done much earlier – in other words that assessments could have been run concurrently, and that this was a failure of joint working.

A second aspect to emerge concerns the interface between section 9 CA and adult safeguarding referrals. In Essex (2019) three adult safeguarding referrals by the ambulance service, none of which were carried forward to a section 42 CA enquiry, failed to prompt a section 9 CA assessment. The SAR recommends that:

> 'The LSAB [local SAB] should review the process by which the need for a s.9 Care Act assessment is raised through the safeguarding referral process. The LSAB may wish to audit the extent to which this occurs currently to establish if this is in line with expected population need. If only a small proportion of safeguarding referrals lead to a s.9 assessment, the LSAB should consider whether there is a need for increased resources or modifications to the safeguarding referral pathway to ensure this occurs.' (Essex, 2019: 21)

Isle of Wight (2018) also alludes to this interface and, in relation to section 9 CA, it emphasizes:

> 'The threshold is low for such an assessment and the failure to conduct and complete an assessment of his care and support needs is a significant omission and missed opportunity.' (Isle of Wight, 2018: 27)

Finally, as described above (in the section on co-operation and co-ordination), assessments became difficult for the homeless person to access when the local authority questioned whether it had any obligation toward the person in an inter-authority dispute over ordinary residence (Newham et al., 2019). This SAR asserted that practitioners had not acted with deliberate intent to harm, but went on:

> '… his legal rights to be appropriately assessed for support to meet his housing and social care needs were also repeated ignored by a number of statutory agencies and as a consequence his health and wellbeing deteriorated. It is accepted that he suffered serious harm, such that the failings would likely have given rise to an action for a breach of his human rights.' (ibid., 6)

The author added reference to 'organisational abuse', implying that Yi had suffered, '"mistreatment or abuse or neglect of an adult at risk by a regime or individuals within settings and services that adults at risk live in or use, that violate the person's dignity, resulting in lack of respect for their human rights"' (ibid.), this being the definition of organisational abuse from the 2014 iteration of the statutory guidance to the CA, as quoted in the Pan London Adult Safeguarding Policy (2015).

Mental capacity assessments

Concern about the quality of practitioner use of the Mental Capacity Act 2005 (MCA) is a recurring feature of these SARs (as in many others: Manthorpe & Martineau, 2019; 2017). We have identified four facets that have a salience to homelessness.

At points of transition

Both Haringey (2017) and Newham et al. (2019) comment on failures to conduct assessments in relation to applications under the Housing Act 1996. One of the purposes of a face-to-face meeting with Robert, following the death of his father, would have been to assess his decision-making capacity (Haringey, 2017). Likewise, there was no evidence of a proper assessment of Yi's decision-making capacity in relation to his application for support under the Housing Act 1996. He had earlier suffered two brain injuries, which affected his functioning and had been clinically assessed as 'unable to manage activities of daily living independently' (Newham et al., 2019: 1). He was unlikely to have had capacity to litigate and should, according to the SAR, have received support when he was facing eviction from sheltered accommodation, possibly extending to a Court of Protection appointment of a property and financial affairs deputy (ibid., 2).

Another point of transition is the focus of Southwark (2016), which is critical of the fact that Adult A's mental capacity was not assessed in relation to decisions involved in his diabetes treatment and Community Treatment Order when, following discharge from inpatient detention under the Mental Health Act 1983, he was allocated bed and breakfast accommodation by Southwark Housing.

Fluctuating and executive capacity

Lincolnshire (2017: 5) reported that practitioners lacked confidence in applying the MCA, 'particularly where the person's capacity may be fluctuating due to their substance misuse'. Similarly, in Isle of Wight (2018) both the Community Mental Health Team's and the Salvation Army's submissions to the SAR acknowledged shortcomings in relation to managing fluctuating capacity. It was noted at a learning event that the appointment of an Independent Mental Capacity Advocate had not been considered. Howard had been assessed as having decision-making capacity when not intoxicated at various times, and fluctuating capacity had also been recorded at other times, but it was 'unclear how it was proposed to act in his best interests when Howard did not have decisional capacity' (Isle of Wight, 2018: 27). This SAR is critical of a seeming failure on the part of practitioners to consider executive capacity in relation, for example, to Howard's assertions that he was taking and would take medication; although he could present coherently, he 'subsequently did not appear to act in line with his statements' (ibid., 26).

'Unwise decisions'

Several of the SARs under consideration refer to section 1(4) MCA, which states that '[a] person is not to be treated as unable to make a decision merely because he makes an unwise decision.' These observations should be seen in the context of the general duty placed on local authorities to promote well-being (section 1 CA), which may be in tension with the wishes of the individual, particularly in instances of self-neglect or reluctance to engage (DHSC, 2018: 1.12). In the learning event associated with Lincolnshire (2017) agencies had described:

> 'a sense of "road blocks" preventing referrals being managed through multi-agency safeguarding procedures…In reviewing the records, the primary road block was that the person had capacity and was not wishing to engage in safeguarding…The Local Authority chronologies repeatedly referenced, *"has capacity, right to make unwise decisions."*' (Lincolnshire, 2017: 53; emphasis in original.)

The SAR suggested that this had led to practitioners taking an oversimplified approach to the question of whether to intervene (particularly given coercion may have been involved; see next section). In a brief executive summary of a case involving modern slavery, practitioners considered that Adult C had the right to take the unwise decision of discharging himself from hospital against medical advice (Nottingham and Nottinghamshire, 2017).

In relation to self-neglect, the author of Isle of Wight (2018) was critical of the attitude housing staff brought to bear on Howard's decision-making:

> 'His alcohol use was seen as "behaviour of choice." On what basis, including access to specialist advice, this judgement was reached remains unclear.' (Isle of Wight, 2018: 23)
>
> 'Lifestyle choice was assumed; no-one appears to have asked Howard whether he was really choosing to self-neglect in this way' (ibid., 27)

Similarly, in the case involving Andrew, a 39-year-old man living in supported accommodation who was reluctant to engage in interventions focused on his alcohol dependence, the SAR observes:

> 'This case has several elements which are common to other cases involving adults who have mental capacity but may still be at risk of self-neglect. Cases of this nature can be particularly challenging for professionals if the adult chooses not to engage with the support being offered by professionals to reduce harm and improve their life outcomes and instead continues to make what could be considered "unwise decisions or choices".' (Waltham Forest, 2017: 10)

In Howard's case, the challenge of working with self-neglect meant that further training and guidance in the assessing of mental capacity and the balancing of autonomy and self-determination with a duty of care might be required (Isle of Wight, 2018). In another SAR involving self-neglect, the author recommended that staff ensure 'that individuals are made aware of the implications of potentially unwise decisions' (Tower Hamlets, n.d., 2).

Effect of experience of coercion

Three of the SARs (involving a total of five individuals) questioned whether what was going on in cases involving a reluctance to engage was less a matter of capacitous 'unwise' decision-making and more a decision-making process shaped by the duress that the person was under from their abusers. In the modern slavery case, in which no agency was aware that Adult C was being abused, the SAR suggested that practitioners should consider how to manage deception on the part of the homeless person resulting from coercion; it appeared that Adult C was protective of his abusers (Nottingham and Nottinghamshire, 2017). Howard told the police he did not wish to take action against those who were financially abusing and/or threatening him, possibly because he was acting under duress (Isle of Wight, 2018).

The domestic abuse offence of controlling or coercive behaviour is limited to those in intimate and family relationships and was introduced in December 2015 by the Serious Crime Act 2015. In a SAR which examined practice in the period 2007-2014 the author suggested that even capacitous individuals may be particularly vulnerable to undue influence and coercion where they have a substance dependency and if they exhibit low self-esteem and loneliness. While she noted the increasing understanding of the phenomenon in domestic abuse, she recommended this should be extended to other safeguarding adults work since in this case '[t]he rightful focus on capacity and consent had eclipsed consideration of coercion and control' (Lincolnshire, 2017: 66).

Suitable accommodation provision

In the SARs where the individual had experienced Multiple Exclusion Homelessness, the importance of supported accommodation provision is often remarked upon. In Essex (2019) Frank, a 55-year-old man who suffered from post-traumatic stress disorder and alcohol dependence, would – in the view of the SAR author – only have been successfully treated if he was also in appropriate, stable accommodation. In his last days he was living in his car, having originally lost his tenancy in circumstances associated with his own anti-social behaviour and drunkenness. He died (as a result of multi-drug toxicity with a background of liver cirrhosis) in a hotel room provided by the local authority under its cold weather provision. The SAR noted that if Frank had been offered inpatient or residential treatment for alcohol detoxification as a homeless person, a NICE guideline that recommended offering residential rehabilitation for a maximum of three months would have applied. The SAR's second recommendation queried whether the district council had access to appropriate accommodation (Essex, 2019). In Milton Keynes (2019), Adult B spent some time at the YMCA as part of a detoxification programme despite this provision having insufficient levels of support to meet his needs, the author finding that there was not enough supported accommodation in the area.

In Southwark (2016) Adult A was considered to have a priority need for accommodation under section 189 Housing Act 1996. A 45-year-old man, he had been diagnosed with schizo-affective disorder, had a history of being detained under the Mental Health Act 1983 (MHA), was diabetic, and had also spent time in prison. He was assessed as being unable to manage a tenancy without moderate support, but none was available. At least three times he was offered bed and breakfast accommodation instead. After a spell rough sleeping he had been provided with supported accommodation by a third sector organisation, but only lasted four days there, due to his behaviour and state of hygiene. Following a period of detention under the MHA he was discharged from hospital to a bed and breakfast where his decomposed body was found less than a month later – he had died of natural causes (associated with his diabetes) to which neglect contributed. The SAR was critical of the risk assessment Adult A received, but Southwark Housing told the SAR author that even with an accurate assessment he would have been housed in a bed and breakfast because of the lack of an alternative. The SAR's first recommendation was that Southwark Housing should ensure that it was commissioning suitable accommodation for individuals with complex mental health conditions (Southwark, 2016).

In Isle of Wight (2018) the author recommended that resources should be improved for individuals who are homeless and who misuse alcohol through the provision of a 'wet' (alcohol permitted) hostel, extra care housing accommodation (tenancies with care that can be accessed on site) and street-based outreach practitioners as well as the bolstering of existing providers on the island. He noted, also, that in a commentary provided by the housing department it was made clear that the demand for temporary accommodation was so great from those to whom a statutory duty was owed that it was not possible to exercise discretionary powers under the Housing Act 1996: 'Thus, decision-making regarding whether or not to exercise a statutory power was driven by resources as much if not more than by an assessment of need' (Isle of Wight, 2018: 22).

The single case among these 14 SARs where the person was in supported accommodation (Waltham Forest, 2017) illustrates that such provision is not a panacea. Andrew had lost his job and lost his tenancy, becoming homeless and moving to Single Homeless Project supported accommodation for the year prior to his death. He had a long-standing alcohol dependency, with alcohol-related liver disease, from which he died about a year after he entered the Project. His case was characterised by

a reluctance to engage on his part, a tendency to 'silo working' by professionals and a failure to refer his self-neglect to adult safeguarding (discussed further below).

Hospital discharge

Two of the SARs under consideration were highly critical of the hospital discharge arrangements in their respective cases. In Isle of Wight (2018) Howard's discharges from hospital (for physical conditions) during the period under review were not accompanied by detailed social work assessments. The absence of co-ordination and care planning following each of the discharges was described as a major omission. On one occasion, in December 2016, he was discharged in his pyjamas with incontinence pads to the homeless shelter although it was possible he would not be accepted there because of his incontinence. Neither the hospital pharmacist nor the hospital staff knew reliably where to contact Howard in relation to medication and the provision of further incontinence pads. Following this discharge, he had stayed in the homeless shelter sometimes, but had also sofa-surfed and slept on the streets. He died rough sleeping in March 2017 (Isle of Wight, 2018).

In Southwark (2016) Adult A's discharge plans following his detention under the Mental Health Act 1983 (MHA) were described as 'woefully inadequate' (Southwark, 2016: 27). The plans exhibited a failure to adhere to the Purpose Principle in the Code of Practice to the MHA. He left hospital on a Community Treatment Order (CTO) without there being a check that he was registered with a GP, despite his mental health problems and diabetic care needs. Local authority housing services did provide him with accommodation (the bed and breakfast in which he died shortly after this discharge) but were not aware of the full dimensions of the risks posed to himself and/or others because the risk assessment supplied to them was a year out of date. There was a failure to assess his mental capacity regarding his decision-making in relation to his diabetes care or his acceptance of the conditions of his CTO. 'This meant that his discharge plans, such as they were, were predicated on a decision that the Trust did not know that Adult A was able to make or carry through' (ibid., 26).

Safeguarding

This section outlines the number of safeguarding referrals and section 42 CA enquiries in these SARs and gives examples of apparent missed opportunities recorded in the reviews. It then focuses on self-neglect, and the extent to which the Making Safeguarding Personal initiative is evident in the SARs. It goes on to record a reported lack of professional curiosity noted in some of the SARs, comments in some of the SARs about the economic climate in which services were operating, and reflections in some of the SARs about the dangers of normalising risk and about the attitudes of some practitioners.

Among the ten SARs that reported practice taking place in part or wholly under the CA (i.e. post-April 2015), six recorded adult safeguarding referrals. Two of these gave rise to a section 42 CA enquiry: in Newham et al. (2019), under the category of neglect and acts of omission; and in Milton Keynes (2019), in relation to financial abuse by Adult B's fellow rough sleepers, although there is little detail about the latter instance. (There was one other such enquiry reported among these SARs, but we have discounted it since it appears to have taken place after the death of Howard, at his half-sister's request, and is not examined by the SAR: Isle of Wight, 2018.)

Possible missed opportunities

Possible missed opportunities that came into sharp relief in retrospect included Haringey (2017), where Robert's GP referred his case to Adult Safeguarding (citing his learning disabilities, low mood

and difficulty coping following the death of his father) – the social worker deciding that it was not a safeguarding concern.

There was evidence suggesting that some agencies did not view safeguarding referrals as part of their role. The Alcohol and Drug Advice Service 'provided the only consistent psychological support or service to Frank' in Essex (2019: 18) and though it 'noted the presence of clear safeguarding issues – formulated along the lines of self-neglect, it did not make a formal safeguarding referral. The reasons for this are not documented.' (ibid., 22). In Newham et al. (2019) Yi, who had been diagnosed with schizophrenia in 2008, was evicted from emergency homeless accommodation on the basis in part that his behaviour could place him or others at risk of harm. Practitioners subsequently reflected that raising a safeguarding concern would have been the more appropriate action on the part of hostel staff. This was an action that might also, the SAR observed, have led to him receiving advocacy support because he was likely to have had 'substantial difficulty' (section 68 CA) in taking part in a safeguarding enquiry due to his cognitive impairments.

As noted above, practitioners in Newham et al. (2019) reported feeling fatigue at the lack of feedback when they did make adult safeguarding referrals or requests for support under other risk management procedures. This was echoed in Isle of Wight (2018) where, although notifications of an adult at risk of harm were made by the police, the Salvation Army, the GP and the ambulance service, in respect of Howard, there was an absence of feedback from Adult Social Care or Adult Safeguarding. Missed opportunities may have come about because professionals were deterred from making repeat referrals because of an absence of response; they might have assumed, for example, that responsibility had been handed on (Isle of Wight, 2018).

Self-neglect

The updated statutory guidance to the CA describes the way in which a safeguarding intervention may be called for in cases of self-neglect:

> 'A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support.' (DHSC, 2018: 14.17)

Eight of the 14 SARs under consideration report self-neglect. This aspect of adult safeguarding is focused on here because some of the SARs raise significant questions about this category, in respect of its recognition by practitioners and in its relevance to alcohol dependence.

In one case where the person exhibited signs of self-neglect (Howard had 'dirty clothes, long dirty fingernails and unkempt appearance': Isle of Wight, 2018: 12) the reviewer expressed 'substantial doubt about the awareness within and across agencies of the threshold criteria for a section 42 enquiry' (ibid., 29). The author, who is an expert on self-neglect and safeguarding, regarded the threshold as having been met in the case under review. The SAR found that housing officials, in particular, were under the misapprehension that to qualify for an adult safeguarding referral, risk must emanate from another. In other words, these staff did not understand the potential of self-neglect to trigger an enquiry.

Two SARs considered the difficulties in respect of self-neglect and alcohol dependence. In Essex (2019), despite three referrals to adult safeguarding for self-neglect by the ambulance service, none proceeded to a section 42 CA enquiry. In the first referral, local authority (LA) staff visited Frank, finding that he had 'no apparent care needs' and that he was 'able to engage in GP and mental health services'. He was signposted to support. At the second referral, four attempts were made to contact Frank by telephone; no contact was made so the referral was closed. At the third referral,

Frank was spoken to and he gave his overview of the situation. The reasons for not taking it to a section 42 CA enquiry were not given, but the LA staff noted the involvement of several other agencies and that he had reduced his alcohol consumption (Essex, 2019: 15-16). The SAR author questioned the assessment that Frank had no apparent care needs given his mental health needs and observed:

> 'With the benefit of hindsight, and an understanding of the interaction between alcohol and mental health needs, one might reasonably reach the view that Frank's ability to protect himself was indeed not fully within his own 'control'. But reaching a determination on this question is complicated. In the present case, it is equally understandable that arguments might be found in the other direction, particularly if his consumption of alcohol was considered in isolation' (Essex, 2019: 16)

In Waltham Forest (2017), practitioners found it problematic to conceptualise long-standing alcohol dependency as self-neglect in the case of Andrew. The SAR reported that it was not routine or shared practice to see chronic alcohol misuse as a form of self-neglect. Indeed, practitioners remarked that self-neglect through hoarding was 'often easier to see and easier to name' (Waltham Forest, 2017: 16). The SAR found 'a universal sense of professional frustration that was caught up in the confusion of not having a universal understanding of chronic alcohol use being self-neglect' (ibid., 17).

Finally, it is of note that in Milton Keynes (2019), which involved alcoholic dependency along similar lines to the above examples, neither the practitioners nor the SAR author considered the case in terms of self-neglect. In the 22 months under review by the SAR the ambulance service attended 17 times and Adult B was nearly always heavily intoxicated or high on drugs on these occasions. He attended the hospital on 41 occasions in the same period, leading to nine admissions (because of alcohol induced seizures) from which he self-discharged. While the SAR author is critical of the lack of a needs assessment given these manifestations (as noted above) it is striking, in the context of the other SARs described in this section, that self-neglect is not considered.

Making Safeguarding Personal

Three of the 14 SARs make substantive reference to the Making Safeguarding Personal (MSP) initiative – all three using it as an evaluative measure in relation to agency activity, but only one reporting its implementation in the practice under review. In Southwark (2016), in its recommendations to the NHS Foundation Trust, the SAR suggested that ensuring mental health patients' access to advocacy and to information about their rights would be in line with MSP. In Isle of Wight (2018) the SAR author found no evidence of MSP practice. Only in Lincolnshire (2017) was MSP found to have been (what the SAR described as) an appropriate focus of adult safeguarding procedures involving working with the person toward their outcomes.

Lack of 'professional curiosity'

A lack of curiosity displayed by some of the professionals involved is a recurring theme among these SARs. There are also some remarks in these SARs about the financial or resource climate in which practitioners operate.

In Essex (2019) the author argued in his recommendation 4 that the SAB should consider developing a long-term strategy for improving the 'professional curiosity' of staff (Essex, 2019: 21). He described professionals as being seemingly uninterested in Frank's 'story'. This was exemplified by the confusion as to whether his birthplace was Iran or Iraq, significant not least because he had reportedly fought in the war between the two countries. In Milton Keynes (2019) a lack of

professional curiosity is coupled with the failure to conduct a mental capacity and a needs assessment as being possibly implicated in the failure to identify Adult B's autism earlier.

In Isle of Wight (2018) the author described a lack of 'concerned curiosity' about Howard's missed appointments with his GP, Adult Social Care and the Salvation Army. As a result, 'contacts with different agencies were seen as episodes in isolation rather than repetitive patterns' (Isle of Wight, 2018: 24). He was recognised by some professionals as being vulnerable, yet there was a lack of curiosity as to why. This was a feeling echoed, according to the SAR, by Howard's family members.

In the internal management review conducted for another SAR by the hospital trust, there was concern that staff had not used professional curiosity when faced with Gerry at Accident and Emergency, unkempt, with no money and using illegal substances (Lincolnshire, 2017). In Brighton & Hove (2017) the author reported insufficient weight being given by practitioners to vulnerabilities associated with transgender people. And in Nottingham and Nottinghamshire (2017: 5) the author recommended that 'existing safeguarding training continues to reinforce professional curiosity and identification of a person as an adult at risk and requiring services, and ensures a link to the risk of modern slavery.'

In Newham et al. (2019) a workshop was held as part of the SAR process, which involved housing, social care, mental health, policing, and safeguarding practitioners together with voluntary sector policy leads and staff. A link was made by practitioners at the workshop between professional curiosity and ownership:

> 'They speculated whether barriers to 'professional curiosity' and ownership in such complex cases was as a result of legal or financial organisational risk and highlighted that the fact that services' responsibilities are linked to geographic footprint and ordinary residence/local connection requirements provides further obstacles for those [who] experience chronic homelessness.' (Newham et al., 2019: 4)

The suggestion here that concern about financial risk might have had a part to play in the quality of service provision is echoed elsewhere in this SAR, in ways that extend beyond professional curiosity: practitioners raised concerns with the SAR author that changes in the legislative framework that should have led to improvements (for example the CA and the Homelessness Reduction Act 2017) had been undermined by the impact of austerity. Both Essex (2019) and Isle of Wight (2018) also reflected on the difficult economic circumstances in which adult safeguarding was taking place.

Difficulties with engagement; normalising of risk; practitioner attitudes

As indicated in the Newham et al. (2019) quote above, levels of practitioner curiosity about and engagement with the homeless population may be suggestive of other contextual factors in which safeguarding is taking place. This section reports on what some of those factors may be.

First, in 13 of the 16 cases practitioners reported episodes or periods when engagement with the individuals concerned was found to be problematic. This was for a variety of reasons – for example, because of the perceived effects of an alcohol dependency or other substance misuse. Alternatively, as in Brighton & Hove (2017), there was evidence pointing towards X's Paranoid Personality Disorder as being a factor in their 'continual refusal to engage' with the Mental Health Homeless Team (Brighton & Hove, 2017: 29). The *Professionals Briefing* derived from the SAR reflects that this condition is characterised by an extremely distrustful outlook (Brighton & Hove, n.d., a). The SAR referenced research (Middleton, 2008) suggesting that about two-thirds of street homeless people meet the diagnosable criteria for Personality Disorder and recommended that the Mental Health Homeless Team and Learning Disabilities Team review their engagement strategies in relation to

those with Personality Disorder. In Milton Keynes (2019) the author speculates that Adult B's (late-diagnosed) autism may have had a role to play in his reported intermittent non-compliance with agencies.

Other SARs (Newham et al., 2019; Lincolnshire, 2017) commended the use of Assertive Outreach Teams (AOT) to assist in engagement. Lincolnshire (2017) reported:

> 'Many of the individuals were challenging to engage. Use of illicit substances can be associated with a chaotic, high risk lifestyle and being part of a sub-culture that may put the person at great risk of harm.' (Lincolnshire, 2017: 49)

This SAR also observed that: 'For some, their vulnerabilities may have been masked by their offending behaviour and the risk that they presented to others.' (ibid., 49). It noted practitioner concern that the AOT had been amalgamated with the Community Mental Health Team thus diminishing 'their ability to provide the intensive multi-disciplinary relational based approach that was often required and valued by their service users' (Lincolnshire, 2017: 38). Milton Keynes (2019) noted that following Adult B's death the local authority had secured funding from MHCLG in 2017 for outreach provision where previously there had been none.

As reported above, in five cases agencies were criticized for not considering the possibility that duress or controlling or coercive behaviour were involved in situations where individuals were to some degree refusing to engage. A further reported problem relates to the normalisation of risk. Noting the low level of safeguarding referrals over the seven-year period that the SAR examined, one author suggested:

> 'There is a danger that practitioners who are continually working with people in these difficult social circumstances, may become blunted to seeing the high levels of risk … At the learning event, mental health practitioners from AOT recognised this phenomenon of normalising high levels of risk.' (Lincolnshire, 2017: 49)

There was a comparable challenge to maintain a realistic assessment of risk over time in respect of self-neglect in two SARs:

> 'It was suggested at the learning event and in material submitted by some agencies that Howard's self-neglect had become "normalised" in the sense that the circumstances in which Howard was found were repetitive and unchanging, with options appearing to those involved to be fairly limited. He was certainly expected at times, in the view of panel members and the independent reviewer unrealistically, to carry out actions to improve his situation without support.' (Isle of Wight, 2018: 34)

In a similar vein, alcohol dependency was described as difficult to grasp as the problem that it was:

> 'The effects of chronic alcohol use will be seen over a long time period and can be less tangible and some emotional wellbeing and daily living issues can be more difficult to solely relate to the alcohol use.' (Waltham Forest, 2017: 16)

Finally, in this section, reference is made in some SARs to the attitudes practitioners bring to bear on working with particular client populations:

> 'At the SAR learning event, agencies reflected on other values that may affect responses to people with problematic drug and alcohol use. Perceptions such as "bringing it on themselves" and "lost cause" may also influence decisions to refer and manage through multi-agency safeguarding.' (Lincolnshire, 2017: 49-50)

Another SAR suggested that assumptions relating to homeless people were a concern:

> ‘A lack of professional curiosity meant that despite frequent assaults by unknown assailants and evidence of physical abuse, ADULT C was not viewed by some as an adult at risk of harm…This area has been explored within the SAR panel and within the practitioner event held as part of this SAR. A number of factors were felt to have influenced professional judgement including assumptions that are made about young male homeless men with injuries with a history of mental health and substance misuse problems. He would provide explanations for his injuries that alleviated professional concern for him and his presentation often reinforced stereotypes of homeless young men and assumptions that are made about non engagement. The additional vulnerabilities and risks to homeless people were not explored in any depth.’ (Nottingham and Nottinghamshire, 2017: 4)

We have presented the main themes emerging from the analysis under five interconnecting headings and now turn to our review of local policy and guidance and third sector literature on homelessness and safeguarding.

Review of learning materials, local authority and third sector policy and guidance

This section reports findings from a brief review of local authority guidance and policy, third sector literature and related material on homelessness and safeguarding. First, we summarise the findings of one (non-SAR) report, two briefings and an audit from cases involving the death of rough sleepers.

Worcester City Council (2018) was a non-statutory review regarding C, a man in his mid-70s, who was found dead in a tent in Worcester in 2016. The review identified four service interactions in the year prior, and recommended: staff training in respect of mental health and capacity, self-neglect and information sharing; an alert system for inter-authority working (he had moved between areas); a local reporting mechanism for the public to report rough sleeping; and, improved outreach services for rough sleepers. The author reported that the local authority had committed to conducting a review following all deaths of rough sleepers.

Doncaster (2018) is a *Shared Learning Brief* about the case of Adult G who was rough sleeping in a doorway when he was violently attacked, resulting in serious head injuries. Prior to this, he had been known to a range of local agencies and suffered physical and mental ill health. He had often declined offers of support. The *Brief* is critical of the failure to appoint a keyworker, of the failure to organise a multi-agency response and to follow disengagement policies, and for the failure to refer for a needs assessment as a result of his self-neglect.

Brighton & Hove (2017), a SAR reported in our thematic analysis, also gave rise to a *Professionals Briefing* which asked practitioners to consider the following areas in order to learn from the SAR:

1. Safeguarding alerts when a client arrives from another authority;
2. Homelessness and housing eligibility;
3. Care assessments;
4. Engagement;
5. Care pathways for people with a Personality Disorder; and,
6. Self-neglect.

(Brighton & Hove, n.d., a)

This SAB also conducted a multi-agency audit of safeguarding responses to homeless adults in Brighton and Hove. The audit found:

1. Agencies were not consistently using Safeguarding as a mechanism for holding multi-agency meetings;

2. Improved co-ordination of care was called for as well as the consistent sharing of support plans and risk assessments across the partnership;
3. Better liaison between Accident and Emergency and the Homeless Team was needed;
4. Better transfer arrangements between services – the identification of a named individual was recommended;
5. Agencies responded well to clients in crisis, but services fell away when the crisis abated, which could result in crisis support being needed again later on; and,
6. Learning disability identification and support was lacking in one case.

(Brighton & Hove, n.d., b)

We make brief mention of three other supporting documents relating to SARs under review in this report. A *Practice Briefing Note* following the Buckinghamshire (2017) SAR directed practitioners to use threshold toolkits (including one for self-neglect) to assist in assessing risk in adult safeguarding (Buckinghamshire SAB, 2018). The *Board Response* to Waltham Forest (2017) SAR is chiefly of interest because in it the SAB recognized the confusion around identifying chronic alcohol misuse as self-neglect and stated it planned to refresh existing policy to emphasize alcohol and substance misuse as forms of self-neglect (Waltham Forest SAB, n.d.). Finally, a *Learning Bulletin* following Lincolnshire (2017) added little to what has been covered in the thematic analysis of this report, alerting practitioners to the danger, for example, of becoming desensitized to high risk situations and of the possibility of coercion being a factor in individuals' refusal to engage (Lincolnshire SAB, n.d.).

Local authority guidance and policy

We found very little guidance and policy at local authority level expressly linking homelessness and adult safeguarding. The Association of Directors of Adult Social Services (ADASS) London has recently updated their Multi-Agency Adult Safeguarding Policies and Procedures (ADASS London, 2019). Having earlier consulted on a new appendix focusing on safeguarding and rough sleeping in the capital, the document now briefly refers to rough sleepers in the body of the report in a section on the groups who are covered by adult safeguarding, hyperlinking to the third edition of a tools and guidance document produced by Pathway et al. (2017). This contains guidance on risk assessment in relation to rough sleepers, screening tools related to the Mental Capacity Act 2005 and the Mental Health Act 1983, and advice on raising an adult safeguarding alert. This document by Pathway et al. was originally produced in 2012 in response to the death of a rough sleeper in Lambeth following the publication of a Serious Case Review (Lambeth, 2012). Also in relation to policy in London, as noted in our introduction, the Mayor of London's *Rough Sleeping Plan of Action* (2018) called for a Safeguarding Adults Review to be conducted after every death of a rough sleeper.

Local authorities have been obliged to produce Homelessness Strategies since the Homelessness Act 2002. Those we reviewed included the Strategy of Tower Hamlets which committed to:

> 'continue to embed links between the homelessness and safeguarding services to identify adult abuse and neglect and take appropriate action. This includes the work undertaken by the High Risk Transition Panel to ensure the risk of homelessness is mitigated amongst vulnerable adults.' (Tower Hamlets Housing Options, 2018: 14)

On the other hand, a 'Scrutiny Review' of Health & Social Care Provision for Homeless Residents, which was returned in response to the DHSC letter to Chairs of Safeguarding Adults Board in England, does not mention adult safeguarding in this context (Tower Hamlets Health Scrutiny Sub-Committee, 2018), though it does address the subject of domestic violence.

Another local authority homelessness strategy raises safeguarding in relation to homelessness, focusing specifically on modern slavery and trafficking (Sunderland City Council, 2019). Elsewhere, we found a resources page (chiefly links to homeless services) on the Manchester (2019) SAB site; the news pages of Norfolk (2019) SAB included several homelessness related items.

Cornwall and Isles of Scilly SAB published a *Procedure for responding to concerns of self-neglect and rough sleeping* which combined these in what it described as a 'joined up procedure' (Cornwall and Isles of Scilly SAB, 2015: 2). This stated:

> 'The Safeguarding Adults Board regards homelessness, and rough sleeping in particular, as self-neglect and extreme cases will fall within the remit of the Procedure for Responding to Concerns of Self-Neglect and Rough Sleeping in Cornwall and the Isles of Scilly.' (ibid., 26)

Among those policy documents we read, we found this to exhibit the closest forging of links between safeguarding and homelessness, although our search did also identify two conference presentations from 2019: Louisa Snow (2019) of the charity, the 999 Club, speaking on 'Safeguarding Homeless People' at Voluntary Action Lewisham, and Michael Preston-Shoot and Adi Cooper (2019) on 'Safeguarding and homelessness' at the London Safeguarding Adults Board Conference (the latter available online).

Third sector guidance

While both St Mungo's and Crisis have called for reviews to be conducted whenever a rough sleeper dies (St Mungo's, 2018; Crisis, 2018), the two main pertinent resources from this sector come from Homeless Link. *Safeguarding Vulnerable Adults* (Homeless Link, 2018) is directed at frontline staff and outlines safeguarding law, how to raise a safeguarding alert and contains links to further resources as well as two case studies. *Taking action following the death of someone sleeping rough – Briefing for homelessness services* (Homeless Link, 2017) describes SARs and the alternatives to the statutory process, namely internal reviews and multi-agency reviews. It also recommends that the death of a person who is homeless should always result in a review.

This report now concludes with a note on the study's limitations and a discussion of our findings.

Discussion

Limitations of this study

This study was based on a small number of Safeguarding Adults Reviews (SARs), three of which were executive summaries, where the full report was not available. As explained in the methods section, we drew the SARs from a range of sources, but because of the absence of mandatory reporting, we may have missed some. Some of the events under review by the SARs took place before the Care Act 2014 (CA) came into effect and so may not reflect more recent practice. The quality of the SARs varies significantly, and the more thorough ones have likely had a greater effect on our reporting in the thematic analysis.

Powerful tools?

As we observed in the introduction to this report, the government's *Rough Sleeping Strategy* described SARs as 'powerful tools, which unfortunately are rarely used in the case of people who sleep rough' (MHCLG, 2018b: 31). While this study confirms that they are rarely used, the question of how powerful they are has come under scrutiny by academics in the field. SARs (and their predecessors, Serious Case Reviews) have been criticized, for example, for their failure to examine

macro level factors such as 'poverty, organisational culture and the impact on staff and services of financial austerity' (Preston-Shoot, 2016: 140) and for their tendency to a repetitiveness in their findings, perhaps suggesting that learning is not taking place across the sector (Preston-Shoot, 2017). On the latter point, it is true that the SARs scrutinised here do feature criticisms which are familiar from other SARs, for example, in relation to poor understanding among practitioners of the Mental Capacity Act 2005 (Manthorpe & Martineau, 2019). As to the wider context, there are some signs in these SARs of their authors taking the economic context into account (Isle of Wight, 2018; Essex, 2019; Newham et al., 2019). Even so, it can be a challenge to establish where causes lie: for example, whether the 'crisis management mode' described in some SARs (Isle of Wight, 2018; Newham et al., 2019) came about as a result of poor management or the financial climate or a mixture of both. To this we might add that we are not aware of any recent evidence as to the cost of SARs and the degree to which this may be an inhibiting factor in their commissioning (see Manthorpe & Martineau, 2012 in relation to the cost of Serious Case Reviews).

There are two ways, though, in which SARs do appear to be powerful tools when seen in the light of their raison d'être, which is to learn lessons in order to improve practice. First, their statutory basis places obligations on agencies to share information (section 45 CA). Worcester City Council notes that a methodological limitation of a non-statutory review is that its findings and recommendations 'are based on the willingness of partners to engage with the review process and share information with the report author' (Worcester City Council, 2018: 6).

Secondly, it is a striking characteristic of several of the SARs we analysed that the authors had run learning events in the course of the review process and incorporated comments and suggestions from practitioners and managers into the report itself (Essex, 2019; Newham et al., 2019; Isle of Wight, 2018; Lincolnshire, 2017; Milton Keynes, 2019). In Essex (2019), for example, this involved two separate events for frontline practitioners and managers who had been engaged in Frank's case. Accounts of these events certainly give the impression of professionals having a stake in the review rather than being the passive recipients of recommendations and give the SARs a feeling of the lived experience of those concerned and the difficulties they faced. (It should be added that in Lincolnshire (2017), where the people who had suffered abuse were still alive, the SAR author invited them to contribute to the review process.) Another of these SARs produced two documents, a *Professionals Briefing* and the results of an audit, both aimed at disseminating lessons from the SAR (Brighton & Hove, 2017). However, the limits of these processes must be acknowledged. In Southwark (2016), for example, the events took place four years before the publication of the SAR and some of the agencies to which it directed recommendations no longer existed.

Joint working

Findings by some SARs that there appeared to be no lead agency, that multi-agency meetings were few in number and of poor quality, and that homeless people would sometimes 'ping pong' between services are unsurprising, given that a 'reasonable cause for concern' that joint working was failing is part of the grounds for commissioning a SAR (section 44 CA). Such mismanagement has also featured strongly in complaints to (what is now) the Local Government and Social Care Ombudsman in relation to safeguarding from well before the CA (Clements, 2017). One might question whether co-ordination would have been better managed under the aegis of a section 42 CA enquiry where the local authority is unambiguously the lead agency. (Even where it requires others to undertake the enquiry, the local authority retains the lead and coordinating role: DHSC, 2018: 14.100.) However, across these SARs only two such enquiries were triggered (Newham et al., 2019; Milton Keynes, 2019).

Safeguarding

The safeguarding enquiries that were initiated were in relation to neglect and financial abuse; none took place in relation to self-neglect, though this was identified in several SARs. Our findings on self-neglect raise the question as to how well understood it is among agencies, both in respect of its inclusion as a form of neglect within adult safeguarding under the CA, and conceptually in relation to substance misuse and alcohol dependency (beyond, that is, hoarding and poor hygiene). Recent analysis of alcohol-related SARs by Alcohol Change UK found that even among those with knowledge of self-neglect alcohol misuse is less readily perceived as self-neglect. The report recommends the development of national guidance on applying safeguarding thresholds to people who self-neglect due to alcohol misuse and suggests that 'free choice' is often an 'unhelpful paradigm' (Alcohol Change UK, 2019: 14). While the ethical difficulties surrounding interventions in such cases should not be under-estimated (Braye et al., 2017), the reluctance to start an enquiry after three referrals for self-neglect in Essex (2019) is a striking case. In the light of the apparent lack of local policy and guidance linking homelessness and safeguarding, one could go further and question whether agencies and practitioners generally conceive of people who are homeless in safeguarding terms. We await with interest the publication of the thematic reviews on the subject that we understand are currently under way.

Our findings section on safeguarding also exposes other elements in this picture. 'Professional curiosity' is a term that has been developed in child protection, not least in relation to the barriers to its flourishing: these have been taken to include the organisational and political context (Burton & Revell, 2017). In Newham et al. (2019) it was suggested by practitioners that the financial and legal risk associated with taking on some complex cases had a chilling effect on professional curiosity. Where the homeless person had experience of substance misuse (and thereby experience of Multiple Exclusion Homelessness), this may also have impacted on engagement on the part of agencies because of negative attitudes (Lincolnshire, 2017). Livingston et al. (2012) have observed that people with substance misuse disorders may suffer stigma as, being perceived as having personal control over their illness, they are more likely to be held responsible. Such perceptions can contribute to inequitable and poor provision of care (Livingston et al., 2012). Whatever the cause, a lack of professional curiosity as described in these SARs certainly appears to be a failing in terms of the Making Safeguarding Personal ethos – mention of which was conspicuous by its absence in most of these SARs. It is also worth noting the absence of any significant attention given to possible racism and discrimination, given that three of the individuals appeared to be from Black, Asian and minority ethnic groups (Newham et al., 2019; Essex, 2019; Southwark, 2016).

Assessment, hospital discharge and accommodation provision

Beyond safeguarding, our findings also throw light on assessment practice. There were instances where housing assessments were found wanting. But there is also some evidence from these SARs of local authorities being reluctant to take up their responsibilities under section 9 CA (care and support needs, which has a low threshold). In two SARs, the authors heard evidence on the interface between section 42 CA and section 9 CA and whether a referral would reliably take place for people whose circumstances had not been deemed serious enough to have triggered the enquiry duty, but who nevertheless had care and support needs (Isle of Wight, 2018; Essex, 2019). The statutory guidance to the CA clearly envisages safeguarding enquiries and needs assessments as parallel processes, where this is appropriate (DHSC, 2018: 6.54-6.57). There was criticism, also, where such needs assessments were not conducted at all or later than they could have been, possibly indicating inertia or a gate keeping attitude between departments, or a reluctance to see the welfare of the person in anything other than housing terms (Brighton & Hove, 2017; Isle of Wight, 2018).

Seeing homelessness in other terms is part of the rationale for using the category of Multiple Exclusion Homelessness (Fitzpatrick et al., 2011). The two SARs that are critical of the hospital

discharge arrangements in their respective cases (Southwark, 2016; Isle of Wight, 2018) are pertinent in this respect, one person leaving hospital on a Community Treatment Order following detention under the Mental Health Act 1983, the other having a history of alcohol abuse. Neither, however, were discharged to suitable supported accommodation. Whiteford and Cornes (2019: 2) have remarked that 'discharge planning for people who are homeless has moved from the periphery to the mainstream in policy formation and practice delivery in England', citing *The NHS Long Term Plan* (NHS England, 2019) and the *Rough Sleeping Strategy* (MHCLG, 2018b) as evidence. It is interesting to consider whether, given this and the latter document's commitment in relation to SARs, both health service provision and safeguarding practice are in the process of becoming better geared toward the health and well-being of people who are homeless.

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