Gloucestershire
Safeguarding Adults
Board

Safeguarding Adults Review

Learning from the circumstances around the death of five women in Gloucestershire

Executive Summary

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1. Introduction

1.1 This Safeguarding Adults Review (SAR) is commissioned by the Gloucestershire Safeguarding Adults Board in order to learn from the circumstances around the deaths of five women in Gloucestershire between November 2017 and September 2019. The five women were referred by the Nelson Trust, a charity that works with women who have multiple and complex needs.

1.2 The five women were known to a range of statutory and non-statutory services. They all experienced childhood trauma. Three had been in the care of the local authority during childhood. All experienced trauma in their adult lives. Their deaths, between the ages of 19 and 43, were related to their drug use.

1.3 This review is conducted in accordance with section 44 of the Care Act 2014 and the Gloucestershire Safeguarding Adults Board Procedures.

Under section 44 of the Care Act 2014 a Safeguarding Adults Board must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if the re

- 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 (whether or not it knew about or suspected the abuse or neglect before the adult died).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

The statutory guidance that underpins the Care Act describes the purpose of a SAR as being to "*promote effective learning and improvement action to prevent future deaths or serious harm occurring again*". The aim of every review should, therefore, be to learn lessons from the case and to make sure that those lessons are applied to future cases by all agencies in Gloucestershire to prevent similar harm occurring. (GSAB Safeguarding Adults Review Protocol 2018).

1.4 This review was commissioned in late February 2020. There were considerable delays in completing the SAR relating to the pressures created on relevant staff and organisations by the COVID pandemic.

2. Summary of learning points

Learning Point 1

One service cannot address the needs of marginalised groups alone. The role of all organisations involved should be identified and understood in order to create an effective system around the person.

Learning Point 2

Organisations who are key to engagement, who meet vital needs and address risk to marginalised groups will need to have consistent capacity to fulfil this role. The failure or incapacity of a key organisation jeopardises the system of support around the person.

Learning Point 3

For some individuals, mental health issues arising from childhood and adult trauma must be addressed as part of any plan to address substance misuse, self-harm or similar behaviours.

Learning point 4

Coordinated and timely responses are often needed to meet the needs of marginalised groups. Organisations must be aware of how 'windows of opportunity' may present and use this understanding in building and contributing to contingency plans.

Learning Point 5

When engagement with services is vital, organisations in the system around the person must work with the person to identify and support an engagement plan. In these plans attention can be paid to engagement strategies, contingency planning and avoidance of re-traumatisation.

Learning Point 6

Statutory organisations (local authority, police) and commissioned health and mental health providers can benefit from awareness raising activities about the lives of these women and other marginalised groups with the intention of improving the identification of exploitation, duress and coercion, understanding the basis for self-neglect and self-harming behaviours, and how care and support needs may be indicated in this group.

Learning Point 7

Strategic leads and practitioners in organisations who encounter both children and adults must use the evidence-based approaches available to identify and assess the risk and wellbeing of both parents and children. This is likely to ensure that the (unborn) child is safer as a result.

Learning Point 8

Benefit, or other income changes can have a devastating effect on people without bank accounts and/or who struggle to maintain their everyday lives. Agreed contingency plans made in advance with the person will potentially prevent crises, for example finding ways to encourage and support opening a bank account without an address/ID or use of partnership approaches to support the person to continue a tenancy.

Learning Point 9

Any organisation who is aware of but unable to resolve a failure to undertake an agreed action from a safeguarding meeting held under the Care Act s42 can use the agreed 'Professional Differences' escalation pathway[1]. This will support discussion and understanding between organisations as to why an action has not taken place with the objective of resolution to the benefit of the person.

Learning Point 10

There are tested approaches available to support parents who will need to cope with the loss of a child, or parents who need intensive support to make changes in their lives to begin or maintain parenting. In this way we may contribute to breaking the cycle of trauma and loss for children and their parents in Gloucestershire.

Learning Point 11

It is essential that all organisations are aware of the impact of trauma on the lives of people and on how they present to and engage with services as well as the trauma aware or trauma informed approaches that can be attempted. This may reduce the impact of 'labelling' and increase confidence and knowledge in planning and sustaining engagement. Trauma awareness will lead to improved professional curiosity and will support the development of flexible responses to need.

Learning Point 12

It is important to disseminate clear explanations about the purpose of each Partnership meeting, promoting knowledge of the pathways available, who will benefit from referral and how to refer. Organisational representatives will need to play an active role in communicating and promoting the relevance and value of the meeting to strategic and practitioner colleagues.

Learning point 13

Good multi-agency partnership responses are promoted by a number of factors:

[1] GSAB (2019) *Escalation of professional differences guidance'* at https://www.gloucestershire.gov.uk/media/2091688/gsab-escalation-protocol-may-2019.pdf

- Understanding and respect for what organisations do, their roles and responsibilities, limitations (legal or capacity), skills and knowledge.
- Feedback to referring organisations from decision makers when requested
- Use of a framework to support partners to work together in a coordinated and timely way.
- An agreed risk assessment and management framework
- Accountability and follow up on assessments and agreed actions, in risk situations this is usually through further meeting(s).
- A common language about risk, the person's experience, key concepts.
- An understanding of legal frameworks.
- A focus on the person in all the above, their perspectives and experiences informing decision making.

Learning Point 14

Organisations working with marginalised people must be confident in making adult safeguarding concern referrals. The three criteria for use of the s42 duty may not always be correctly interpreted regarding referrals about marginalised people. Timely conversations between referrer and decision makers will help to clarify matters. Referrers need to know what decisions have been made and should be able to request feedback. If risks are high and the referrer disagrees with the decision the escalation of professional differences policy[2] can be used.

Learning Point 15

The learning from this SAR can contribute to the development of an improved pathway for care leavers which should also consider care leavers who are being supported by another local authority whilst living in Gloucestershire. The pathway will also include young people who have not been in care but who are being exploited or are in circumstances presenting a risk to life. We must also remember that the wellbeing duty applies to all over the age of 18, through discussion with children's colleagues we may identify preventative approaches to implement together.

Learning Point 16

Health and social care commissioners of services will, taking account of local information, need to build flexibility into commissioning frameworks so that services focused on substance misuse, trauma, and mental health, are able to span the transition to adulthood as well as address the needs of adults through the life course.

[2] GSAB (2018) ibid

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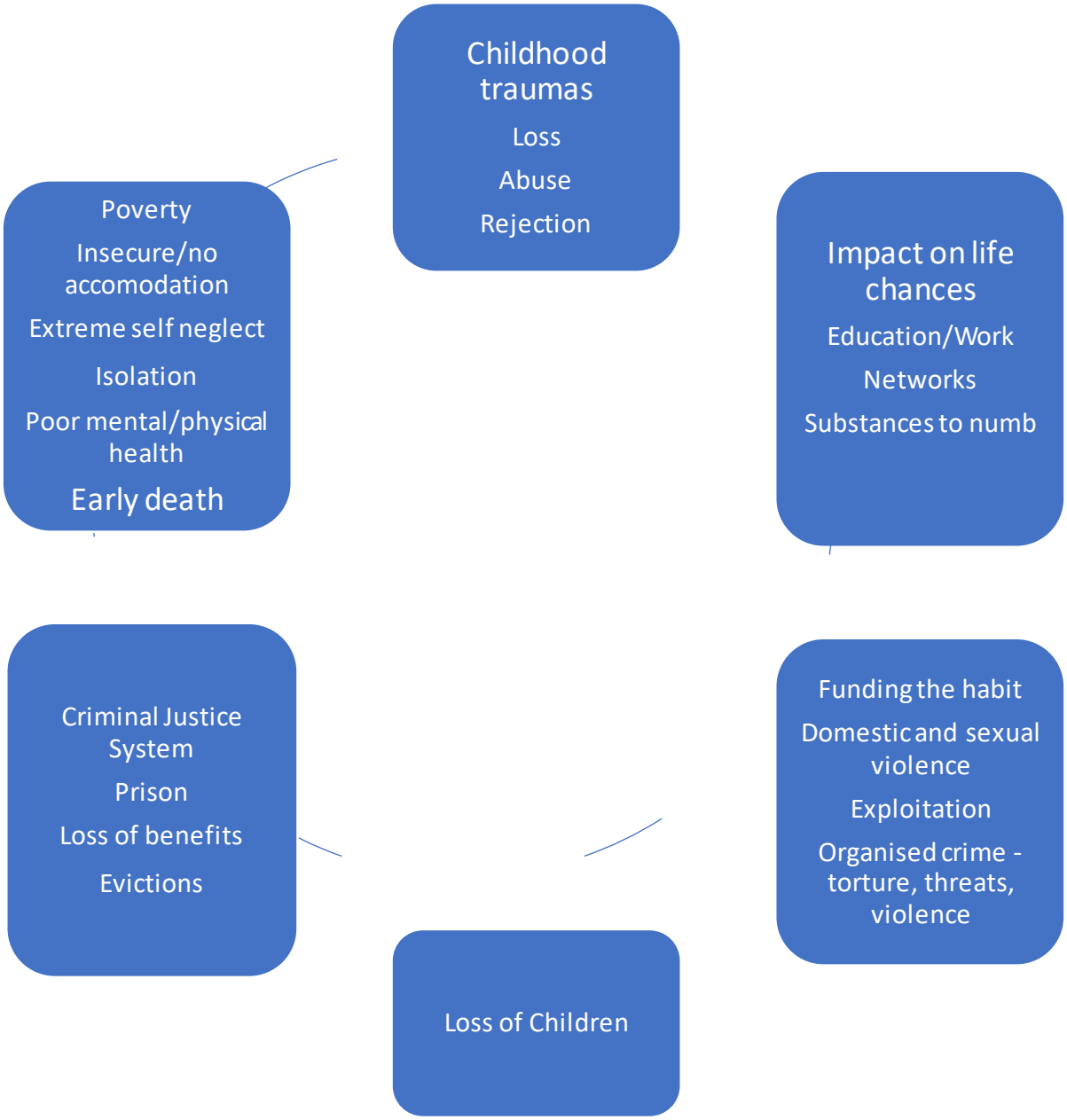

Fig. 1 The cycle of trauma across the life course

Figure 1 illustrates the life experiences of the five women. The cycle of trauma in their lives may echo the trauma their parents and grandparents experienced as well as the potential future experiences of their children.

3. Terms of Reference

3.1 The full terms of reference can be found in appendix 1 at the end of this Report.

3.2 Scope and specific area of focus of the SAR:

Timeframe: Between 1st January 2017 and the 30th September 2019.

Rationale for timeframe:

The five women were all being discussed in the multi-agency Sex Worker Outreach Project (SWOP) forum during this time. The women were also known to other organisations.

Relevant information prior to January 2017 is summarised and included to give context to the lives of the women.

3.3 Specific areas of focus:

How are services addressing needs of this group of women? What is available? What is working well? What are the barriers to addressing needs?

How are services working together? What is working well? What are the barriers to working together?

What do we need to do to improve support to this group – and other marginalised groups in similar positions? Which services are engaging, which services are missing?

How are services working to engage people, how person centred and flexible is their engagement approach?

How do trauma informed approaches contribute to positive outcomes for this group?

When should the local authority section 42 duty support work to protect this group from abuse or self-neglect? What is needed to promote good outcomes from use of the duty?

What transition pathways should be used to support young care leavers at risk of exploitation?

3.4 Methodology:

The SAR was conducted in three stages:

Stage 1: Information gathering. Organisations involved with each of the five women were asked via a questionnaire to submit

- Personal background information they were aware of

- A summary of their involvement with a narrative about what worked and what were the challenges and barriers.
- First thoughts about what's needed now and what opportunities exist.

We hoped that the perspectives of individuals and families would also form part of the information gathering stage. The lead reviewers intended to hold informal discussions with women who use NT services and are in a similar situation to the women who are SAR subjects. This was not possible during the pandemic and so a questionnaire for women was developed with NT. We received two responses and have included these perspectives in our analysis. The lead reviewers also examined a range of documents relating to care and support or adult safeguarding related to the five women and spoke with relevant members of staff.

Stage 2: The lead reviewers worked with a Panel of involved organisations to develop relevant themes for further exploration.

Stage 3: The SAR Panel convened a series of online 'learning conversations' where frontline practitioners, their managers and strategic managers developed the SAR findings, identifying good practices and opportunities, together with recommendations for improvements in multi-agency working.

3.5 Organisations who participated in the SAR

Organisation	Role
Gloucestershire County Council	Adult Social Care (ASC) Children's services Adult Safeguarding team
Gloucestershire Constabulary	Police – locality Police representation on the SWOP forum, liaison with SWOP.
Gloucestershire Change Grow Live (CGL)	Drug and alcohol charity – provides advice, needle exchange, assessment and prescriptions to support detox.
Gloucestershire Clinical Commissioning Group	
Gloucestershire Hospitals NHS Foundation Trust	Acute Trust – Emergency Department (ED) Maternity services.
Gloucestershire Health and Care NHS Foundation Trust	Mental Health Trust Improving Access to Psychological Therapies (IAPT) Homeless Healthcare team Mental Health Liaison Team (MHLT)

	Community health services
Gloucestershire People Potential Possibilities (P3)	Charity providing outreach, support and accommodation services.
GP Surgery	
Nelson Trust (NT)	NT is a charity which offers a range of trauma informed services to people with needs including substance misuse. The Sex Workers Outreach Project (SWOP)[3] was founded in 2013 to address the unmet needs of on street sex working women and women trading sex, providing safety advice, harm minimisation and one-to-one confidential support. NT also run a women's centre
Peterborough City Council	Placing local authority for X Leaving care team
Riverside Housing	Accommodation including high support accommodation and emergency (low support) housing.
South Western Ambulance Service NHS Foundation Trust	
Stonham Housing	Housing Provider
National Probation Service	
Kingfisher Treasure Seekers (KTS)	KTS[4] is a social enterprise organisation in the centre of Gloucester who run a number of community initiatives to engage 'hard to reach' groups, including 'Support at the Cavern', a non-clinical, mental health drop-in service, open every night of the year from 6pm-11pm. It is a constant service that people know, attendees are on average between 20 and 30 years old.
Gloucester City Homes	Housing Provider
Stroud District Council	Housing Provider

[3] To find out more see https://nelsontrust.com/how-we-help/womens-community-services/sex-worker-outreach-project/

[4] To find out more see https://www.kftseekers.org.uk/

3.6 Family participation:

Families were initially written to via the Gloucestershire Coroners' Office inviting participation. Four families agreed for information held by the coroner to be released to the SAR lead reviewers, an invaluable contribution. One family considered participation but did not follow this through, to do so is very painful for relatives. Four families were written to again toward the end of the SAR process to update them, invite question or comment and to ask if they wished to be informed if and when the SAR is published. At the time of writing no responses have been received.

4. Key Themes

Drawing on questionnaires, discussion at learning events and individual interviews we identified some key themes from the stories of the five women within the SAR.

4.1 The impact of childhood trauma on adult lives.

All five women experienced trauma in childhood including bereavement, physical, sexual, and emotional abuse, rejection, and loss. The potential impact of childhood trauma in adult life is well researched [5] and will amplify and compound traumas experienced in adult life. [6]

The term 'Adverse Childhood Experiences' or ACEs is often used to refer to childhood trauma. But we must be careful to understand that not all traumatic events are covered within the specified list of ACEs. ACEs are traditionally understood as a set of ten specified traumatic events or circumstances occurring before the age of 18[7][8] that have been shown through research to increase the risk of adult mental and physical health problems as well as the perpetration of further ACEs. It is important to be person centred in our thinking about what may constitute trauma to a child and the impact on the individual. Whilst 'desertion' is thought to be an 'indirect' ACE[9] bereavement is not mentioned in the ACE categorisations most commonly used. We risk rendering an individual child's traumatic experience invisible[10] and fail to use trauma informed or trauma aware responses in supporting them if we do not work from the person's life experience rather than a list of specified adverse childhood experiences.

Being removed from family and known environment is often the result of adverse experiences but is also in itself traumatic and has a long-term impact on the person. Young

[5] https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Briefing%20Paper%20-%20Adverse%20Childhood%20Experiences.pdf
[6] ibid
[7] https://www.actionaces.org/what-are-aces/
[8] https://www.local.gov.uk/case-studies/adverse-experiences-childhood
[9] ibid
[10] Asmussen,K; Fischer, F and McBride, T (2020) Adverse Childhood Experiences, what we know, what we don't and what should happen next' Early Intervention Foundation at https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next

people interviewed as part of a recent Local Child Safeguarding Practice Review in Gloucestershire[11] spoke about their experiences. The most significant absence for them was the lack of a positive and supportive adult relationship in their life. Whilst we may leave home and make our way into the world at 18 the majority of us will have adults around us who have a consistent and beneficent interest in their lives. The five women in this review did not have this solid ground to fall upon.

Young people in the Practice Review said[12] that

- Effective support was not provided in their early childhood which may have helped to prevent them from suffering harm. Neglect and domestic abuse in the home made them more vulnerable to future exploitation.

- They felt let down by the 'system' and felt that some professionals were not interested in them as individuals. The services provided were inconsistent and did not provide them with positive outcomes.

- They did not feel listened to. Often the only way to be heard was to act in a way that was subsequently termed disruptive by adults who were supporting them.

- It was clear that not having stable positive adult relationships in their life (parental or others) provided perpetrators the opportunity to exploit them. They describe feeling alone.

- There was a mistrust and dislike of the Police, who were often the ones who would 'force' them to go home after being reported missing.

- All now wanted the opportunity to have further education and employment, and to form positive stable relationships. They described wanting to take responsibility for improving their emotional health but wished to have support in helping them achieve this. The provision of mental and emotional health support was a key issue.

- Whilst each looked forward to greater independence at the age of eighteen, they identified the need for continued support from agencies into early adulthood.

The women in this SAR may well have had similar thoughts as young adults, angry that no one listened when they disclosed childhood abuse, four of the women left school between the ages of 12 and 15. Two had difficulties in learning which impeded them in negotiating the complicated world of adult life. Little to no education contributed to the poverty all five women experienced. The five women struggled with their emotional health and forming stable relationships. One only felt secure when in a relationship but, like other women considered by the SAR, formed relationships with men who abused her. None of the women are reported to have been able to access help with emotional wellbeing in their early

[11] Gloucestershire Child safeguarding Practice Review (2021) *Thematic Review of Child Exploitation Safeguarding Practice'*
[12] Ibid section 3.1

adulthood. One was reported to have benefitted from counselling whilst in prison regarding her mother's death but does not appear to have either had or used opportunities afterward. Report authors have said that despite her '*experiencing a childhood characterised by parental neglect and acute physical abuse there is no evidence to indicate that the intervention and support she received at this time, or subsequently, was ACEs aware or trauma informed'.*

The youngest woman within the group had great difficulties in regulating her emotions or trusting people who worked in organisations and needed the consistent presence of reliable adults in her life from before she left care and into her adulthood. She had potentially just begun to find this through Nelson Trust (NT), supported accommodation staff and the Cavern drop-in just before her death. Her local authority care leavers team could not easily support her from a distance, and it does not appear that agreed protocols[13] were used to negotiate more pragmatic arrangements.

The five women moved from childhood to adulthood already struggling to cope with the traumatic experiences of their youth. One had her first child at 16, who she was unable to care for and the child was taken from her at three months old. Another had left school at 12. By early adulthood women were being exploited for money and resources and drawn into networks of drug use, sexual and financial exploitation.

4.2 Sustaining engagement with people who continued to experience trauma.

The five women continued to experience traumatic events during their adult lives; these include the death of friends, loss of children, sexual and physical assault, control, exploitation and cuckooing, poverty and homelessness.

Some organisations who contributed to the SAR talk about the person '*not engaging'* with offers of support. The five women did not engage with offers of support or could only do so intermittently. What might be the reasons for this?

As we have seen above, young people who have experienced trauma may have a low level of trust and expectation of organisations who offer support. This may be compounded by their experiences post-18

'The attendees (at the Support at the Cavern drop in) are almost all people who agencies deem 'hard to engage' or 'unreliable'. In turn they feel rejected by agencies and have often been from a young age'.

Three of the women were involved in dangerous drug networks and found it extremely threatening to risk being seen to be involved with either the police or statutory organisations. Despite serious injuries, women would not give details about their assault to the police.

[13] https://www.proceduresonline.com/stockport/cs/pdfs/national_protocol_care.pdf

Women spoke about the need to numb the pain of child and adult trauma. Using drugs to do so creates ambivalence about engaging with substance misuse services, and the slightest crisis or upset will derail the effort to stop using.

'She had experienced a number of traumas (and likely more that we are not aware of). She cited one of the reasons for using heroin particularly was to 'stop her thinking'. She was often guarded about disclosing information but had times when she was more open. The aim of drug treatment - particularly when on court orders to undertake treatment - is to reduce and stop drug use. Without having substances, particularly strong opiates which are emotionally blunting, it would possibly have been too much of a challenge for her to have coped with the repeated traumas she had experienced without having drugs'.

Services to work with women to address emotional and mental health issues were thought to be needed but observed to be hard for women to engage with. A recent study [14]has explored the feasibility of using a trauma focused approach to reduce the use of substances alongside therapies for PTSD. What type of intervention women will find helpful and how best they will be able to access support needs further consideration with the women themselves and the services who currently work with them?

Three of the women appear to have used regular sex work to fund their drug use and day to day lives. The other two may have also done so. Four of the women had convictions, in the main for theft and similar offences, and three had served time in prison. The women had very limited resources which meant that they could be easily exploited or would have to return to sex work. The move to Universal Credit created huge problems for these women who had no bank accounts of their own and could not negotiate the complexities of the system without support. During this time, one was served with an eviction notice whilst another went back to sex work to 'bridge the gap' in income.

Some of the women at times had nowhere to live and could only keep accommodation by offering sex or being involved in drug supply. Another, a young care leaver, abandoned the flat were she had a tenancy, overwhelmed with the difficulty of protecting herself from exploitation and living independently.

The circumstances that these women lived in, and the people they associated with, would not encourage them to trust and engage with mainstream services, in addition to the emotions described above they are likely to have experienced shame and be unwilling to let their true situation be known.

One report concluded that *'non-engagement is therefore seen as a refusal of services, not a common symptom of mental health, trauma and complex needs, when sometimes attending appointments can feel overwhelming and frightening'*.

[14] Patel R, Redmond NM, Kesten JM, et al. (2020) *Drug Use in Street Sex workers (DUSSK) study: results of a mixed methods feasibility study of a complex intervention to reduce illicit drug use in drug dependent female sex workers*. BMJ Open 2020;10: e036491

4.3 How did organisations try to engage with the five women?

Participants at interview and at the learning events talked about the range of ways in which organisations engaged with the women. Examples were given of case closure after non-attendance at appointments or of writing to the person to advise they could ask for support in the future. The barriers people experience may not be recognised, particularly by statutory agencies.

Third sector organisations were more likely and able to use flexible strategies. KTS say that '*There are boundaries, people are asked to leave but can always come back, unlike families or agencies people are not rejected. They usually don't trust formal services; they have been in care or have been 'rejected' by services. It is a fine line between keeping the trust of attendees and having services available at the Cavern. Very informal dropping in for a chat works best. Attendees then get to know other agencies and will feel more comfortable about asking for help.'*

P3 have had an informal 'drop in' presence at the Cavern in the past. We need to know all of the organisations involved to understand who individuals are comfortable with and whether our engagement can be supported by them in some way.

Nelson Trust were a constant and reliable presence in the lives of the five women. The women who SWOP reaches out to '*have a range of complex needs; childhood trauma and abuse, poor physical and emotional health, homelessness, limited access to mainstream services, with addiction often being the end result'.* SWOP initiates engagement with women on the street*, 'we reach out at night by taking food, condoms, and vital information about Ugly Mugs[15] in each area. We start by building relationships and talk to the women about their options. We offer them a place of safety and some respite from the street. Our aim is to get them to our Women's Centres where they get structured support and the opportunity to get into rehab'[16].*

One woman was supported intensively by her NT SWOP worker who was also able to facilitate other organisations to engage with her, working closely with Change Grow Live, police, primary care services, adult social care and some teams within the housing provider. Two women were supported into more stable housing whilst planning and working on a range of needs. NT staff are trained and supported to use a trauma informed response and also employ peer mentors, women who have had similar experiences to the five women and are now free of drug use and sex work and have built their lives back to achieve their aims.

The small number of women consulted as part of the SAR confirmed the central importance of '*the worker who did not give up on me'* at NT as well as the peer support from women

[15] Find out more at https://www.nationaluglymugs.org/
[16] Nelson Trust ibid.

who had been in similar circumstances but had created new lives for themselves. Women only spaces were valued together with accommodation free from drugs or alcohol.

In a recent national research study women in similar situations to those of the five in the SAR reported[17] that *'peer-led services and recruitment of ex-service users offers an empowering opportunity, as they move from someone receiving a service to someone involved in designing and delivering them. Women still accessing peer-led services reported feeling inspired and empowered by role models who have had similar experiences. This approach can lead to feelings of shame, guilt and isolation being transformed to feeling valued and respected because of the valuable contributions they have to offer. In one area, two-thirds of the women we spoke to were now working for a service that had previously supported them'.*

Whilst the five women were recognised as difficult for organisations to engage with, report writers noted an absence of advice on how to engage being sought or given,

'The biggest challenge ..was the lack of engagement she had with services therefore the support she badly needed could not be provided. However, no one seemed to be able to provide a solution to this despite it being well documented …there may be a better solution to how this can be addressed. ... It may be better that these issues are identified early on at face-to-face meetings with women like her and ask them how best they like to work with others and how we can support them. I do believe that sometimes organisations are quick to label people if they are homeless or substance misusers that they are forgetful etc or may be using drugs. However, I think we need to understand and appreciate the background and Adverse Childhood Experiences these people have experienced and try to understand why they do not engage'.

Some agencies are consciously following a trauma-informed approach, in particular Nelson Trust and the Kingfisher Treasure Seekers. However, if other organisations in the system are not able to understand and complement the approach, opportunities to open up the possibilities of support will be lost.

4.4 What would a trauma informed approach look like?

Participants at workshops were concerned that many organisations would not be able to use a trauma informed approach because of the pressure on organisations, work flows and need to regulate appointment systems. The impact of the COVID 19 pandemic has made these pressures more acute. But there are aspects of 'trauma aware' work which can be encompassed in everyday practice. Being aware of why a person may not trust organisations, may be ambivalent or afraid of addressing their addiction, be unable to cope

[17] Sharpen, J. (2018) Jumping through hoops: How are coordinated responses to multiple disadvantage meeting the needs of women? Page 7 London: AVA, MEAM, Agenda and St Mungo's. At https://avaproject.org.uk/wp/wp-content/uploads/2018/09/Jumping-Through-Hoops_report_FINAL_SINGLE-PAGES.pdf

with 'everyday life' etc. can inform more flexible engagement practices. Asking 'what has happened to you?' instead of 'what is wrong with you?'[18] listening to the person' story and confirming the strength of the person who has used strategies to survive trauma is part of person- centred social work and mental health practice, it is not an alien approach. Being reliable, telephoning when agreed and doing what has been agreed are part of good professional practice. Being aware that we need to avoid practices that compound trauma will increase the possibilities of engagement and support.

The barriers to understanding and using a trauma informed or aware approach can be increased by the perspectives practitioners and their organisations use to understand a situation. The five women were seen in different contexts as either exploitative or as being exploited. The reality is of course not as simple as this. The youngest woman was recognised as vulnerable to exploitation, self-neglect and self-harm by a number of organisations including the police, who submitted good detailed VIST reports, the acute trust and mental health trust who also made safeguarding referrals. The risks to her wellbeing may have been seen and understood because of her age or presentation.

The response to women considered by this SAR who were pregnant or thought to be pregnant was focused on the safety of the child and did not focus on the safeguarding needs of the mother despite evidence of exploitation, domestic abuse, and coercive control. We did not 'think family' in these instances. Children's and adult safeguarding, including domestic abuse, approaches need to be closely aligned in these instances. We cannot protect children, especially the unborn, without considering how to protect their mothers.

Three of the women in the SAR were involved in dangerous drug networks, they were dealing, associated with violent or threatening people, and/or were threatening in their responses to some agencies. One appears to have been exploiting older people. These women were not easy to work with and at times staff from all organisations felt concerned about their own safety. Practitioners need good support to be able to work with this group of people.

The women's behaviour also obscured their risks, no referrals were made to adult safeguarding with regard to risk to two of the women despite their ultimately catastrophic self-neglect. One very ill woman was referred to adult safeguarding and found to meet the criteria for use of s42, but only after great effort by the NT SWOP and police to make sure her situation was fully understood. She subsequently had her need for care and support assessed under section 9 of the Care Act 2014, although it is but it is uncertain what support was offered or negotiated with her.

How much do we appreciate the degree to which women are 'trapped' by the need to keep numb by using substances, by coercion from violent associates or in their relationships?

[18] https://nelsontrust.com/referrals/our-approach/

Feedback from on the questionnaires sent to women now using NT SWOP is that to get clean and start addressing issues they need to be away from people who are still using. Women wanted others who have had similar experiences to themselves (identified as abuse, addiction and mental health issues) but have been able to establish substance free fulfilling lives to become volunteers and peer mentors at NT '*to prove it can be done'*.

4.5 Multi agency working, including information sharing and coordination.

Respondents and learning event participants thought that the way that organisations worked together to support the women and each other was not always effective and did not result in coordinated actions utilising the full range of organisational knowledge and resource to support change.

'*The biggest gap is that organisations don't tend to work together. There are lots of great organisations in Gloucester, but we lack a joined-up approach. There is also the problem that a lot of people don't quite 'fit' certain criteria and thus slip through the net…. we try to link in with other organisations as we become aware of them, however we (Kingfisher Treasure Seekers) find that organisations don't tend to connect with us very often'.*

'I do believe that sometimes people 'fall through the gaps' when each agency assumes that the other one is doing something'.

We do not always 'close the feedback loop' with high-risk referrals. Police made many VIST reports regarding one woman who they encountered in various risky environments, but the opportunity was not used by ASC or the police to work with other organisations to create a contingency plan. If ASC gave feedback on the outcome of all VISTs sent by the police both organisations could be overwhelmed, but there could be an option for any referring organisation to indicate on a referral the need for feedback and further conversation about next steps.

'*Adult safeguarding doesn't feel as truly multi agency as children's safeguarding. Information sharing is not as clearly understood. The police do not always know what is done as a result of the VISTS submitted, they need to be part of actions as part of protection planning'*

It is important to have a framework to guide multi-agency responses. The framework used needs to be clear about which organisation 'owns' the case and to promote shared responsibility and risk taking. A culture of shared responsibility underpins accountable and resourceful responses, shared ownership can create dilution and confusion, potentially no-one 'owns' the case.

We need to observe some basic principles in using or creating multi-agency frameworks when working with women in similar situations.

- we need a full understanding of each organisation's skills, roles and responsibilities
- known routes for information sharing

- co-ordinated and well-planned multi-agency responses
- the ability to develop a multi-agency response when a crisis or opportunity presents
- follow up meetings to support action and accountability.

In most of the five women stories there were multi agency meetings, but not all organisations involved were known about or attended them, the meetings (apart from SWOP) were usually 'one -offs'. One woman's situation demanded a determined focus from a range of involved organisations, but the one adult safeguarding strategy meeting held appears to have resulted in information gathering but no further meetings to determine next steps. During 2017 another had life threatening needs and was subject to a safeguarding strategy meeting with, on this occasion, plans made to mitigate risk. Without follow up only one element of the plan was actioned and further actions that could have been considered as her circumstance changed were not considered under the s42 framework. Organisations used other frameworks, including a 'high risk' meeting about the woman whose self-neglect risked a fatal outcome, but again this was a one-off meeting without all organisations involved present. Police colleagues have said that

'It would appear that she had multiple and complex needs and was faced with numerous risks that could not be solved alone. The police should look to work with partner agencies wherever possible to share and develop a risk management plan. There is evidence in this case that one high risk planning meeting took place in April 2017 between partner agencies. However, given the continuing risks she faced it would have been helpful to have further multi-agency meetings including housing, health and adult social care. It was clear however in this case that there was a lot of effort by agencies to attempt to help her. However, there could have been a co-ordinated, documented multi-agency approach to manage risk. There may well have been good work that went on in the background to help her, but it's not clear that there was a co-ordinated approach'.

Organisations working with another woman reflect that

'*There was no clear evidence of a joined-up assessment and planning approach from a housing, police, social care or commissioning perspective to address her holistic needs'.*

We need to understand which services are valuable 'anchors' in working with groups like the five women. Who do we need to be connected with? Housing charity P3 outreach was key to identifying and supporting two women at the time of homelessness and crisis, P3 observe in their reports that

'When you get somebody complex (especially when they are mostly unknown to homelessness services) a joined up and unified approach would help with key services – P3 Outreach, Council, Mental Health, NHS, Nelson Trust, Homeless healthcare team, Police, acute trust, district council etc. I think P3 (outreach) was really the one that could pull a lot of resources together as we had a great portion of the contact with people in the situations

we are discussing and more of a wider view of their situation than some specialised services. Making sure we have quick fire multi agency approaches are very important'.

Nelson Trust is a key 'anchor' both in initial identification and engagement and in long term work with women. Recent research (Sharpen 2018)[19] identifies good practice from programmes across England working with marginalised women. Like Nelson Trust, successful programmes offer women-only drop-in services, one lead specialist to help women navigate other services, assertive outreach and peer support. But the research also emphasises the need for

- Multi-agency meetings
- Shared standard practices and protocols
- Holistic risk assessments which (are) shared across services

The research recommends strategic partnerships chaired by the voluntary sector who have the experience, skill and knowledge of this group but also cautions that an over-reliance on the voluntary sector to respond to more complex issues must not be allowed to develop.

In interview some SAR participants noted that extremely high-risk cases are left with third sector and often non-qualified and low paid practitioners, these organisations hold a high level of risk and responsibility.

Key voluntary services must be supported by a long-term commissioning plan. Research also notes that competition for funding is also a barrier in partnership working between third sector organisations.

4.6 What arrangements do we need to engage in multi-agency flexible coordinated planning?

During the learning events and in interviews we explored some of the existing frameworks available.

The NT SWOP has a monthly meeting at which information is exchanged between organisations, risks to women are rated and actions agreed between attending organisational representatives. There is a core group of organisations including NT, CGL and police with other organisations attending as needed, Gloucestershire Domestic Abuse Support Service, housing providers, adult and children's safeguarding or others. There is no mental health representative.

The SWOP meeting creates an essential and effective framework to share information, understand risk and create action plans on an on-going monitored basis. The lead reviewer would observe that many women are discussed at each meeting and further meetings are

[19] Sharpen, J. (2018) ibid page 8 At https://avaproject.org.uk/wp/wp-content/uploads/2018/09/Jumping-Through-Hoops_report_FINAL_SINGLE-PAGES.pdf

potentially needed to explore detailed actions, also whilst the organisational representatives are accountable at the meeting it is difficult for this group to coordinate or hold other organisations to account. One woman's very poor environment remained unaddressed by her social landlord for many months despite determined efforts from her NT support worker. Escalation to other multi-agency frameworks is necessary when risk is high and representatives at the SWOP forum are unable to effect change themselves.

At the learning events we discussed other multi agency frameworks and meetings which may have relevance to women in the SAR including, MARAC, the Blue Light meeting, the Complex Case Cell, High Intensity Network, co-ordination under the local authority S42 duty and the High-risk behaviours policy and meeting.

One woman identified as at risk of domestic abuse does not appear to have had these risks assessed via DASH, or been referred to a MARAC, during the time in scope despite potential risk to her from her partner being identified whilst she was in the acute trust ED. Two other women were also reported to have been abused by men, but whether these were seen as intimate partners or drug associates is unknown. The Gloucestershire MARAC has recently been successful in obtaining funding from the Ministry of Justice for two Independent Domestic Violence Advisors dedicated to working with people who have 'complex needs' and will include women in similar situations to those within the SAR. Participants remarked that within concerns about mental health, substance misuse and housing, the risk and impact of domestic violence can be lost.

The Blue Light meeting focused on people with entrenched alcohol issues who come to the attention of emergency services frequently. It meets monthly and at the time of the learning event covered the Gloucester and Cheltenham areas. Regular attendees are housing providers, CGL, Nelson Trust and the police, the acute trust alcohol nurse, and P3. The ambulance trust attends as necessary, membership has grown 'organically'. Participants at the learning event report that it is difficult in this, and potentially similar, meeting, to focus on people individually and there is an overlap as people are discussed at multiple forums. Actions, progress and people are discussed on a monthly basis and a spreadsheet of actions is kept. The majority of these actions fall to the substance misuse charity, CGL.

As part of Gloucestershire's response to Covid-19 a Complex Case Cell was formed as a subgroup of the Gloucestershire Covid-19 Rough Sleeper/ Homeless Cell: it was designed not to provide a reactive, emergency response but to give an opportunity for agencies to come together to consider, assess and plan proactive longer-term solutions for individuals. This multi-agency group is chaired by Gloucestershire County Council. Housing commissioners attend together with P3, CGL and Nelson Trust. The cell meets weekly and has ensured that there is a process to assist people whose complex needs mean that access to accommodation through the District Authorities or the Rapid Rehousing Pathway (RRP) and Homeless START pathway is not possible and a more individual innovative partnership

solution is required. The cell has identified a small group of entrenched rough sleepers who have very complex needs.

We also noted Gloucestershire's High Intensity User Network which the acute trust, mental health, police and the ambulance trust attend. The emphasis of the network is on reducing ED admissions, and subsequently attendances. The meeting creates a management plan for everyone involved – and pulls in every organisation who is involved in working with the person.

There was optimism within the learning events that the commitment to multi agency partnerships in Gloucestershire will contribute to good partnership working to create bespoke solutions for individuals. We discussed a model of national excellence, the Plymouth Creative Solutions Board[20] [21]which has contributed to a culture change across Plymouth[22] and city-wide work toward becoming a trauma informed city[23]. Participants pointed out that Plymouth has integrated commissioning arrangements as a basis for their work. Some of the principles used in Plymouth can be followed, but future partnerships will be specific to the arrangements and opportunities in Gloucestershire.

There is a potential for the use of statutory frameworks when approaches are unsuccessful and high-risk situations continue, section 42 of the Care Act 2014 (when the person is believed to have care and support needs) or the GSAB High Risk Behaviours Escalation Policy.

4.7 The Section 42 duty. Local authorities must decide whether a person's circumstances meet the criteria for use of the s42 duty. The criteria, as specified in s42(1) of the Act are

where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)

- has needs for care and support (whether or not the local authority is meeting any of those needs) **and**;
- is experiencing, or at risk of, abuse or neglect; **and**
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Gloucestershire County Council uses a definition of a person with a care and support need to include:

[20] https://www.councils.coop/wp-content/uploads/2020/03/Social-Care-Creative-Solutions-Forum-Plymouth.pdf
[21] https://www.plymouth.gov.uk/sites/default/files/CsfTermsRef_0.pdf
[22] Ibid page 2 (number 18)
[23] http://www.plymouthscb.co.uk/wp-content/uploads/2019/04/Trauma-Informed-Plymouth-Approach-FINAL-April-2019.pdf

- an older person who is frail due to ill health, physical disability or cognitive impairment
- a person with a physical disability, a learning difficulty or a sensory impairment
- someone with mental health needs, including dementia or a personality disorder
- a person with a long-term health condition
- someone who misuses substances or alcohol to the extent that it affects their ability to manage day-to-day living.

Women met this definition, they were adults with care and support needs because of

frailty or disability or a long-term condition

misuse of substances which meant they were not able to live their everyday lives

learning disability and/or mental health issues

The risks associated with self-neglect can be referred to Gloucestershire adult safeguarding for a discussion and decision about what further action is needed including an enquiry to establish what is happening, what risks exist and how these can be mitigated or addressed and how the person might be supported to recover from self-neglect.

Several factors appear to have impeded the positive use of the s42 duty with:

- Both nationally and in Gloucestershire post care act safeguarding practice has been dominated by relationship based 'Making Safeguarding Personal'[24] practice. Whilst this is now well-established good practice the dominance of the approach has coincided with a decline in skill and confidence in coordinating partners to address risky situations. The ability to co-ordinate a partnership response around the adult at risk is a core skill in adult safeguarding.
- This in turn has led to less safeguarding meetings and less confidence in engaging partners, particularly the police.
- ASC locality practitioners currently lack confidence in working with people with addiction who are struggling with their lives. The locality adult safeguarding response to one woman was that 'she did not want support' from the local authority. Practitioners need to be able to risk assess using professional curiosity and have insight into what influences such a person's decision, making the connection between trauma and behaviours. Such practice needs to be legally literate,

[24] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal#:~:text=Making%20Safeguarding%20Personal%20%28MSP%29%20is%20a%20sector-led%20initiative,support%20people%20to%20improve%20or%20resolve%20their%20circumstances.

understanding concepts of decisional and executive capacity, duress and duty of care[25].

- The high risks identified around a very ill woman's self-neglect appear to have resulted in an assessment of her care and support needs under section 9 of the Care Act and uncertainty over what else the s42 duty indicated the practitioner should do. In a high-risk situation of self-neglect, the s9 assessment should be part of an enquiry under s42. The duty to undertake a care and support needs assessment under section 11 if the person refuses consent but is thought to be at risk of abuse or being abused – including self-neglect – must also be understood. These principles will apply in many situations of high-risk self-neglect, we need to support practitioners to gain confidence in enacting these legal duties.

Lastly, the GSAB High Risk Behaviours Escalation Policy can be used[26] when other processes, including an enquiry under the Care Act s42, have been exhausted, the person has needs for care and support, and is capacitated to make a specific decision, for example about the support they will or will not accept in relation to the risks they can understand. This framework is led by the local authority with the Clinical Commissioning Group, Police and Fire and Rescue as standing members of high-risk panel meetings. The panel will offer a reflective space for consultation, reconciliation, problem solving and agreement in cases where the levels of risk raise concerns. The panel may make recommendations that require consideration of alternative resources and may seek to reverse previous decisions. The core panel includes key senior individuals that can contribute and commit to the assessment of risk and/or the risk management response. In addition, this may also include representatives from other organisations who have particular roles or expertise to contribute and who are able to support the individual presenting the case.

The two latter processes use the principle of the person at the centre of decision making. The person's views are formally ascertained, they can attend meetings with support. We were not able to explore innovations in practice in depth in the learning conversations due to time prohibitions, but we would draw attention to partnerships who ensure women retain agency over their lives, and ideas behind 'Team Around Me' approaches. [27]

[25] Useful approaches can be found in Preston-Shoot, M and Ward M (2021) '*How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales'* pub. Alcohol Change at https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf

[26] Gloucestershire Safeguarding Adults Board (June 2021) High Risk Behaviours Policy – Referral criteria.
[27] https://www.shp.org.uk/team-around-me

4.8 Taking a Life Course approach to the five women's stories.

We considered points along each woman's life course which could be points of opportunity or times when trauma is caused/compounded. In the first section we looked at the impact of childhood trauma. Several of the women within the SAR were born to parents who may have also experienced childhood trauma. We noted that between them the women had 12 children removed from their care. This figure could be higher as we do not know what happened to the children of the older women considered within the SAR. We do not know what childhood traumas the children of the SAR subjects experienced.

We were joined in this discussion by staff from midwifery services as well as commissioners and health practitioners from a number of services. We were told the number of births where there were 'maternity concerns' was rising, previously 6-10% in Gloucester, this has risen to 13.7% of births (March 2021). This was thought to have the potential to create a resource impact on the county for years to come. The national directive on 'Better Births' (2016) recommends better post and perinatal mental health support[28] for up to a year after birth, but this has not yet been implemented across England, although Gloucestershire Health and Care NHS Foundation Trust services do use the definition of '*anytime in pregnancy and up to the child being 12 months old'*[29] in providing mental health support.

We noted that if a parent is bereaved they get support, if a child is removed from them, also a devastating loss, they do not. Currently the parents of children who have been removed from their care in Gloucestershire get no long-term support. Mental Health services currently have a perinatal service for women with moderate to severe mental health issues, definitions vary as to how long the 'perinatal 'period lasts but it is usually up to 28 days after birth. In addition, there is the year long IAPT offer for women.

There are specialist midwives who work with women who misuse substances, they stay involved for up to six weeks after a live birth. There is nothing after six weeks. The acute trust has started a pilot for women who have had children removed and need support regarding the avoidance of future pregnancy. Some of the women who are signed up to the pilot have had up to nine children removed. Specialist midwives work closely with NT and CGL, but participants reported the frequent experience of pregnant women trying to leave their previous lifestyles but returning to addiction after birth. In Y's case she could not keep away from drugs whilst pregnant but was 'clean' for weeks after her baby was born, committed to trying to keep her seventh baby. Participants reported that they observe the perspective of some agencies to be that '*they don't want to work on change'* and '*don't*

[28] https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf page 10

[29] https://www.england.nhs.uk/wp-content/uploads/2018/05/perinatal-mental-health-care-pathway.pdf

meet the thresholds' or *'have capacity to make these decisions'*. The previous trauma of losing children, or the traumatic experiences that mean these women struggle to stay away from numbing substance, are not recognised. The shame of having a child removed is acute, there is no sympathy for such families. One participant who had previously worked in midwifery services told us that some midwives struggle once they see that a woman has had multiple children removed or has complex needs, their attitude changes. We need a trauma informed approach in midwifery.

Participants noted the focus is on women, but there are also a group of men in Gloucestershire who father and lose a number of babies. Certainly, within the reports received by the SAR the same names of boyfriends/partners/fathers recurred.

Participants uphold the vital principle that the child's needs are paramount in this work. But we risk compounding the existing cycles of trauma by believing that the needs of the child are not connected to the needs of the mother or parents, siloed approaches to 'children' and 'adults' in commissioning and practice amplify the division. Mothers and fathers continue to have children who are removed, care leavers often gravitate back to birth families, if we support the birth families the children can rebuild these relationships.

Participants were keen to explore how to break this cycle, for the benefit of children and their families. Some other areas (Bristol and Wiltshire locally) offer support to women who have had children removed from their care through Pause[30];

Pause works with women who have experienced, or are at risk of, repeated pregnancies that result in children needing to be removed from their care. '*We aim to give women the opportunity to pause and take control of their lives breaking a destructive cycle that causes both them and their children deep trauma.*"

The project has been independently evaluated through Department for Education[31] as a cost-effective intervention.

New Beginnings[32]/[33] works with families whose children are in the child protection process. and has also been evaluated well in providing intensive support to families on a day basis. New Beginnings, like Pause, has a trauma informed perspective, and also has a 'life membership' ethos with opportunities for peer mentorship.

[30] https://www.pause.org.uk/

[31] Department of Education (2020) Evaluation of Pause pages 97-109 at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/932816/Pause_-_Sussex.pdf

[32] https://www.newbeginningsgm.com/
[33] https://www.newbeginningsgm.com/evaluation-reports

We have also seen that as women become long term drug users their health becomes frail, and death from the complications of IV drug use, injuries, and long-term self-neglect is more likely. There are no agreed clinical tools to identify this stage of life, and women may recover from what may seem a steep decline. The NT, CGL and police staff supporting one woman during her life-threatening illness were, in the face of her refusal to go to hospital, trying to cope with high levels of risk with no clinical background.

These situations, where a person's 'vital interests' or 'right to life' [34] is at stake, must be addressed through an agreed partnership response involving health and housing providers and the police. The woman concerned continued to be exploited during this period which also reduced the ability of practitioners to work with her. There may be approaches to reduce the influence of drug gangs when a person's health has made them extremely vulnerable. Coordination of a partnership response may well be best supported through the local authority using the s42 duty in these life-threatening circumstances.

4.9 Afterword to analysis

We have identified the need for development work and additional resources to ensure consistency in service provision and new developments targeted at this group of women as well as other marginalised groups. When considering this aspect of the SAR learning event participants also drew attention to the cost of not developing the resources available to this group. As can be seen from the women's stories there are high costs around children in the care system, ED attendances, ambulance call outs, police intervention and arrest, court costs, the cost of imprisonment, probation costs and more.

There have been national efforts to 'cost out' the benefits of intervention. For example, [35] a whole system approach to women at risk of contact with the criminal justice system in Bury concluded that:

'About £5.70 might be saved for every £1 invested in the project. Of these benefits, it was proposed that 27% of the benefits fall to the MOJ/criminal justice system agencies (excluding the police), 20% fall to Local Authorities, 28% of the benefits fall to Health and 24% of the benefits fall to the police'.

The independent evaluation of SWOP [36] estimates that

'*women's centres and projects like SWOP are crucial in plugging this gap between a patchwork of services and can deliver approximately £14 of benefit for every £1 spent on their services, though this is likely to be much higher with SWOP, given the complex needs and social exclusion facing some of its clients*. p81.

[34] HRA article 2

[35] Ministry of Justice (2020) *The Concordat on Women in or at risk of contact with the Criminal Justice System page 19*

[36] Balderston, S (2019) *Advocacy & Social Policy Impact Research Evaluation: Nelson Trust Sex Worker Outreach Project (SWOP) Final Report 2015 – 2018 page 81*

We have also referenced the research evaluating the cost and impact of Pause[37] above.

5. Findings and Learning Points

We will consider our findings for each of the questions posed in the SAR Terms of Reference below. We draw attention to the financial cost to all organisations of our inability to prevent and address the risks to these five women and many other marginalised groups in their position. Each finding will take organisational effort and resource, but as we have indicated in section 4.9 above, there is national and local evidence that developing better resources and partnerships to meet these needs can create significant savings and benefits.

One of the questions within the terms of reference asked, '*What do we need to do to improve support to this group – and other marginalised groups in similar positions?'*

Improvements are indicated below and in recommendations made to the GSAB in section 8. These points will apply to marginalised groups in Gloucestershire although if there is a gendered or specific aspect to the finding this will be indicated.

5.1 How are services addressing needs of this group of women? What is available? What is working well? Which services are engaging, which services are missing? What are the barriers to addressing needs?

5.1.2 How are services addressing needs of this group of women? What is available? What is working well? Which services are engaging, which services are missing?

Nelson Trust services, and the partnerships created around them, provided opportunities for organisations to engage with all five women considered within the SAR as well as offering trauma informed gender sensitive support to the women themselves. There are opportunities to extend the range of offers to women through working with and alongside Nelson Trust support workers. Gloucestershire police were committed to engagement through liaison with NT. There was a wealth of third sector organisations who also worked consistently with this group of women. Some are well recognised, P3, Riverside and CGL for example. Others are not commissioned organisations, and do not appear to wish to be, but provide reliable and consistent support to marginalised young people on a daily basis, in this SAR we have noted the work of the KTS but there may be other organisations we are unaware of. Organisations need to be visible and part of a partnership around each individual whether commissioned or not. They must have routes to information share and escalate on their behalf. When people who find it hard to trust do find a group that they can engage with, it is important to 'follow the person' and identify support groups they find acceptable.

[37] Department of Education (2020) Evaluation of Pause pages 97-109 at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/932816/Pause_-_Sussex.pdf

Learning Point 1

One service cannot address the needs of marginalised groups alone. The role of all organisations involved should be identified and understood in order to create an effective system around the person.

P3 outreach, support and accommodation were instrumental in bringing some stability to the lives of two women, offering as appropriate accommodation as possible quickly after assessment. P3 appears to have a good grasp of and connection with the services used by the women who they encountered.

Some key organisations (The Homeless Healthcare team) were not resourced to fully respond as flexibly as needed, home visits were impossible, and attendance at important information sharing meetings difficult without jeopardising the daily running of the service. Given the health needs of the women flexible access to primary care services appears essential.

The women's stories illustrated how having consistent support from a trauma informed organisation can provide an anchor around which other organisations can connect. In Gloucester that organisation is Nelson Trust which does not at the time of writing have sustained funding over the next few years.

Learning Point 2

Organisations who are key to engagement, who meet vital needs and address risk to marginalised groups will need to have consistent capacity to fulfil this role. The failure or incapacity of a key organisation jeopardises the system of support around the person.

Mental health services were least engaged in addressing the needs of the women.

The majority of participants indicated the need for engaged mental health services and all five women were seen as experiencing mental health issues. These issues were often described as 'depression' or 'anxiety' and were related to past and current traumas/life events, very low self-esteem, the effect of substances. Personality disorders were mentioned in the notes of two women. Women were seen during a crisis, either in ED or custody suites, and did not attend follow ups when offered, cases were closed if they did not attend. GPs referred women to mental health services, but services were unable to engage even for initial appointments. One woman referred herself through IAPT.

Mental health colleagues have noted that it would have been useful to have the support of a referral to IAPT through an organisation that knows the woman well so that the full range of her needs and potential support could be understood. Women did mention benefit from counselling or other interventions but found the mechanisms for entering into regular contact with services impossible to use.

This may relate to how primary and secondary mental health services operate, with failed appointments most often leading to case closure. Eligibility criteria, the need to ration services which were under severe pressure prior to the pandemic and even more so now, or the inability to be flexible may all impact on the service inability to engage with the women referred. The involvement of mental health services can also be a 'chicken and egg' issue with services not invited to meetings because they are not involved, but not being involved as they have not understood how they can engage with women.

Trauma informed dual diagnosis services may well present a way forward. The mental health trust is also planning a small team to work with marginalised people who have complex needs. This is a key service need to be addressed.

Learning Point 3

For some individuals, mental health issues arising from childhood and adult trauma must be addressed as part of any plan to address substance misuse, self-harm or similar behaviours.

5.1.3 *What are the barriers to addressing needs?*

Responses to requests for support with this group of women need to be immediate, but not all services have the capacity or flexibility to provide this. Windows of opportunity to help may present but then might not occur again for a period of time. We need to be able to create contingency plans based on a shared understanding of what a window of opportunity looks like for that individual, a shared risk framework and a common understanding of the role each organisation can play in addressing need together. P3, together with other organisations, have noted that they would be able to address the needs of women who present in crises more effectively if they had coordinated and timely responses from appropriate organisations.

Learning Point 4

Coordinated and timely responses are often needed to meet the needs of marginalised groups. Organisations must be aware of how 'windows of opportunity' may present and use this understanding to build and contribute to contingency plans.

The most significant barrier organisations reported was related to their inability to engage and sustain engagement with the woman. Organisations and individual workers worked with great commitment to address the needs of this group, sometimes in the face of behaviour which came from fear, mistrust, and addiction, and which made finding a way forward difficult.

Although women were known to be 'hard to engage' there was an absence of information sharing on how to engage, for example for maternity teams working with one woman.

Learning Point 5

When engagement with services is vital, organisations in the system around the person must work with the person to identify and support an engagement plan. In these plans attention can be paid to engagement strategies, contingency planning and avoidance of re-traumatisation.

Barriers to an organisation's ability to identify, refer on or address needs appear to be related to difficulties in understanding the situation of the woman. Police submitted highly informative VISTs detailing risk, abuse, and urgency regarding two women, a very young woman unable to protect herself from exploitation or manage her everyday needs, and a woman whose self-neglect was life threatening. A VIST was submitted regarding another woman when she was encountered in a situation of domestic abuse whilst pregnant, but the VIST was sent to children's services with no duplicate to adult safeguarding. Two women were not seen as vulnerable. Police colleagues have noted the need to see the potential for women in this situation to be 'victims' as well as perpetrators, to identify coercion and exploitation as well as self-neglect and the attendant risks, and to make relevant referrals.

Adult Social Care did not see the needs arising from the women's situation as 'care and support' needs. Social Workers undertaking assessments under s9 of the Care Act took a narrow view of one woman's care and support needs arising from her physical illness and addiction. In another case the young care leaver's care and support needs appear to have been 'downplayed' and considered in the light of her own reports rather than what could be seen or was concerning other professionals. There was little professional curiosity about her situation.

Learning Point 6

Statutory organisations (local authority, police) and commissioned health and mental health providers can benefit from awareness raising activities about the lives of these women and other marginalised groups with the intention of improving the identification of exploitation, duress and coercion, understanding the basis for self-neglect and self-harming behaviours, and how care and support needs may be indicated in this group.

The risks to the adult woman were not seen when the woman was pregnant, or thought to be pregnant, the needs of the unborn child were focused on, but the needs of the primary source of safety of the unborn, the mother, were not. In one case, Acute Trust policy on Domestic Abuse was not followed in respect of the partner's coercive behaviour, but her attendance and negative pregnancy test reported to her social worker in children's services. No DASH assessment was completed in respect of this incident in hospital. No referral was made to adult safeguarding although the pregnant woman was seen as vulnerable and possibly having learning difficulties. Another woman's claim of being pregnant resulted in a s47 strategy meeting regarding risk to the unborn child and subsequently a concern about

her being a danger to others. Although her ASC social worker was present, there was no consideration of her needs in her own right or new safeguarding plan made for her.

Learning Point 7

Strategic leads and practitioners in organisations who encounter both children and adults must use the evidence-based approaches available that identify and assess the risk and wellbeing of both parents and children. This is likely to ensure that the (unborn) child is safer as a result.

Accommodation and support providers struggled to engage the women, and to support them to address addiction issues. Women were often unable to keep to the conditions of their licence or tenancy. Of note was the crises caused by the change to Universal Credit, two women had their tenancy or licence threatened as they were unable to cope with the change, neither had bank accounts and despite determined efforts from their landlords did not engage with efforts to sort out either benefits or outstanding rent. A change in the benefit system had a serious impact on their security, in one case contributing to eviction from safe accommodation. The local Department for Work and Pensions have indicated willingness to be involved in contingency planning and to assist in addressing crises.

Learning Point 8

Benefit, or other income, changes can have a devastating effect on people without bank accounts and/or who struggle to maintain their everyday lives. Agreed contingency plans made in advance with the person will potentially prevent crises, for example finding ways to encourage and support opening a bank account without an address/ID or use of partnership approaches to support the person to continue a tenancy.

The woman with the most settled accommodation was unable to maintain her property which impeded re housing in a flat more suitable to her health and safety needs. A deep clean of her property was agreed but delayed by thirteen months, during which time she also needed repairs to plumbing and could not use her bathroom. Her dignity was seriously compromised by her self-neglect and the delay in cleaning and repairs by her landlord.

Learning Point 9

Any organisation who is aware of but unable to resolve a failure to undertake an agreed action from a safeguarding meeting held under the Care Act s42 can use the agreed 'Professional Differences' escalation pathway[38]. This will support discussion and understanding between organisations as to why an action has not taken place with the objective of resolution to the benefit of the person.

[38] GSAB (2019) *Escalation of professional differences guidance'* at https://www.gloucestershire.gov.uk/media/2091688/gsab-escalation-protocol-may-2019.pdf

Responses to the needs of the women during particular times of their lives were noted to need further development. This SAR, as well as a recent (*not yet published*) DHR have drawn attention to the absence of long-term planning around women (and parents (DHR)) who have had children removed. Between them the five women had twelve children, perhaps more, removed from their care, some at birth and others as a result of parental neglect. Three of the women had also been removed from neglectful and abusive homes in childhood, we do not know if their parents had also been in care, but they too had issues with substances/mental health/domestic abuse. We have discussed known and evidenced approaches from organisations (for example, Pause and New Beginnings) who can work intensively with families as well as the need to provide support beyond the first month after birth to women who are not with their children.

Learning Point 10

There are tested approaches available to support parents who will need to cope with the loss of a child, or parents who need intensive support to make changes in their lives to begin or maintain parenting. In this way we may contribute to breaking the cycle of trauma and loss for children and their parents in Gloucestershire.

5.2 How are services working to engage people, how person centred and flexible is their engagement approach? How do trauma informed approaches contribute to positive outcomes for this group?

As above, individual agencies who follow trauma informed practice were able to (re)initiate and sustain engagement over a period of time. There are many good practice examples in all five cases of the trust and connection women had with their Nelson Trust worker who provided a consistent and reliable source of support. NT outreach on two nights a week allowed opportunity for engagement at the level the woman could tolerate, with the backup of other resources/organisations as women increased trust and engagement.

KTS appealed to two of the younger women, a centre that had a 'life membership' and welcoming open-door policy, workers there formed strong relationships with the two women who attended for extended periods of time.

Where agencies were able, there was evidence of individual approaches to promote flexibility of response. CGL was able to offer a Rehabilitation placement to one woman without pre-work in a situation where her life was at great risk.

Understanding of the impact of trauma is patchy across the organisations involved with the women. Not all services can use a trauma informed approach, but they can be trauma aware. Health organisations struggle to provide open access whilst coping with volumes of patients needing to access services. It will be useful for them to have an awareness of why appointments may be missed, together with contact with supportive organisations who know the woman and can plan and support engagement.

Outreach services can engage with services who are trauma informed via 'drop in' arrangements or regular clinics, or seconded staff. Some of these arrangements exist and others are planned at the time of writing.

Learning Point 11

It is essential that all organisations are aware of the impact of trauma on the lives of people and on how they present to and engage with services as well as the trauma aware or trauma informed approaches that can be attempted. This may reduce the impact of 'labelling' and increase confidence and knowledge in planning and sustaining engagement. Trauma awareness will lead to improved professional curiosity and will support the development of flexible responses to need.

5.3 How are services working together? What is working well? What are the barriers to working together?

There are very positive examples of operational joint working (Police, Nelson Trust, CGL, housing providers) in response to the situation of individual women.

Organisational representatives meet regularly in a range of multi-agency meetings, most notably the SWOP forum which shared information, considered risk, and planned responses to the situations of all five women. During the COVID 19 pandemic multiagency forums have been created and existing forums strengthened in response to the situation of people with complex needs, the complex case cell, Blue Light and others. MARAC and the Stalking Panel are also relevant to the needs of these women. If organisations experience barriers or are unable to address high risk behaviours escalation is possible using the High-Risk Behaviours policy.

We have considered whether the range of forums/multi agency meetings is helpful, the same representatives may attend the same meetings and sometimes discuss the same people. However, it is thought that currently having multi agency meetings that focus on a specific aspect of need is helpful in developing knowledge, skill, and experience. What may be of concern is how multi agency meetings are utilised and perceived. Operational staff may be unaware of meetings or misunderstand their purpose. For example, MARAC is currently led by the police who refer the majority of cases, other organisations may not be considering referral believing that the police are responsible for this.

Partnership meetings do not guarantee partnership working across organisations. Key questions are: How successful are organisational representatives in communicating the purpose, work plans, criteria etc of the meetings they attend to strategic leads or senior managers, or to other practitioners in their organisation. How do we embed and develop the use of existing mechanisms by practitioners?

Learning Point 12

It is important to disseminate clear explanations about the purpose of each Partnership meeting, promoting knowledge of the pathways available, who will benefit from referral and how to refer. Organisational representatives will need to play an active role in communicating and promoting the relevance and value of the meeting to strategic and practitioner colleagues.

Throughout the period considered by the SAR multi agency meetings were convened in response to crises or deteriorating situations, by Nelson Trust, by housing providers and by either children's or adult safeguarding. The majority of these meetings were one-offs to organise a response, and efforts were not maintained – risks were not reassessed, plans went unmonitored by partners. A good multi agency coordinated response must be maintained via regular meetings to review and refine plans. It may be that virtual contact during the pandemic has improved regularity of planning meetings. It is of concern that the mind set apparent in the SAR was that one meeting is enough.

Learning Point 13

Good multi-agency partnership responses are promoted by a number of factors:

- **Understanding and respect for what organisations do, their roles and responsibilities, limitations (legal or capacity) skills and knowledge.**
- **Feedback to referring organisations from decision makers when requested**
- **Use of a framework to support partners to work together in a coordinated and timely way.**
- **An agreed risk assessment and management framework**
- **Accountability and follow up on assessments and agreed actions, in risk situations this is usually through further meeting(s).**
- **A common language about risk, the person's experience, key concepts.**
- **An understanding of legal frameworks.**
- **A focus on the person in all the above, their perspectives and experiences informing decision making.**

5.4 When should the local authority section 42 duty support work to protect this group from abuse or self-neglect? What is needed to promote good outcomes from use of the duty?

At different points during the period under consideration of this SAR all five women could be considered as having 'care and support' needs as their addictions meant that they self-neglected, they could not maintain their everyday lives. Two of the women were thought of as people who had learning disabilities by various practitioners, they struggled to cope with aspects of everyday life. One woman, a care leaver, was thought by her personal advisor to 'lack capacity' to understand the concept of tenancy or make the decisions needed to maintain an independent life. Her mental capacity was never assessed but continuously

presumed. Another woman was disabled with mobility and neurological issues. Two others experienced extremely poor physical health through self-neglect.

s42 referrals and VISTs were submitted in respect of two women. The information gathering and recommended actions from the adult safeguarding team to the locality team making the enquiry regarding the younger care leaver were excellent, and if followed may have prevented the events of the following 18 months.

However, there were;

- Unhelpful barriers to making a referral, these had to be overcome by persistence on the part of NT and the police and were resolved by a conversation between NT and the ASC front door.
- The needs of the two women referred for a care and support needs assessment were not explored with professional curiosity by ASC. ASC social workers did not have the knowledge and confidence to involve specialist services to meet eligible unmet needs of these women.
- Although the s42 duty was in place only one 'information gathering/sharing' meeting was held regarding one woman's situation, it was well attended by relevant agencies but there were no follow up meetings, no coordinated risk assessment or planning. This represented a lost opportunity to create a well-coordinated network or plan around the very vulnerable young woman.
- There was a lack of clarity as to whether the s42 duty had ended, on the part of other organisations and the practitioner themselves.

It may be useful to consider how a s42 enquiry is understood in localities, is the prevalent model now one of relationship led enquiry with the emphasis on direct work with the individual? This may still be a potential model with the assistance of a practitioner who has a trusted relationship, i.e., an NT support worker. Part of the s42 duty is to create partnership working for the benefit of the person at the centre, there appears to be respect for the s42 duty in partner agencies who participate in meetings when invited. As well as improving the understanding of the situation of marginalised people it may be that confidence and connection with other local organisations needs to be addressed. The s42 duty is a powerful opportunity for coordinated multi agency approaches when adults have care and support needs that prevent them from protecting themselves, and development is needed to ensure this aspect threads through all enquiries.

Learning Point 14

Organisations working with marginalised people must be confident in making adult safeguarding concern referrals. The three criteria for use of the s42 duty may not always be correctly interpreted regarding referrals about marginalised people. Timely conversations between referrer and decision makers will help to clarify matters. Referrers need to know what decisions have been made and should be able to request feedback. If

risks are high and the referrer disagrees with the decision the escalation of professional differences policy[39] can be used.

5.5 What transition pathways should be used to support young care leavers at risk of exploitation?

This aspect of the SAR has also been addressed in part within the recently published Thematic Review of Child Exploitation Safeguarding Practice[40]. The recommendations of this Review are very pertinent to the situation of young people about to enter adulthood. The Review references the duty to provide support to care leavers up to the age of 25.

However, the Thematic Review does not clearly consider the interface with the local authority adult safeguarding s42 duty which applies to all over 18-year-olds. The recently published 'Bridging the Gap' (2021)[41] is a knowledge briefing about transitional safeguarding and the role of social work with adults and provides a useful starting point for strategic leads and practitioners to develop a joint approach to the exploitation of young care leavers'

'Transitional Safeguarding is not simply transition planning for people moving from children's to adult social care services. It is about activity that often falls outside of traditional notions of both 'transitions' and 'safeguarding', emphasising a needs-led, personalised approach. It requires practitioners, leaders and all involved in services for children and adults, to consider how they might work together and think beyond child/adult silos for the benefit of young people at a key life stage'[42]

Transitional safeguarding practice advocates the same approaches described within this thematic review, trauma- informed, personalised and rights based with a strong partnership approach.

Learning Point 15

The learning from this SAR can contribute to the development of an improved pathway for care leavers, which should also consider care leavers who are being supported by another local authority whilst living in Gloucestershire. The pathway will also include young people who have not been in care but who are being exploited or are in circumstances presenting a risk to life. We must also remember that the wellbeing duty applies to all over the age of 18, and that of corporate parenting up until the age of 25, through discussion with children's colleagues we may identify preventative approaches to implement together.

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[39] GSAB (2018) ibid

[40] https://www.gloucestershire.gov.uk/media/2104788/lcspr0120-gscp-thematic-review-of-child-exploitation-safeguarding-practice-feb-2021.pdf

[41] Dhsc 2021 '*Bridging the gap: transitional safeguarding and the role of social work with adults' at* https://www.gov.uk/government/publications/bridging-the-gap-transitional-safeguarding-and-the-role-of-social-work-with-adults

[42] Ibid page 7.

Learning Point 16

Health and social care commissioners of services will, taking account of local information, need to build flexibility into commissioning frameworks so that services focused on substance misuse, trauma, and mental health, are able to span the transition to adulthood as well as address the needs of adults through the life course.

6. Recommendations to the Gloucestershire Safeguarding Adults Board

These recommendations apply to women in similar circumstances to the five women considered in this SAR. They may also be useful in considering support to people in other marginalised groups.

6.1. Gloucestershire SAB (GSAB) is recommended to implement the national suggested guidance[43] on collaborative partnerships and collective endeavour, together with the wider core messages of the guidance. These approaches can be integrated into all subsequent SAB guidance and into partnership behaviour.

Learning Points 1 and 13

6.2. GSAB is recommended to take steps to make sure that all third sector organisations know how to use the GSAB Escalation of Professional Differences Guidance.

Learning Points 1, 9 and 13.

6.3. GSAB is recommended to promote trauma aware and trauma informed responses to marginalised groups. There are a potential range of approaches that can be used to do this:

- A film, written report or workshops led by NT peer mentors on their experiences and how they would advise organisations to work with their peers.
- Other activities to raise awareness and improve identification of exploitation, duress and coercion, how care and support needs may present in this group of people, understanding what perpetuates self-neglect and self-harm.
- Asking each partner agency to consider what changes they can make to increase their ability to sustain engagement with marginalised groups using the learning within this SAR.
- Building in the expectation of trauma aware and/or informed responses into policies and procedures, particularly by connecting personalised and professionally curious trauma aware approaches to preventing harm and adult safeguarding.

[43] LGA/ADASS (2020) 'Understanding what constitutes a safeguarding concern and how to support effective outcomes Suggested multi-agency framework to support practice, recording and reporting' at https://www.local.gov.uk/sites/default/files/documents/25.168_Understanding_what_constitutes_a_safeguarding_07.1.pdf

Learning points 1, 5,6 and 11

6.4. GSAB is recommended to work with all partners, including all relevant third sector organisations, to develop a shared risk assessment and management framework to underpin the identification and assessment of risk in marginalised groups in order to support multiagency responses. The framework should describe 'windows of opportunity', person-centred contingency planning and how to create agreed engagement strategies that can be shared and understood by other organisations. Specific contingency planning around changes to benefits or similar should also be described.

Learning Points 1, 13 and 4.

6.5. GSAB is recommended to engage with the Gloucestershire Children's Partnership in a joint working group to

- embed the transitional safeguarding approaches recommended in the recently published local Thematic Review of Child Exploitation Safeguarding Practice[44] and in the national 'Bridging the Gap'[45] briefing.
- agree approaches for all organisations to work together to identify, assess and mitigate risks to children and their parents using the learning in this SAR.

Learning Points 7, 15 and 16.

7. Recommendations to individual agencies.

7.1 Gloucestershire Clinical Commissioning Group are recommended to

- consider developments to support the primary healthcare needs of women who are long - term substance users.
- consider developments to meet the emotional and mental health needs of women who have experienced trauma and are using substances to cope with their lives. To also consider how to provide emotional and/or mental health support to parents who have their children removed after birth.

Learning Points 2, 3 and 16.

7.2 Gloucestershire County Council and Clinical Commissioning Group commissioners are recommended to consider similar organisations to those referenced in this SAR and develop approaches to break the 'cycle of trauma' pre and post birth and in early childhood.

Learning Points 10 and 16.

[44] https://www.gloucestershire.gov.uk/media/2104788/lcspr0120-gscp-thematic-review-of-child-exploitation-safeguarding-practice-feb-2021.pdf

[45] DHSC 2021 '*Bridging the gap: transitional safeguarding and the role of social work with adults' at* *https://www.gov.uk/government/publications/bridging-the-gap-transitional-safeguarding-and-the-role-of-social-work-with-adults*

7.3 All commissioners and funders are recommended to consider consistent support to the Nelson Trust SWOP in the knowledge of its key role in engaging and enabling women to connect with systems of support.
Learning point 2

7.4 Gloucestershire Adult Social Care is recommended to
- take action to promote practitioner confidence in the coordination of partnership adult safeguarding responses.
- ensure that decision makers understand 'what constitutes a safeguarding concern' in groups who may not have commonly understood care and support needs.
- invite concern referrers to indicate that they need to know what the decision of the local authority is regarding the s42 duty and the need for further discussion as to next steps.
Learning points 13 and 14.

7.5 multi-agency partnerships and frameworks referenced within this SAR are recommended to ascertain that all representatives ensure that
- the purpose of the partnership is widely understood
- organisational arrangements include regular reports to strategic managers about the relevance, value, challenges and success of the partnership.
- updates are available to practitioners on activity, including anonymised case examples.
Learning Point 12.

8. Glossary of terms used

ACEs – Adverse Childhood Experiences

ASC – Adult Social Care

CGL – Change Grow Live

DASH – Domestic Abuse, Stalking and Honour Based Violence (DASH) Risk Identification Checklist

ED – Emergency Department (sometimes called Accident and Emergency)

GCH – Gloucester City Homes

GP – General Practitioner

GSAB – Gloucestershire Safeguarding Adults Board

HHT – Homeless Healthcare Team

IAPT – Improving Access to Psychological Therapies service

KTS – Kingfisher Treasure Seekers

MARAC – Multiagency Risk Assessment Conference

MHLT – Mental Health Liaison Team

NT – Nelson Trust

OT – Occupational Therapist

P3 – People, Potential, Possibilities

PTSD – Post Traumatic Stress Disorder

SAR – Safeguarding Adults Review

SWOP – Sex Workers Outreach Project

VIST – Vulnerability Identification Screening Tool