Hampshire Safeguarding Adults Board

Discretionary Safeguarding Adult Review

Vicky

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Section 1 - Introduction

1.1 Why was this case chosen as a Discretionary Safeguarding Adults Review?

1.1.1 Safeguarding Adults Reviews must adhere to the six safeguarding principles outlined in Care and Support Guidance (Department of Health, 2018); these are Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability. In addition to these, this Safeguarding Adults Review will be conducted in line with the following principles:

- Culture of continuous learning – incidents can provide the opportunity to learn and improve
- Proportionality
- Independence and independent challenge
- Meaningful involvement of practitioners without fear of blame for actions taken in good faith
- Involvement of family members and individuals affected by circumstances of the case
- Awareness of risks of hindsight bias and outcome bias
- Focus on system and teams functioning and do not provide simply a re-investigation of incidents or performance

"A Safeguarding Adults Board may arrange for there to be a review of any other case involving an adult in its area with needs for care and support" (Department of Health, 2018). These are often known as 'discretionary reviews'.

Vicky's case

1.1.2 Vicky had an established diagnosis of epilepsy, secondary to acquired brain injury, and of Emotionally Unstable Personality Disorder. She had been in receipt of specialist services for her epilepsy and mental health. She was known to have mental impairment and poor recall. Vicky has a history of trauma; her partner had been admitted to residential care suffering from motor-neurone disease. In the past she had been raped in her accommodation and later set fire to her accommodation, resulting in a custodial sentence and discharge to new accommodation where she later experienced abuse and exploitation. Vicky was prescribed medication for her epilepsy and due to her mental impairment, she had relied on her mobile phone reminders to maintain compliance. During her experience of abuse, she did not have control of her phone and was unable to maintain concordance with medication treatment.

1.1.3 Vicky was found deceased in Bed and Breakfast accommodation by a duty Social Worker in July 2019. She was 34 years old when she died. Vicky had a known history of mental health difficulties and a history of abuse and exploitation in her previous stable accommodation in Hampshire. Vicky had disengaged with mental health services in Hampshire and had surrendered her accommodation. Social Services in Portsmouth had become aware of Vicky following a Safeguarding Notification raised by the Portsmouth County Council Housing Options Team. The report concerned alleged assault and financial abuse from the partner of a friend she had been staying with. The Duty Social Worker was concerned her mental health and she had been admitted to the Queen Alexander Hospital in Portsmouth. She was discharged to Bed and Breakfast accommodation without a Care Act Assessment, and after not engaging with the mental health team at the Hospital. Following her discharge concerns were raised by Housing Options about a continued need for a Care Act Assessment which led to a Duty Visit being arranged. When the visit took place, Vicky was found dead.

Decision-making by the Safeguarding Adults Board

1.1.4 In 2019-20 the Safeguarding Adults Board considered the case of Vicky who died in July 2019. Vicky had been known to a number of agencies and following their death it was felt that agencies could have worked together more effectively to support them. The purpose of a Safeguarding Adult Review (SAR) is to determine what the relevant agencies and individuals involved in this case might have done differently that could have prevented Vicky's death. This is so that lessons can be learned from the case and those lessons applied in practice to prevent similar harm occurring again. Vicky has been considered by Portsmouth Safeguarding Adults Board, in whose area she had died, however for Portsmouth services, the criteria for Safeguarding Adult Review was not met.

1.1.5 It had been identified that learning for Hampshire services may be significant and the referral was passed to the Hampshire Safeguarding Adults Board Learning and Review Sub-group. The Learning and Review Sub-group made a recommendation to the board that a discretionary Safeguarding Adults Review would be appropriate. The recommendation was accepted.

1.2 Pen picture of Vicky

1.2.1 Family members described Vicky as a bright child and young woman who was enthusiastic about her administrative job at the local hospital. She experienced her first epileptic seizure at the age of 17 and her family noted a cumulative decline in her cognitive capacity and short-term memory since that time. Vicky rarely lived on her own but when she did it was apparent that she struggled to look after herself effectively (e.g. personal hygiene, cooking, negotiating public transport). Vicky used the alarm on her mobile phone to remind her to take her epilepsy medication.

1.3 Terms of Reference

1.3.1 Terms of reference for Safeguarding Adults Reviews are agreed by the Safeguarding Adults Partnership Board and should be published and openly available (Department of Health, 2018). The findings in this report are structured around the agreed terms of reference which were adapted during the early stages of the review to reflect emerging evidence during the collation of the case chronology.

1.3.2 The Reviewers have selected the approach of developing research questions to shape the structure and analysis of the case, in order to develop findings. The Research questions for this review are as follows:

- In cases where adults experience cuckooing and financial-material abuse, what helps or hinders services in their recognition and response to psychological mechanisms of abuse and exploitation?

- When service users decline input or begin to disengage how do services take into account a person's mental capacity, resilience, and risk factors in the application of eligibility criteria and the gatekeeping of resources?

- Vicky had been supported by different services across Hampshire and Portsmouth. How do services across boundaries work together to assess and manage health and social care related risk factors, and underlying physical and mental health diagnoses?

1.3.3 Overview Report

This methodology is expected to produce a final report, written in plain English, which details learning about the multi-agency system and Findings about how the system may be improved to safeguard adults in Hampshire.

Findings will be based upon Vicky's experience of receiving services in Hampshire and Portsmouth, and a wider evidence base that can include research, national and local guidance, and learning from other Safeguarding Adult and Case Reviews. This report will not seek to formulate the specific actions that the Safeguarding Adults Board must take – this is the responsibility of the members of the Safeguarding Adults Board.

1.4 Methodology

1.4.1 The initial Reviewers that began the review were Alison Ridley (Learning and Review Manager, Hampshire County Council), Eliot Smith (Named Nurse Safeguarding, Southern Health NHS Foundation Trust) and Jane Mills (Named Nurse Safeguarding, Southern Health NHS Foundation Trust). Unfortunately, due to other commitments that emerged Eliot Smith and Jane Mills were unable to proceed with the review and instead Anne-Marie Appleton (Clinical Quality Facilitator, Safeguarding Adults, Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups) continued the work alongside Alison Ridley.

1.4.2 Hampshire Safeguarding Adults Board have approved a number of methodologies for conducting Safeguarding Adults Reviews. Further information on the different types of methodology can be found in the Safeguarding Adults Review Policy and Toolkit (Hampshire Safeguarding Adults Board, 2019). The review methodology chosen will be the 'Multi-Agency Partnership Review'. This methodology will draw on systems learning theory to evaluate and analyse information and evidence gathered from referral and scoping forms and to identify additional areas for further investigation. As required, practitioners may be met individually or as part of a workshop. The Partnership Review will be led by senior managers from Hampshire County Council and Southern Health NHS Foundation Trust. The Reviewers are independent of involvement and line management of teams and staff involved in the case. An Overview Report will be produced and presented to the Learning and Review Sub-group and Hampshire Safeguarding Adults Board ahead of publication. This Review is taking place at a time when HM Government have put in place restrictions to manage the Covid-19 public health crisis and the methodology will be adjusted accordingly.

1.4.3 Agency involvement - the following agencies provided information, or were invited to contribute to the Review:

- Hampshire County Council Adult Social Care
- Hampshire Multi-Agency Safeguarding Hub
- Hampshire Police
- Southern Health NHS Foundation Trust
- Vine Medical Group
- Havant Borough Council Housing
- The Guinness Partnership
- Portsmouth Hospitals NHS Trust
- Portsmouth Multi-Agency Safeguarding Hub
- Portsmouth Safeguarding Adults Board

- Portsmouth City Council Adult Social Care
- Portsmouth City Council Housing Needs, Advice and Support
- South Central Ambulance Service

1.5 Involvement of the family

Vicky's mother and sister were able to be fully involved in the review process and shared their views about what had happened and also provided comments on the report as it developed. They expressed very positive feelings about the amount of input and support Vicky received from the various services, which they had not been aware of, and were particularly pleased to hear of the responses provided by Hampshire Constabulary to support Vicky.

Section 2 – the appraisal of professional practice in this case

This appraisal provides an overview summary of what happened in this case, which incorporates analysis by the Review Team about how timely and effective the help that was given to Vicky, including where practice was above or below expected standards. The analysis is divided into six Key Practice Episodes.

2.1 Key Practice Episode 1 – Professionals recognise early signs of exploitation (19.01.18 – 11.04.18)

2.1.1 In the middle of January 2018 Vicky's Care co-ordinator (OT 1) within the Havant CMHT raised a safeguarding concern that Vicky may have been financially exploited by two 'friends'[1] she was staying with. During this period Vicky was experiencing more frequent epileptic seizures[2], sometimes requiring assistance from paramedics. On 12 March Vicky did not attend her outpatient epilepsy clinic appointment. A follow up appointment was sent for September 2018 which she attended.

2.2 Key Practice Episode 2 – Safeguarding response to suspected cuckooing has limited impact (07.05.18 – 29.08.18)

2.2.1 On 7th May 2018 Vicky was injured by a female assailant. OT1 raised the incident with the police, who visited Vicky and found she was no longer living in her own flat which appeared dirty and unlived in and was instead staying in a nearby neighbour's flat. The police had previously expressed concerns that the location of Vicky's flat (which was in an area known for drug dealing) was not ideal for Vicky given her vulnerabilities, however Havant Borough Council Housing Team had liaised with the CMHT (in 2015) prior to the allocation of the flat, to ensure they felt the accommodation was appropriate for Vicky. At that time the area had not been regarded as a known 'sensitive let area'. In addition, Vicky's choice may have been influenced the allocation as her partner at that time lived nearby.

2.2.2 The police could not proceed with any criminal investigation in relation to the physical assault as there was insufficient evidence and Vicky was reluctant to provide the name of the witnesses. A Police PPN1 Safeguarding notification was sent to the HCC Hantsdirect CART[3] team on 22 May. CART took no action as the PPN1 had identified that the case was open to the CMHT, so had an allocated key worker.

2.2.3 Two months later (July 2018) OT1 advised the Hampshire MASH (Multi-Agency Safeguarding Hub)[4] that Vicky had again been assaulted and was being financially exploited by people she regarded as 'friends'. OT1 took several key actions to respond to the pattern of harm that was emerging. She began arranging a multi-agency meeting which included the

[1] Although we are using the word 'friends' as this was how Vicky referred to them, it is important to be aware that from the perspective of the professionals the relationship was an exploitative one, so we use it with inverted commas.

[2] Vicky experienced two types of seizures; generalised seizures which are identified by the changes in the electrical activity in the brain, and pseudo-seizures that are not due to epilepsy are sometimes called 'non-epileptic seizures' or dissociative seizures.

[3] CART is the 'front door' team that triages calls for Adults Health and Care for Hampshire County Council. Complex safeguarding concerns are escalated by the CART to the MASH.

[4] The MASH is a small multi-agency team based in the same office to enable effective sharing of safeguarding related information across agencies.

police, made a referral for additional support, and arranged for a standing order to be set up to limit the money loss. The professionals' meeting on 23 August 2018 was chaired by the Consultant Psychiatrist and attended by OT1, a duty social worker, the Police and Guinness Housing. Vicky joined the meeting for the second half. Professionals had become concerned that Vicky was a target for cuckooing[5], but Vicky remained reluctant to agree to police involvement, so it was not possible to progress a criminal investigation. Vicky confirmed that she had a cannabis issue but declined any help and support with this.

2.2.4 The view of the neighbourhood police officer (who knew Vicky quite well) was that Vicky did not always fully understand the consequences of the decisions she made and may lack capacity in relation to certain decisions, however the view of OT1 (who had also worked with Vicky for some time) was that Vicky had the mental capacity to make the decision to give her 'friends' the money and was making 'unwise decisions'. A year earlier (07.09.17) OT1 and a social worker had visited Vicky with the intention of gaining a better understanding of her mental capacity in relation to her finances and care needs. They talked with her but found no reason to move away from the starting point of assuming she had capacity (in line with the Mental Capacity Act 2005 principles). Based on this they did not progress to a formal capacity assessment in 2017. The Review Team noted it is important for professionals to bear in mind that assessments of capacity are both decision specific and time specific, and where there are different views held this may indicate that a reassessment is useful. It is a common experience for professionals to hold different views about an adult's mental capacity, and it is important that these are openly discussed to ensure a more robust and broadly informed view can be reached. The need for a willingness to broach these different professional opinions is explored in **Finding 1.**

2.2.5 The Guinness Housing officer advised that if Vicky continued to allow others to live in her flat, they would need to look at enforcement action for sub-letting. A 'management housing move'[6] was suggested to enable Vicky to have a new start elsewhere, which Vicky initially agreed to. This kind of intervention allows the professionals to 'override' the usual processes and support a move to a safer setting or environment, however it is dependent upon the adult being in agreement with the move. Unfortunately, although Vicky initially agreed to the proposal, she subsequently changed her mind and opted to remain where she was. Vicky subsequently decided not to progress the additional support proposed at the multi-agency meeting, or to consider the suggestions about alternative accommodation made by OT1.

2.3 Key Practice Episode 3 – Limited professional response to vulnerability related to epilepsy control (09.12.18 – 22.12.18)

2.3.1 On 9 December Vicky contacted the police to report that her epilepsy medication had been stolen. The police and OT1 highlighted to the Hampshire MASH their continuing concerns about financial exploitation and the possibility of 'cuckooing'. Having talked with OT1, the view reached by the Hampshire MASH was that the situation did not meet safeguarding criteria because Vicky did not appear to have any social care needs, and was thought to have the mental capacity to be making unwise choices rather than to be lacking mental capacity in relation to the money she gave her 'friends' in return for cannabis. Given Vicky's known vulnerabilities and the suspicion of criminal activity that posed a risk to her, the Review Team felt this referral should have resulted in a safeguarding enquiry being

[5] Cuckooing occurs when drug dealers take over the home of a vulnerable person in order to use it as a base for county lines drug trafficking

[6] This mechanism allows the Housing Landlord to arrange a move to alternative accommodation.

opened. The nature of an adult's capacity to make key decisions, does not form a part of the '3 part test' used to determine if a safeguarding enquiry should be opened under section 42 (1) (The Care Act 2014)[7], so this consideration should not have formed a part of the decision not to open a section 42 safeguarding enquiry. Practice issues relating to how mental capacity and unwise decisions form part of professional decision making about services and interventions is explored in **Finding 3**.

2.3.2 The professionals were struggling to know how to respond to the combination of Vicky's vulnerability to risk, her 'unwise' decision-making and her ambivalence about engaging with the services. The Review Team acknowledged the widely recognised difficulties for services seeking to protect adults who appear to have mental capacity and struggle to engage consistently with services. It was acknowledged that limitations on resourcing and changes in ethos mean that a more proactive 'assertive outreach' style of approach is not generally available.

2.3.3 The ambulance service was called on 14 and 15 December in response to Vicky having two epileptic seizures. The paramedics notified other services of the "filthy" home conditions and recognised that Vicky had no access to her epilepsy medication (as it had been stolen a week earlier). Vicky confirmed she would collect fresh epilepsy medications that afternoon. The following week Vicky attended her annual epilepsy review with the Consultant Neurologist and was given routine advice in relation to the risks posed by her epilepsy medication. The Consultant was aware that Vicky had mental health issues, substance misuse issues and that there were a number of safeguarding concerns. The CMHT generally regard it as being the role of the GP to liaise with specialist services such as the Epilepsy Service, so there is not necessarily direct communication between the CMHT and Epilepsy Team. This case has highlighted gaps in the communication arrangements between primary care and secondary services such as mental health and epilepsy services in cases with this level of complexity, an issue which is explored in **Finding 2.**

2.4 Key Practice Episode 4 – Professionals' response to Vicky's infringement of her tenancy responsibilities (23.01.19 – 20.03.19)

2.4.1 On 23 January 2019 the Guinness Partnership Housing Association received an anonymous report that Vicky's property was not being lived in. Their fraud team began investigating and the following week a joint visit was undertaken with the police. Vicky was found living in her neighbour's flat rather than her own, which appeared unlived in. Despite a discussion with Vicky about the risks to her of being investigated for fraud, Vicky confirmed that she was reluctant to move back into her flat and said instead she would prefer to give up her tenancy. Vicky subsequently followed this up with a text saying that she wanted to terminate her tenancy and asking if the Housing Association could instead find her a bigger property so she could live together with her 'friends'.

2.4.2 Given the serious consequences of giving up her tenancy in this way (i.e. the possibility of being designated 'intentionally homeless' and thereby losing her right to be housed in the future) the Review Team noted that it would have been appropriate for OT1 and Housing

7 This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—
(a) has needs for care and support (whether or not the authority is meeting any of those needs),
(b) is experiencing, or is at risk of, abuse or neglect, and
(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

colleagues to have arranged for a formal assessment of Vicky's mental capacity to make decisions about her tenancy, however this was not considered because OT1 felt Vicky had the capacity to make unwise decisions, she assumed that Vicky's 'friends' would continue to house and support Vicky and she felt that if Vicky kept her tenancy, her behaviour in letting others live there would leave her open to be investigated and potentially prosecuted for fraud. When these risks were explained to her, Vicky initially told the professionals that she would return to live in her own flat, but subsequently changed her mind and notified the Housing Association that she would like to end her tenancy.

2.4.3 On 8 March the police advised the Housing Association that Vicky was locked out of her flat and no longer had keys to her own property. The increasing evidence that Vicky seemed unable to maintain the security of her flat suggested that she was struggling to be able to sustain the tenancy. Guinness Partnership Tenancy Fraud Team sent a letter to Vicky requesting contact so they could discuss her options, however the case worker struggled to get engagement. The possibility of a 'management move' was not re-visited at this point as the picture that had emerged was that Vicky was not able to manage the requirements and responsibilities of holding an independent tenancy and Guinness Housing did not have any supported accommodation stock that could have been offered as an appropriate alternative.

2.4.4 The neighbourhood police officer sent an account of his concerns (PPN1) to Hantsdirect advising that he believed Vicky was neglecting herself, was prone to on-going suicidal thoughts, was potentially at risk of abuse or harm and needed a more supported living setting. The police officer was aware that the CMHT were intending to close their involvement shortly, and so he also contacted the Richmond Fellowship to see if they could provide support. The Review Team were impressed by the level of personal commitment shown by this officer.

2.4.5 Hantsdirect (CART team) recognised that although the PPN described a chronic situation of generalised risk, it did not identify a specific crime or abusive incident that would require a safeguarding enquiry under section 42, however there were clear risks factors present. The CART worker processed the PPN1 on 13 March and tried to contact Vicky by phone on 25 March to undertake a wellbeing check. This delay was not unusual due to the volume of PPNs that are received[8] by CART. When Vicky did not answer her phone, a letter was sent instead the same day offering advice and signposting to support, which Vicky did not respond to. The CART worker recognised that it was important for a local team to make further checks and forwarded the PPN1 electronically to the Havant HCC mental health team to ensure they were aware of the on-going picture of risk and could decide how to respond.

2.5 Key Practice Episode 5 – Un-coordinated professional response by Hampshire agencies to Vicky's crisis following her case being closed and her tenancy ended (25.03.19 – 06.06.19)

2.5.1 On 25 March a Care Programme Approach (CPA) meeting was held by the CMHT, attended by the Guinness Partnership and the police. Vicky was invited to join the second half of the meeting. It was felt that Vicky had the mental capacity to make a decision about whom she lived with. However, Vicky was not using the property as her sole and principal home, there were concerns that she did not have control of the keys and other people had access to the flat. Vicky wished to relinquish her tenancy and it was agreed that Vicky would be discharged by the CMHT due to non-engagement, and that the Housing

[8] Typically over 1000 per month

Association would serve an Eviction Notice. The Review Team noted that by this point Vicky appeared to have increasingly limited control over her circumstances and safety and that it would have a been appropriate for the agencies to revisit their intention to close her case and consider alternative support mechanisms given the risk of homelessness. However, it is recognised that professionals had offered a considerable number of options over the preceding months and were struggling to know how to make a positive impact on Vicky's situation. This dilemma links to the challenges faced by services in knowing how to respond when an adult's circumstances amount to chronic 'lower level' risks that do not always meet the various legal and organisational thresholds for an on-going service response. This issue is explored in **Finding 3.**

2.5.2 Three days later Vicky presented at QA Hospital feeling suicidal. She was seen by the Mental Health Liaison Team and discharged with follow-up by the MH Crisis Team. On 2 April HCC Havant mental health team received the PPN1 which had outlined the ongoing concerns for Vicky's welfare, and in response the mental health duty social worker rang the CMHT and spoke with OT1 who confirmed the CMHT decision to close the case. The duty social worker rang Vicky who advised that she was happy to continue living with her neighbours and a 'carer'[9]. Vicky said she was being well supported. She confirmed she was giving up her tenancy however she sounded a little confused about this and said she felt that she had no choice.

2.5.3 In the following week Vicky's mood continued to fluctuate, and she required a short admission to Parklands Hospital with thoughts of self-harm. The following day Vicky attacked her 'friend' who contacted the ambulance service to seek medical attention for Vicky and subsequently took Vicky to QA hospital. The hospital MH Liaison team provided advice and felt she could be discharged to the care of her 'friend'. The following day (29 April) Vicky's tenancy expired.

2.5.4 A week later (7 May) the pharmacist raised concerns about Vicky's mental health to her GP who responded promptly by trying to contact Vicky, the crisis team and OT1. The pharmacist subsequently raised concerns again when Vicky presented with no credit on her phone. These actions by the pharmacist were noted by the Review Team to have been prompt and responsive practice. In response the GP booked a face-to-face appointment with Vicky for 10 May, however Vicky did not attend. The GP asked the pharmacist to contact the surgery if Vicky presented there again.

2.5.5 The following week Vicky presented at the GP reception with a facial injury but was unwilling to attend the minor injuries unit or to consider support from MIND. Vicky advised the GP that she was living with a couple and had been attacked by one of them, but also said that she felt safe living with them. The GP rang the HCC Hantsdirect to report her concerns and that Vicky's mental health was currently poor. HCC MASH decided not to proceed to a section 42 safeguarding enquiry on the grounds that the assault had occurred over a week earlier and Vicky had said she now felt safe. The Review Team felt that the decision not to open a safeguarding enquiry was odd in the circumstances and that given Vicky's unstable mental health and lack of an allocated worker, it would have been appropriate for further exploration to have been undertaken by the MASH to understand whether or not Vicky was a victim of domestic abuse or possibly mate crime (or hate crime), to gain a clearer understanding about Vicky's living arrangements and why she was reluctant to talk to the police. It should be noted that since that time HCC MASH has put in place more robust arrangements and training to support better responses to domestic abuse concerns and closer links to MARAC.

[9] This was not a paid carer but one of the longstanding 'friends' that were thought to have been exploiting Vicky

2.6 Key Practice Episode 6 – Professional's struggle to provide a joined-up response to Vicky who becomes homeless and increasingly vulnerable (10.06.19 – 22.07.19)

2.6.1 Vicky's 'friend' asked her to leave the flat, making her homeless, and she moved to Portsmouth to be closer to her sister. On 10 June she contacted the PCC Housing Options Team and was placed in temporary B&B at the Ibis Hotel in Portsmouth while the team undertook initial checks to understand the circumstances around her homelessness[10].

2.6.2 On 14 June Vicky informed her GP that she had moved to Portsmouth. The GP surgery made sure that Vicky had enough medication. The following day Vicky missed her appointment with the practice nurse for a smear. The GP called Vicky to follow up. Vicky confirmed she had been placed in the Ibis Hotel but the call cut out and there was no answer when the GP tried to call back. On 4 July Vicky's GP surgery received a call from the Portsmouth Boots pharmacist and the surgery prescription clerk advised that as Vicky was now living 'out of area' she would need to re-register with a new GP in Portsmouth. The Review Team noted the difficulties often generated for adults with vulnerabilities who need to maintain regular medication supplies and /or support but are re-housed in emergency accommodation away from their usual support networks and services (e.g. GP, CMHT). The potential consequences for more vulnerable adults are explored in **Finding 4**.

2.6.3 The Portsmouth Options Housing Team were gathering information to understand Vicky's needs and whether or not she was 'intentionally homeless'[11]and whether she needed a social care assessment so that a support package could potentially be arranged to support her in B&B while more appropriate accommodation was located. On 4 July PCC's Housing Options Team contacted Havant Borough Council's housing services for background information about Vicky, but HBC Housing Team had only had very limited contact with Vicky so had little information they could share. Instead, they signposted PCC to Sanctuary Supported Housing who had worked more directly with Vicky in the past. PCC Housing Options Team had become increasingly concerned about Vicky's presentation. They completed an application for supported housing, contacted Vicky's GP by email and on 8th July raised a safeguarding concern to their Portsmouth ASC OP/PD team, having received complaints from two B&B hotels that Vicky's behaviour was inappropriate and bizarre. Vicky had told them that her 'friend' in Havant had access to her bank card, and that Vicky had been assaulted by her 'friend's' partner. The Review Team were impressed with the committed and efficient approach demonstrated by the Portsmouth Housing Options Team and their ability to put together a comprehensive assessment of need and risk in a short period of time.

2.6.4 On 9th July an ambulance was called to the Petersfield Premier Inn as Vicky appeared vacant, drifting in and out of consciousness, and was possibly having multiple seizures. The team called an ambulance which took her to QA Hospital and contacted the hospital social work team. Vicky disclosed she had taken a small overdose of medication but denied suicidal intent and advised it was only 2 tablets. Vicky was discharged 5 hours

[10] The Housing Act 1996, Part VII sets out the legal framework within which homelessness is assessed. It places a legal obligation on Local Authorities to make enquiries to determine whether there is any duty to provide housing.
[11] The definition of intentional homelessness under the Housing Act 1996 Section 191(1) provides that a person becomes homeless intentionally if all of the following apply: (a) they deliberately do or fail to do anything in consequence of which they cease to occupy accommodation; and (b) the accommodation is available for their occupation; and (c) it would have been reasonable for them to continue to occupy the accommodation.

later with her 'next of kin' (this was in fact one of Vicky's 'friends' not a family member) and was advised to seek a review from her GP. Vicky went back to Waterlooville with her 'friend'.

2.6.5 The following day (10 July) Vicky experienced a further episode and seemed confused with changed mood. Her 'friend' took her to hospital where she was reviewed by a Senior Emergency Department Doctor who undertook a comprehensive physical assessment. A full mental health assessment was not possible due to poor engagement, but Vicky was felt to have the capacity to choose not to engage with the assessment. She also declined a referral to Community Mental Health Team. The team at A&E does not have access to an IT system that interfaces with other key agencies and so it is challenging for them to be able to understand the wider needs and vulnerabilities of the adult, which in this case included homelessness. These issues are further explored in **Finding 5.**

2.6.6 On 12 July the PCC OP/PD team decided that a Care Act 2014 assessment of Vicky was needed in order to inform their decision making about Vicky's eligibility. However, Vicky had already left the hospital, so it remained unclear to the OP/PD team whether or not a support package and/or safeguarding enquiry was indicated. Since then, a new triage process by the PCC team has been piloted to ensure that all safeguarding concerns are screened within 24 hours and communication of outcomes across agencies is clearer and more robust.

2.6.7 The following day Vicky's 'friend' called the Hampshire GP surgery to book an appointment, concerned that Vicky was still confused. An urgent appointment was given but Vicky did not attend the surgery, however her routine prescription for epilepsy medication was issued on 12 July. Vicky had been invited to attend for a social care assessment by PCC OP/PD team several days later, but she did not attend. She stayed briefly with her 'friend' in Waterlooville who then asked her to leave several days later, so Vicky was homeless once again and presented to Havant BC Housing Services and was also seen by the HCC duty mental health social worker (both teams are based at the same office). Vicky indicated she wished to live in Portsmouth and so it made sense for Vicky to continue with the Portsmouth application had already commenced, and B&B accommodation was arranged for that night with a plan for Vicky to re-engage with the Portsmouth Housing Team.

2.6.8 The PCC OP/PD duty team arranged to visit Vicky on 22 July, but sadly the social worker found that Vicky had died in her hotel room. Her cause of death was subsequently found to be (SUDEP[12]), uncertain but most likely related to her epilepsy. The Review Team formed the view that it is not possible to make a direct causal link between Vicky's sad, sudden, and unexpected death and the responses of the professionals in the preceding weeks and months, however the review of professional practice has generated some important areas of learning for the local safeguarding system that are explored in the findings.

[12] SUDEP - Sudden unexpected death in epilepsy is a fatal complication of epilepsy. It is defined as the sudden and unexpected, non-traumatic and non-drowning death of a person with epilepsy, without a toxicological or anatomical cause of death detected during the post- mortem.

Section 3. The Findings

This section contains five findings that have emerged from the review. Each finding also lays out the evidence identified by the multi-agency Review Team that indicates that these are not one-off issues. Evidence is provided to show how each finding could create potential risks to other adults in a similar position in future cases, because they undermine the reliability with which professionals can do their jobs.

3.1 In what ways does this case provide a useful window on our systems?

This case highlights the challenges for professionals when working alongside adults who are at a high risk of exploitation and harm but are ambivalent about the professional support and intervention being offered. Professionals are faced with a difficult balance of priorities, while they must seek to respect the wishes of the service user who appears to have capacity, but also wanting to find ways to reduce the high risks of harm that are involved in the choices the service users makes.

3.2 The Findings Chart

1	When professionals hold differing views about whether an adult has capacity, agreement is not always reached, and the rationale for differing views is rarely documented. This can result in a slowing of progress to a capacity assessment or risk management work.
2	Current structures and processes locally involving Epilepsy Services and Mental Health Services require the GP to act as the point of contact for communications, however due to pressures of time this is increasingly difficult for GPs to achieve effectively.
3	Eligibility and service thresholds can mean that adults who appear to have mental capacity and make ‘unwise’ decisions involving personal risks, may still be vulnerable and find it difficult to access support, particularly if at times they are ambivalent about engaging.
4	Homeless adults with care and support needs can be further disadvantaged when they are placed in emergency accommodation without a support package outside their ‘home’ area, away from their usual network of support and services.
5	There are currently limitations in how the hospital Emergency Department fulfil their statutory ‘duty to refer’ homeless people under the Homelessness Reduction Act (2017).

3.3 Findings in detail

Finding 1 - When professionals hold differing views about whether an adult has capacity, agreement is not always reached, and the rationale for differing views is rarely documented. This can result in a slowing of progress to a capacity assessment or risk management work.

3.3.1. Background context to this issue

The MCA Code of Practice confirms that assessments of capacity should be undertaken by the most relevant professional working closely with the adult, depending on the nature of the decision being assessed (Chapter 4.38-3.43). In many cases assessment of capacity will involve active input from a number of professionals. Where capacity is less clear, it is inevitable that there will be differences between professionals. What is key is to ensure that differences are resolved in a constructive way, and not allowed to slow or halt the work across agencies of protecting and supporting the adult.

The recent 39 Essex Legal Chambers guidance note in relation to mental capacity assessments (p.5 of 'Carrying Out and Recording Capacity Assessments', December 2020)[13] advises that practitioners "must also be prepared to justify a decision not to carry out an assessment … whilst the presumption of capacity is a foundational principle, you should not hide behind it to avoid responsibility for a vulnerable individual". The guidance also advises that with decisions involving higher risk "the more one should document the risks that have been discussed with P (the adult) and the reasons why it is considered that P is able and willing to take those risks" (p.6).

3.3.2 How was this finding illustrated within this specific case?

In this case there were a number of points when professionals raised questions about Vicky's mental capacity to make certain decisions. She was capable of articulating her views and reasons clearly, but at times questions remained about how far she understood the risks that her decisions were likely to generate. She had placed her trust in a number of people she believed were her 'friends' but it became clear that they were exploiting her.

In the summer of 2018 professionals discussed concerns around Vicky's ability to sustain her tenancy and her wish to give up her tenancy and live with her 'friends'. She was known to be vulnerable to exploitation and was already a victim of cuckooing, her flat had been taken over and was being used to deal drugs. It was understood by the professionals that if she gave up her tenancy, she would be placed in a position of greater dependence on her 'friends' and potentially at greater risk of becoming homeless. One year prior to that a view had been formed by her Care Co-ordinator (OT) and a Social Worker that Vicky was able to make her own decisions about her care and support[14], however no assessment had taken place in relation to her ability to make decisions about her tenancy.

At a multi-agency meeting in August 2018 there were mixed views amongst professionals. The police officer who knew her in the community felt Vicky lacked capacity, however the OT and social worker who had talked with Vicky about her decision-making a year before felt she did have capacity. It seems that the views of police officers and housing colleagues about mental capacity in this case were not given equal value to health or social care colleagues. Despite the difference of view and the significance of the decision (about the tenancy) under consideration, the outcome

[13] Editors Alex Ruck Keene, Victoria Butler-Cole QC, Neil Allen, Annabel Lee, Nicola Kohn, Katie Scott, Katherine Barnes and Simon Edwards

[14] This was not a formal assessment but a view formed following discussion with Vicky.

of the meeting was not to formally assess Vicky's capacity, and there was no distinct recording outlining the differing views or clear rationale for the decision of the meeting not to assess capacity. Although attempts were made to persuade Vicky to consider other options, she subsequently continued with her plan and relinquished her tenancy, placing herself in a much more vulnerable position.

3.3.3 How far does this finding have a broader relevance to the safeguarding system?

Multi-agency meetings provide ideal opportunities to discuss differing professional opinions about risks and the adult's mental capacity. Feedback from the Review Team suggests that professionals do not always use these meetings to adequately explore differing opinions, give sufficient consideration to the views of all professionals attending or produce a clear recorded rationale for deciding not to undertake an assessment of capacity, which would be valuable in situations of professional difference and significant risk to the adult.

It is not unusual for professionals to hold different opinions, and if managed constructively and ideally working closely with the adult, discussion of different professional views can lead to deeper explorations of the case as agreement about the way forward is reached. However, where differences remain unresolved, it is important that the situation is not allowed to drift while professionals seek to clarify the legal framework. Protective interventions should continue.

The 4LSAB 'Safeguarding Adults Escalation Protocol'[15] can be utilised where there is disagreement about a decision or if there is concern about the appropriateness or effectiveness of a response to an adult's safeguarding support. However, it is not clear how often the policy is used, perhaps because it may be regarded as more appropriate for quite extreme situations.

3.3.4 Recommendations and questions for the Board

Finding 1 - When professionals hold differing views about whether an adult has capacity, agreement is not always reached, and the rationale for differing views is rarely documented. This can result in a slowing of progress to a capacity assessment or risk management work.

• Is there a need for further awareness raising by agencies of the value of the 4LSAB 'Safeguarding Adults Escalation Protocol'?

• How can the use of joint agency assessments of capacity involving professionals from two different disciplines be better utilised, to provide a 'richer' more holistic understanding of the adult's risks and needs.

• Would the SAB training programme want to consider supporting learning sessions aimed at multi-agency audiences about mental capacity including an emphasis on how to proceed when professionals hold a difference of opinion?

• Would it be useful to reinforce the value of recording the rationale for decision -making in circumstances where the professionals decide not to proceed to an assessment of mental capacity in a situation in volving significant risk to the adult?

[15] Responding To Self-Neglect And Persistent Welfare Concerns (hampshiresab.org.uk)

Finding 2 - Current structures and processes locally involving Epilepsy Services and Mental Health Services require the GP to act as the point of contact for communications, however due to pressures of time this is increasingly difficult for GPs to achieve effectively.

3.3.5 Background context to this issue

Structure of health services to support adults with epilepsy

There are three main types of mental health care provision these are referred to as primary, secondary and tertiary care. There are some individuals with severe and persistent mental illnesses who cannot be managed by primary and secondary services and who require tertiary care. There is a well-documented national shortage of GPs many GPs are choosing to work part time and there is difficulty in recruiting and retaining GPs. GPs are experiencing an increasingly complex workload adding to this burden. In June 2020 there were 33,515 full time equivalent GPs in England, 599 less than there were in June 2019. There is very little training or support available for General Practitioners in the management of patients who neglect to care for their own chronic health needs. Examples of secondary mental health services are hospitals, community mental health teams (CMHTs), crisis resolution and home treatment teams (CRHTs), assertive outreach teams and early intervention teams. Primary mental health care is that which is delivered by the GP and primarily for those with milder mental health problems whose needs can be met with less intensive support. When an individual refuses secondary care support and is not considered a risk to themselves or others they are referred back to the GP. Mental Health services and Epilepsy services require a referral to be sent by the GP. Mental Health Services for the local population are provided by Southern Health Foundation Trust (SHFT).

Prevalence of epilepsy

There are 2102 adults living with Epilepsy in the South East which equate to 2% of the population, it is not known how many of these also suffer with mental health and substance misuse. 3552 ambulances were required to attend for a primary cause of epilepsy over the course a year for the residents of Hampshire. This equates to 51% of all adults with epilepsy registered under GPs in the South Eastern Hampshire area have or had called an ambulance on their behalf to provide support with their condition, in the last 12-month period. This is indicative of the intensity and unpredictability of needs associated with epileptic residents alone. There are no figures for adults with epilepsy and a co-occurring condition such as a mental health disorder.

Patients omitting to self-care for their own chronic health needs have increased risks and are therefore an increased challenge for primary care practitioners. It has been identified that those with chronic health needs are more likely to experience mental health concerns. Evidence suggests 20–30% of patients with epilepsy experience symptoms of depression. Compared with healthy people, patients with epilepsy have a 40–50% higher suicide rate.

Communication across local services

There are four main IT systems that can be used in primary care records management, these are TTP System one, EMIS web, InPS vision, and Microtest Evolution. Individual GP practices are able to select which of these they prefer to work with. Community Health providers such as Southern Health and Solent each has their own IT system. When there is an allocated key worker (e.g. a CPA Care Co-ordinator or Social Worker) they may not hold the case open for long. Often in these circumstances practitioners in specialist services do not liaise directly to share information or updates, and instead rely on keeping the GP informed.

Most GPs locally are unable to alter epilepsy medication without making a fresh referral to the epilepsy service which creates additional work and delay for the GP's response to the patient. This is in part a reflection of the nature of the specialism and expert knowledge required.

3.3.6 How was this finding illustrated within this specific case?

In this case the surgery made considerable efforts to highlight risks (e.g. potential domestic abuse) to Vicky to the Hampshire MASH when they were aware of it. However, although there was an awareness amongst agencies of several on-going safeguarding concerns, no direct or active communication took place between the Epilepsy Service and the Mental Health Team during the period under review. Although several key agencies (i.e. social care, mental health, housing, and the police) did meet together to share information, the Epilepsy Service were not a part of that meeting or involved in any updates as Vicky's risk factors (social, physical, and psychological) escalated, they were not aware of Vicky's increasing vulnerabilities and risks.

The professionals' meeting on 23 August 2018 was chaired by the Consultant Psychiatrist and attended by OT1, a duty social worker, the Police and Guinness Housing. Vicky joined the meeting for the second half. Professionals had become concerned that Vicky was a target for cuckooing, but Vicky remained reluctant to agree to police involvement, so it was not possible to progress a criminal investigation. Vicky confirmed that she had a cannabis issue but declined any help and support with this. On 25 March 2019 a Care Programme Approach (CPA) meeting was held by the CMHT, attended by the Guinness Partnership and the police. Vicky was invited to join the second half of the meeting. On 25th March 2019 it was felt that Vicky had the mental capacity to make a decision about whom she lived with. However, Vicky was not using the property as her sole and principal home, there were concerns that she did not have control of the keys and other people had access to the flat. Vicky wished to relinquish her tenancy and it was agreed that Vicky would be discharged by the CMHT due to non-engagement, and that the Housing Association would serve an Eviction Notice.

The Epilepsy service were not included in these meetings and no advice was sought with regards to the risks resulting from Vicky's epilepsy, and the fact that there may be a requirement to support Vicky to manage this element of her life. Care was placed back in the hands of the GP to remain the point of contact.

The average GP practice in South Eastern Hampshire has 8, 871 people registered. This figure will vary from surgery to surgery as some will have more GP's. In comparison the practice Vicky was registered with has approximately 27,100 registered patients currently. Vicky's GP surgery at the time has since merged to consist of three surgeries made up of 10 GP partners, and six salaried GPs. Not all the GPs in the surgery were full time.

3.3.7 What is the significance for how effectively the safeguarding system works?

Lack of patient engagement with services leading to safeguarding concerns is a widespread issue referred to in safeguarding adult reviews across the country. This broadly refers to a symptom of self-neglect for those in need of care and support. Due to the accessibility of Primary care Doctors, it is not easy to pick up the phone and hold a conversation about a particular patient. Where there is an impact on health a Primary care Doctor is required to support the assessment of any risk as they are accountable for decisions made regarding the health of the patients they serve.

The impact on General Practice arising from the need to promote self-care has been identified in the wider context and is recognised within the publication of the NHS long-term plan in January 2019. The NHS long term plan introduces the concept of social prescribers. In the current pandemic scenario access to a GP is considered more difficult especially when patients are not IT literate.

Following discussion with Primary care practitioners since the pandemic E consult professional lines of communication between secondary and primary care, and emails between CCG s and GPs lead to more fluid professional conversations, GPs can contact the hospital and liaise directly with specialist services in the acute sector via a consultant connect service. However, there are limitations to consultant connect as it is not possible to contact the epilepsy service, the rationale for this is it is a hosted service that is provided by Southampton General Hospital.

Increasing pressures on the time available for GPs creates pressures on the efficacy of the existing communication arrangements between primary care and secondary services such as mental health and epilepsy services in cases with this level of complexity. General Practitioners have variable access to supporting systems to help improve communication. In order for GPs to have a clear idea of what community input their patient is receiving from other providers, they would need to view other providers records via the Graphnet system. The Graphnet system referred to by GP's as challenging, without undergoing extra training hence this is not utilised often in primary care.
In Hampshire Farnham and the Isle of Wight the electronic system CHIE (Care and Health Information Exchange) is a secure system which shares summary health and social care information from GP surgeries, hospitals, community and mental health, social services, and others. Access to this system has improved communication between the local mental health teams and the GP, but there continue to be difficulties for mental health teams when communicating with other specialist services including the Epilepsy Service. The NHS has long been identified as an organisation working in silos. New ways of working are now coming to the fore thanks to the implementation of Integrated Care Systems. The Multi Agency Safeguarding Hub only have computer access to half of Hampshire health records.

3.3.8 Recommendations and questions for the Board

Finding 2 - Current structures and processes locally involving Epilepsy Services and Mental Health Services require the GP to act as the point of contact for communications, however due to pressures of time this is increasingly difficult for GPs to achieve effectively.

- The population number with Epilepsy is small at 2%, however the intensity of care and support needs for this group are often high. Further work is needed to understand the risks to the adult, associated with the impact of epilepsy and other long term health conditions.

- Does the resource in the community for epileptic patients match the intensity of the need?

- How can the board best support bespoke training for Primary care practitioners and social care prescribers in the context of their work?

- How best can GP's and primary care teams appreciate and act upon multi-faceted risks for complex individuals that extends beyond their role as primary health care provider?

- How best can GPs be supported in the leadership of care and risk planning for patients at risk?

- The electronic records and case management systems are varied across Hampshire an audit should be undertaken to review the impact of these various systems on safeguarding work.

Finding 3. Eligibility and service thresholds can mean that adults who appear to have mental capacity and make 'unwise' decisions involving personal risks, may still be vulnerable and find it difficult to access support, particularly if at times they are ambivalent about engaging.

3.3.9 Background context to this issue

Adults may appear "on the surface" to be coping and are capable of articulating decisions about risk, but this can disguise a more underlying inability (executive capacity) to act on the decisions and views articulated to keep themselves safe. Research confirms that there is a continuing lack of confidence amongst many professionals in relation to assessing executive mental capacity.

Aspects of an adult's circumstances and behaviours may not always meet the various legal and organisational thresholds for a service response, even though the adult may be facing a high and chronic level of risk. In relation to support with mental health problems many services are not able to hold open a case if an adult's disorder is deemed 'not treatable' and the adult additionally demonstrates variable engagement. Similarly in relation to access to housing, adults who hold a housing tenancy need to be able to demonstrate the are consistently capable of safely sustaining a tenancy, if not their tenancy may be placed at risk. Even where Housing Teams recognise that the adult needs more support, alternative 'extra support' accommodation is often less available locally in Portsmouth for example.

Local authorities can sometimes mistakenly think that if an adult appears to have mental capacity in relation to their risks, they do not meet eligibility for a safeguarding enquiry to be opened.

3.3.10 How was this finding illustrated within this specific case?

Over the years Vicky had been in receipt of a considerable variety of services and support, however during the period under review (Jan 2018 – July 2019) her personal circumstances had become more risky and she found herself being exploited and mistreated by so called 'friends'. The professionals struggled to know how to respond to the combination of Vicky's vulnerability to risk coupled with her 'unwise' decision-making and her ambivalence about engaging with the support that had been offered. Vicky was also reluctant to actively support any criminal investigations the police tried to undertake. Despite the risks she faced, her lack of engagement (and the nature of her mental disorder) resulted in the closure of her case to the mental health team in April 2019. At the same time her inability to refuse her 'friends' access to her flat ultimately led to her decision, which professionals assumed was an unwise decision, resulted in her surrendering her tenancy in May 2019, which soon left her homeless.

In addition, assumptions about Vicky's mental capacity influenced a decision not to open a section 42 safeguarding enquiry on 9 December 2018. Vicky had contacted the police to report that her epilepsy medication had been stolen. The police and OT1 highlighted to the Hampshire MASH their continuing concerns about financial exploitation and the possibility of 'cuckooing'. Having talked with OT1, the view reached by the Hampshire MASH was that the situation did not meet

safeguarding criteria because Vicky did not appear to have any social care needs and was thought to have capacity and be making unwise choices. However, the nature of an adult's capacity to make key decisions, does not form a part of the '3-part test' used to determine if a safeguarding enquiry should be opened under section 42 (1) (The Care Act 2014)[16], so this consideration should not have formed a part of the decision not to open a section 42 safeguarding enquiry**.**

3.3.11 How far does this finding have a broader relevance to the safeguarding system?

The Mental Capacity Act 2005 confirms that as a starting point capacity should be assumed. Refusing support may appear to be an unwise decision but on its own this cannot be taken as evidence of a lack of capacity. However, an adult's history needs to be considered too in terms of risk as repeated refusal to engage may create a risk for the adult, a pattern often seen in cases of self-neglect. The adult may be able to articulate their wishes and views about a decision (decisional capacity) but not be able to actually see those decisions through (i.e. their executive capacity). This is significant if this inability is linked to 'an impairment of, or a disturbance in the functioning of, the mind or brain'. This area of practice continues to pose significant challenges for practitioners, which can be demonstrated by the number of Safeguarding Adults Reviews which have explored this issue. This case highlights the difficulties for adults in accessing and/or retaining support if they appear to have mental capacity, continue to make 'unwise' decisions and are ambivalent about engaging consistently with services or support. Many adults with mental health problems and/or substance misuse issues are vulnerable to these kinds of difficulties and can fall through the 'safety net' despite the professionals' best efforts to support them. Where adults fall outside of the eligibility for secondary mental health or substance misuse services or are unable or unwilling to engage with those services, the significance of primary care services and other universal services gain increased significance in providing a safety net that may be able to recognise and respond to safeguarding risks. However, these services are themselves under extreme pressure, particularly now in the period of the covid pandemic

3.3.12 recommendations and questions for the Board

<u>Finding 3 – Eligibility and service thresholds can mean that adults who appear to have mental capacity and make 'unwise' decisions involving personal risks, may still be vulnerable and find it difficult to access support, particularly if at times they are ambivalent about engaging.</u>

- The commissioning of services needs to encompass resource considerations and priorities so systems can seem quite rigid, particularly in relation to thresholds for eligibility. For all kinds of reasons adults with a variety of needs may struggle to fit in to the professional services and systems that are in place. Without the 'luxury' of an assertive outreach approach, are there any other ways that agencies can work together to create a greater flexibility 'at the edges'?

[16] This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—
(a) has needs for care and support (whether or not the authority is meeting any of those needs),
(b) is experiencing, or is at risk of, abuse or neglect, and
(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

- This review has highlighted the particular challenges faced by adults who have a mixture of physical medical and mental health needs and find themselves in risky situations including the risk of abuse, exploitation, and homelessness. How could the local system work together to provide responses and services to meet this challenging mixture of needs?

- The medical member of the Review Team suggested that an on-line training offer in relation to self-neglect, mental capacity, and Multi-Agency Risk Management Meetings (MARMS)[17] would be of value to colleagues in primary care, and perhaps a lunch time practice discussion slot for GPs for cases of self-neglect and non-engagement.

[17] Responding To Self-Neglect And Persistent Welfare Concerns (hampshiresab.org.uk)

Finding 4 - Homeless adults with care and support needs can be further disadvantaged when they are placed in emergency accommodation without a support package outside their 'home' area, away from their usual network of support and services.

3.3.14 Background context to this issue

Homeless adults with care and support needs are coping with the psychological and physical pressures of being homeless in addition to the task of managing their health and social care needs. It can be immensely disruptive and challenging for adults to find they also have to leave their 'home' area where they have a network of friends and possibly also family and are also most likely registered with a GP and potentially other key services they rely on.

Housing Departments have an interim duty to ensure accommodation is available to a homeless person believed to be in 'Priority Need' pending their assessment outcome and then a second test' the Intentionality Test' is applied before emergency accommodation is offered. However, if an adult is found to have become 'intentionally homeless' (e.g. if they had voluntarily given up a previous tenancy) the local authority homeless service has no statutory responsibility to secure the adult settled/permanent housing. Portsmouth City Council (PCC) housing team has very limited stock within the city and so will often need to place homeless adults in temporary emergency accommodation outside Portsmouth. Often this accommodation will be Bed and Breakfast accommodation.4.2 How was this finding illustrated within this specific case Vicky moved to Portsmouth to be closer to family during June/July 2019 but was homeless and so she presented to PCC Housing Options Team. The Housing Options Team tried to source local supported accommodation for but there is a shortage within the Portsmouth city area so as an initial step Vicky was placed in B&B accommodation in a neighbouring Hampshire local authority area. For Vicky one critical aspect of maintaining her physical health was to ensure she had a supply of her epilepsy medication. Moving out of area meant she had to consider re-registering at a different GP and pharmacy to ensure the supply of her medication continued or travel back to her previous pharmacy. Vicky's physical and mental health appears to have deteriorated over the previous months, and she struggled to cope in B&B accommodation. Her behaviour became erratic, and she was asked to leave two establishments because her behaviours generated complaints from other guests. PCC Housing Options Team were conscious of Vicky's vulnerability and that she appeared to have care and support needs and raised a safeguarding concern on 8th July, which would also have been a gateway to a consideration of her social care needs by the Local Authority.

3.3.13 How far does this finding have a broader relevance to the safeguarding system?

In addition to any other vulnerabilities and/or needs for care and support they may have, many adults in Portsmouth and parts of Hampshire who are homeless, face the prospect of moving outside their usual area and network because of a shortage of local accommodation options for homeless people. This can bring isolation and logistical challenges to their ability to access primary care or pharmacy input. PCC Housing Options Team try to avoid using B&B in travel lodges for homeless adults with vulnerabilities because the environments do not provide any support, but the shortage of accommodation options means this is often necessary. Additionally, it is often very difficult to find appropriate accommodate move-on accommodation into a tenancy or privately

rented accommodation, which would provide an environment where care packages could be more effectively arranged if needed.

The need for additional support is very often clear to the Housing Team at the point that the need to provide emergency accommodation is evidenced and it is important that a holistic understanding of the adult's needs can be built up quickly by the Housing Teams, but this is dependent upon collaboration and prompt responses from colleagues in partner agencies particularly social care and primary care. Members of the Review Team acknowledged that currently there is a sense in which services work in silos at the point when it is essential for a more holistic understanding of the adults' needs to be produced by the Housing Teams. When a formal social care assessment is needed to establish the adult's 'eligible needs', it is not always possible to get a prompt response from the community social care teams. If a complete picture of not possible on the day of crisis, then the housing teams provide the accommodation in the knowledge that additional needs are unmet, and this is likely to impact on how long the accommodation arrangement will work. The PCC Housing Options Team have noticed that there has been an increasingly number of adults facing situations where the accommodation provider (hotelier/B&B proprietor) asks the person to leave, usually resulting from behaviour linked to their physical/mental health needs, or because their additional care needs are evident and outside of the remit of hotel/B&B staff to support.

3.3.14 Recommendations and questions for the Board

Finding 4 - Homeless adults with care and support needs can be further disadvantaged when they are placed in emergency accommodation without a support package outside their 'home' area, away from their usual network of support and services.

- How can we more effectively identify adults with health and/or care and support needs threatened with homelessness (and likely to require placement into temporary accommodation) at an earlier stage, so we can proactively develop support plans with them and housing colleagues?
- Are there opportunities for health and social care partners to work more closely with their local Housing Departments to provide a prompter holistic assessment of health and/or care and support needs (including capacity assessments) to homeless people?

- Are commissioning arrangements and services available to enable Housing Departments to access suitable support packages to reduce the risk and /or length of homelessness?

- Are we able to consider extending our supported housing offer to include emergency placement for homeless adults with identified complex support needs which have been unable to be met in emergency accommodation provided by Housing Needs?

Finding 5 - There are currently limitations in how the hospital Emergency Department fulfil their statutory 'duty to refer' homeless people under the Homelessness Reduction Act (2017)

3.3.15 Context of the issue

Duty to refer

The Homeless Reduction Act 2017 (which came into force in April 2018) places a duty to refer for all public bodies. In order to act on the duty to refer protocol in Hampshire. The government statistics state since the duty to refer came into force, over 240,000 households have had their homelessness successfully prevented or relieved through securing accommodation for more than 6 months. The aim of the act is to provide early intervention to reduce the impact of homelessness and be more proactive in approach. The implementation of the duty to refer also heavily relies upon patients informing the hospital of their status in order that they are identified as homeless or potential to be made homeless.

Prevalence of homelessness

The homeless population for Hampshire is lower than the National figures as recorded in 2018 (later data is not available). Statistics for this are measured per head of population, for Hampshire there are half the amount of homelessness persons at 1.2 persons in every thousand, whereas England as a whole records 2.4 persons homeless in every thousand in the population.

Limited current guidance for professionals on providing an integrated response

The National Institute for Clinical Excellence (NICE) are in the process of producing guidelines for Integrated health and social care for people experiencing homelessness which is due for publication in March 2022.

3.3.16 How was this finding illustrated within this specific case

Vicky discharged from Queen Alexandra Hospital following a short episode in the Emergency Department (ED) on 9th July 2019. She was admitted from temporary accommodation at the Premier Inn in Petersfield. On discharge staff agreed Vicky would stay with her 'next of kin' in Waterlooville. The hospital mental health Liaison team provided advice and felt she could be discharged to the care of her 'friend'. Vicky was discharged 5 hours later with her 'next of kin'. This was in fact one of Vicky's 'friends' about whom professionals who knew Vicky had expressed concerns, not a family member. The following day (10 July) Vicky experienced a further episode and seemed confused with changed mood. Her 'friend' took her to ED where Vicky was assessed but declined a referral to the Community Mental Health Team.

As Vicky was accompanied for both those attendances staff gained the impression of a support network. The ED team were unaware that there were recent concerns amongst local agencies about Vicky being vulnerable and homeless, as the database system used in ED does not interface with systems in the wider hospital. There was no flag for safeguarding concerns on the hospital records accessed at the time. No referral was made by any department at the hospital regarding housing needs.

3.3.17 How far does this finding have a broader relevance to the system?

In Hampshire, Queen Alexandra Hospital have identified the referral of homeless individuals is not consistently undertaken from the emergency department. Between April 2019 and November 2020 Hampshire received 1 referral from the Emergency Department for a homeless adult. The General Hospital placed 14 referrals, Mental Health Hospitals in comparison for the same time frame placed 36 referrals in the same time frame. Portsmouth City Council received 0 referrals from the Emergency Department in the same time frame. It is unclear what these figures illustrate as it could be a result of mental health conditions leading to homelessness, or that attendance into the emergency department is less for these groups. It could be a reflection of reduced referrals from the Emergency Department more work is needed to identify which of these issues is the rationale for this.

One consequence for Housing providers of not receiving early notification of an adult being homeless is that the Housing providers do not have time to plan a good housing options solution for an individual, which can result in them being placed in inappropriate and unsuitable accommodation. Providers may struggle to have the time to organise the necessary support/care that the adult might need, which can have a detrimental effect on their recovery.

At the Queen Alexandra Hospital an account of a homeless individual had been shared via a complaint from a member of the council regarding the absence of a referral; the individual had then taken an overdose. The hospital have shared it is an issue they want to address the implementation of the duty to refer is to be expanded to the wider hospital audience not just from the discharge planning team.

3.3.18 Recommendations and questions for the Board

Finding 5 - There are currently limitations in how the hospital Emergency Department fulfil their statutory 'duty to refer' homeless people under the Homelessness Reduction Act (2017)

- In the 12 months between April 2019 and April 2020 there was only one referral made to Housing Providers in Hampshire, from the Emergency Department, to alert them to homeless adults who have presented at A&E. Additionally we have limited information available to understand the size of this issue as statistics are not collected from the hospital. Numbers of referred individuals are only available on specific request to housing and may not reflect referrals not accepted.

- Is there enough safeguarding presence/experience in the Emergency Department to identify and respond when they are treating an adult who may be at risk of abuse or neglect and is also homeless?

- Does the board feel assured that staff in Emergency Department settings are well placed to provide initial signposting and advice to homeless adults who may be at risk?

Section 4. Appendix

4.1 Timeline of key dates

Abbreviations
CMHT – Community Mental Health Team (NHS Trust) HCC – Hampshire County Council PCC – Portsmouth City Council MASH – Multi-Agency Safeguarding Hub CPA – Care Programme Approach (Mental Health care management framework led by CMHT)

Date	**Intervention**
07.09.17	Hampshire social care Mental Health team visit Vicky who is felt to have mental capacity around finances and care and support needs. CMHT will be co-ordinating multi-agency meeting and will contact Hampshire social care Mental Health team.
19.01.18	Havant CMHT raise safeguarding concern – possible financial abuse of Vicky by two 'friends' she is staying with.
23.01.18	Patient said to be fitting – tonic clonic seizure witnessed by friend. Patient also had a current chest infection. Paramedics attended.
20.02.18	Pharmacist provides telephone consult regarding antiepileptic medication. Previous plan from Neurology had been to consider weaning dose, but due to increased recent seizures decision made not to alter dose at that time.
23.02.18	Paramedic notes face to face review following epileptic seizure (had been seen recently by Neurology)
12.03.18	Vicky did not attend outpatient epilepsy clinic appointment. Alternative appointment offered by Epilepsy Nurse Specialist
11.04.18	Friend called ambulance – Vicky having multiple seizures. Paramedics attended. Patient had smoked marijuana this evening. Patient advised to contact own GP and epilepsy nurse for a review.
07.05.18	Vicky was subjected to an apparently unprovoked assault by a 37-year-old female. Injuries were scratches across her neck which bled. Police spoke with VICKY who did not want any police action. Vicky staying with neighbours. Her own flat was described as appearing as though it wasn't cleaned or lived in. No formal police action.
25.07.18	Alleged physical assault by one of the 'friends' and continued financial exploitation – money given in exchange for friendship and cannabis. CMHT seek to put additional support in place and arrange standing order to reduce loss of money.
27.07.18	Vicky's care coordinator has again raised concerns to HCC around her vulnerability and her financial dealings with her two neighbours. Vicky has capacity to make this decision, however the two neighbours are asking for this money as "a loan" and not paying the money back. MASH contacted Vicky wo advised she had been hit but would not elaborate on the incident.
July/August 2018	Intelligence was received by police that VICKY was being financially exploited by people who lived in nearby and/or adjacent flats to her. That there was drug dealing going on from these addresses, she was a regular cannabis user and is sub-letting her flat. PPN completed and submitted to MASH.
23.08.18	Multi agency meeting (police, CMHT and Housing). Vicky joined for second half. Measures put in place to support her. Police attempts to help are limited as Vicky is not cooperating with them. Housing considering enforcement action if she continues to sublet her flat.
29.08.18	Vicky's flat had been broken into and a TV stand stolen. Police investigated and arrested a man from a neighbouring property, but he denied the offence and a purported witness would not provide a statement. No further action was taken. Vicky was not recognised as vulnerable.
Nov 2018	Case closed to HCC – lack of engagement.
07.12.18	Vicky referred to Domestic Violence Outreach Service, but the referral was declined as inappropriate as it was regarding issues between Vicky and two friends, who the referrer said had previously been

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	described as her carers, however Vicky had left their property, and so they were no longer in a caring role.
08.12.18	Police PPN sent to MASH - concern for welfare - Vicky is lending all of her benefits every week and not seeing any of this money back. Vicky is a vulnerable adult living with known drug dealers. Previous PPN1 indicated 'cuckooing'. MASH view - no evidence that this is safeguarding – as Vicky has capacity and was making unwise choices in staying with the friends and she is no longer there now. She has recounted previously that she knew the consequences of giving money to her friends and was mutually beneficial as she was provided with cannabis. MASH feel no sign or suggestion of social care needs.
09.12.18	111 call made – patient stated her medication had been stolen. Police intelligence subsequently received that the original female had taken Vicky's medication and was using her property to take heroin.
13.12.18	999 call following 1-minute seizure whilst in the friend's flat, evidence of cannabis use in the property. Vicky had epilepsy meds stolen so had not been taking meds but is collecting new medications that afternoon. Concerns "filthy" home conditions
14.12.18	999 call Vicky seen by friends to have single seizure lasting approximately 40 seconds, seen by paramedics previous day for similar episode,
20.12.18	Annual epilepsy review with Consultant Neurologist Outpatient routine advice given. For annual review.
22.12.18	Concerns from CMHT raised with MASH who are supporting Vicky. CMHT have been advised to refer back into adults' health and care if assessment of care and support needs needed or for a safeguarding concern. MASH shared risk info with GP re epilepsy and loss of her medication.
17.01.19	Paramedics visit following bump to head and possible post injury fit.
23.01.19	Housing association receive anonymous report received that Vicky's property is not being lived in. Fraud Team investigating. (Tenancy Enforcement)
06.02.19	Housing association and the police carried out a joint visit to Vicky. She was located in neighbour's flat. Advice provided that this cannot continue, and she is committing fraud. Vicky was happy to give up her tenancy, however the tenant from 103a asked for some more time. Permission provided by Vicky to inspect her own flat. It was clear the property has not been lived in. This was discussed with the CMHT - no evidence of anyone else using the property. Vicky is unable to sustain her tenancy. Text received from Vicky confirming she wanted to terminate her tenancy, and could the Housing association find a bigger property in order they could all live together. The Customer Liaison Officer replied to confirm this was not possible. Due to her vulnerability, we discussed further with Vicky and her support workers, and she then retracted her decision and confirmed she would return to her own flat.
10-15.02.19	GP face to face review: upper respiratory tract infection and epilepsy review, followed up by 2 telephone consults for chest wall pain
18.02.19	Housing association - Vicky has reiterated she would like to end her tenancy and intends to go on holiday (103a Laburnum Road). CMHT due to close case due non engagement from Vicky.
19.02.19	The Housing association send a letter to Vicky from Tenancy Fraud Team, requesting contact to discuss her options. Customer Liaison Officer has discussed this with Vicky.
08.03.19	Vicky stated she locked out of 103a Laburnum Road and did not have keys to her own flat. Vicky stated she had been discharged from all services. Freely admitted she uses cannabis, and this affects her epilepsy. Police report submitted to MASH and significant concerns raised for her welfare and risk of harm.
08.03.19	MASH -concern from the police raised in relation to financial exploitation of Vicky by others. Police noted that Vicky was epileptic and used cannabis, and that there was evidence of self-neglect at the flat.
15.03.19	Police advised The Housing association they had attended the flat following reports of anti-social behaviour, drug use and numerous people coming in and out of the property. Vicky opened the door and giggled and denied any wrongdoing. Support and advice provided to Vicky to ensure she was not be taking advantage of. A bong, tin foil and 3 empty cannabis bags seen in property. Vicky

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	admitted to using them last night. Keys have not been located and the door is insecure. Emergency job raised to secure the property, and this was completed on the same day. New keys provided to Vicky.
20.03.19	Vicky is currently being supported by CMHT but is deemed to have capacity. Professional's meeting arranged for 27th March 2019 due to the concerns we have. Case also been referred to Fraud Team related to Housing Benefit and other benefits.
24.03.19	MASH attempts to contact Vicky by phone failed so a letter was sent from the Hampshire CART Team (Contact, Assessment and Resolution Team) on 24 March asking her to make contact if she would HCC like advice or support.
w/c 25.03.19	CPA held by CMHT, Vicky attended, the Housing association and police attended and had concerns about financial exploitation. It was felt that she had the mental capacity to make a decision about who she lived with. Vicky is going to relinquish her tenancy. Actions from meeting: • Discharge of Vicky from CMHT due to non-engagement. • Housing association to serve an Eviction Notice to Vicky as she is not using the property as her sole and principal home and refer her to Housing Options.
28.03.19	Hospital ED attendance - self presentation with suicidal ideation. Referred directly to Mental Health Liaison Team. No acute medical issues. Discharged with follow up by community Crisis team.
01.04.19	Vicky gave The Housing association notice on her tenancy. This expired on 29th April 2019 (4 weeks' notice).
02.04.19	CPN rang HCC community team to advise them CMHT are about to discharge Vicky, who is now living with a neighbour and has a 'live-in carer'.
02.04.19	HCC duty worker rang Vicky who said she was happy to live with her neighbours and a carer. Vicky assured the duty worker that she was ok and that her carer was supporting her. Vicky said she was giving up her tenancy on 29/04/19.
28.04.19	111 call. Informant contacted Ambulance service to seek medical attention for her friend, Vicky who was having a mental health episode, had lashed out at her causing a black eye and scratches on the informant's face. No further action taken.
28.04.19	Vicky attended Hospital with thoughts of self-harm. A plan was formulated with supportive regimes offered and re referral to crisis team for support. A full risk assessment completed, and discharge home agreed with family friend.
07 - 10.05.19	Pharmacy raised concerns to GP about patient's mental health. Following day GP tried to make contact with patient. GP contacted crisis team and also left message with CPN. Following day Pharmacist raised concerns again as Vicky presented again with no credit on phone. Face to face appointment booked with GP (10.05.19) but patient did not attend. GP notified pharmacy to contact the surgery if VICKY presented there again.
16.05.19	Vicky presented to the GP reception with a facial injury following an alleged assault. Receptionist advised minor injuries unit; patient declined. Receptionist offered to call for an ambulance to take patient there for assessment, patient declined.
24.05.19	GP contacted MASH safeguarding concerned for patient. She reported being attacked by her partner. Did not report to police.
28.05.19	GP called patient again to check she was alright. Follow up call in 2 weeks planned by GP
31.05.19	Police Intelligence was received that Vicky was seen with a black eye and it was thought that she might be being abused by other occupants of the shared flat that she was living in. A PPN was submitted.
06.06.19	Police Intelligence was received that Vicky was subject to regular violent abuse from her 'partner'.
10.06.19	PCC housing - Vicky homeless and requesting support to resolve her housing - now staying at the Ibis Hotel in Portsmouth temp accom.

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11.06.19	The Housing association - joint visit with Police to Vicky's neighbour/'friend' who confirmed she had asked Vicky to leave the property and PCC had placed her in the hotel and are looking at supported housing for Vicky. As the alleged assault was reported by a third party, no further action will be taken by the police at this time, with no witnesses. Nothing was reported by Vicky herself.
14.06.19	GP informed by patient she was living in Portsmouth and out of area. Following day Vicky did not attend appointment with nurse for smear. GP called patient again to follow up. Vicky confirmed she had been to council and placed in Ibis, they were looking at new accommodation for her. Phone line cut out and no answer when GP tried to call back.
04.07.19	Havant Council's housing services contacted by PCC's housing services team for information.
04.07.19	Call from chemist (Portsmouth) requesting Vicky's medication be sent there - patient was now out of area and would need to reregister.
08.07.19	PCC Housing Options raised safeguarding concern to the PCC Older Physical Disability Team as Vicky seems to require help with taking medication and daily living tasks, she is epileptic and has frequent fits. Complaints from hotel about Vicky walking around barefoot and acting inappropriately.
09.07.19	999 call - Vicky was at B&B, is believed may have taken an overdose. Vicky talking with paramedics and reported that she had not taken any more of her tablets than she should have and did not know why an ambulance had been called.
09.07.19	Vicky presented at PCC housing options, appeared vacant, drifting in and out of consciousness, multiple suspected seizures. Staff called ambulance - crew conveyed Vicky to hospital. CT brain normal - episodes were felt to be non-epileptic attack disorder and therefore did not require an inpatient medical treatment. Transferred to ED observation ward for Mental Health Liaison Team review following disclosure of thoughts of self-harm and wanting to commit suicide, reportedly small overdose of medication but denied suicidal intent and said it was only 2 tablets.
10.07.19	Vicky presented back at A+E with confusion. Reviewed by Mental Health Liaison Team, full assessment not possible due to poor engagement, she was felt to have the capacity to choose to not engage with the assessment. Declined referral to Community Mental Health Team. There were some communication issues which led to VICKY being discharged without a SW assessment and without clarity about the follow up support/treatment needed to meet her health needs. Discharged home by Taxi into the care of 'friend' whilst permanent accommodation was being sought.
10.07.19	Next of kin phoned Emergency Department that patient was not her normal self, was confused, Vicky believed it was February 2016, a change in personality. Advice provided. An ambulance was dispatched, arriving on scene at 19:00, advised friends to convey Vicky back to hospital.
10.07.19	Second ED attendance (19:53): reviewed by a Senior Emergency Department Doctor who undertook a comprehensive physical assessment. A CT (computed tomography) scan of the patients' head was performed - was normal. Patient was discharged 5 hours later with next of kin and advised to seek review from her GP for any ongoing concerns.
11.07.19	Carer called GP surgery to book appointment concerned. She did not attend 2 hours later. GP does not know if carer followed it up.
12.07.19	PCC social care - unclear at the current time if Vicky has care and support needs so cannot ascertain if Section 42 duty is met. Care Act assessment intended to take place prior to discharge from hospital – but VICKY had been discharged on 10/07/2019 without a Care Act Assessment as hospital unaware of the request from social care.
17.07.19	CMHT visited Havant Housing Services to advise Vicky was homeless. Vicky's neighbour (whom she was staying with) had asked her to leave so she was homeless. PCC housing still working on this case and think that there are safeguarding issues. Housing assessment undertaken by Havant Council Housing Officer plus the duty HCC Mental Health social worker. Vicky was advised by HBC Housing to go to PCC Housing Options.

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17.07.19	HCC Duty social worker spoke to PCC Housing Options worker asked why HCC were not assessing Vicky. HCC Duty social worker confirmed that Vicky needed to go to her GP in order to progress referral to CMHT as HCC cannot refer directly to the CMHT. PCC housing agreed to book a room for Vicky at the Travel Lodge.
17.07.19	HCC Duty social worker advised Vicky that PCC had secured accommodation for 1 night at the Travel Lodge in Portsmouth but that she has to present at PCC tomorrow for further assistance.
17.07.19	PCC - She was placed by Housing in a Travel Lodge B&B. She was invited in for an appointment with PCC Adult Social Care on 17/07 but did not attend
18.07.19	PCC - She was moved to a different B&B. Concerns were raised by Housing Options about a continued need for a Care Act Assessment which led to a PCC Duty Visit being arranged for 22/07.
22.07.19	PCC - sadly Vicky was found deceased in a B&B room by a duty Social Worker.