

PORTSMOUTH SAFEGUARDING ADULTS BOARD

THEMATIC REVIEW FOLLOWING THE DEATHS OF Mr G, Mr H, Mr I and Mr J

2022

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THEMATIC REVIEW FOLLOWING THE DEATHS OF Mr G, Mr H, Mr I and Mr J

Portsmouth Safeguarding Adults Board

1. INTRODUCTION

1.1 This Safeguarding Adult Review concerns four men, Mr G, Mr H, Mr I and Mr J who died between 7th April 2020 and 3rd July 2020.

1.2 This is thematic review, which means that it focuses on themes rather than on each individual and identifies similarities and differences between the lives of the four men and the approaches taken by services to engage and support them. Consequently, it will only consider chronological events where these show a meaningful pattern from which lessons can be learned or the value of alternative approaches can be illustrated.

1.3 **A summary of the lives of the four men is as follows:**

1.4 Mr G

1.5 Mr G was a white British man who was 53 years old when he died. It appears that he arrived in Portsmouth in 2017, fleeing drug related threats in London. Mr G had been living in private rented accommodation in 2018 and there were reports that he had twice assaulted his partner in December 2019 at her address. Mr G was arrested following this and imprisoned. Mr G was released from prison on 19th March 2020 after serving slightly over two months in prison.

1.6 Between 23rd March and 30th March 2020, Mr G attended the Queen Alexandra Hospital twice for suspected opiate overdoses (an overdose was confirmed during only one attendance) and for facial injuries and arm lacerations.

1.7 Between 1st April and 5th April 2020, the Solent Mental Health Team became involved with Mr G since he said that he felt suicidal. An assessment was made but no current suicide plans or intent were identified, but there was a history of self-harming. It was concluded that there were no current symptoms to indicate severe or enduring mental illness requiring treatment from mental health services. Mr G moved into a hotel as part of the "Everyone In" programme on 2nd April 2020.

1.8 On 7th April 2020. Mr G was found dead in public toilets approximately 2 miles away from the hotel in which he was living.

1.9 Mr H

1.10 Mr H was a white British man who was 41 years old when he died. He had extensive previous contact with the police from at least 2003 and had served several terms of imprisonment. Mr H was admitted to the ANA Treatment Centre (a service which supports people who rely on drugs and alcohol) on 19th February 2020 for Methadone Detoxification and was reported to have fully engaged in the programme. Mr H was due to graduate from the ANA recovery

programme on 1st April 2020. Unfortunately, the graduation ceremony, to which he had invited a member of the Substance Misuse Team and a support worker from the Society of St James, was cancelled as part of the “lockdown”. From the ANA Treatment Centre Mr H then moved to Society of St James (SSJ) supported housing. This accommodation was for people who are abstinent from, and for those who choose to use, alcohol.

1.11 Mr H was disappointed that services had closed and was worried about returning to his SSJ accommodation. He wanted to know if anyone there had Covid-19. He was also reported by practitioners to be concerned about living with other people who might be using drugs or alcohol. Substance misuse team staff became concerned when Mr H made no contact with them after he left the ANA treatment centre. Mr H was not at home in the independent accommodation managed by SSJ in which he lived when welfare checked by the substance misuse team.

1.12 On 29th May, Mr H contacted the substance misuse team and explained that he had tried to come off his mental health medication (he claimed that he had been given the wrong medication at the ANA Treatment Centre) but had realised that his mental health had deteriorated as a result. Mr H said that he wanted to reengage with Community Day Rehabilitation and the Substance Misuse Team agreed to contact him in a week about this. This was the last contact by services with Mr H.

1.13 Mr H died between 30th May and 3rd June 2020 in his room. He was discovered by a fellow resident and is believed to have died of a drug overdose.

1.14 Mr H had previously had a long-term relationship with the mother of his son.

1.15 Mr I

1.16 Mr I was a White British man who was 52 years old when he died. Mr I had intermittent contact with the Portsmouth City Council Housing Needs Advice and Support Service between 2014 and 2020. Mr I had been involved in pushbike thefts and in supplying drugs. He moved into a hotel as part of the “Everyone In” programme. The support staff there became increasingly concerned about his physical health. Mr I was not eating and appeared under-nourished. Half hourly welfare checks were conducted.

1.17 Between 13th June and 15th June 2020, the support staff telephoned for an ambulance three times for Mr I. Mr I was not taken to hospital on two of these occasions despite signs and symptoms of weight loss, self-neglect, shortness of breath and physical instability. On 15th June, however, the ambulance crew took Mr I to the Queen Alexandra Hospital where he died the next day (16th June 2020).

1.18 Mr I had a sister and he told services that he visited his mother every day.

1.19 Mr J

1.20 Mr J was a White British man who was 53 years old when he died. Until c.8th April 2020, Mr J lived with his sister in Portsmouth. He moved out due to non-

compliance with the “lockdown” restrictions, reportedly due to his alcohol intake. It is thought that Mr J moved in with another tenant of Portsmouth City Council. (see reference to S17 “Child in Need” assessment, below). The extent of his relationship with this person is, however, unclear.

- 1.21 On 21st March, Mr J was taken to the Queen Alexandra Hospital by Ambulance following a fall whilst under the influence of alcohol. He was discharged “home” on 22nd March 2020 with no follow up required.
- 1.22 On 4th May 2020 checks on Mr J were requested by Portsmouth Children’s Services Department as part of its s17 “Child in Need” assessment since Mr J was believed to have been living at the same address as the mother and child who were the subjects of this assessment. Mr J does not appear to have been involved in the assessment or the circumstances leading to it.
- 1.23 On 17th May 2020, Mr J attended the Queen Alexandra Hospital by Ambulance after having been found by a member of the public outside a library, difficult to rouse and breathing noisily. Upon admission, Mr J became verbally aggressive and refused all investigations. Once Mr J was more sober, he asked for support with alcohol dependency and was discharged. No medical follow up was required but the Emergency Department staff referred Mr J to the Alcohol Specialist Nursing Service. The outcome of this referral is unknown.
- 1.24 Mr J had been a member of a library, making use of its computers. It appears, from evidence of drinks cans and litter that he had been sleeping rough outside the library at some point after its closure, in response to Covid-19, from 17th March 2020, and possibly in the last week or weeks leading up to his death.
- 1.25 Mr J was found dead outside the library on 3rd July 2020.
- 1.26 Whilst Mr G, Mr H, Mr I and Mr J differed from each other, their individual circumstances and the nature of their deaths shared certain similarities and patterns. There are some individual concerns that will be explored further in this review.

2. SAFEGUARDING ADULT REVIEWS

- 2.1 Section 44 of the Care Act 2014 places a statutory requirement on the Portsmouth Safeguarding Adults Board (SAB) to commission and learn from SARs (Safeguarding Adult Reviews) in specific circumstances, as laid out below, and confers on Portsmouth Safeguarding Adults Board the power to commission a SAR into any other case:
- 2.2 ‘A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –
- 2.3 there is reasonable cause for concern about how the PSAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

- 2.4** the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect..., or
- 2.5** the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.
- 2.6** The SAB may also arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).
- 2.7** If the criteria appear to be met, Safeguarding Adults Boards may agree to proceed with an alternative and more appropriate Review. These Reviews remain statutory Reviews.
- 2.8** The Portsmouth Safeguarding Adults Board agreed that a Thematic Review rather than individual SARs was the most appropriate way to consider the systemic factors and processes, which may have impacted on the circumstances of the deaths of four homeless people in Portsmouth during the 2020 calendar year.
- 2.9** A Thematic Review promotes effective learning, improvement actions and recommendations, which contribute to the improved safety and wellbeing of adults with care and support needs, therefore, reducing the risks of future deaths or serious harm occurring again.
- 2.10** As with a SAR, Thematic Reviews are required to reflect the six safeguarding adults' principles, as defined in the Care Act. These are empowerment, prevention, proportionality, protection, partnership, and accountability.
- 2.11** Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the facts (what happened), an analysis and findings (what went wrong and what went right), the recommendations to improve services and to reduce the risk of repeat circumstances and, a shared action plan to implement these recommendations. It was not the purpose of the Review to re-investigate the suspected abuse or neglect, or to apportion blame to any party.
- 2.12** The Review has followed due process, which has involved: the Independent Reviewer chairing an initial panel meeting to agree the Review terms of reference; conducting research by analysing Individual Management Reports, chronologies and relevant records held by involved agencies; interviewing representatives of agencies; holding a Practitioner Learning Event, using a questionnaire and interviewing homeless people in Portsmouth and holding Thematic Review panel meetings and finally a presentation to the Portsmouth Safeguarding Adults Board. Twelve homeless people completed the questionnaire and four agreed to be interviewed face-to-face by the reviewer.
- 2.13** Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –
 - a) identifying the lessons to be learnt from the adult's case, and

b) applying those lessons to future cases.

- 2.14** Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons to the future (s44(5), Care Act 2014).
- 2.15** The purpose and underpinning principles of this Review are set out in the Portsmouth Multi-Agency Safeguarding Adults Policy and Procedures:
- 2.16** All PSAB members and organisations involved in this Review, and all Review panel members, agreed to work to these aims and underpinning principles. The Review is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice (“tell it like it is”).
- 2.17** All four cases were referred to the SAR Sub-group of the PSAB between May and July 2020 and were considered for a Safeguarding Adult Review/Thematic Review at the meeting on 9th September 2020.
- 2.18** The SAR Sub-group considered that together rather than separately, these cases met the criteria for a SAR/Thematic Review, and the Independent SAB Chair ratified this on 20th September 2020.
- 2.19** The report writer, Patrick Hopkinson, is an independent safeguarding adults review writer, a chair and writer of domestic homicide reviews, and a trainer and consultant in adult safeguarding. He had no connection with any of the organisations that worked with Mr G, Mr H, Mr I and Mr J.
- 2.20** This Thematic Review used, chronologies, combined scoping documents and other submissions from partner organisations, a practitioner learning event, results from a questionnaire completed by homeless people and interviews with staff members and with homeless people themselves.
- 2.21 Family involvement**
- 2.22** Letters were sent to relatives of the four homeless people who died in Portsmouth inviting them to participate in this Review. The independent report author met Mr J’s sister as part of this thematic review. Mr J’s sister provided information about Mr J’s background.
- 2.23 Overview of the case and circumstances leading to the Thematic Review**
- 2.24** During 2020, twelve homeless people are known to have died in Portsmouth. This compares with five people who are known to have died during 2019.
- 2.25** The deaths in 2020 happened within the context of the world-wide coronavirus pandemic and the consequent “Everyone In” project to temporarily house all homeless people and the “lock down” restrictions placed on people, services and businesses from 24th March 2020.

2.26 Non-essential shops reopened on 15th June 2020, with increased lifting of restrictions from 18th July until 14th August. Restrictions were reintroduced from 14th September and a second “lockdown” began from 5th November 2020.

2.27 The Portsmouth Safeguarding Adults Board decided that the reasons for the increase in the number of deaths in 2020 should be explored to identify both the reasons for the increase and any lessons that might be learned for the future.

2.28 To do this, the Board’s Safeguarding Adults Review Sub-Group chose four deaths to be the focus of a Thematic Review. Commonalities between the four cases included:

- Homelessness;
- substance and/or alcohol abuse;
- male and middle aged;
- known to agencies;
- attempts to provide support had met with occasional and sometimes frequent disengagement;
- low level offending and repeated physical injuries and/or physical/mental health concerns resulting in contact with health services.

2.29 The review aimed to identify systems-based learning by a variety of methods to assess service design and commissioning, and how agencies:

- Engaged with the individual
- Understood the individual’s life experiences
- Assessed risk
- Assessed Mental Health and Mental Capacity
- Identified Care and Support Needs
- Provided Safeguarding
- Managed transition (where appropriate)
- Identified circles of support within friends and family
- Used temporary accommodation and how suitable this accommodation was.

3. CONNECTING THEMES

3.1 Mr G, Mr H, Mr I and Mr J were in contact with various services. Throughout this report acronyms are sometimes used, the most prominent of these being:

3.2 PCC – Portsmouth City Council

3.3 HNAS – Housing Needs, Advice and Support (PCC)

3.4 SSJ – Society of St. James

3.5 QAH – Queen Alexandra Hospital

3.6 Connecting themes present in childhood

- 3.7** Two of the four men reported they had been the victims of traumatic childhood experiences.
- 3.8** Mr G disclosed to Solent Mental Health services on 5th April 2020 that he had a history of childhood sexual abuse. Mr G also disclosed being the victim of sexual abuse to Two Saints (night shelter) saying he was aged nine at the time.
- 3.9** The Solent Mental Health Services' assessment of Mr G on 5th April 2020 identified "dynamic risk factors including unresolved trauma following a history of childhood sexual abuse." The assessment resulted in a plan for Mr G to seek a "self-referral" to the Portsmouth Abuse and Rape Counselling Service (PARCS) for sexual abuse trauma support and for Mr G to engage with drug and alcohol services, to continue with prescribed medication and to contact the Samaritans and or SHOUT (a free, confidential 24/7 text support service) if and when necessary. It was explicitly noted that Mr G's willingness to engage with substance and alcohol misuse services was poor. Although this was identified as a "dynamic" risk factor, it is not clear if it was therefore entirely realistic and appropriate to expect Mr G to then begin engaging with services on his own volition, as part of his post-discharge plan.
- 3.10** At an Access to Intervention Team (Solent NHS Mental Health Services) assessment appointment on 10th January 2020, Mr J disclosed that he was affected by anxiety, low mood and traumatic childhood experiences. The details of the childhood trauma have not been made available to the Review author.

3.11 Connecting themes present in adulthood

- 3.12** All four men experienced homelessness and change(s) in accommodation in the last months of their lives.
- 3.13** All four men were drug and / or alcohol dependent. Some had received treatments and interventions.
- 3.14** Mr G spent time in prison from 10th January to 19th March 2020. During that time, he underwent alcohol detoxification. Mr G was advised about the dangers of mixing drugs and alcohol, and that his tolerance would be reduced after detoxification. However, on 23rd March 2020, Mr G was taken by ambulance to the QAH with a suspected opioid overdose. Mr G was referred to the Alcohol Specialist Nurse Service (ASNS) (part of the alcohol team at Queen Alexandra Hospital) for assessment.
- 3.15** Mr H had been addicted to heroin for 20 years and had recently been through rehabilitation at the ANA Treatment Centre. On completion of the six-week programme Mr H tested negative for both drugs and alcohol. Mr H was concerned about moving to SSJ (Society of St James) accommodation because people who still used alcohol lived there. Mr H wanted to relocate to Bognor Regis to enable him to access the Sands Project. The Sands Project is a service for people who are abstinent from substances and require stabilisation, as well as for people who have completed a rehabilitation programme who request a further support. The service is also able to support

clients who experience mental health problems and works with local mental health teams to deliver support to them. Mr H did not relocate to Bognor Regis, but instead, moved to SSJ supported housing on 1st April 2020. It is not clear why Mr H did not move to Bognor Regis and what was done, if anything, to support and advise him in a potential relocation there. It appears that Mr H relapsed to drug taking in the last days of his life. He was found dead with drug paraphernalia around him.

- 3.16** Mr I was well known to the substance misuse team and had irregularly been on a methadone prescription for several years. Mr I saw a doctor at the Recovery Hub on 27th December 2019. Mr I was opiate dependent at the time and appeared to feel strongly that he should stop using heroin completely. Between December 2019 and May 2020 the police received twelve pieces of intelligence that suggested that Mr I was involved in using and supplying controlled drugs in the Portsmouth area.
- 3.17** At the Access to Intervention (the entry point for mental health services provided by Solent NHS Trust Mental Health Services) assessment appointment for Mr J on 10th January 2020, it was identified that Mr J would obtain support via the Recovery Hub and would therefore be discharged. It does not appear that Mr J contacted the Recovery Hub, but he engaged with the Alcohol Specialist Nurse Service (ASNS), part of the alcohol team at Queen Alexandra Hospital). A SSJ support worker based within the team met Mr J and discussed his drinking and homelessness situation, and the value of making a housing referral, with him in June 2020. They agreed that Mr J would contact the support worker again, but no contact was made despite the worker having tried to contact Mr J several times without success.
- 3.18** All four men had mental health needs, the detail of these is known to varying degrees.
- 3.19** Mr G had a history of suicidal ideation and of self-harm. For example, on 31st March 2020, Mr G was found in a railway lineside hut with a broken bottle neck that he had used to make a deep cut in his forearm. Solent Mental Health Services identified that Mr G had apparently served a prison sentence in 2018 for trespass on a railway line while attempting to end his life.
- 3.20** Mr H was on anti-depressants (no further information is available to the SAR author).
- 3.21** Mr I was referred to the Single Point of Access Solent NHS Trust Mental Health Services in January 2018. However, Mr I did not attend his scheduled assessment appointment with this service in February 2018, and it appears that there was no further engagement with services regarding his mental health.
- 3.22** Mr J was referred to Solent NHS Trust Mental Health Services in December 2019 and at the assessment appointment on 10th January 2020 was described as affected by anxiety, low mood and traumatic childhood experiences. The outcome was that Mr J would access the Recovery Hub and that he was motivated to engage with the group activities that may be offered there for people with problems with substance misuse). On this basis Mr J was discharged from Solent NHS Mental Health Trust Services. However, it

appears that Mr J did not engage with the Recovery Hub, and that there was no further engagement to support Mr J with his mental health needs.

3.23 Three of the four men were reported to be involved in criminal activity or domestic abuse.

3.24 Mr G arrived in Portsmouth in 2017, fleeing drug related threats in London. On 24th September 2019 Mr G was arrested for assault and criminal damage following a domestic incident with his partner. Mr G was charged and ordered to pay a fine and compensation. According to police reports Mr G was later “shown” to be the aggrieved party when he was assaulted with a spade and a piece of wood at his partner’s address (then his home address). Mr G’s partner and a member of her family were arrested but there was no prosecution due to lack of independent evidence.

3.25 On 16th October 2019, Mr G was released from prison (reason not given) whereupon he attempted to gain entrance to his partner’s property by trying to kick down the front door and threatened violence to the occupants whilst holding a bat. Mr G was arrested and sentenced to a term of imprisonment and a referral was made to the domestic violence MARAC. In December 2019, there were reports that Mr G had twice assaulted his partner at her address, where he was living. Following the second assault, the Police issued Mr G with a Domestic Violence Protection Notice (DVPN) to prevent him returning to his partner’s address on 8th December 2019. Mr G was recalled to prison on 13th December 2019 and then released on 20th December 2019. The following day he was arrested for breaching the DVPN. On 8th January 2020, police were called to reports of Mr G causing damage at his partner’s property. He was arrested and, in the process, assaulted two police officers.

3.26 Mr G was in prison from 10th January 2020 to 19th March 2020. Upon release, Mr G attempted gain entry to his partner’s house and left before the police arrived. He returned later in the evening and caused property damage attempting to gain access again.

3.27 In early hours of 26th March, Mr G assaulted a staff QAH and later that day, the police were called to a report that Mr G was drunk and was trying to assault people. Mr G then attempted to assault a police officer. On the night of the 27th/ 28th March 2020, Mr G violently assaulted his partner again in a public place. Mr G was arrested and subsequently bailed to allow for completion of the investigation. Mr G died before the return bail date.

3.28 Mr H had extensive previous contact with the police from at least 2003 and had served several terms of imprisonment. There were also two reported breaches of curfew imposed in a court order with electronic tagging in 2020.

3.29 Mr I had been involved in pushbike thefts and in supplying drugs.

4. THE EVIDENCE BASE FOR THE REVIEW

4.1 Preston-Shoot (2020) argues that, “Drawing on existing evidence about effective practice would mean that reviewers are not starting out with a blank canvas. What is proposed here is that SARs begin explicitly with the available

evidence-base, using it as a lens with which to scrutinise case chronology and explore through panel meetings, interviews and learning events with practitioners and managers what facilitates good practice and what presents barriers to effective practice”.

- 4.2 The advantage of this approach is that, “The emphasis then is less on description and more on immediate reflection and systemic analysis of facilitators and barriers, across nationally determined policy, legal and financial systems as well as local arrangements and staff values, knowledge and skills” (Preston-Shoot, 2017).
- 4.3 Reinforcing this, The Local Government Association Analysis of Safeguarding Adult Reviews April 2017 – March 2019 section 3.4 “Type of Reviews” describes a number of “methodological” requirements and related shortcomings of SARs, which can be summarised as follows:
- 4.4 SARs should connect their findings and proposals to an evidence base. Few SARs compare actual practice with that suggested in guidance and few explore the reasons why there was a difference between the two.
- 4.5 SARs should be based on research. Over 50 Safeguarding Adults Boards have carried out SARs on the same set of circumstances on more than one occasion but have treated each discreetly. The SARs do not refer to each other, build on each other, or ask why it happened again.
- 4.6 SARs should be analytical. There is too much description and not enough analysis.
- 4.7 SARs should not shy away from difficult or sensitive topics. Few SARs engage in the legal and financial context of practice or decision making and should raise the impact of funding cuts, government strategy and reductions in services.
- 4.8 Consequently, a study was made of both the research evidence and practice evidence that provides insight and guidance when working with men like Mr G, Mr H, Mr I and Mr J.
- 4.9 **Literature Review referencing Local and National learning**
- 4.10 A literature review was undertaken to understand the deaths of Mr G, Mr H, Mr I, Mr J and other homeless people in Portsmouth during 2020 within a wider context.
- 4.11 **The impact of COVID-19**
- 4.12 First phase of the COVID-19 pandemic began in 2020. On 16th March 2020, the Government advised against non-essential travel and encouraged working from home in all but exceptional circumstances. On 20th March 2020, entertainment venues were also ordered to close.
- 4.13 On 23rd March 2020, the government restricted contact between households and the UK population was ordered to “stay at home”. The only permissible

reasons to leave home were food shopping, exercise once per day, meeting medical needs and travelling for work when absolutely necessary. All shops selling non-essential goods were told to close and gatherings of more than two people in public were banned. These 'lockdown' measures legally came into force on 26th March 2020.

- 4.14** In response to the threats posed by COVID-19, on 26th March 2020, Baroness Casey of Blackstock announced the "Everyone in" project and issued an instruction to local authorities to ensure that all rough sleepers were "*inside and safe*". According to Neale et al (2021), the "Everyone In" project was a ground-breaking UK Government policy initiative to provide temporary accommodation for everyone experiencing rough sleeping and a range of other forms of homelessness during the COVID-19 pandemic. Nationally, approximately 15,000 people were placed into emergency accommodation.
- 4.15** On 2nd April 2020, rough sleepers in Portsmouth and the 57 individuals who were using shared Night Bed spaces were relocated to a hotel which provided self-contained rooms. The existing Homeless Night Bed and Day Services, provided by two commissioned providers, were collapsed and relocated at the hotel. The providers worked together with the Homeless Health Care Team, hotel staff, and a safety team to support and manage the accommodation. Health screening was provided for all residents on arrival and in conjunction with Portsmouth City Council and the voluntary sector, residents were provided with three meals per day. A Hotel Management Group, comprising Housing, Public Health, the commissioned support providers, hotel and safety teams, the Police and the Community Wardens Service, provided oversight.
- 4.16** Approximately 100 people were expected to be housed under "Everyone In" in Portsmouth. Exceptional efforts, however, were made to accommodate 444 people who presented themselves as homeless (this included people who had no fixed abode and were "sofa surfing" as well as people who were street homeless). This was a notable achievement.
- 4.17** The Museum of Homelessness report on the Impact of COVID-19 (Coronavirus) on homelessness published in April 2021 identified that the "Everyone In" project represented an "*internationally significant effort across the UK, from central and local government, charities and community groups to accommodate people who were homeless during the pandemic*"
- 4.18** Three main achievements were identified by the Museum of Homelessness. Only 3% of homeless deaths in 2020 were COVID-19 related; there were formal changes in practices for some local authorities and there was a shift from dormitory provision to individual rooms. In addition, the Museum of Homelessness found that "Everyone In" brought people off the street who had not been accommodated for years and that some homeless people interviewed declared that "Everyone In" had saved their lives and were committing to methadone treatment as a component of being accommodated.
- 4.19** Despite these successes, the Museum of Homelessness found that the number of deaths of homeless people during 2020 had increased by 37%. These were related to several, "*Systemic challenges during the year*", which included:

- A collapse in the supply chain and in services in the early stages of the pandemic, with community groups filling gaps in provision.
- Failings in the provision of accommodation, specifically related to more marginalised people within the homeless population.
- Failures with Street Link – the primary channel for referrals through the year
- Failures of support services when people received accommodation – including around food provision and PPE use.

4.20 The Museum of Homeless also identified that there were, “*Widening inequalities, stigma and isolation*”, which included:

- Counter-productive public messaging about the success of activity from authorities and charities resulting in the abuse of homeless people
- Aggressive enforcement from local authorities and police
- Increased risk to homeless migrant people
- Evidence of an increase in homelessness caused by COVID-19
- Structural problems with homelessness and housing
- Evidence of an increase in deaths of homeless people from factors other than COVID19
- Evidence of spikes in suicides around the lockdowns.

4.21 The accuracy of official figures for the number of deaths of homeless people during the COVID-19 pandemic is acknowledged by the Office for National Statistics (ONS, 2021) to have been affected by difficulties in identifying people as homeless.

4.22 COVID-19 restrictions began to be lifted from 10th May 2020, but local lockdowns were introduced from 29th June.

4.23 Other deaths of homeless people in 2020 in Portsmouth

4.24 Whilst the four people who are the focus of this review were chosen at random, they are, except for gender, representative of the other eight homeless people who are known to have died in Portsmouth in 2020 and of the five who are known to have died in 2019 and the two who had died in 2021 by the time this review began. The following is a breakdown of their characteristics.

4.25 Out of the other fifteen homeless people known to have died, five were women and ten were men. One was Black British, two were White Other and ethnicity was unknown for two. Their average age was 42 years old. The youngest was 21 and the oldest was 60 years old.

4.26 Two had been known to be the victims of domestic violence and abuse, one was known to have been the perpetrator.

4.27 The following table summarises the other demographic characteristics:

4.28 Table 1: *Known characteristics of the other 19 homeless people who died between 2019 and February 2021.*

Known characteristics	Yes	No	Unknown
Alcohol use	9	5	5
Substance Use	7	4	8
Past Trauma	3	4	12
Criminal Justice System Involvement	5	6	8
Change of accommodation	13	5	2
Physical and/ or mental health needs	12	4	3

4.29 The strongest correlation between the sample of four people in this Thematic Review and the other homeless people who died is in a change of accommodation (which may be a result of the “Everyone In” project) and in the presence of physical and mental health problems. Unfortunately, only a little is known about the lives of some homeless people so there may be other similarities which have not been detected.

5. EVIDENCE FROM RESEARCH, PRACTICE AND GUIDANCE AND ANALYSIS OF THESE WITH THE LIFE EXPERIENCES AND CONTACT WITH SERVICES OF Mr G, Mr H, Mr I AND Mr J

5.1 Adverse childhood experiences and the impact of trauma

5.2 There are strong evidential, as well as logical and intuitive, links between child sexual abuse, physical abuse and trauma and the experience in adulthood of mental health problems, excessive use of drugs and/ or alcohol, self-neglect and chaotic and abusive personal relationships (Lewis et al, 2021; Maniglio, 2019; Greenfield, 2010). These traumatic events in childhood are often referred to, somewhat euphemistically since the term barely captures their extremely disturbing nature, as adverse childhood experiences (ACE) (Felitti et al, 1998).

5.3 ACEs include growing up in a household with someone who has mental health needs, misuse substances or has been incarcerated in the criminal justice system. They include exposure to child maltreatment or domestic violence and losing a parent through divorce, separation or death (WHO, 2012).

5.4 Exposure to such ACEs has been associated with poor health outcomes including substance use, mental ill-health, obesity, heart disease and cancer, as well as unemployment and continued involvement in violence.

5.5 Importantly, the impact of ACEs appears to be cumulative, with risks of poor outcomes increasing with the number of ACEs suffered. Significantly, people who have been exposed to multiple ACEs are more likely to die at a young age from natural causes, suicide or homicide (Bellis et al, 2013).

- 5.6** Both Mr G and Mr J reported traumatic childhood experiences. Although these do not appear to have been explored in depth, the research evidence suggests that they are likely to have impacted negatively on their adult lives. Mr G and Mr J do not appear to have accessed services to support them with the effects of trauma.
- 5.7** Not everyone who has experienced trauma will be affected by it in the long term. However, there is considerable practice and research evidence that people with a history of trauma struggle to engage with the services that try to help and support them. Of the two men known to have suffered childhood trauma Mr G was described as hard to engage with services. Mr J was keen to join activities offered by the Recovery Hub, but these were not available because of the COVID-19 lockdown.
- 5.8 Adult experiences and themes connecting Mr G, Mr H, Mr I and Mr J**
- 5.9 Non-engagement with services**
- 5.10** The 2020 East Sussex Safeguarding Adults Board safeguarding adults review following the death of Adult C, found that, *“Current service set ups locally are not joined up or tailored to the needs of a small cohort of women who struggle with a combination of needs related to chronic trauma, drug and alcohol dependencies, homelessness and domestic violence and abuse. This leaves some of the most vulnerable women either excluded from services altogether based on eligibility criteria, or unable to access them because of the lack of proactive, flexible and intensive outreach support”*. It is likely that this finding can be applied to the men in this Portsmouth Thematic Review too.
- 5.11** Other Safeguarding Adults Reviews (for example, the Thematic Review following the deaths of four women, West Sussex Safeguarding Adults Board, 2022; the Safeguarding Adults Review following the death of Adult D, London Borough of Camden, 2022; Mary and Graham, Leicester Safeguarding Adults Board, 2019) have identified the challenge faced by services when working with hard to engage, or “involuntary”, clients. These reviews highlighted that services often waited for periods of stability or for a spontaneous change in engagement. Unfortunately, these opportunities rarely arose and instead, people who found it difficult to engage with services, to attend meetings or to comply with requirements were discharged from the services that might support them.
- 5.12** The report Alcohol Change UK report, “Safeguarding Vulnerable Dependent Drinkers England and Wales (Ward and Preston-Shoot) states that, *“if a person is vulnerable, at risk of abuse and neglect (including self-neglect) or having a significant impact on the community, it is unhelpful, if not self-defeating, to require someone to leap a hurdle like attending an appointment with a stranger in a distant part of town. Assessment structures need to accommodate the difficulties faced by the client rather than be convenient for the worker. In particular, assessment should not be seen as a point in time, but rather as a process whereby services work with someone to enable an assessment to be undertaken. Without a process focus, services will fail the most challenging clients”*.

- 5.13** While two of the men, Mr H and Mr J, were motivated to engage with services, Mr G and Mr I were described as difficult to engage. For example, Mr I was referred by his GP to the Single Point of Access in January 2018. Mr I did not attend his scheduled assessment appointment with the service in February 2018 and did not respond to attempts to contact him by telephone. Mr I was then sent an 'opt-in' letter on 21st February 2018, but did not respond to it, and was therefore discharged from the service on 28th February 2018.
- 5.14** Even though Mr J appeared to be motivated to engage, there was a reliance on him to contact services, which failed, for example, when Mr J did not remake contact with SSJ member Alcohol Specialist Nurse Service (ASNS) (the alcohol team at Queen Alexandra Hospital) after June 2020.
- 5.15** The practice of discharge following missed appointments does not fit well with people who behave in a chaotic way because of their traumatic life experiences and is a factor that has been identified in other Safeguarding Adults Reviews and in published guidance.
- 5.16** The Blue Light Project Manual (Alcohol Concern 2014), for example, challenges the assumption that if the person who uses substances does not want to change, or does not believe that change is possible, no treatment programme is likely to yield positive results and that there is little that services can do to help them. The Manual sets out alternative approaches that can be used with this client group, including motivational and harm reduction interventions built around assertive outreach and multi-agency working.
- 5.17** There was one reference to assertive outreach with Mr I, when he was sofa surfing. There are no other references to assertive outreach for any of the other three men, although there were some attempts to engage with them before referrals were closed or services were shut down because of the COVID-19 lockdown.
- 5.18 The false conflict between freedom and protection**
- 5.19** Most of the contacts with Mr G, Mr H, Mr I, Mr J took place within a policy context that emphasises choice, independence and personal control (essentially the Article 8 Rights set out in the European Convention on Human Rights) and which form part of an overall neo-liberal approach to adult health, social care and welfare (Ward et al, 2020).
- 5.20** Safeguarding Adults Reviews (amongst others Adults B and C, South Tyneside; Mr I, West Berkshire and W, Isle of Wight) have increasingly focused on the challenges of practicing in a way which balances the principles of freedom of choice and self-determination with the duties, public expectations and moral imperatives of public services. These take place within a legislative framework which includes the Human Rights Act 1998, the Care Act 2014, the Mental Capacity Act 2005 and the Mental Health Act 1983.
- 5.21** At the intersection of all these factors is the question of the extent to which adults should be left by public services to behave in a way that is objectively detrimental to their health and wellbeing, or which threatens their lives. More fundamentally it is question of prioritising freedom of choice or prioritising

protection from harm (essentially Article 2 of the European Convention on Human Rights).

5.22 Self Neglect

5.23 There was a recognition that Mr I might be self-neglecting, but this was not identified for Mr G, Mr H and Mr J. Despite this, guidance on working with people who self-neglect is relevant since it provides insights into approaches to working with people who can be hard to engage.

5.24 Self-neglect is one of the ten categories of abuse and neglect specified in the adult safeguarding sections of the Care and support statutory guidance. Self-neglect can be defined as, “*the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well-being of the self-neglector and perhaps even to their community*” (Gibbons et al, 2006, p.16).

5.25 There is extensive research into and guidance on working with people who self-neglect, which was available during the time period for this Review. For the purposes of this Review, it is sufficient to focus only on a summary of this guidance. Practice with people who self-neglect is more effective where practitioners:

- Seek to understand the meaning and significance of the self-neglect, taking account of the individual’s life experience
- Work patiently at the pace of the individual, but know when to make the most of moments of motivation to secure changes
- Keep constantly in view the question of the individual’s mental capacity to make self-care decisions
- Communicate about risks and options with honesty and openness, particularly where coercive action is a possibility
- Ensure that options for intervention are rooted in a sound understanding of legal powers and duties
- Think flexibly about how family members and community resources can contribute to interventions, building on relationships and networks
- Work proactively to engage and co-ordinate agencies with specialist expertise to contribute towards shared goals

5.26 To do this, the following approaches should be used:

- History taking. Explore and ask questions about how and when self-neglect started.
- Be proactive and identify and address repeated patterns of behaviour

- Try different approaches, use advocates and concerned others, raise concerns, discuss risks, maintain contact, avoid case closure
- Ongoing assessment review of mental capacity.

5.27 Substance Use, Mental Capacity and Lifestyle Choice

5.28 The Mental Capacity Act sets out the process for assessing and determining whether or not someone with an “*an impairment of, or a disturbance in the functioning of, the mind or brain*” is able to make a specific decision at a specific time. Impairments and disturbances in functioning can include drug and alcohol use and addictions to them.

5.29 Mr G was assumed to make mentally capacitous decisions, even though the results of these decisions were potential harmful to him.

5.30 The guidance on working with people who self-neglect helpfully challenges the either / or nature of the question of the right to protection and the right to autonomy by asking practitioners to consider:

5.31 Is a person really autonomous when

- They do not see how things could be different.
- They do not think they are worth anything different.
- They did not choose to live this way, but adapted gradually to circumstances
- Their mental ill-health makes self-motivation difficult.
- They have impairment of executive brain function.

5.32 Is a person really protected when:

- Imposed solutions do not recognise the way they make sense of their behaviour.
- Their 'sense of self' is removed along with the risks.
- They have no control and no ownership.
- Their safety comes at the cost of making them miserable.

5.33 Decisional and Executive Capacity

5.34 Whilst the Mental Capacity Act does not explicitly recognise the difference between decisional capacity (the ability to make a decision) and executive capacity (the ability to turn that decision into action), it is an important distinction in practice.

5.35 There is growing evidence of the impact of both long-term trauma and of alcohol and substance use on cognitive ability and especially on executive brain function (which includes working memory, mental flexibility, and self-control and regulation) which in turn impacts on mental capacity. Approximately 50% of dependent drinkers have frontal lobe damage; another reason for practitioners to be thorough in carrying out mental capacity assessments. Of

particular relevance is that, compared with control groups, people with frontal lobe damage caused by alcohol use and traumatic experiences:

- Are significantly slower and less accurate at problem solving when it involves planning ahead.
- Persisted with riskier behaviours for longer and were less responsive to negative outcomes.
- Were no different when identifying what the likely outcome of an event would be.

5.36 As a result, people with frontal lobe damage caused by alcohol use and traumatic experiences might have the mental capacity to predict what might happen but are less likely to be able to take action to prevent it from happening. Significantly, these cognitive deficits are unlikely to be detected using the verbal reasoning tests frequently used in mental capacity assessments.

5.37 The report Alcohol Change UK report, “Safeguarding Vulnerable Dependent Drinkers England and Wales (Ward and Preston-Shoot) identifies that at times dependent drinkers may be wrongly believed to have mental capacity to make decisions about their safety, for example. The Mental Capacity Act defines the ability to make a decision requires that a person can understand information about the decision to be made, retain that information in their mind, use or weigh that information as part of the decision-making process, or communicate their decision. If a person is unable to do at least one of these, then they are unable to make the decision.

5.38 However, for dependant drinkers, “*their compulsion to drink means that they are unable to use the information they are given, even if they understand it*” (Ward and Preston-Shoot). Cognitive impairments caused by long term alcohol and drug use are often not recognised.

5.39 The Alcohol Change Report also highlights that a long-term view should be taken when assessing capacity, which includes the history of decisions that a person has made, based on the lack of understanding of risks, or inability to weigh up information. The approach described by Alcohol Change UK is to consider mental capacity as a “video” rather than as a “snapshot”. This recognises that all interventions need to be within the context of an understanding that people addicted to substances will often not have the mental capacity to make free decisions that are unaffected by the controlling and coercive influence of their addiction.

5.40 All four men had a history alcohol and/or drug misuse. There are references to mental capacity for two of the men: Mr G on five occasions was considered to have capacity to make decisions against medical advice. On the one occasion in which mental capacity was noted for Mr J, the conclusion was that he did not have capacity because he was intoxicated at the time.

5.41 On 23rd December 2019, Mr G was brought into the Emergency Department (ED) via ambulance with a reported head injury. Mr G discharged himself. The hospital completed a mental capacity assessment, which deemed Mr G to have

capacity to make an informed decision regarding his treatment. The risks of self-discharge were explained to Mr G, documented, and witnessed by two members of staff. It is not clear from the documentation provided to the SAR author if Mr G was intoxicated at the time, or whether the hospital was aware that Mr G had problems with alcohol dependency.

- 5.42** On 26th December 2019, Mr G attended the ED alleging that he had been assaulted four days previously. X-rays were taken and multiple fractures to Mr G's ribs were identified. Mr G required a surgical chest drain and was admitted to QAH for ongoing monitoring and pain relief. Mr G discharged himself on 31st December 2019, against medical advice, following several episodes of verbal aggression towards staff and after consuming alcohol on the ward with his current partner. The hospital noted that Mr G was deemed to have the capacity to make an informed choice about the risks of discharging himself against medical advice. It was clear that Mr G had been drinking. There does not appear to have been any consideration of whether Mr G's drinking affected his ability to make capacitous decisions.
- 5.43** On 8th January 2020, Mr G attended the ED at QAH via ambulance. Mr G was reported to be intoxicated with alcohol and presented with a head injury, reporting that he had hit his head on a door frame. Mr G refused care and treatment. The hospital deemed that Mr G had mental capacity and gave advice to Mr G to return to the ED if there was any change in how he felt. Mr G discharged himself from the hospital and went back into police custody. Again, it is clear that Mr G was intoxicated, but that does not seem to have been considered in the mental capacity assessment.
- 5.44** On 23rd January 2020, Mr G attended the ED at QAH with a suspected opiate overdose. He received some treatment and left, but was admitted to a ward later that day. On 25th January 2020 Mr G repeatedly threatened to discharge himself if he was not given diazepam. Mr G said that he would "throw himself on the railway tracks". Hospital notes document numerous attempts by medical staff to offer support and help to Mr G. Advice was sought from the Mental Health Liaison Team (MHLT) because Mr G was known to Elmleigh Hospital (an Acute Mental Health Crisis Hospital). The hospital completed and documented a mental capacity assessment, which deemed Mr G to have capacity to make decisions about his care, support and treatment needs, and noted that he could self-discharge if he chose to.
- 5.45** On 30th March 2020, Mr G attended ED with a wound to his arm. Medical staff explained the risk of not having treatment, which included the risk of losing his arm. Mr G reportedly said, "I don't care if I die", and discharged himself against medical advice. The hospital deemed that Mr G had the capacity to make this decision.
- 5.46** Conversely on 17th May 2020, Mr J attended the ED at QAH, having been found by a member of the public. He was reported to have been intoxicated. Upon admission he was verbally aggressive and refused all investigations. Medical staff acted in Mr J's best interests since he was deemed to lack mental capacity to make decisions about his care, support and medical needs due to alcohol intoxication. Medical staff administered intravenous fluids and made observations. It is not clear why Mr J was treated differently from Mr G.

5.47 It does not appear that Mr H and Mr I's mental capacity was assessed in any of their contacts with services. Whilst a principle of the Mental Capacity Act is the presumption of capacity unless demonstrated otherwise, there were opportunities when a capacity assessment might have been useful. Examples include when appointments were not attended, and there were repeating patterns of behaviour.

5.48 There does not appear to have been an operational understanding of the impact of substance addiction upon decision making, particularly for Mr G, Mr H and Mr I. Their dependence on alcohol and drugs could have been considered to have a coercive and controlling influence on their mental capacity, even when they were sober. This approach is promoted by the Alcohol Change UK December 2020 report, "Safeguarding Vulnerable Dependent Drinkers".

5.49 Housing and Homelessness

5.50 There is substantial, as well as intuitive, evidence that the well-being of both individuals and families is substantially affected when the need for satisfactory housing is not met. According to the United Nations (UN) Committee on Economic, Social and Cultural Rights, satisfactory housing consists of: legal security of tenure; availability of accessible services, facilities and infrastructure; habitability; accessibility (e.g. access to employment, health services, schools, etc); cultural adequacy; and affordability.

5.51 The Homelessness Reduction Act 2017 requires that local authorities must offer early intervention and prevention to avoid homelessness, must assess housing need, offer advice and information, work with other agencies and develop personalised housing plans. Mr G, Mr H, Mr I and Mr J were all in intermittent contact with housing services but appear to have remained living without any form of security or stability.

5.52 Mr G had lived at the same address as his partner, but after altercations, and DVPN and time in prison, Mr G used the Night Service (managed by SSJ) on 29th and 30th March 2020 and another night service managed by Two Saints on 31st March and 1st April 2020. Mr G moved to a hotel on 2nd April 2020 when the Night Service was relocated in response to the COVID-19 pandemic. Following enquiries with Mr G's GP, a decision was made that no statutory housing duty was owed under the 1996 Housing Act on 18th March 2020. There was no further contact with the Housing Needs Advice and Support service.

5.53 Mr H, who did not stay in a hotel, had completed the ANA Treatments Centre recovery programme and returned to his homeless hostel accommodation. He did not want to return there because he was trying to remain drug free.

5.54 Mr I accessed the Portsmouth Night Bed Service on six occasions between 18th December 2019 and 7th January 2020. Mr I then accessed Night Beds continuously between 8th January 2020 and 5th February 2020 except for two nights. Mr I sofa-surfed with a friend for a couple of months, who then told him to leave, and he was placed at a hotel as part of "Everyone In".

- 5.55** Mr J had lived at his sister's address, but had to leave due to his drinking and non-compliance with lockdown rules. It appears the Mr J then moved in with another person, but in the last weeks of his life was living rough in the grounds of the library.
- 5.56** Housing is also included in the Wellbeing Principle, set out in section 1 of the Care Act 2014, and the provision of suitable accommodation should be considered when making decisions about care and support needs (Ch.15 of the Care Act statutory guidance). Meeting a housing need, however, does not mean that care needs are met (s.23, Care Act 2014).
- 5.57** There is a strong interrelationship between mental health and homeless, such that housing can be considered to be "foundational" to good mental health and wellbeing (Padgett, 2020). Without stable and secure housing, other efforts to support people with their mental health needs, their drug and alcohol use, their chaotic and dangerous behaviours are unlikely to be successful.
- 5.58** Homelessness is also often combined with other problems in living. Multiple Exclusion Homelessness is the term used to describe people who have been homeless (including the experience of temporary, unsuitable accommodation as well as sleeping rough) and who have also experienced one or more of the following additional domains of social exclusion:
- 5.59** Institutional care (prison, local authority care, psychiatric hospitals or wards); or
- 5.60** Substance misuse (drug problems, alcohol problems, abuse of solvents, glue or gas); or
- 5.61** Participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work).
- 5.62** People who meet this definition are likely to be homeless for longer, have escalating health and care needs and have a reduced life expectancy compared with other homeless people who do not have multiple exclusions.
- 5.63** Given what is known of Mr G, Mr H, Mr I and Mr J's substance misuse and life experiences it would seem that they met the definition of Multiple Exclusion Homelessness.
- 5.64** The "Everyone In" project developed overtime and took homeless people off the street and from other temporary or unsuitable accommodation to protect them from Covid-19. People were accommodated in two hotels. Despite the great success in housing homeless people, practitioners and homeless people identified that this also meant that they were brought together with each other and were surrounded by other chaotic people with serious problems (including physical and mental health needs; drug addictions; violent behaviours etc). Some homeless people were also taken away from their familiar environments.
- 5.65** As a result of the unprecedented level of demand it was sometimes difficult to practice a therapeutic environment in the hotels due to the number of residents and the capacity of staff. Practitioners argued that a therapeutic environment was an essential component of any effective intervention with homeless

people. Just putting roofs over people's heads was insufficient and a trauma informed approach, which placed clear boundaries on behaviours, was required.

- 5.66** Unless this was done, there was a risk that hierarchies could be established in which bullying, coercion and control and violence often featured. People with significant physical and mental health needs were housed with people with extensive criminal histories who were still involved in crime. Several homeless people carried weapons (usually knives).
- 5.67** Some people had come forward to report themselves as homeless and had previously been staying with friends but did not have a background of street homelessness. Some practitioners considered that the milieu in the hotels was unsafe for these people so that they were quickly moved on. This revealed an environment which created an alternative definition of "vulnerability", in which people who had not experienced institutions and street homeless were identified to be more at risk than those who had.
- 5.68** Mr G, Mr I and Mr J were accommodated in hotels, but it appears that Mr J did not stay there. The findings from the interviews with and questionnaires completed by homeless people was ambiguous and reflected the different personal circumstances and experiences of those who participated. For example, three questionnaire respondents who did not want to be interviewed said that they had also been accommodated in hotels. Of these, one said that they had felt safe there whilst the other two said that they felt unsafe but all reported that they had received some support from staff. Of the small sample of four homeless people interviewed face to face, two said that they stayed at a hotel and said that it had been worse than staying at a hostel for homeless people. They said that support staff working at the hotels were often too busy to provide help. A further seven questionnaire respondents, one of whom was also interviewed, had stayed in homeless hostels rather than in hotels. Three said that they had felt safe whilst three had not and one had felt safe at times. Six said that they had felt supported.
- 5.69** These concerns must be set within a wider context, however. Covid-19 was an unknown, unpredictable, and dangerous threat and services made tremendous efforts to adapt to it in the face of restrictions, staff illness and isolation and changing guidance. Accommodation became limited and options, including hotels, reduced as they closed in response to Covid-19. The "Everyone In" project resulted in closer liaison at a strategic leadership level between adults social services and housing services, including regular meetings between directors and the consensus was that the environment of cooperation and joint working had improved beyond the pre-Covid level.
- 5.70** The challenges faced by homeless people were also not just confined to the services provided as a result of "Everyone In". Pressure to conform and take drugs can have an impact of homeless people in any shared accommodation. Mr H, for example, who did not stay in a hotel, had completed the ANA Treatments Centre recovery programme did not want to return to his homeless hostel accommodation since he was trying to remain drug free. Practitioners identified that the only accommodation where abstinence was enforced was that accessed through the criminal justice system. Any other accommodation in

which homeless people were supported might include people who were using drugs or alcohol. There are practical reasons for this: making licence agreements contingent upon abstinence increases the number of homeless people who are evicted only to be offered accommodation again. This “revolving door” is known by practitioners to be disruptive, wasteful and to undermine therapeutic relationships.

5.71 Practitioners were unaware of any accommodation for those who have completed recovery programmes and were committed to remaining drug and alcohol free. However, Mr H had talked of his desire to relocate to Bognor Regis in order to access the Sands Project, which does appear to be for people who are abstinent. It is not clear why he was not supported to achieve his desire. Lockdown may have made this more difficult.

5.72 There has, however, been significant development in the services provided. Following a successful Portsmouth City Council led bid to the Department for Levelling Up Housing and Communities, moves of formerly homeless people into more settled housing was progressed. Throughout August and September 2020, residents assessed as having lower support needs moved into shared housing in the private rented sector or into properties leased to provide 'move on housing'. On 15th September 2020 residents assessed as needing more supported housing moved into new accommodation in the Rough Sleeping Pathway. The Pathway comprised of three buildings, formerly student accommodation, totalling 105 units of housing. The buildings were initially leased and subsequently purchased by Portsmouth City Council. The two commissioned services continued to work together to provide support whilst the new service was commissioned.

5.73 The three buildings form a Pathway with an intensive support property and medium support property, both of which are staffed 24 hours a day, 7 days a week. A third property is for individuals with lower support needs and has visiting support. It is a temporary Pathway for rough sleepers and those at risk of rough sleeping, with flexibility for people to enter and move within the Pathway according to their level of support need. There is a full time social work post funded to work within the Pathway. There is also support from services commissioned by Public Health providing recovery support, psychology support, a mental health worker, health care services and wellbeing services.

5.74 Working in conjunction with Housing, residents move on from the Pathway into more settled housing either within existing commissioned services or to private rented housing. There is a Rough Sleeping Hub which provides advice, support and practical help for rough sleepers in the day and an Outreach Service engaging with individuals at their rough sleeping locations in the city. This service was subject to a tender process, and the contract for the newly commissioned service commenced on 1st October 2021.

5.75 Lockdown, isolation and services

5.76 The “lockdown” in response to the Coronavirus pandemic also led to the closure of support services (including homeless day centres), safe places (libraries etc) and a lack of distractions from drugs and alcohol. One person

interviewed said that they had wanted to attend Recovery College but that it was closed. Some people, afraid of Covid-19, stayed in their rooms.

- 5.77** Homeless people said that there was nothing to do and nowhere to go during the “lockdown”. Access to mental health services and counselling were also severely limited. Out of twelve returned questionnaires, seven homeless people identified difficulties accessing GPs and two identified difficulties accessing dentists. Problems included not being able to see doctors in person and doctors not visiting, difficulties in obtaining medication, and having to wait 6 months for an appointment.
- 5.78** Staff were self-isolating, in accordance with government guidance, reducing the number of staff available to meet increasing demand. This included providing food for clients who were also self-isolating. Face-to-face contact decreased yet demand for services, sometimes to replace those that had been closed or limited by other agencies’ responses to coronavirus, increased.
- 5.79** Practitioners also referred to the impact of the stigma of homelessness and drug and alcohol use, especially upon health service use. Homeless people had refused treatment because they did not like how they had been treated and had felt blamed for their health needs (such as the treatment of infected injection sites). In some cases, homeless people had refused to even attend. Some homeless people also mentioned that they had felt more identifiable as homeless when they were living together in the hotels. There were, however, no mentions of unfriendly encounters with the public like those included in the Museum of Homelessness Report.
- 5.80** The closure of, and restrictions, on services affected people who were keen to engage with services. Mr J and Mr H were described as ‘motivated to engage’. Mr J was keen to join the group activities offered through the Recovery Hub and Mr H had completed the recovery programme. Neither was not able to attend further sessions due to the lockdown.
- 5.81** These closures and restrictions may have also affected people who were harder to engage, but the evidence is more ambiguous. Mr G was described as unwilling to engage with services for substance misuse and alcohol dependence and Mr I was described by practitioners as “hard to engage”. Practitioners reported, however, that there were some benefits from the replacement of face-to-face meetings with telephone appointments, which were noted to have been useful for chaotic clients.
- 5.82** To an extent separate from this, there were concerns about Mr I’s physical health and delays in taking him to hospital. No safeguarding concerns were raised about him due to his apparent self-neglect, which does not appear to have been recognised at the time.
- 5.83 Drugs and alcohol supply**
- 5.84** The only “services” still available were those offered by drug dealers who greatly appreciated having their customers gathered in one or two places rather than dispersed throughout the city.

- 5.85** All four people in this review were drug and/ or alcohol dependent for which they had received treatments and interventions but, as far as is known, were continuing to use until their deaths.
- 5.86** Homeless people said that the three most common drugs were Spice, which some believed had become stronger, heroin and crack cocaine. Of these, the malevolent effects of Spice and the desire to be free from it were referenced most frequently. Whilst from the perspective of homeless people and of practitioners, the availability and the range of drugs on offer appears to have increased during lockdown, it was difficult to obtain a clear picture from homeless people about the extent to which being served by different dealers affected the strength and purity of drugs. Practitioners, however, considered that this may have been a factor in the deaths of homeless people. Mr H, for example, appears to have been abstinent for some time prior to dying from a drug overdose and this may have been a consequence of a change in drug strength and a reduction in his resistance to it. It appears that some effects are continuing to have an impact in 2021. According to the homelessness lead nurse at Queen Alexandra Hospital, there were more admissions for drug overdose after “lockdown” than during it.
- 5.87** Some changes, however, were more positive. Practitioners also identified that there were some therapeutic advantages in that methadone monitoring by support staff had improved since methadone was delivered reliably rather than collected by the people who used it.

6. Summary.

- 6.1** Mr G, Mr H, Mr I and Mr J shared several similarities in their backgrounds. Mr G and Mr J were known to have experienced childhood trauma, which in Mr G’s case included sexual and physical abuse. Mr I and Mr H’s backgrounds are less well understood but the research and practice evidence would suggest that they are also likely to have survived traumatic experiences.
- 6.2** These adverse childhood experiences appear to have impacted on Mr G and Mr J in a way that is predicted by the research evidence since they and Mr H and Mr I’s adult lives which involved violence, loss, physical assaults, homelessness, unstable and temporary housing, mental health problems, self-harm and suicide attempts, drug and alcohol use and a lack of safety in their homes.
- 6.3** Mr G, Mr H, Mr I and Mr J struggled to engage with services and services struggled to find ways to engage with them.
- 6.4** Mr G, Mr H, Mr I and Mr J appear to have been assumed to have the mental capacity to make decisions about their welfare and safety, but given what is known of their backgrounds, life experience and use of alcohol and drugs, this may not always have been the case.
- 6.5** The specific circumstances of Mr G, Mr H, Mr I and Mr J’s contact with services during the last months of their lives were affected in various ways by the COVID-19 pandemic and the introduction of the lockdown in response to it. Services closed or access to them was restricted, homeless people were

brought into accommodation as part of “Everyone In” but this sudden change overwhelmed the ability of services for homeless people to manage their needs.

- 6.6** Whilst extraordinary efforts were made to house people safely, the bringing together of homeless people in large groups as part of “Everyone In” also appears to have placed people with significant levels of different needs together. This increased both the risk of harm and demands on services at a time when they faced capacity problems due to the pandemic.

7. Learning and development opportunities

- 7.1** The following learning and development opportunities were identified during the review. These include areas for development by single agencies.
- 7.2** There are several areas for development in the provision of health services for homeless people. For example, Queen Alexandra Hospital does not routinely record whether patients are homeless, which can lead to difficulties in identification and in prioritising interventions for them. This is also significant since, whilst the South-Central Ambulance Service works across 16 Safeguarding Adults Board areas, the Portsmouth area has the most ambulance call outs for homeless people (**Recommendation 8.2**)
- 7.3** There is also a need to strengthen community mental health support for homeless people. For example, the community mental health team that works with homeless people and visits street homeless people, lost its GP member from April 2021 onwards. Developments are already underway, however and a new peer crisis team is being piloted to facilitate timely crisis support. A new complex needs team is also now in place, which could have supported clients like the four homeless people in this thematic review.
- 7.4** Supported accommodation for homeless people is not commissioned to provide high levels of support, so there is a need for a cohesive approach between housing, homeless services, social services and health services to meet the wide range of needs presented by homeless people (**Recommendation 8.3**).
- 7.5** Support services for homeless people were described by practitioners as hard to navigate. Some homeless people become used to not getting what they want and therefore do not contact services, are easily put off or have low expectations of the help that can be provided (**Recommendation 8.4**).
- 7.6** This is compounded by the low status of services for homeless people and there are misapprehensions and misunderstandings about roles, responsibilities, and powers between voluntary and statutory organisations. It can also be difficult to identify what services are available. Services for homeless people are fragmented with multiple providers. Practitioners identified a need for a directory of services and the need to increase the familiarity of staff with the services available. This perception is being responded to by the enabling SSJ workers, for example, to be trusted assessors who can make assessments under the Care Act (**Recommendation 8.4 and 8.5**).

- 7.7 The impact of long-term alcohol and drug use on mental capacity, either because of the coercive and controlling influence of addiction, or through cognitive impairment needs to be recognised in assessments of mental capacity. Services such as CABIS (Sunderland and Gateshead Community Acquired Brain Injury Service) operate a flexible model of engagement for people who find it hard to comply with the demands of other therapeutic services and may provide ideas that could be developed in Portsmouth. Similarly, the Plymouth Creative Solutions Group provides a model for senior managers to lead on coordinating and managing interventions with people who are hard to engage (**Recommendations 8.6**)
- 7.8 Links with the criminal justice system could also be improved. Prisons have a statutory obligation to refer homeless people to housing services before their release but providers such as the Society of St James do not always have good information about clients when they leave prison to enable them to manage risks. Some people are released from prison with little notice. Some prisons have employed housing specialists but there is a need for improved coordination with the Probation Service, for example (**Recommendation 8.7 and 8.8**)
- 7.9 Housing for people who are abstaining from using drugs and alcohol is only available through the criminal justice system, as part of a condition of release from prison. Due to the need to reduce evictions for relapsing into drug and alcohol use, support providers do not otherwise require abstinence. As shown by Mr H's case, this risks exposing people who have completed recovery programmes and want to remain drug and alcohol free to other people who are still using them (**Recommendation 8.10 and 8.11**)
- 7.10 The Centre for Homelessness Impact "What Works Evidence Notes 01 Drugs and Alcohol" (2021), highlights a range of service models including MAPS (Managed Alcohol Programmes) to stabilise drinking patterns and reduce the use of liquids containing alcohol which are not meant for consumption and Supervised Consumption Facilities to reduce the risk of, monitor and control the use of alcohol and other drugs. Housing led interventions such as therapeutic communities and approaches such as Intentional Peer Support and Intensive Care Management offer alternative ways of meeting the needs of people who use drugs and alcohol may provide options for further research and development in Portsmouth (**Recommendation 8.10 and 8.11**)
- 7.11 The four homeless people interviewed and the seven who completed the questionnaire but did not agree to be interviewed, also identified the need for more support from GPs for example, to be listened to and respected, easier access to housing and other services and more personal care and face to face support (**Recommendation 8.12**)
- 7.12 Homeless people are often estranged from their families, but as in the case of both Mr I and J, family members had tried to support them. A "Think Family" approach might help to support engagement, risk assessment and family support. This approach builds the resilience and capabilities of families to support themselves (Wong et al, 2016) and recognises that individuals rarely if ever exist in isolation and that whole-family approaches are often necessary to

meet individual and family wide needs. The core principles of the "Think Family" approach are that practitioners (**Recommendation 8.12 and 8.13**):

- Consider and respond to the needs of the whole family; including the poverty, drug and alcohol use, domestic abuse and mental health difficulties of everyone in the home (including frequent visitors) in all assessments and interventions
- Work jointly with family members as well as with different agencies to meet needs
- Share information appropriately according to the level of risk
- Escalate concerns if they are not otherwise being responded to.

7.13 Family members could also be offered Carer's Assessments under the Care Act. These could assist family members to have their own needs for support met to better enable them to support their homeless relatives (**Recommendation 8.12 and 8.13**)

8. Recommendations

8.1 Building on the learning points set in section 7, the following recommendations are made:

8.2 Health services should routinely record the homelessness to assist in identifying and prioritising interventions to improve the health of homeless people (**L&D 7.2**)

8.3 Commissioners of services for homeless people should review the levels of support available in accommodation-based services and ensure that these services can meet the wide needs of homeless people (**L&D 7.4**)

8.4 Commissioners (local authority, NHS and public health), and homelessness service providers (both statutory and commissioned) in Portsmouth should identify joint working opportunities to adapt their services to make them easier for homeless people to engage with, based on the principles identified by Alcohol Change UK. (<https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf>) and in the Blue Light Manual (<https://alcoholchange.org.uk/help-and-support/get-help-now/for-practitioners/blue-light-training/the-blue-light-project>) These include creating a directory of services, training specialist and non-alcohol specialist staff in the Blue Light approach (Take every opportunity; Not everyone will change; Change is not the only option; use a whole system and holistic approach; record unmet need and learning lessons); developing a multi-agency operational group to ensure a joint identification and ownership of the highest impact clients, developing assertive outreach approaches by designing and evaluating services, improving the response of local alcohol services through staff training and pathway development (**L&D 7.5 and 7.6**)

- 8.5** The Portsmouth Safeguarding Adults Board should continue to monitor the number of deaths of homeless people in Portsmouth. The Board should bring the need for longer term funding for rough sleeping and homelessness services and the need for long term rather than short term service provision to the safeguarding adults board chairs' network to raise the profile of homelessness services with central government and the need to recruit, retain and professionally develop skilled staff. **(L&D 7.6)**
- 8.6** The PSAB should seek assurance that workforce development plans address the need for staff to understand the Mental Capacity Act, and the assessment of mental capacity particularly for adults who are dependent on drugs or alcohol. **(L&D 7.7)**
- 8.7** Homelessness service providers (both statutory and commissioned) in Portsmouth, the Probation Service and Hampshire Police should agree a process for sharing information about risk and accommodation needs before release from prison. This should form part of prison release planning and should also include sharing information on potential domestic abuse risk. **(L&D 7.8)**
- 8.8** The PSAB should raise the need to agree a process for sharing information about risk and accommodation needs before release from prison with the Prison Service at national level **(L&D 7.8)**
- 8.9** PSAB should seek assurance across all services that the Duty to Refer under the Homelessness Reduction Act 2017 (<https://www.gov.uk/government/publications/homelessness-duty-to-refer/a-guide-to-the-duty-to-refer>) is understood and that workforce development plans (including legal literacy, think family, trauma informed approaches) are in place to equip staff to identify, support and refer on homeless people. **(L&D 7.8)**
- 8.10** The PSAB should lead the development of a multi-agency forum to explore what can be done to improve access to, and expand, service options (wet/ dry accommodation etc) and how to use resources most effectively. **(L&D 7.9 and 7.10)**
- 8.11** Homelessness service providers in Portsmouth which support homeless people who are substance dependent but want to recover and commissioners should review the opportunities for supporting people who have successfully completed recovery programmes to remain abstinent and to have move on plans in place before treatment begins so that there is a seamless follow on between recovery and abstinence. **(L&D 7.9 and 7.10)**
- 8.12** The PSAB should seek assurance that services have put plans in place to identify and reduce barriers to accessing services for people experiencing multiple disadvantage **(L&D 7.11)**
- 8.13** Services that work with homeless people should implement "Think Family" approaches to maximise the support options available for homeless people and to offer Carer's Assessments to family members to assess their support needs to better enable them to support their homeless relatives **(L&D 7.12 and 7.13)**

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