Milton Keynes Safeguarding Board

Safeguarding Adult Review

Overview Report

Adult B

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Independent Report Author: David Byford

MKSB Independent Chair: Jane Held

A Milton Keynes Safeguarding Board Commission

Contents

Chapter 1

Overview Report

1 Introduction and Executive Summary

1.1 Introduction

1.2 This Safeguarding Adult Review (SAR) was commissioned by the Milton Keynes Safeguarding Board (MKSB) for Adult B, a 33-year-old homeless male who died of hypothermia, in February 2016 on the streets of Milton Keynes. He was an alcohol and illicit substance misuser who, three months prior to his death, had been diagnosed with Autism.

1.3 His death was referred by the Milton Keynes Adult Safeguarding Team Manager to the Adult Case Review Panel for a SAR consideration in November 2017. This followed a Coroner's hearing held for Adult B earlier in the month after which, the HM Coroner's Office wrote to Milton Keynes Council (MKC) Chief Executive, asking for the death to be reviewed.

1.4 The Coroner requested MKSB to consider the following for Adult B: -

- Lack of support or assessment of need following his autism diagnosis or referral for such.
- Lack of inter-agency response and communication.
- Lack of professionals or safeguarding meetings.

1.5 Background

1.6 Adult B was a vulnerable homeless adult who lived on the streets of MK for more than ten years. He was well known to Milton Keynes Council Adult Social Care (ASC), South Central Ambulance Service (SCAS), Milton Keynes University Hospital (MKUH), YMCA, British Transport Police, (BTP), Thames Valley Police (TVP), Compass, (Alcohol and Drugs Service provider) Thames Valley CRC (Probation) and other community services over a number of years. Adult B regularly approached MKC, hostels and homeless projects for help.

1.7 Adult B's life was complex. He had a tragic childhood; losing his mother at a young age and later witnessing his father commit suicide when a teenager.

1.8 He had a known history of not being able to maintain Local Authority tenancies, alcohol dependency and substance misuse including New Psychoactive Substances (NPS). He was subject to an Anti-Social Behaviour Order (ASBO) at the time of his death and was frequently arrested for breaching this. Just before Christmas 2015, he had been residing in a YMCA hostel but was asked to leave due to bringing alcohol into the hostel and using and supplying NPS to a younger resident who subsequently collapsed as a result.

1.9 In November 2015, Adult B was diagnosed with Autism. As a result, he was awaiting a MK Adult Social Care (ASC) assessment to help find him supported housing accommodation, in order to be assessed. The assessment and finding him accommodation were not completed prior to his death and was a significant failing to protect his welfare as alluded to by the Coroner.

1.10 It was in February 2016, three-months after the diagnosis, Adult B was tragically found lifeless in the grounds of a local church in Milton Keynes by the local Pastor. He was certified dead at the scene by attending paramedics.

Comment: This review concurs with the concerns raised by the Coroner (See Findings and MK SAR OV Report and Agency Recommendations in Chapter 4 and 7).

1.11 Executive Summary

1.12 Purpose of the Safeguarding Adult Review

1.13 The purpose of the Safeguarding Adult Review is not to re-investigate or to apportion blame. It is: -

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work to support adults at risk.
- To review the effectiveness of procedures.
- To inform and improve local inter-agency practice.

1.14 Legislation, Guidance and Definitions

1.15 The Mental Health Act 1983, the Mental Capacity Act 2005 and the Care Act 2014,[1] which defines the safeguarding duty as applying to any adult and, as in ADULT B's case, who: -

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

1.16 The Care Act 2014 is significant legislation for adult social care and children and young people with Special Educational Needs and Disability (SEND.) There were changes made to the legislation in April 2015 that includes responsibilities for promoting wellbeing, a focus on prevention, personal budgets, eligibility criteria and support for carers, as well as Deprivation of Liberty Safeguards (DoLS).

1.17 Milton Keynes Safeguarding Adults

1.18 The Multi Agency Policy and Procedures (April 2014 Policy – updated July 2016)[2], sets out the policy for the Safeguarding Adults process in Milton Keynes. This policy must be read and implemented in conjunction with: -

- Safeguarding Adults Practice Guide.
- Serious Case Review Policy.
- Deprivation of Liberty Safeguards Policy and Practice Guidance.

Comment: The policy provides the legislative requirements and expectations on individual services to safeguard and promote the well-being of adults in the exercise of their respective functions. It relates to adults with the need for care and support and for carers, and provides a framework for SABs to monitor the effective implementation of policies and procedures.

[1] The Care Act 2014: sets out in one place, local authorities' duties in relation to assessing people's needs and their eligibility for publicly funded care and support.
[2] The Milton Keynes Multi Agency Policy and Procedures (April 2014 Policy – updated July 2016).

1.19 Definition of Rough Sleepers

1.20 Under the Ministry of Housing, Communities and Local Government (HCLG), rough sleepers are defined for the purposes of rough sleeping as:

- People sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments).
- People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or 'bashes').[3]

1.21 This definition does not include people in hostels or shelters, people in campsites or other sites used for recreational purposes or organised protest, squatters or travellers. Bedded down is taken to mean either lying down or sleeping. About to bed down, includes those who are sitting in/on or near a sleeping bag or other bedding.[4]

1.22 Definition of Autism

1.23 Autism is a lifelong developmental disability that affects how people perceive the world and interact with others. Autistic people see, hear and feel the world differently to other people. If you are autistic, you are autistic for life; Autism is not an illness or disease and cannot be cured. Often people feel being autistic is a fundamental aspect of their identity.[5]

1.24 Autism is a spectrum condition. All autistic people share certain difficulties; however, Autism affects all people in different ways. Some autistic people also have learning disabilities, mental health issues or other conditions, meaning people need different levels of support. All people on the Autism spectrum learn and develop.[6]

1.25 Adult B was only diagnosed with Autism in November 2015. The full assessment of his condition was delayed and overdue at the time of his death, some three months later. Autism was not recognised, identified or considered previously by practitioners and providers to Adult B.

1.26 There is limited research on Autism and the effects of the combined use of alcohol, illegal substances and legal highs. It is possible that the combination of his diagnosis, substance abuse and the behaviour he portrayed contributed and hid his Autism. The need for practitioners to be aware of the signs and symptoms of Autism is therefore of significance, which this review will seek to address. **(See Findings and MK SAR OV Report and Agency Recommendations in Chapter 4 and 7)**

1.27 Voice of Adult B

1.28 The voice of Adult B is evident throughout the narrative in this report. It is clear practitioners listened and complied with his views. He was often non-compliant with practitioners attempting to support him. This review cannot determine whether and to what extent his Autism impacted on his communication and understanding, as his condition was never fully assessed.

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[3] Ministry of Housing, Communities and Local Government, Rough Sleeping Statistics, Housing Statistical Release, February 16th, 2018, p.g. 10

[4] Ibid

[5] National Autistic Society, About Autism, what is Autism? 2018, https://www.autism.org.uk/about/what-is/asd.aspx#

[6] Ibid.

1.29 Family involvement

1.30 There has been no involvement with Adult B's family. There were no recorded details of his next of kin submitted to the review. A request was made at the outset by the Lead Reviewer, but no information was supplied. Throughout contact with professionals, Adult B did not want any contact with his siblings or any other person (an aunt was mentioned in newspaper cuttings at the time of his death) and details of family members were not made available to the SAR.

1.31 Diversity

1.32 There is no information within the submissions from agencies in this review to suggest diversity or culture was an issue.

1.33 Abstract of Findings

1.34 This SAR has identified the following findings which are further developed within Chapter 3, Analysis of Key Events and Professional Practice (**See Findings, MKSB SAR OV Report and Individual Agency Recommendations in Chapters 4 and 7)** as follows: -

- **Finding 1.** Signs and symptoms of Autism
- **Finding 2.** Appropriate use of Independent Mental Capacity Advocate (IMCA) and Mental Capacity Act (MCA) assessments
- **Finding 3.** Clarity of the provision of services for MK Rough Sleepers and vulnerable adults and those suffering MH and substance abuse
- **Finding 4**. Governance and supervision oversight
- **Finding 5.** Referrals and risk safeguarding assessments
- **Finding 6.** Record keeping and sharing information
- **Finding 7.** Professionals meetings
- **Finding 8.** Rapid response meetings
- **Finding 9.** Rough Sleepers Tasking Group (RSTG)
- **Finding 10.** Training and professional knowledge of legislation
- **Finding 11.** MKC use of Government funding for Rough Sleepers
- **Finding 12.** Courts
- **Finding 13.** Delays in carrying out Coroner's Inquests
- **Finding 14.** Escalation policies

1.35 Adult Safeguarding Principles – Sharing Information

1.36 There are six adult safeguarding principles practitioners need to take into account when dealing with a safeguarding adult case which are: -

- **Empowerment** - People being supported and encouraged to make their own decisions and informed consent.
- **Prevention** - It is better to take action before harm occurs.
- **Proportionality** - The least intrusive response appropriate to the risk presented.
- **Protection** - Support and representation for those in greatest need.
- **Partnership** - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability** - Accountability and transparency in safeguarding practice.

Comment: There is evidence the six principles above were being applied by professionals. There was however, no overall lead practitioner or service provider championing or considering the wider picture of Adult B's underlying issues.

Adult B did not always accept the help recommended or provided. It is possible his Autism may have been affecting his understanding and behaviour; unfortunately, there were no proper assessments to confirm this prior to his death. He may not have been aware or could not comprehend how his behaviour and his understanding how rough sleeping and his misuse of drugs and alcohol were impacting on his health and welfare (see findings above).

There were episodes where he accepted support and advice from professionals, but this was often of short duration and sporadic. He made it clear he preferred to be back on the streets with likeminded people. In the two years under review and increasingly in the preceding months leading up to his death, the chronology of key events completed for the review captures his personal lifestyle and interaction with health providers. The worry of his life style and health concerns was mounting in frequency with no signs of improvement or any professional scrutiny.

1.37 Circumstances of Adult B's life

1.38 Early Years

1.39 Further details of Adult B's background are discussed within the Analysis of Key Events and Professional Practice in Chapter 3.

1.40 Adult B had a traumatic childhood as his mother died when he was only 7 years of age. A couple of years later, a stepmother was introduced into the family home. Adult B had three siblings, two brothers and one sister. He declined any contact with them or the two aunts who are mentioned in Individual Agency Reports (IMR) submitted for the SAR process. (Their details are unknown to this review).

1.41 He became known to Children's Social Care (CSC) on ten occasions between 1995 and 1997 (aged 13 to 15 years) for concerning behaviour of fire setting, theft and missing person episodes. He was assessed with special educational needs (SEN) and became subject to an Emergency Protection Order (EPO) and given a fostering placement. Both he and his sister were placed into Local Authority care as their father could not cope with them. ADULT B was placed on a child protection plan (CPP) under the category of emotional abuse.

1.42 Adult B remained in care to an advanced age because he was identified as 'vulnerable,' although no formal assessment of the cause of his vulnerability was identified. He failed academically at school and rarely attended beyond 14 years of age. Adult B was in Local Authority care from the ages of 12 years to 21 years. CSC closed Adult B's case on his 21st birthday due to his age but CSC records do not record what the legal status of his post EPO was.

1.43 His reluctance to have contact with any of his family, he later explains, relates to when aged 18 years old (his exact age varies in information supplied to the review), he tragically witnessed his father's suicide by hanging. This terrible event repeatedly haunted him. He intimated that to have contact with his family would bring back these bad memories. This, and flashbacks of his father's death, was the reason he immersed himself in alcohol or substance misuse.

1.44 Adult B was supported by MKC on two occasions with housing tenancies for a number of years which ended in 2009 due to rent arrears and anti-social behaviour. (It is believed he was supported in total with four tenancies overall in his life.)

1.45 Previous convictions and offending

1.46 Adult B had forty-seven convictions for sixty-two offences between 23 September 1999 and 4 January 2016.

1.47 Between the TOR dates (1 May 2014 to 22 February 2016) he had sixteen convictions for twenty-one offences. Adult B was made the subject of an Anti-Social Behaviour Order (ASBO) on 16 September 2014 to run until 25 March 2017. He was arrested on nine occasions for Breaching his ASBO. The ASBO was still in force at the time of his death.

1.48 The majority of the convictions were for offences relating to police, courts (such as breaches of his ASBO, offences against property and public disorder offences). The ASBO offences related to drinking in the street, often in 'No Drinking Zones', becoming aggressive and/or getting involved in fights, begging, making a nuisance of himself (such as refusing to move from the road), openly vomiting and distressing members of the public. ADULT B always entered a guilty plea to charges preferred against him when appearing at court.

1.49 The Police National Computer (PNC) recorded warning signals for Adult B, such as mental disorder (possible depression), self-harm (biting himself, cutting), suicide (threats to jump under trains, to hang himself, he once tied a sweatshirt around his neck in custody), ailment (being an alcoholic and alcoholic seizures), weapons, violence, making allegations, concealing items and drugs.

1.50 Rehabilitation

1.51 MKC record there were three attempts to place him in rehabilitation services, the first occurred during 2010 with REHAB but the reason why this intervention finished early is not recorded.

1.52 The second occasion was in November 2014, discussed at the newly formed Rough Sleepers Tasking Group (RSTG). P3, who at the time were a local service-based provider working with rough sleepers, arranged for a twelve-week residential rehabilitation in Chester to address his alcohol dependency. The centre was managed by a company called Turning Point. Through the group there was a post-treatment plan around suitable support services following successful completion, largely focussed on supported accommodation. Due to a number of warnings and due to other substance misuse, Adult B was asked to leave the centre after seven weeks. He returned to Milton Keynes.

1.53 In August 2015, a professionals meeting was held for a third occasion where updates were provided at the RTSG. Probation agreed to lead on a detoxification plan in partnership with other agencies, including YMCA and Compass (a commissioned service for MK for drug and alcohol intervention). This was ongoing, and Adult B spent some time at the YMCA before being evicted due to his behaviour in November 2015.

1.54 Events leading up to Adult B's death

1.55 The full events leading up to Adult B's death shows numerous presentations to MKUH and sixteen occasions when SCAS attended to him incapacitated in the streets through substance

abuse. He would be found collapsed often having a seizure in the street by members of the public who had called the emergency services.

1.56 Adult B described his mood as 'low' to practitioners when he was in communication with them, especially when the effects of any alcohol consumed had worn off. He kept having flashbacks of his father's suicide, as previously alluded to. He had previously disclosed a history of self-harm and was observed by practitioners to experience side effects of alcohol use, tremors, sweating, feeling sick, unsteady gait and experiencing seizures at times. Adult B stated he felt vulnerable as he was homeless on the street and was worried that he would be attacked.

1.57 Adult B showed in 2013 he had some resilience if he had the right support and care to stay off alcohol. This he managed to achieve for approximately nine months when he lived with a friend's mother who took him in. Unfortunately, he started drinking again, giving her no alternative but to evict him from her home. She had considered him vulnerable, hence her decision to initially give him a home.

1.58 In November 2015, a safeguarding alert was raised by TVP to ASC in relation to financial abuse against him by other associate rough sleepers. In January 2016, the safeguarding enquiry is shown as completed with no rationale recorded.

1.59 Shortly before his death in January 2016, the TVP IMR disclosed a Health Care Professional (HCP) (a Police Forensic Medical Examiner) who knew him from his repeated arrests whilst in the custody of police, wrote a letter to the courts asking them to consider applying legislation for Adult B to be assessed when he was before the court.

1.60 It recorded everybody who encountered Adult B found him child-like and to have little insight into his situation, with no ability to take control of it or change it. He was physically small and underweight after years of homelessness and alcohol abuse. He was generally passive in his behaviour, soft-spoken and unable to defend himself physically or emotionally.

1.61 The HCP disclosed Adult B was referred for a formal assessment by a psychologist with the first referral going astray. He was finally seen in September 2015 (reported November 2015). He was assessed as having both a learning difficulty and an autistic spectrum disorder. The assessment suggested he be placed in supported accommodation that would provide him with a therapeutic environment.

Comment: The ASC Social Worker assigned Adult B's case stated accommodation for Adult B would be difficult as there is a lack of supported housing within MK. This was never resolved.

1.62 The letter describes Adult B as a resident in the YMCA since September 2015 and praised their actions in keeping him off the streets and succeeding in keeping him sober until early in January 2016. Apparently, his former homeless associates constantly tried to contact him (frequent robberies were mentioned). He became frustrated at the lack of progress on finding him a permanent home and lost faith in the ability of the relevant authorities to help him.

1.63 From the beginning of January 2016, Adult B was living on the streets again, drinking heavily and abusing NPSs and possibly other substances. He frequently turned up in A&E intoxicated and requiring treatment. This behaviour put him at considerable risk (he had had life-threatening alcohol withdrawal seizures in the past). There was a consideration of asking the

court to consider imposing a s37 Mental Health Act hospital order on Adult B, however, he had already been referred for his social care needs to be met. The letter warned Adult B's current concerning and worrying health and coping mechanisms, suggested unless his disability was quantified, he was likely to continue to engage in activities that risked his health and even his life.

Comment: The comments within the HCP's letter to the courts have no recorded outcome. Within a month of the letter, the premonition of possible risk of death unfortunately came true. The delay in ASC securing accommodation and carrying out an assessment of his needs is a finding in this SAR. MKC has, since 2016, increased their determination and made positive steps with set objectives to increase available supported housing in order to move rough sleepers into accommodation and off the streets. (See Findings in Chapter 4 and Recommendations in Chapter 7).

1.64 The last contact with practitioners and agencies was on 11 February 2016. Adult B arrived at the Probation Office reception. His Probation Officer saw Adult B was shaking and looked as though he was going to fit or fall to the floor and called an ambulance. SCAS attended and believed he was displaying pre-seizure symptoms. The SCAS staff knew Adult B sometimes presented with these symptoms which preceded a seizure which was related to taking NPSs. Adult B denied taking any on this occasion, only admitting consuming alcohol. Adult B did not want to go to hospital for any treatment and refused transportation. Adult B wanted to go back to his tent at MKCS where he had drink, he says he needs. SCAS staff advised him to ask someone to call again if he is concerned and feels unwell.

Comment: The SCAS report records "This is the only incident that Adult B was not under the influence of drugs or alcohol and as such had full capacity and decided that he didn't want to go to hospital. No safeguarding issues identified during this incident. Patient discharged at scene at his request."

1.65 The Death of Adult B

1.66 On 22 February 2016, the Pastor of the Church of Christ the Cornerstone saw Adult B outside the church lying face down outside 300 Saxon Gate West, Milton Keynes with a friend. The Pastor returned 30 minutes later to find Adult B on his own still in the same position. The Pastor called the emergency services. SCAS attended and saw Adult B lying face down in the recovery position and record his condition as '*Cyanosed, Rigor Mortis.*' The SCAS crew were unable to move him due to the rigor mortis. An NPS (legal high) packet was found by his head with a number of beer cans. There were no signs of needles or other drugs paraphernalia. Adult B was declared deceased at the scene. TVP attended and took charge of the situation in order to investigate his cause of death. TVP confirm there was no criminal allegation or third-party involvement.

1.67 In November 2017, a Coroner's inquest confirmed the post mortem findings and recorded the cause of Adult B's death as a result of hypothermia. Due to perceived safeguarding concerns, the Coroner requested MKSB to review Adult B's death as alluded to above.

Chapter 2 - Initiation of the Safeguarding Adult Review

2. Terms of Reference (Summarised)

2.1 The Terms of Reference (TOR) are set by Milton Keynes Safeguarding Board to be addressed by agencies participating in the SAR for Adult B. A summary of the TOR is as follows: -

2.2 Referral

2.3 This case was referred by the Adult Safeguarding Team Manager to the Adult Case Review Panel for a SAR consideration in November 2017. The referral included the following points:

- Adult B had a history of not maintaining tenancies, with subsequent rough sleeping and also had alcohol dependency issues.
- Adult B had been diagnosed with Autism in November 2015.
- A safeguarding alert was submitted to MKC in November 2015 in relation to financial abuse by people with whom he frequented.
- Adult B had supported a community care assessment referral.
- Adult B was in receipt of an ASBO due to his behaviour in public places relating to alcohol intake.
- He was frequently arrested for breach of his ASBO.

2.4 A Coroner's hearing was completed on 8 November 2017, following which HM Coroner's Office wrote to Milton Keynes Council Chief Executive asking for the death to be reviewed.

- Adult B had been discussed at the Rough Sleepers task group on a number of occasions.
- In January 2016, a safeguarding enquiry was completed.
- Adult B was arrested on several occasions in 2015 and 2016 for breach of ASBO.
- Adult B had MKC housing tenancy for a number of years which ended in 2009 due to rent arrears and anti-social behaviour.
- Autism diagnosis was confirmed in November 2015.
- In November 2015, a safeguarding alert was raised by TV Police in relation to financial abuse.
- Adult B had left a detox programme before completion on more than one occasion.

The full background of the review is outlined within Chapter 1 above.

2.5 Scope

2.6 This multi-agency Safeguarding Adult Review covers the time period: 1 May 2014 – 22 February 2016 (date Adult B died).

2.7 Whilst the review covered the above time period agencies were asked to include additional background information they felt was of any significance outside the above time period.

2.8 General Terms of Reference

<u>Early Intervention</u>

- What opportunities were there for your agency to engage with Adult B and was there an opportunity to engage with Adult B at an earlier stage to better understand his needs?
- Were there opportunities to identify Autism at an earlier stage – whether there were reasonable adjustments made for Adult B's Autism in relation to his homelessness?

<u>Interventions and Multi-Agency Working</u>

- How responsive was your agency in relation to addressing Adult B's alcohol and substance misuse?

- Comment on agency communication - intra-agency, and between agencies – was this sufficient to understand and facilitate single and multi-agency response to Adult B's needs?
- How did agencies work together to assess the needs of Adult B – authors are asked specifically to comment on the quality of assessments, including risk assessments and how needs identified during assessments were acted on?

Involvement of Adult B and those Important to him

- How Adult B was able to have his voice/views heard – how did agencies facilitate this?
- What efforts did agencies make to engage with Adult B – did agencies take all reasonable opportunities to help Adult B understand the consequences of the decision he was making and help him to consider options (with due regard to Mental Capacity Act)? Is there evidence in agency records of MCA consideration?
- What steps were taken to involve others who may be important to Adult B's family/friends?

Systems to Support Practice

- Identify learning regarding systems that facilitated or acted as barriers to support people who are street homeless.
- Identify learning about services that MK agencies provide to adults with Autism.
- Identify learning about services that MK agencies provide to adults who are street homeless and who may have additional vulnerabilities.
- Comment on interface between community safety services and safeguarding services – specifically how these systems work together to reduce risks to people who are street homeless and who may be adults at risk.
- Identify any gaps in their systems that they identify during the SAR process.

2.9 Agencies requested reports should identify good practice by individual agencies and practitioners, any changes in practice or service provision subsequent to the scoping period and learning for their own agency and how that learning will be acted upon.

2.10 Agency Reports Commissioned

The following agencies were asked to submit a report and chronology:
Milton Keynes Adult Social Care
Central & North West London NHS Foundation Trust
Compass
MK Council Housing Department (included in CSP IMR below)
MK University Hospital NHS Foundation Trust
Safer MK (Community Safety Partnership)
South Central Ambulance Service
Thames Valley Police
Thames Valley Community Rehabilitation Company (Probation)
YMCA (chronology not completed subject to comment within the review)

**Adult B was not registered with a Milton Keynes GP during the time period this review is covering.*

2.11 SAR Panel

2.12 The SAR Panel members were independent of the practitioners and had no involvement in Adult B's case.

2.13 Independent SAR Author

2.14 Mr David Byford was commissioned as the Lead Reviewer for the SAR. He has no previous involvement in the case or with any person or agency concerned within the SAR process for Adult B.

2.15 Methodology

This Level 2 Safeguarding Adult Review used a proportionate methodology and a robust individual analysis by each involved agency but added the greater involvement of practitioners and clinicians and encouraged reflection and learning.

Chapter 3 - Analysis of Key Events and Professional Practice

3.1 Key Events

3.2 An analysis of the key events was carried out and a detailed chronology was provided to the MKT team for reference. There were significant events in Adult B's life and these have been considered and where relevant are addressed within the Findings and MKSB OV Report and Individual Agency Recommendations in Chapter 4 and 7.

3.3 Professional Practice

3.4 Professional practice, together with the key events and learning from the practitioner's event, outline the professional interaction and actions taken, issues with guidance and decision making in Adult B's case. The Findings and Lessons to be learnt are detailed within the Milton Keynes SAR Overview Report at Chapter 4 and 7 for the MKSB to consider.

3.5 Practitioner's Event

3.6 A practitioner's event was held that was well received and attended by agency practitioners involved in Adult B's case. It was hosted by the MK Together (MKT) team and the Lead Reviewer. The issues discussed were elicited from the analysis of agency submissions. Practitioner's views were taken into consideration and identified further analysis subject to the findings in this report. The event discussed the following: -

- High risk cases and notifications.
- The referral processes.
- Empowerment.
- Clarity of agency's responsibilities.
- Challenges for professionals dealing with similar persons with Adult B's issues?
- Training and professional knowledge of legislation.
- Communication with the courts.
- MKC use of Government funding for rough sleepers.
- Local or National Rough Sleepers database consideration
- Effectiveness of Rough Sleepers Tasking Group.
- Consideration of a 'One Stop Shop' dedicated professional team.
- Diagnosis of Autism and appropriate assessments and opportunity to identify his Autism much earlier.
- Information sharing and record keeping.
- How do we capture the bigger picture, a lead professional?
- Adult B's voice.
- Addressing the Coroner's request of MKSB and concerns**.**

3.7 The comments and responses of the attendees were recorded and have been retained by the MKT team. All the issues and views raised have been, where relevant, incorporated within the narrative and learning of this SAR for Adult B. It was clear, the event confirmed, practitioners only wanted the best outcome for Adult B and always offered him advice and support, but he did not always accept the help or advice given.

3.8 It was clear there were confusing pathways for practitioners, with agencies working in silos. It was also not known who had overall responsibility for Adult B and other rough sleepers whose situation and concerns were evident and needed addressing within MK.

3.9 Mental Capacity Assessments

3.10 There were no MCAs completed or considered by practitioners in Adult B's case. Other than in 2014, when the MHHLT advised a Senior House Officer (SHO) to assess Adult B's mental capacity in relation to taking blood from him for testing. This was the correct advice and it would be for the SHO to determine Adult B's lack of mental capacity to consent to the treatment, but no MCA was carried out. In Adult B's case suggests there was no professional curiosity displayed considering his virtual daily contact with MKUHFT providers to address his obvious and worrying needs particularly in the latter period of his life.

3.11 He was already a vulnerable adult who was consistently, within the TOR scoping period, being picked up by SCAS and taken to MKUH after being found collapsed in the street, often as a result of a seizure, under the influence of alcohol and/or substance misuse.

3.12 There was a safeguarding investigation being held in the months before he died, regarding his vulnerability with his finances. There was a missed opportunity as a full assessment was not carried out, therefore his mental capacity and housing accommodation needs were never addressed.

3.13 There is a strong argument for utilising the services or obtaining the advice from an IMCA, considering Adult B was a very vulnerable person with increasing and worrying health problems even before he was diagnosed with Autism. After his condition was disclosed, it should have been obvious to practitioners he was at a much higher critical risk level than was first thought.

3.14 His autism may have contributed greatly to the lifestyle he led and his reliance on alcohol and substance misuse. If there had been structured risk and care assessments with professional curiosity displayed, these may have identified his Autism earlier. Services of an IMCA could have assisted in the communication with Adult B to better understand the appropriate course of action required to secure his wellbeing and safety and to consider the most appropriate services to support his needs.

3.15 Care Act 2014

3.16 The Act states: - '*Where a person has substantial difficulties in participating in either a Care Act assessment (section 67(2)) or a Safeguarding Enquiry (section 68 (2)*[7] *and there is no appropriate person available, an advocate or IMCA must be appointed.'*

3.17 A person lacks capacity if at a specific time they are unable to make a specific decision because of a temporary or permanent impairment of, or disturbance in, the functioning of the mind or brain (Autism). A person is deemed as unable to make a decision if they are unable to understand information relating to the decision, or unable to retain the information or use and weigh up the information as part of the process of making the decision, or unable to communicate the decision.

3.18 Agency Individual Management Reports

3.19 The following information is an analysis and summary of the IMRs submitted by the agencies to the SAR process: -

3.20 **<u>South Central Ambulance Service</u>**

[7] Care Act 2014 assessment (section 67(2)) or a Safeguarding Enquiry (section 68 (2).

3.21 On every occasion SCAS were called to attend to Adult B within the TOR period (17 incidents), apart from one incident and the last incident on 22 December 2016, he was either heavily intoxicated or high on illegal drugs or NPSs. This made the short time crews had with him difficult to assess and accurately determine how best to protect him. It is clear SCAS attending crews always acted in the best interest of Adult B due to his lack of capacity at the time. This resulted in a hospital attendance in all but one occasion to ensure his welfare was protected.

3.22 In the past SCAS attempted to notify safeguarding teams of vulnerable persons of no fixed abode. Unfortunately, due to these individuals not having a permanent address, Local Authority safeguarding teams had difficulty in identifying and locating these vulnerable individuals once they received a safeguarding alert. The IMR Author believes there is a gap exposed in the contacts SCAS had with Adult B. Other than transporting vulnerable persons with no fixed abode to hospital, there needs to be a robust pathway SCAS crews can access when they come across persons like Adult B for them to follow, to protect and actively support these vulnerable individuals and to include this pathway in SCAS procedures. **(See SCAS Agency Recommendation 1 and 2 in Chapter 7)**

3.23 **<u>MKC Adult Social Care</u>**

3.24 MKC ASC provides assessment and reviews for people with varying needs for care and support and supports them to access the necessary community support services required within statutory guidelines. Other statutory services such as Deprivation of Liberty safeguards, and adult safeguarding processes, are also provided. Referral to other services where applicable, is also undertaken. ASC record there were many interactions with ADULT B, at times he was non-compliant and at other times he worked well with ASC and had been interviewed as part of the most recent safeguarding enquiry. Most contacts were undertaken face to face, either initiated by him attending the MKC office, or negotiated through a third party as he had no telephone contact for most of the time.

3.25 In the referral underway at the start of the TOR time period, there was an agreement for funding for rehabilitation service, however the case was closed without this occurring due to Adult B not wishing to use the service at the time. Funding however occurred in November 2014, for transport to attend this service. No other service was ever offered. It is noted that frequent support and advice was given to Adult B by his previous ASC worker to maintain the links with him due to concerns.

3.26 The IMR Author identified there was no case conference or Professionals meeting ever called or considered. They report there was evidence of good information sharing with TVP, MKUH alcohol nurse, and also MKC housing. **(See MK ASC Agency Recommendations in Chapter 7)**

Comment: In analysing the responses to this SAR, there is evidence other agencies and services, notably from YMCA, TV-CRC and TVP, were discussing the delay of the assessment required for Adult B following his diagnosis of being on the autism spectrum. There appears concern in the lack of urgency and support for ASC to arrange a care assessment on Adult B and to find him Local Authority accommodation. At the time of Adult B's death, the outstanding assessment was both overdue and was never carried out. Nevertheless, none of the agencies concerned invoked escalation procedures. (See Findings and MKSB OV Report Recommendations within Chapter 4 and 7)

3.27 British Transport Police

BTP had five recorded crimes for Adult B (three separate incidents) and six intelligence submissions. The first record is from 16 August 2009 for Railway Trespass and Fare Evasion at MK Central Station, and the last from 24 October 2014. All the records held are from BTP legacy systems and have been converted on to the force's Niche computer system.

3.28 Compass

Compass[8] is a national charity providing services in substance misuse, emotional health and wellbeing, sexual health and school nursing to young people and adults. In respect of Adult B's problems, the substance misuse service provided a recovery treatment service with support programmes for adults experiencing substance misuse in the MK area.

3.29 Compass confirmed there were no family members or carers for Adult B during his episode of care with their service. Their main contacts were with other agencies involved in his care at the time. Adult B informed them he had a six month period of stability when he was housed with a friend's mother. He had lost contact at the time of his referral to Compass and was not able to provide details of the friend's mother, so she could be contacted.

3.30 Adult B was involved with Compass for one episode of care which commenced on 4 September 2015 and ended following the notification of his death on 23 February 2016.

Comment: It is a pity this previous period of stability could not have been explored further.

3.31 Adult B had 32 recorded contacts ranging from face to face contacts between Adult B and Compass staff, assessments conducted, referrals completed, and contact made with partner agencies.

3.32 Adult B's treatment with Compass commenced following a referral from the probation service to support Adult B with his alcohol and cannabis misuse. During the treatment episode with Compass, other substance misuse needs were identified namely, the use of new psychoactive substances (NPSs).

3.33 During the episode of care with Compass Adult B had three inpatient hospital admissions at the MKUH, all as a result of alcohol or drug misuse. On the first two admissions, 14 September 2015 and 9 October 2015, Adult B was admitted after he allegedly suffered an alcohol related seizure due to the sudden or rapid withdrawal of alcohol. The third admission, 22 December 2015, was due to a respiratory infection with evidence of alcohol dependency. Two of the admissions resulted in unplanned discharges. The first was after ADULT B was found smoking cannabis on hospital premises and the second occasion is not documented on electronic patient records.

3.34 Two professionals' meeting were convened between Compass, Probation Services, Open Door and YMCA staff to discuss the complexity of Adult B's needs and try to manage Adult B's risks. When Adult B was assessed for learning disabilities, namely autism in November 2015, no further information was shared following the assessment and diagnosis with no information being requested by the Compass team.

[8] **Compass -** Drug and Alcohol Service for adults aged 18 and over, offers services including medically assisted recovery, 1-2-1 support, group sessions, counselling and family support.

3.35 **Thames Valley Community Rehabilitation Company (TV-CRC)**

3.36 TV-CRC delivers probation services to the population of Berkshire, Buckinghamshire and Oxfordshire. It covers a large geographical urban and rural area and population. It is contracted to deliver statutory offender services in the community and in custody, subject to various statutes, including Offender Management Act 2007 and Offender Rehabilitation Act 2014.

3.37 TV-CRC has a site located in Milton Keynes. The service delivers community sentences, custodial and post release supervision for offenders allocated by the National Probation Service (NaPS) as well as a range of supervisory services and interventions with the aim of reducing reoffending and protecting the public.

3.38 The IMR Author identified escalation concerns for the service, which is a theme identified within this SAR for other agencies. It also identified the need for front line staff to increase their understanding of undiagnosed autism and to enhance their understanding of the MCA[9]. **(See Findings and MK OV Report and TV-CRC Agency Recommendations in Chapter 4 and 7)**

3.39 During their first period of involvement TV-CRC staff worked together with staff from Open Door, P3 and medical staff to try and support Adult B to access medical services. This appears to be successful, with Adult B registering with a GP and being admitted to hospital for an operation on 26 August 2014 (specific nature of operation is unclear from records).

3.40 On his release from hospital TV-CRC staff supported Adult B by storing his medication in the office and providing bus passes to facilitate his daily collection, due to concerns about his ability to take the medication as prescribed. He was vulnerable to having his medication stolen. TV-CRC also arranged and funded a taxi to ensure Adult B attended the GP surgery to arrange an alcohol detox. This contact went on after the technical end of Adult B's Community Order.

3.41 TV-CRC's records in relation to Adult B then stop until 20 July 2015 when Adult B was sentenced to a 12-month Community Order. During this period, TV-CRC staff had 41 contacts with Adult B, both planned and unplanned. It is evident during this period Adult B's situation had deteriorated since their last period of involvement with him. This second period compared to the previous period was reportedly less focused and appeared to be more crisis management in response to Adult B's deteriorating health, increasing substance misuse and vulnerability.

3.42 It is noteworthy that despite Adult B's ambivalence to treatment, he was supported to enter hospital for an in-patient alcohol detox in October 2015. It should be noted that he had deferred his voluntary admission once and was ultimately admitted following a seizure. TV-CRC staff and others working with him supported Adult B when he was released to the YMCA, despite this accommodation provision having insufficient levels of support available to meet his needs.

Comment: There was an opportunity for TV-CRC, with the second period of involvement, to raise their concerns. If they believed the process with agencies was less focused and more crisis management led, in response to Adult B's deteriorating health, increasing substance misuse and vulnerability this should have been escalated.

[9] Mental Capacity Act 2005

3.43 **Thames Valley Police**

3.44 On every occasion Adult B breached his ASBO, he was transported from custody straight to court. A '*Personal Escort Record Form Risk Indicator'*[10] is completed to alert the company transporting ADULT B and court staff to difficulties that he may have disclosed, such as self-harming and/or substance abuse.

3.45 Several police officers knew and interacted with Adult B, which the TVP IMR details. These officers also attended the Practitioner Learning Event (see Chapter 6). They were aware Adult B was supported by Open Door[11] and YMCA, and an officer knew about the six-month period of stability when he was housed with a friend's mother. Police were also aware there is a Homeless Partnership in MK, introduced to encourage collaboration with the third sector including working with the YMCA, Open Door and Compass,[12] to look at a long-term strategy around the homeless situation.

3.46 The IMR Author notified this review of the information regarding the HCP/FME letter (as discussed elsewhere in this report) was put forward as an application for a treatment order in relation to Adult B, expressing grave concerns. This was towards the end of Adult B's life. It is believed this was discussed with Adult B by the HCP and adjustments made to the wording (not confirmed with the HCP), specifics not known by TVP as they were not party to the discussions.

3.47 **MK University Hospital**

3.48 Adult B was a frequent attender at MKUH, and as such was well known to health professionals. Adult B attended MKUH on forty-one occasions during the scoping period. Within these occasions, nine resulted in admission to treat alcohol induced seizures and treatment for sepsis. He self-discharged on seven occasions as an inpatient and two occasions from the Emergency Department (ED), some evidence of non-engagement by Adult B.

3.49 Adult B was known to be of no fixed abode and alcohol dependent. The IMR Author believes this potentially could have led to professionals stereotyping Adult B, as it is not evidenced if professionals raised concerns regarding the number and frequency of attendances and admissions to hospital.

3.50 It was identified as a learning opportunity, for the facilitation of a professionals meeting for ADULT B would have been prudent given the frequency of presentations to the ED.

3.51 MKUH record it would not be normal practice to contact a person's next of kin without their permission if the person had capacity (as Adult B was considered to have). Various professionals reported Adult B had capacity, although no formal assessment was documented to confirm this fact.

3.52 Throughout the scoping period, good practice was evidenced by professional referrals and facilitation of inter-agency collaboration. A learning point identified by the IMR Author was there could be external agencies sharing information about a frequent attender to ED, in

[10] Personal Escort Record Form Risk Indicator - commonly known as a 'Per' Form.

[11] Open Door works with and for homeless people and those who are 'vulnerably housed' to support them into accommodation and to reintegrate them into society.

particular referencing the diagnosis of autism. had the acute trust been aware of this diagnosis staff may have potentially engaged with Adult B from a different perspective, particularly regarding Adult B non-compliant behaviours (long periods off inpatient ward areas) with examples of a person having capacity but displaying challenging behaviours could be incorporated into safeguarding training by the trust.

3.53 **Central and North-West London NHS Trust (CNWL)**

3.54 CNWL record services were first involved with Adult B in August 2010, when he presented in the A&E department of MKUH. Adult B had fallen over whilst drunk and hit his head. The medical notes at the time report that Adult B was referred to Mental Health Hospital Liaison Team (MHHLT) based at MKUH. MHHLT offers multi-disciplinary integrated care for patients who have physical and mental health problems. The team is based at the Health Centre on the hospital site and has a senior mental health liaison practitioner/team leader, mental health liaison practitioners and administrative support.

3.55 Adult B was known to substance misuse services. He presented as unkempt and alcohol dependent. He had attended three sessions but then chose to disengage from the service. Adult B reported a long history of substance misuse (Cocaine, Ecstasy, amphetamines, MDMA, LSD, cannabis). He stated that he had stopped using drugs three years previously, apart from using cannabis.

3.56 There was no evidence of psychotic symptoms and Adult B reported he had never experienced any. He subjectively described his mood as low, especially after the effects of alcohol had worn off. Adult B reported a history of self-harm.

3.57 Other than on one occasion being detained under s136 MHA (January 2011) from which he was immediately discharged, Adult B was never detained under the MHA. If Adult B's intoxication levels were too high, then the MHHLT practitioner would return a few hours later. On occasion, he had left MKUH prior to any MH assessment taking place.

3.58 During CNWL's involvement with Adult B there was no diagnosis made regarding autism or reference to such a diagnosis. CNWL are not commissioned to provide autism services however if Adult B presented to CNWL with symptoms suggesting autism he would have been referred to a Consultant Psychiatrist trained to diagnose autism. Staff would then have provided literature regarding autism. In 2015/2016 there was no commissioned ongoing support for those who had been diagnosed with autism.

3.59 **Community Safety Partnership (CSP)**

3.60 The CSP IMR reports the Rough Sleepers Tasking Group (RSTG) meeting's aim was to ensure that a "sustainable plan is put into place for known individuals who are rough sleeping in MK". There was an awareness of Adult B's complex needs in terms of substance misuse, intoxication through alcohol, and mental ill-health. The RSTG, however, had limited reference to actions or options considered to be undertaken in respect of those needs and risk factors, save the reference to the MH assessment. The CSP IMR Author on behalf of the CS Team identified opportunities to improve practice, and are general themes identified within this SAR.

3.61 **Housing (from CSP IMR)**

3.62 Adult B had been known to Housing Options for some period prior to his death and outside the period of this SAR. There were two notable events during the relevant period that relate to housing applications. On the most recent on 16 January 2015, he made a housing application. On this first application, he was offered temporary accommodation owing to SWEP but did not return to complete his full application. The case was marked 'closed' after his failure to return.

3.63 On 6 February 2015 Adult B attended Milton Keynes Council (MKC) and it is apparent he had previously made applications for housing outside the time period and had not continued his application owing to having been placed into drugs rehab in Chester. He explained that he had been evicted from this programme owing to drugs related issues and therefore presented at MKC. He failed to pursue this application and the case was closed. Entries were logged on the Housing Options system known as Northgate.

3.64 **YMCA reduce issues around retention assuring board**

3.65 There was an issue for YMCA of the failure to be able to provide chronological information and detail for their interaction with Adult B for the SCR. YMCA had advised at a SAR IMR Authors meeting attended by the Lead Author that YMCA had changed their recording systems and did not have access to the old records where information about Adult B was stored.

3.68 YMCA has assured MKSB and this SAR they have amended their practices to ensure that copies of all records are saved electronically in the future.

3.69 Specified Questions

3.70 The TOR in Chapter 2, identified specified questions for agencies to consider in their IMR submissions. Information from their responses have been elucidated from the IMRs narratives and have been considered and outlined further within the Analysis of Key Events and Professional Practice in Chapter 3 and subject to the Findings in Chapter 4.

Chapter 4 - Findings and suggested SAR Recommendations for the consideration of MKSB

This chapter outlines the findings identified from the analysis of professional practice. They are produced for consideration by the MK Safeguarding Board to reflect and implement any learning from this SAR. The findings contain suggested MK SAR Overview Report Recommendations that overarch, encompass and support Individual Agency Recommendations which have come from the analysis of the chronologies, IMR's and the practitioner learning event. The MK SAR Overview Report Recommendations are set out in Chapter 7. The findings are as follows: -

FINDING 1 - Signs and symptoms of autism

What are the issues and what should be considered? There is a need for practitioners to improve their awareness and knowledge in being able to recognise and identify the signs and symptoms of autism and other mental health conditions which is not evident within this SAR. This will assist practitioners' awareness in capturing the needs of the vulnerable adult much earlier, in order to signpost the subject to the most appropriate pathway, service provider and support. **(See Milton Keynes SAR Overview Report Recommendation (1) in Chapter 7)**

FINDING 2 - Appropriate use of IMCA and MCA assessments

What are the issues and what should be considered? There was no consideration of carrying out a MCA or using the services of an IMCA for Adult B either before or in the short period before his death, when he was diagnosed with Autism. There were missed opportunities to assess his mental capacity earlier in order to fully understand his lifestyle and emerging health concerns on decision specific issues. It is appreciated this could also be attributable by Adult B not engaging with professionals. Appropriate use of an IMCA to be engaged to understand and support a vulnerable person must be considered should he have been found to have lacked capacity. If a health professional advises on a course of action such as the doctor who diagnosed Adult B's autism that suitable accommodation and a full Care Act assessment is required, it must be carried out forthwith and within MK Safeguarding Policy and Procedures guidelines. **(See Milton Keynes SAR Overview Report Recommendation (2) in Chapter 7)**

FINDING 3 - Clarity of the provision of services for MK Rough Sleepers

What are the issues and what should be considered? There was a lack of clarity for practitioners as there was not a clear pathway as to who or which agency would take responsibility for Rough Sleeping and Vulnerable Adults particularly those suffering MH, alcohol and substance misuse. There should a consideration of a Homeless and Safeguarding Adult team as a **'one-stop shop'** or an appointed lead person, responsible to ensure the right support and action is being taken to safeguard adults. There should be a consideration to have a local database for rough sleepers available for practitioners to access. There will be a requirement data protection is also considered and who the data owner is, if a local database is agreed after consultation.

These suggestions were raised and received a positive reaction at the Practitioner Event. The new MKC developments implemented or planned since Adult B's death, possibly utilising the newly agreed VARM process recently endorsed for implementation, will support individual action and challenge non-compliance. Other options to support, or protect, including all other legislation and provisions including the MHA 1983, MCA 2005 and Care Act 2014 etc, should be considered. The numerous services provided for Adult B were confusing for practitioners. MKSB should ensure all agencies and voluntary organisation are made aware of who takes overall responsibility, provide

clear thresholds and pathway to support agencies and practitioners in dealing with complex and challenging vulnerable adults. Recently in 2018, ASC has identified a dedicated social work team for rough sleepers which may provide the clarity required and confirmed as an issue by practitioners. **(See Milton Keynes SAR Overview Report Recommendation (3) in Chapter 7)**

FINDING 4 - Governance and supervision oversight

What are the issues and what should be considered? There is a requirement for enhanced governance and supervision oversight in homeless and rough sleeping cases. Supervision is required to be enhanced to capture the wider picture of an individual's wellbeing and to ensure professional curiosity of action and non-action is displayed and the rationale is recorded. There were forty-one presentations to MKUH, numerous arrests by TVP mainly for ASBO and breaches of his ASBO and sixteen contacts with SCAS. There was never a consideration to call a professional meeting to discuss Adult B's case earlier. Supervisors need to be mindful of repeated reported concerns and the high-risk to health and wellbeing of rough sleepers and any vulnerable adult requiring support and protection.

TVP showed evidence of dealing with Adult B in custody where supervision was applied in a custody setting. This review however, has identified that governance and supervision was not consistently applied within all agencies or evidence supplied to the contrary as agency records were not always completed or available. There were numerous contacts of Adult B's worrying concerns with no management guidance or direction to look at the overall process and manage a solution to provide effective support.

If escalation policies were followed and applied (See Finding 14), this would pinpoint the need for managerial oversight and supervision of practitioner's actions and non-action in a case, which should be occurring - particularly in high-risk cases - as a priority.

There should be supervision of the quality of professional meetings, actions, outcomes and challenge cases this review has been informed have often been closed too early. Supervisors should ensure professional curiosity is applied by practitioners in decisions and actions made. **(See Milton Keynes SAR Overview Report Recommendation (4) in Chapter 7)**

FINDING 5 – Referrals, risk and care assessments

What are the issues and what should be considered? Referrals, risk and care assessments need to be actioned earlier to support adults with repetitive alcoholism, substance and legal high misuses, in order to capture and recognise any other underlying conditions the person's behaviour may be displaying, in order to address their needs. Outcomes of decisions made must be supplied to the initial referrer. There was a lack of referrals with missed opportunities to refer Adult B for inter-agency working. **(See Milton Keynes SAR Overview Report Recommendation (5) in Chapter 7)**

FINDING 6 – Record keeping and sharing information

What are the issues and what should be considered? Agencies need to adopt robust and efficient record keeping systems and share appropriate information. When Adult B was diagnosed with autism, his condition was not widely known or shared with other health and social care professionals. There are a number of entries where record keeping and retention of information from the submitted agency IMRs was not to a satisfactory standard, with no recorded outcomes or rationales recorded in case files. No agency within this review has submitted any contact details of Adult B's siblings which was requested at the outset by the Lead Reviewer. All practitioners and service providers in contact with vulnerable persons should ascertain family information for future

reference in case urgent contact is required, as in Adult B's case. YMCA failed to retain hard copy records and no back-record conversion was made on to their electronic system, and in Adult B's case were destroyed. This SAR has been assured this has now been addressed for the future by YMCA. **(See Milton Keynes SAR Overview Report Recommendation (6) in Chapter 7)**

FINDING 7 – Professionals' meetings

What are the issues and what should be considered? There is a need to ensure there are sufficient and appropriate professional meetings in relation to protecting vulnerable adults. Supervisors and Chairs of meetings must ensure all relevant professionals are invited to ensure good practice. This aspect should now be addressed by the recent MKC priorities and new developments to address Rough Sleepers, identifying appropriate accommodation and supporting vulnerable adults. **(See Milton Keynes SAR Overview Report Recommendation (7) in Chapter 7)**

FINDING 8 – Rapid response meetings

What are the issues and what should be considered? There should be a Rapid Response meeting held in similar circumstances of Adult B's case or in other vulnerable adult's death where the cause of death may be a concern. This would allow the MK Adult Safeguarding Team to consider the outcome of the death at an early stage and take any appropriate action necessary, such as commissioning a review and/or provide information to any subsequent Coroner's Inquest. **(See Milton Keynes SAR Overview Report Recommendation (8) in Chapter 7)**

FINDING 9 – Rough Sleepers Tasking Group (RSTG)

What are the issues and what should be considered? Adult B was discussed at several RSTG meetings. This review has established the management, record keeping, and outcomes were not sufficient for the purpose, with limited risk assessments for Adult B. Minutes of meetings were not comprehensive and were not always shared. This has also been acknowledged by the Community Safety Partnership IMR Author and recommendations for change to improve Record Keeping**,** Terms of Reference for the Rough Sleepers Tasking Group**,** Risk Assessments**,** Action Planning and Case Management are made.

Comment: The Agency has identified improvements for practice and has since implemented the learning, therefore no MK SAR OV Recommendation is made.

FINDING 10 – Training and professional knowledge of legislation

What are the issues and what should be considered? There is a need to ensure there is sufficient professional understanding and training to remind or make practitioners aware of the MK Rough Sleeping Reduction Strategy, the MHA 1983, MCA 2005 and Care Act 2014 and utilise the services of an IMCA to ensure the necessary awareness for both practitioners and supervisors is known. **(See Milton Keynes SAR Overview Report Recommendation (9) in Chapter 7)**

FINDING 11 – MKC use of Government funding

What are the issues and what should be considered? It is suggested the recent Government funding secured by MKC for Rough Sleepers, the MK's Rough Sleepers Strategy 2017 should consider the recommendations of learning from this SAR when considering the overall use and application of the funding (see Finding 3 above where there is a consideration of a local database), appointed lead professional for high risk cases, one-stop shop which would be able to have an overview of Rough

Sleepers and Overseas Homeless which is a possible evolving concern and the availability of an autism practitioner for agencies to refer to.

Where there is a referral for housing from a key professional, which is pertinent in Adult B's case, a concerted effort must be made to obtain accommodation and escalate if necessary. If there is a delay or there will be no provision the outcome must be recorded, and the decision supervised by line managers. Cases for housing applications where a person is vulnerable and considered high-risk should not be closed unless this is sanctioned by a supervisor. MKC is addressing the lack of accommodated housing as part of its drive and strategy to tackle and reduce Rough Sleeping in MK. These suggestions will tighten the structures and provide accountability. **(See Milton Keynes SAR Overview Report Recommendation (10) in Chapter 7)**

FINDING 12 – Courts

What are the issues and what should be considered? There should be effective communication with the Courts in a safeguarding adult case such as Adult B's. In his case he is considered high-risk, he was repeatedly arrested by police, charged and often appeared in court for repeatedly breaching his ASBO and other minor allegations of crime but was never considered for a mental health assessment. The Court should be asked to consider their powers to ensure a thorough assessment is carried out on a vulnerable adult persistently appearing before the court. **(See Milton Keynes SAR Overview Report Recommendation (11) in Chapter 7)**

FINDING 13 - Delays in carrying out Coroner's Inquests

What are the issues and what should be considered? There was a twenty-two month delay from the death of Adult B until the inquest. This SAR is aware of the constraints and the backlog of cases which the Chief Coroner is addressing, however, vital lessons in the intervening period could have been considered to address any concerns. If Finding 8 for rapid response meetings is endorsed, this would be able to pinpoint where remedial action would be required, negating some of the time period that may occur between a person's death and the Coroner's Inquest outcome. **(See Milton Keynes SAR Overview Report Recommendation (12) in Chapter 7)**

FINDING 14 - Escalation Policies

What are the issues and what should be considered? MKSB and individual agencies need to remind practitioners involved in this SAR of the requirement to challenge decisions of concern in adult cases. Appropriate use of escalation policies and procedures which are in place and current must be applied. There were several missed opportunities where action to escalate should have been taken, particularly with the overdue housing issues and ASC assessment after his diagnosis of autism. **(See Milton Keynes SAR Overview Report Recommendation (13) in Chapter 7)**

Chapter 5 – Milton Keynes Council - Developments since February 2016

5.1 In 2017, MHCLG (Ministry of Housing, Communities and Local Government) funding was secured to provide an outreach provision for MK (there was no provision previously). The successful bid was also in partnership with Luton, Beds and Central Beds. The funding provides a dedicated rough sleeper worker for MK and a mental health practitioner employed by CNWL for a two-year period.

5.2 In 2017, MKC extended its winter offer to rough sleepers in addition to SWEP (Severe Weather Emergency Protocol) placements. Following assessment, those with a local connection who were eligible continued to be offered emergency accommodation when the weather improved pending MKC's ambition to launch a Housing First scheme.

5.3 In 2018, MKC funding was agreed to launch a Housing First model in MK. Emergency temporary and secure accommodation has been provided as part of this, alongside Connections, a support provider, to offer intensive support to sustain settled accommodation.

5.4 In 2018, MHCLG funding was secured to improve MKC's response to rough sleeping, including increasing rough sleeper outreach workers, additional emergency accommodation, a rough sleeping coordinator, a reconnection officer and a personal allowance budget. These additional resources aim to enhance the current pathways, particularly for those with no recourse to public funds and/or no local connection.

5.5 In 2018, ASC identified a dedicated social work team for rough sleepers.

5.6 Owing to internal restructures, the responsibility for chairing the Rough Sleepers Tasking Group meeting has fallen to team leaders. Pending the recruitment of a Rough Sleeper Coordinator, ownership for the meeting transferred to the Community Cohesion Manager in July 2018. A number of changes have been implemented to the meeting including the terms of reference and how it is conducted. It is recognised that these changes will require refreshing on the basis of the CSP IMR and these overview report findings. **(See CSP Agency Recommendation in Chapter 7)**

5.7 A Council Committee review in 2016 agreed that a 'Homeless Partnership' should be created with all stakeholders in MK who have a role in working with rough sleepers. The aim of this partnership was to provide a platform to understand the needs of rough sleepers and to develop a borough-wide plan to reduce rough sleeping. MK Council has recently launched a consultation on a draft 'Rough Sleeper Reduction Strategy'.

5.8 Through this partnership MKC has supported the development of the Winter Night Shelter and a proposal for a homeless bus project, which is currently going through a planning application. MKC has recently agreed to provide an additional thirty places for individuals rough sleeping, a proposal currently being explored.

5.9 Homelessness and Rough Sleeping (improvements since the death of Adult B)

5.10 Ministry of Housing, Communities and Local Government outline the launch of The Homelessness (Review Procedure etc) Regulations 2018,[13] which have been made under the

[13] The Homelessness (Review Procedure etc) Regulations 2018, Ministry of Housing, Communities and Local Government.

HRA 2017.[14] Regulations 2 and 3 set out the procedure to be followed by a local housing authority (LHA) when issuing a notice to bring their duties to an end in cases of an applicant's deliberate and unreasonable refusal to co-operate.

5.11 As part of the prevention and relief duties introduced by the HRA, LHAs must work with an applicant to develop a personalised housing plan which will set out the steps to be taken by both parties to ensure the applicant has, and is able to retain, suitable accommodation. LHAs are able to issue a notice bringing their prevention or relief duties to an end if the applicant deliberately and unreasonably refuses to cooperate with the required steps. This is designed to encourage applicants to take responsibility for working proactively with the LHA to resolve their housing situation as soon as possible. The Acts provide full details of the obligations of the legislation.

5.12 Homeless Partnership

5.13 There is a Homeless Partnership in MK, introduced to encourage collaboration with the third sector. Examples include work with the YMCA, Open Door and Compass[15] to look at a long-term strategy around the homeless situation.

5.14 MKC organises a regular survey of the homeless in MK within the boundaries of Central MK area but does not include the periphery. During the survey, leaflets are handed out signposting to housing opportunities and to drug and alcohol services.

5.15 Rough Sleepers and Outreach Services MK partnership with other Local Authorities

5.16 As part of their commitment to prevent homelessness and rough sleeping, MK, Bedford Borough, Central Bedfordshire, and Luton Councils, following the successful bid for grant funding, are working in partnership to deliver an outreach service to rough sleepers. It works by providing a combination of outreach support and assessment hubs where people can go to access help. The Rough Sleeper Outreach Service started operating across MK and Bedfordshire in June 2017 and works with existing services and partners to identify, engage and provide support to those most vulnerable on the streets, sleeping rough and homeless.

5.17 SWEP (Severe Weather Emergency Protocol)

5.18 MKC provide SWEP accommodation to get rough sleepers off the streets when the night time temperature is predicted to be zero degrees or below for three consecutive nights.

5.19 MASH (Multi-Agency Safeguarding Hub)

5.20 MK Multi-Agency Safeguarding Hub (MASH) was set up in September 2014, to promote interagency working. Adult Safeguarding was introduced in June 2017 with trained staff who are able to assist in terms of reviewing safeguarding concerns and filtering reports for sharing.

[14] The Homelessness Reduction Act 2017, Ministry of Housing, Communities and Local Government.
[15] Compass - Drug and Alcohol Service for adults aged 18 and over offers services including medically assisted recovery.

Chapter 6 – Conclusions

6.1 This SAR Overview Report for Adult B is the MKSB response to the sad death of ADULT B. MKC has prioritised and implemented positive changes within MK to reduce rough sleeping in the community having secured recent Government funding. Learning has been identified before and during this SAR process and the progress for change is indicated below. Actions to support and reduce the numbers of rough sleepers, or eradicate the need for individuals to sleep rough, if ever possible, will ensure that Adult B's death was not in vain.

6.2 Predictability and Preventability

6.3 Adult B was known by practitioners to be vulnerable. There was repeated presentation by Adult B at MKUH, SCAS transported him on numerous occasions to the hospital and Adult B was continually arrested for breaching his ASBO. He was regularly having alcoholic seizures requiring hospital intervention. You would think 'how many more times?' should a person displaying such concerning behaviours and worrying health concerns have, before a professionals meeting is called to consider his case.

6.4 This review confirms practitioners wished Adult B well and there was good work and support offered and provided but, his commitment to comply or take advice and support was sporadic. Overall, agencies and practitioners often worked in silos with no one lead practitioner or agency taking an overview of Adult B's prevailing concerns. Opportunities to carry out a risk assessment or to make a referral or escalate his case earlier were missed on many occasions.

6.5 On the information supplied to this review, it is suggested Adult B's case should have been considered as high-risk from the emerging interaction with practitioners that was clearly evident at the time. The likelihood of a tragic outcome for Adult B was high even before it was known he had autism. It cannot be known for certain but, it is suggested in Adult B's case it was both predictable and probably preventable.

Comment: This review shows the steps and development MKC has since taken to address the issues in Adult B's case. If the Findings and Recommendations in Chapter 4 and 7 are adopted, it will go towards supporting the MKC Rough Sleepers Strategy 2017 - 2020 in order to reduce Rough Sleeping in the Local Authority and provide protection and support for the most vulnerable.

6.6 It must be appreciated that dealing with vulnerable adults and rough sleepers, often with additional complex needs, is a very difficult process for practitioners to contend with. This is particularly so when there is added mental health, alcohol and substance misuse concerns that can impact on their health and welfare.

6.7 Previous Milton Keynes SARs

6.8 **MK Learning Review:** A recent learning review recommended the implementation of the VARM process, which was ratified by the MK Programme Board (2018). It will provide professionals with a framework to facilitate effective multi- agency working with vulnerable individuals aged 16+ who are deemed to have mental capacity but are at risk of serious harm or death through severe self-neglect, risk taking behaviour or refusal of services. The process applies in both residential care settings and in the local community. It will consist of practice guidance, risk assessment and a management tool.

6.9 It should be used in conjunction with MK Safeguarding Adult Policy and Procedures, taking into account where applicable, the principles of the MCA 2005[16]. It is not a substitute as agencies should follow existing legislation and their internal processes as they have primacy, including the MHA[17], MAPPA, MARAC and other guidance. The VARM will be used if the vulnerable adult does not fall within these processes or if it is felt that a VARM will reduce the risk of serious harm or death. MKC has recently agreed to implement a VARM for MK after a recommendation made in a recent MK Learning Review and will be developing the process.

6.10 The findings from this SAR suggests the VARM could be used in managing high risk cases and oversee the findings and suggested learning relating to this report when Vulnerable Adults and Rough Sleepers do not comply and require assisted support. **(See Findings in Chapter 4)**

6.11 It is suggested Adult B's case was high risk due to the worrying health and social problems he had and his non-compliance to offered support. The VARM could hopefully support others who are rough sleepers with alcohol, substance misuse and mental health problems in the future. It can address vulnerable adults who may lack capacity and make recommendations for interventions.

6.12 **Adult A SAR** 2013/2014: recommendations made which are relevant and still evident in Adult B's case are: -

- ASC - Managers in front line teams receiving referrals should review practices and ensure referrals are inputted promptly and appropriate action taken without delay (Governance and supervision is a finding).
- Children and Families - MCA training to be reviewed for C and F staff (The findings of this review will ensure a wider remit of learning for all MKC and safeguarding partners' staff).
- Multi-Agency for MK Adult and Children Boards – Should receive reports from partner agencies on electronic information sharing system across statutory agencies (record keeping and sharing information is a finding in this review).
- MKSB – A policy and procedures for an escalation policy of partner agency disputes (Escalation is still a failing and is a finding in this review).

6.13 Final Comments and Submission

6.14 After his death, the community held a candlelight vigil for Adult B to remember him. His death will not be in vain if the recommendations from this SAR, together with the MKC developments and identified priorities, are implemented and are effective.

6.15 **This SAR Overview Report for Adult B is submitted to the MKSB to consider the findings and recommendations and to promulgate necessary learning through the SAR Action Plan that accompanies this report.**

[16] Mental Capacity Act 2005
[17] Mental Health Act 1983

Chapter 7 – MK SAR Overview Report and Agency Recommendations

7.1 Listed below are the suggested Milton Keynes SAR Overview Review Report Recommendations. Individual Agency IMR Recommendations have been reviewed and quality assured within their respective agencies. All the findings and recommendations have been considered and accepted after consultation by the MKSB. The measurability, action taken by the agencies and timeliness for the completion of all recommendations and learning are contained within the SAR Action Plan that will accompany this report.

7.2 Findings in Chapter 4, detail the rationale and concur with and/or supports the suggested recommendations of the Milton Keynes SAR Overview Report and Individual Agency Recommendations as follows: -

Milton Keynes SAR Overview Report Recommendations

Recommendation 1 - Signs and symptoms of autism

Milton Keynes SAR Overview Report Recommendation for MKSB for Milton Keynes Safeguarding Partners

It is recommended that Milton Keynes Safeguarding Board ensure all safeguarding partner agencies including voluntary organisations within MK are made aware of the signs and symptoms of autism, other health concerns or learning disability in order that a vulnerable adult will obtain the necessary support if identified at an earlier stage, to protect their welfare.

Recommendation 2 - Appropriate use of IMCA and MCA assessments

Milton Keynes SAR Overview Report Recommendation for MKSB for Milton Keynes Safeguarding Partners

It is recommended that the MK Safeguarding Board, in adult cases concerning any Vulnerable Adult who is a Rough Sleeper with possible Mental Health, autism or any other significant health concerns, including alcoholism and substance misuse, that a MCA must be carried out for the person, supported by the appointment of an IMCA if necessary to ensure the 'best interest' to protect the welfare of the person is obtained.

Recommendation 3 - Clarity of the provision of services for MK Rough Sleepers

Milton Keynes SAR Overview Report Recommendation for MKSB for Milton Keynes Safeguarding Partners

It is recommended Milton Keynes Safeguarding Board implement a policy for all safeguarding partners including voluntary organisations to provide clarity of agency thresholds, a clear pathway and access to an autism professional and a lead person or a one-stop shop, to oversee high risk cases to ensure compliance with legislation and guidance.

Recommendation 4 - Governance and supervision oversight

Milton Keynes SAR Overview Report Recommendation for MKSB for Milton Keynes Safeguarding Partners

It is recommended that MK Safeguarding Board remind all safeguarding partner agencies participating in this SAR there must be appropriate and timely supervision in MK for Vulnerable Adults and Rough Sleepers. In such cases, managers and supervisors within safeguarding agencies

need managerial oversight and supervision of practitioner's actions and non-action to ensure a rationale is recorded for the accountability of the decisions made.

Recommendation 5 - Referrals, risk and care assessments

Milton Keynes SAR Overview Report Recommendation for MKSB for Milton Keynes Safeguarding Partners

It is recommended Milton Keynes Safeguarding Board ensure all safeguarding partner agencies including voluntary organisations within Milton Keynes in safeguarding adult cases involving Vulnerable Adults and Rough Sleepers, that appropriate referrals and risk assessments are carried out and in high-risk cases, are not deferred without management oversight. Any decision or outcome of a referral or assessment must be reported back to the referring agency who will challenge and escalate the decision if felt necessary.

Recommendation 6 - Record keeping and sharing information

Milton Keynes SAR Overview Report Recommendation for MKSB for Milton Keynes participating agencies to the SAR

It is recommended that Milton Keynes Safeguarding Board ensure all safeguarding partner agencies including voluntary organisations within Milton Keynes Local Authority provide assurance they have a robust and efficient record keeping systems in place and remind staff of the need to share relevant information promptly where it could impact on an adult case.

Recommendation 7 - Professionals' meetings

Milton Keynes SAR Overview Report Recommendation for MKSB for Milton Keynes participating agencies to the SAR

It is recommended that Milton Keynes Safeguarding Board ensure all partner agencies, including voluntary organisations within Milton Keynes when circumstances justify, call a prompt professional meeting when continuing concerns with Vulnerable Adult and Rough Sleepers are evident, where professionals can consider the wider options available to protect the welfare of the person.

Recommendation 8 - Rapid response meetings

Milton Keynes SAR Overview Report Recommendation for MKSB and MK Adult Social Care

It is recommended that MK Safeguarding Board and Adult Social Care when notified of the death of a Rough Sleeper or other Vulnerable Adult where the cause of death may be a concern, ensure a rapid response meeting in all cases is called to consider the circumstances and consider further options or enquiries to be made and information shared if necessary.

Recommendation 9 - Training and professional knowledge of legislation

Milton Keynes SAR Overview Report Recommendation for MKSB for Milton Keynes Safeguarding Partners

It is recommended that Milton Keynes Safeguarding Board ensure all safeguarding partner agencies including voluntary organisations practitioners within Milton Keynes, are reminded to utilise the Milton Keynes Rough Sleeping Reduction Strategy 2017, the Mental Health Act (MHA) 1983, Mental Capacity Act 2005, Care Act 2014 and an Independent Mental Capacity Advocate (IMCA) when necessary in adult cases.

Recommendation 10 - MKC use of Government funding

Milton Keynes SAR Overview Report Recommendation for MKSB for Milton Keynes Council and MK Programme Board

It is recommended that Milton Keynes Safeguarding Board request that Milton Keynes Council consider the findings and recommendations of this SAR when considering the dispersal, overall use and application of recent Government funding secured by MKC for Rough Sleepers, and the MK's Rough Sleepers Strategy 2017, consider the recommendations of learning from this SAR when considering the overall use and application of the government funding.

Recommendation 11 - Courts

Milton Keynes SAR Overview Report Recommendation for MKSB for Milton Keynes County Court

It is recommended Milton Keynes Safeguarding Board request a memorandum of understanding with MK County Court for the consideration to utilise their legal powers in a case of an identified vulnerable adult who is persistently before the court. The court could be asked in specific high-risk cases to make a direction and order a mental health assessment.

Recommendation 12 - Delays in carrying out Coroner's Inquests

Milton Keynes SAR Overview Report Recommendation MKSB for the Milton Keynes Coroner's Office

It is recommended Milton Keynes Council via the Milton Keynes Safeguarding Board communicate with Milton Keynes Coroner's Office to agree an understanding of the possible impact of a significant delay in holding the inquest for a death of a vulnerable adult within the Local Authority.

Recommendation 13 - Escalation policies

Milton Keynes SAR Overview Report Recommendation for the Participating agencies to the SAR

It is recommended MK Safeguarding Board ensure partner agencies within Milton Keynes are made aware of the need to challenge decisions or actions taken during a Safeguarding Enquiry, which are not agreed. Practitioners should raise the concerns to their line manager and if the matter is unresolved should utilise either Milton Keynes Safeguarding Board or their own agencies escalation policy.

Individual Agency Recommendations

Identified agency recommendations contained with their submitted IMRs, have been agreed by their respective senior management for the process of completing this SAR and are not replicated here. Milton Keynes SAR Overview Report Recommendations confirm and supports the agency recommendations for learning and where relevant encompasses and overarches support of the individual agency findings. A MKSB SAR Action Plan will follow this report and will include all the recommendations for learning from this SAR process.

Appendix 1 - Biography

The Independent Overview Author of the SAR

David Byford is a Safeguarding Expert and Managing Director of his own Safeguarding Consultancy. He retired in September 2014 after 40 years within the Metropolitan Police Service (MPS) including over 25 years' experience in Child Protection. He was a Senior Investigating Officer responsible for investigating serious crimes against children, young people and adults. In 2003, he developed the serious case review (SCR) process for the MPS.

After retirement as a serving Police officer (2006,) he was again employed by the MPS as an expert Senior Review Officer, responsible for the MPS SCR responses for all 32 London Boroughs. He has acted as an adviser on SCRs' to the MPS, Association of Chief Police Officers (ACPO) now the National Police Chiefs Council (NPCC), CEOP's, police forces nationally, local authorities, independent schools and LSCB's. He was personally selected to carry out national sensitive and bespoke reviews, including for the Attorney General, Lord Goldsmith regarding *Regina* V *Sally Clark* and for the Director of Public Prosecutions who identified experts to research and write the CPS Disclosure Manual for expert witnesses. In 2010, he conducted an ACPO National Review for CEOP's, identifying how the Police Service should conduct SCRs'. He has presented nationally on conducting SCR parallel criminal and coronial processes and has effected strategic change.

David has completed the DfE sponsored training "Improving the Quality of SCRs" and he was asked to participate in the DfE funded NSPCC and SCIE led "Learning into Practice Project (LiPP) for Improving SCRs (2016) to look at quality markers for Lead Reviewers. He was invited as part of a small selected group of SCR Authors by the DfE, to meet with Alan Wood so he could consult prior to concluding his "Wood Report into LSCBs" (2016). David is an Independent Chair and Author for Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews. His name is on the Association of Independent LSCB Chairs National Directory as an SCR Lead Reviewer/Author which includes his detailed biography.

Acknowledgements

The Lead Reviewer and Overview Author would like to take the opportunity to thank the MKSB and participating agencies and key professionals who contributed to the SAR. The review could not have been completed without the valued assistance of the Independent MKSB Chair, MK Together Programme Manager and Clerk to the Board, SAR panel members and IMR Authors.

Appendix 2 – Bibliography

The following legislation, documentation and guidance was consulted for the process of completing this SAR (see also inserted footnotes):-

Care Quality Commission (2010) Guidance about compliance: Essential standards of quality and safety. What providers should do to comply with the section 20 regulations of the Health and Social Care Act 2008, London: CQC

Care Act 2004, 2014

Equalities Act 2010

European Convention on Human Rights (ECHR)

Human Rights Act 1998

Mental Capacity Act 2005

Mental Health Act 1983

Milton Keynes Multi Agency Safeguarding Policy and Procedures 2016

Milton Keynes Rough Sleepers Strategy 2017

Appendix 3 – Glossary of terms

Adult Social Care	ASC
Community Safety Partnership	CSP
Deprivation of Liberty Safeguards	DoLS
General Practitioner	GP
Human Rights Assessment	HRA
Independent Chair	IC
Independent Mental Capacity Advocate	IMCA
Independent Overview Author	IOA
Lead Reviewer	LR
Local Authority	LA
Local Government Association	LGA
Mental Capacity Assessment	MCA
Mental Health Act	MHA
Mental Health Hospital Liaison Team	MHHLT
Milton Keynes Council	MKC
Milton Keynes Multi Agency Safeguarding Policy and Procedures	MKASPP
Milton Keynes Safeguarding Team	MKST
National Probation Service	NaPS
New Psychoactive Substances (Legal Highs)	NPS
Police Officer	PO
Rough Sleepers Tasking Group	RSTG
Safeguarding Adults Board	SAB
Safeguarding Adult Review	SAR
Senior House Officer	SHO
Severe Weather Emergency Protocol	SWEP
Social Worker	SW
Team Manager	TM
Terms of Reference	TOR
Thames Valley Police	TVP
Vulnerable Adult Risk Management	VARM