Overview Report

Safeguarding Adults Review into the death of 'Steven'

Report – Approved and signed off by SSAB on 17th September 2025

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1. Contents

2. Introduction

2.1. To protect dignity and privacy, and to comply with the Data Protection Act 1998, the subject of this review is referred to under the pseudonym of Steven.
2.2. On a day in February 2024, Steven fell approximately six metres onto a concrete floor. Despite advanced life support attempts, resuscitation was stopped due to an un-survivable brain injury.
2.3. Steven had a history of drug use and mental ill health and, following the breakdown of his relationship, he experienced homelessness.
2.4. Greater Manchester Mental Health referred Steven for review and the Salford Safeguarding Adults Review sub-group unanimously agreed (in October 2024) that self-neglect was pertinent in Steven's situation and that the criteria were met for a mandatory review under The Care Act 2014.
2.5. The purpose of a Safeguarding Adults Review is clearly defined in the Care Act 2014. It is to promote effective learning and improvement actions to prevent future deaths or serious harm occurring again. The lessons learnt for this case should be applied to future cases to ensure continuous improvement of practice. It is not the purpose of the review to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation.
2.6. This report has been authored by Allison Sandiford. Allison is an independent safeguarding consultant with no links to Salford Safeguarding Adults Board or any of its partner agencies. Allison gained experience in safeguarding whilst working for a police service. Since leaving the force in 2019, Allison has conducted serious case reviews in both children's and adults safeguarding, and domestic homicide reviews.

3. Methodology

3.1. This Safeguarding Adults Review has reflected upon multi-agency work systemically. Importantly it has recognised good practice and strengths that can be built on, as well as identifying things that need to be done differently to encourage improvements.
3.2. The review has engaged frontline practitioners and their managers with a Practitioner Reflective Session - during which practice and decision-making around Steven was analysed and discussed in order to aid understanding as to why professionals working to support Steven had acted in a certain way, at that time.

4. Terms of Reference

4.1. The review panel[1] identified the following key lines of enquiry for the review:

- What did agencies understand of Steven's lived experience?
- Did professionals recognise Steven's care and support needs and were there missed opportunity to refer to safeguarding?
- Explore the current co-occurring conditions/dual diagnosis pathways and professionals' knowledge/understanding of them.
- How do professionals include family in healthcare plans?
- What pathways were available to professionals to support Steven with his homelessness - taking into account his care and support needs and the local authority's duty to safeguard.
- Do professionals recognise/understand the power of addiction?
- Identify areas of positive practice

4.2. It was agreed for the review to look at the 12 month period preceding the day when Steven sadly died. But in addition, the report will include background information re any significant events and safeguarding issues prior to the scoping period - if agencies consider that it would add value and learning to the review.

[1] See Appendix 1 for panel membership.

5. Involvement of Family and Wider Community

5.1. The Independent Reviewer and Salford Safeguarding Adults Board would like to offer their condolences to the family and friends of Steven.
5.2. The subjective experiences of support and services provided to the deceased, from the point of view of family members, is an important aspect of the Safeguarding Adults Review. As such Salford Safeguarding Adults Board contacted Steven's wife (hereafter referred to as Sophie) by telephone to advise her of the review and invite her to participate.
5.3. The Board and the Independent Reviewer would like to thank Sophie for agreeing to speak with the Independent Reviewer by telephone and further communicate throughout the review process.
5.4. Sophie's contributions are woven into the report.

6. Parallel Reviews

6.1. A Coroner's Inquest concluded in August 2024 that Steven had died as a result of an accident.
6.2. Greater Manchester Mental Health has undertaken a Rapid review of Care. The identified actions required to make improvements are detailed at Appendix 2 of this report.
6.3. The police deemed there to have been no third-party involvement in Steven's death and no criminal investigation necessary.

7. Dissemination of the Learning

7.1. Once agreement for the final report has been given by Salford Safeguarding Adults Board and its partner agencies, the Overview (or an Executive Summary) will ordinarily be published and made available on the Board's website. The decision about whether to publish rests with the Board.
7.2. Upon completing the review, partner agencies will be made aware, and the improvement plan will be shared with the agencies involved.
7.3. The review has been assured by Salford Safeguarding Adults Board that the learning will be disseminated by means of publication of the report (if agreed) and/or briefing documents which will be shared across the partnership and with the relevant senior leader and specialist forums.
7.4. Additionally information will be further shared via the Salford Safeguarding Adults Board newsletter and a learning event.
7.5. To assess the impact of the learning event on practice, it will be evaluated both immediately after the event and again in three months.

8. Who was Steven?

Sophie has described Steven as a ball of energy who was very loving, caring and extremely funny. She expressed him to be a beautiful soul, very sensitive, and a soft person.
8.1. Despite a traumatic and chaotic childhood (during which Steven was introduced to drugs) he exampled his intelligence at school, learned a trade and grew his own business. Sophie has described him as hard-working, and generous to the point of giving away his last penny.
8.2. Away from work Steven loved cooking, and Sophie praised his skills as restaurant-quality.
8.3. She has said that Steven was an amazing father and an amazing man. He just did not have the correct help.

9. Equality and Diversity

9.1. Whilst writing this report the Independent Reviewer has evaluated the nine protected characteristics under the Equality Act 2010[2] and additionally assessed whether any factors have disadvantaged Steven in accessing services.

9.2. Steven was a 37 year old white British[3] cisgender male. He was married but prior to his death had very recently separated from his wife[4] with whom he has one child.

9.3. Steven also has two adult children from a previous relationship.

9.4. Steven had no recorded disability, but he was known to use substances and experience poor mental health.

9.5. Around 2019/2020, professionals began assessment with Steven in relation to borderline personality disorder. However, Steven did not complete the assessments and so, although he exhibited traits of the disorder, he was never formally diagnosed. Nevertheless, Steven was prescribed medication during this period, and he reported that it provided him with stability and *'levelled him'* - though during times of crisis and drug use, he was unable to adhere to his prescription and consequently would experience delusions.

9.6. The NHS website describes borderline personality disorder as a disorder of mood and states that in general, someone with a personality disorder will differ significantly from an average person in terms of how he or she thinks, perceives, feels and relates to others. Many people with borderline personality disorder will also have another mental health condition or behavioural problem, such as misusing alcohol and/or drugs, generalised anxiety disorder, bipolar disorder, depression or another personality disorder, such as antisocial personality disorder.

9.7. Whilst many people diagnosed with borderline personality disorder can live a 'regular' life, it is a serious condition, and many people with the condition self-harm and attempt suicide.

9.8. Consequently whilst everyone's experience is different and unique to them, as an individual potentially living with borderline personality disorder, Steven could have experienced rapid shifts in emotions which could have led to unpredictable behaviour.

9.9. Additionally borderline personality disorder often includes chronic emptiness, which could have affected Steven's ability to focus and engage in activities.

9.10. Sleep issues are common in those with borderline personality disorder and Sophie has told this review that sleep was often an issue for Steven; he experienced irregular sleep schedules - waking at early hours and napping during the day. Sophie also said he would sleep talk and wake anxious.

9.11. Any poor sleep would have worsened his symptoms such as irritability, mood swings, and difficulty concentrating; creating a vicious cycle.

9.12. According to University of Manchester research, people with borderline personality disorder are 13 times more likely to report childhood trauma than people without any mental health problems – and a clinical assessment which dates from 2016 evidences that Steven did report significant trauma within his childhood.

9.13. The study was carried out by researchers at the University of Manchester in collaboration with Greater Manchester Mental Health NHS Foundation Trust and the Spectrum Centre for Mental Health Research, Lancaster University. It is published in the journal Acta Psychiatrica Scandinavia[5].

9.14. It analysed data from 42 international studies of over 5,000 people and found that 71.1% of people who were diagnosed with the serious health condition reported at least one traumatic childhood experience. The most common form of adverse experience reported by people with borderline personality disorder was physical neglect at 48.9%, followed by emotional abuse at 42.5%, physical abuse at 36.4%, sexual abuse at 32.1% and emotional neglect at 25.3%.

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[2] Age, disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation

[3] Steven is not recorded to have followed a religion or faith.

[4] Sophie told this review that when Steven died, he had been away from the marital home for a period of two weeks - which was something that often happened. Sophie explained that she had said that she was finished with the relationship but said that if Steven had returned and proved that he was going to get help, they would have worked things out.

[5] Childhood adversity and borderline personality disorder: a meta-analysis - Porter - 2020 - Acta Psychiatrica Scandinavica - Wiley Online Library

9.15. There is reference in Steven's case notes to him living with Attention Deficit Hyperactivity Disorder but further exploration of this has concluded that similar to the borderline personality disorder, there is no evidence of him ever being medically diagnosed.

9.16. All the same it is important to note that whilst trauma does not directly cause the development of Attention Deficit Hyperactivity Disorder, an increasing body of research is supporting a connection between the two and has linked the onset and severity of Attention Deficit Hyperactivity Disorder to stressful events, life experiences, and memory processes[6].

9.17. In relation to drug use, Steven historically self-disclosed that he had become addicted to class A drugs in his early teens (which offers further insight into his childhood). However Steven had periods in his life where he was drug-free and engaged with support.

9.18. Sophie has informed this review that during the scoping period, Steven continued to reside at the family home intermittently but there were times when he was unable to stay due to relapse and/or his mental health condition.

9.19. During the periods when Steven could not return home, he experienced homelessness.

9.20. Homeless individuals in England face significant health issues and have a life expectancy below the national average. Between 2001 and 2009, the average age of death for homeless men was 48 years, compared to 74 years in the general population)[7].

9.21. A 2010 audit of over 2,500 homeless people found that 45% had diagnosed mental health problems (compared to 25% in the general population) and 36% had used drugs in the past month (compared to 5%)[8]. Additionally, excessive alcohol consumption is a known factor in homelessness[9].

9.22. Homelessness makes it harder for an individual to seek support for health and wellbeing issues, but it is notable that in Steven's case, he was always able to provide Sophie's address for contact details, and he remained registered with a GP Practice until the day before he died when for unknown reasons, he re-registered with the inclusion service.

9.23. Whilst this offered an element of stability, the availability of an address also potentially 'masked' his homelessness circumstances and true vulnerabilities.

10. Analysis and Response to Key Lines of Enquiry

Following:

- examination of the information gained from the agency reports and documentation shared with this review,
- discussions with professionals during the Practitioner Reflective Session[10], and
- discussion and analysis with panel members[11].

the subsequent responses have been generated to the Key Lines of Enquiry.

Lessons learned are stated within the body of the report. In relation to any lessons which have not been addressed, there are questions at the end of the report for Salford Safeguarding Adults Board to consider; the answers to which will drive the Board and its partner agencies to develop an improvement plan that will respond directly to the learning.

[6] Sugaya L, Hasin DS, Olfson M, Lin KH, Grant BF, Blanco C. Child physical abuse and adult mental health: a national study. *J Trauma Stress*. 2012;25(4):384–392. DOI: 10.1002/jts.21719

[7] Homelessness: A Silent Killer (2011) | Crisis | Together we will end homelessness

[8] The unhealthy state of homelessness: Health audit results 2014 | Homeless Link

[9] is-england-fairer-2016-most-disadvantaged-groups-homeless-people.pdf

[10] See Appendix 4 for details.

[11] Panel met on three occasions.

What did agencies understand of Steven's lived experience?

10.1. It has been established that professionals from the following agencies/organisations had contact with Steven during the scoping period of this review and therefore had opportunities to learn of Steven's lived experience.

- Greater Manchester Police
- North West Ambulance Service
- GP Practice
- Northern Care Alliance – predominantly the hospital Emergency Department
- Greater Manchester Mental Health
- Housing Services

10.2. The majority of the police contacts during the scoping period relate to incidents whereby Steven had been in suspected drug-induced mental health crisis within the community. Police Officers responded by bringing Steven to safety and requesting medical assistance. As such it was known from records on the police data system that Steven was a drug user and that his usage could affect his mental health.

10.3. When a call is received by the police Force Contact Centre, background checks on the data system are conducted by operators and supervisors real-time; and any warning signs or welfare issues recorded on the system are relayed to the responding Officers as they attend.

10.4. However in order to do this, the identity of the person Officers are attending must be known, and there were many occasions during the scoping period of this review whereby Officers did not know that the subject of the call they were responding to was Steven (often the report would, for example, be a person on a roof or a person in a tree, made by a third party without knowledge of any identity). On such occasions, in the absence of identification; no background check was possible (though an example of positive police practice occurred when, on the day of Steven's death, an Officer with local knowledge identified that a man on a roof could be him. This allowed for immediate checks on Steven's recent history.)

10.5. When, during incidents Steven was brought to safety and identified, the Officer's priority was to get him the medical help he required, not to explore his lived experience.

10.6. Similarly North West Ambulance Service responded to Steven's immediate presenting medical needs and followed the appropriate emergency care pathway.

10.7. Steven often presented to North West Ambulance Service with Acute Behavioural Disturbance which is a potentially life-threatening syndrome of delirium, dysregulated physiological responses and aggressive behaviour. It is most commonly caused by illicit drug use. Uncontrolled catecholamine[12] release, metabolic acidosis[13] and hyperthermia[14] can lead to rapid physical deterioration and death[15].

10.8. Ambulance crews recognised Steven's presentation as an acute life-threatening medical emergency and therefore transported him to the local Emergency Department for ongoing care.

10.9. Whilst North West Ambulance Service crew hold Electronic Patient Clinical Records (which enable crews to capture information and supports real-time information to be shared quickly and easily with healthcare partners) like all ambulance services they do not hold caseload records. Consequently the ambulance service do not hold historic information about an individual on a data base (like the police do), to which their crew and staff can refer.

10.10. Additionally patients presenting in Acute Behavioural Disturbance as Steven often did, do not usually have the ability to provide rational information or articulate themselves to describe care and support needs. Accordingly on the majority of the contacts with ambulance staff and crew, Steven was not able to share any insightful information regarding his circumstances.

[12] The body releases catecholamines in response to emotional or physical stress. Unusually high or low levels of individual catecholamines can cause medical issues.

[13] Metabolic acidosis is a condition in which acids build up in your body. Symptoms include an accelerated heartbeat, confusion and fatigue.

[14] Drugs can cause dysregulation of the hypothalamic–pituitary–adrenal axis which can result in a rise in core temperature.

[15] Acute behavioural disturbance: a physical emergency psychiatrists need to understand | BJPsych Advances | Cambridge Core

10.11. Nevertheless this review has learned that on one occasion Steven was able to be reflective and told the ambulance crew that he had tried to seek support from mental health services but was *"getting nowhere"*. On this occasion the crew recorded on the Electronic Patient Record that they had made further attempts to seek information from Steven - in order to better understand his personal circumstances - but that Steven was not able/willing to disclose more.

10.12. The GP Practice has informed this review that in relation to Steven's lived experiences and personal circumstances; their case notes do record that Steven had informed during some appointments that he was sofa surfing or staying with friends, and also that he had previously used drugs. But the Practice further informed that on most occasions Steven presented to the Practice with acute medical complaints, and it was therefore not feasible to explore his personal circumstances as the priority was to refer Steven into secondary healthcare.

10.13. Staff at the hospital Emergency Department did not hold information in relation to Steven's history or lived experiences. However, this review has been assured that staff offered Steven support to address the issues that they were able to see.

10.14. When Steven presented to the Emergency Department, staff responded to and addressed any physical injuries (on one occasion Steven presented with injuries reportedly caused by an assault[16], and on another Steven had scratches on his body caused by sleeping rough in the bushes) and Steven was also provided with showering facilities and clean clothing when he was unkempt. Onward referrals were made (for example to the Tissue Viability Nurse), and Steven was seen by the mental health liaison team. Steven's homelessness was responded to by contact with the homelessness coordinator, in order to try and sort out emergency accommodation.

10.15. Mental health professionals gained the greatest insight into Steven's lived experience.

10.16. The most comprehensive understanding is encapsulated in a clinical assessment which dates from 2016. This assessment provides extensive details regarding Steven's traumatic childhood, early adulthood, educational and career opportunities, previous relationships, fatherhood, and criminal history.

10.17. Though the Community Mental Health team did learn of Steven's drug use and homelessness during their assessment, the risk assessments conducted by mental health professionals during the scoping period of this review, albeit informative and adequate, do not fully capture the profound and traumatic impact of Steven's experiences on his life trajectory as the earlier one did in 2016.

10.18. In relation to the housing sector, assessment was completed with Steven by the Housing Options Service but at this time the priority was to respond to the current situation and the need to make a decision on whether to place Steven or not (pending enquires as part of the homeless assessment). Consequently there were limitations in relation to how far back the assessment went into Steven's history and lived experience.

10.19. The Supported Housing Team assessment may have delved deeper, but their assessment was not completed due to Steven having left the hotel accommodation prior to the scheduled appointment.

10.20. It is apparent from the above descriptions, that due to the varying purposes of contact and/or assessment, not all agencies gained a comprehensive understanding of Steven's situation and lived experiences.

10.21. Though not directly related to this review or to Steven's circumstances, it is important to note that conversations during the Practitioner Reflective Session often returned to the quality of assessment as it was recognised that this provides an opportunity for agencies to gather information about an individual and learn of their lived experiences. There was a general agreement that time constraints were at risk of dampening professional curiosity, both within the assessment process and later in relation to triangulating information from other agencies - and that this can affect the quality of agency assessment.

10.22. This practitioner feedback regarding time constraints is valid and should be brought to the attention of service commissioners.

[16] Steven did not wish to report this to the police.

Learning 1: *Time constraints can affect the standard of assessment and consequently affect practitioner's ability to learn of an individual's lived experience.*

Recommendation: Salford Safeguarding Adults Board should highlight practitioners' concerns regarding the impact of time constraints on assessment to members of the Directorate Management Group[17].

10.23. In relation to understanding Steven's lived experience, it was crucial that every agency utilised any opportunity to learn about him (and appropriately recorded and shared his information) because understanding Steven's experience of trauma was essential to his recovery plan.

10.24. Trauma can make a person more vulnerable to developing mental health problems (and can also be linked to both Borderline Personality Disorder and Attention Deficit Hyperactivity Disorder) and numerous research studies confirm a link between traumatic experiences in childhood and addictive behaviours in adulthood.

10.25. One of the most notable research papers in relation to addiction, is the original study of Adverse Childhood Experiences by Felitti and colleagues (1998)[18]. Within this study, Adverse Childhood Experiences included traumatic experiences (within the first 18 years of life) such as physical, emotional, and sexual abuse, neglect, loss of a parent, witnessing intimate partner violence, and living with a family member with a mental illness. And the researchers found that as the number of Adverse Childhood Experiences increased, so did the risk of substance use in adulthood.

10.26. Consequently it was crucial for professionals to approach Steven with interventions that reflected his trauma exposure, i.e., within a trauma-informed practice model that would have supported for Steven's mental health and substance addiction to be treated according to his specific circumstances.

10.27. As mentioned, the clearest evidence of professionals effectively exploring Steven's trauma history with him is within the clinical assessment completed with Steven by mental healthcare professionals in 2016. No other documentation submitted for this review has detailed the significant and distressing effects of Steven's experiences.

Learning 2: *It is crucial that practitioners from all agencies are aware of the importance of trauma-informed practice and utilise any opportunity to seek to understand (and record) an individual's lived experience*.

10.28. It is commendable that the Supported Housing Service has already acknowledged the need for trauma-informed practice and subsequently commissioned the Salford Dual Diagnosis team[19], which works with individuals by recognising that many have experienced traumatic histories which affects their ability to access services. But all agencies can find support for their professionals in relation to adopting a trauma-responsive approach on the Salford Safeguarding Adults Board website[20]. The pages includes resources and links to valuable learning, including an e-learning module provided by NHS England[21] for healthcare professionals.

10.29. This review has also been made aware of free Psychologically Informed Environment Training[22]. Psychologically Informed Environments are services that are designed and delivered in a way that takes into account the emotional and psychological needs of the individuals using them. This training is designed to increase the learner's knowledge of homeless people, understand their narratives and respond appropriately.

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[17] The Directors Management Group whose membership is the Senior Leadership Team (and can be opened up to Heads of Service including the Principal Social Workers in the Adult an Health Partnership), meets weekly.

[18] Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study - PubMed

[19] The Salford Dual Diagnosis Homeless team (now known as Inclusion Health Homeless Team - Salford) is commissioned by SCC through a grant from the Ministry of Housing, Communities and Local Government to address rough sleeping in the area. This team works alongside the Rough Sleeper Drug and Alcohol service.

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[20] Trauma Responsive | Salford Safeguarding Adults Board

[21] Trauma-Informed Care - elearning for healthcare

[22] FREE Spring 2025 Homeless PIE Training Course - Manchester Safeguarding Partnership

It is a four Session Course, and it is recommended that all four sessions are attended as they link to each other and reference will be made to past and future sessions throughout.

10.30. Additionally Salford Health and Well-being Board has been awarded a contract for trauma training with Dignifi Ltd through a procurement process and will be mobilising their offer in June 2025. Salford Health and Well-being Board will publish and promote this via the website and comms channels. There are three types of training that will be on offer -

- Trauma aware - for everyone
- Trauma enhanced - for professionals with substantial interaction with service users
- Compassionate leadership - for leaders, managers etc

This is for 12 months but Salford Health and Well-being Board are working on a specification for a multi-year contract.

Did professionals recognise Steven's care and support needs and were there missed opportunity to refer to safeguarding?

10.31. The criteria for establishing a safeguarding concern is derived from Section 42 (1a and b) of the Care Act 2014 and requires professionals to have asked whether there was a reasonable cause to suspect that Steven had care and support needs (whether or not those needs were being met). And whether there was a reasonable cause to suspect that Steven was experiencing, or at risk of, abuse or neglect.

10.32. Professionals attending the Practitioner Reflective Session demonstrated a clear knowledge of this and it is good practice that Salford Safeguarding Adults Board have Process Maps and Case Studies[23] on their website to reflect the requirements of the Care Act.

10.33. If this criteria had been met, a safeguarding concern for Steven should have been submitted and the local authority would have thereafter further considered whether the statutory three stage test[24] criteria for safeguarding had been met, and whether there was a legal duty to make enquiries or cause others to do so.

10.34. Decision-making regarding the third criterion[25] of the test (which requires consideration of whether due to his care and support needs, Steven would have been unable to protect himself against abuse or neglect, or the risk thereof) can be complex. It is therefore not always immediately clear and often the local authority needs to gather additional information.

10.35. If a safeguarding concern had been raised for Steven and the local authority determined that it did not meet the criteria for an enquiry, the local authority would have considered other forms of support. This is because the responsibility for adult safeguarding extends beyond situations that lead to a safeguarding enquiry; there is a collective duty among organisations to address risks to wellbeing and safety, whether through safeguarding measures or alternative support solutions.

10.36. No safeguarding concerns were submitted for Steven during the scoping period of this review, which raises two points for this review to consider:

- Were there potential missed opportunities to refer to safeguarding. And,
- Was the collective responsibility across the agencies to address Steven's safety through alternative support pathways respected.

10.37. Often the first agency to respond to Steven was the police. Police Officers operate under the force Adults at Risk policy and procedure[26] which reflects the Legal Framework within the Care Act and aims to:

- Protect the lives and preserve the safety of adults who may be at risk of harm.

[23] https://salfordadultsg.trixonline.co.uk/chapter/process-maps-and-case-studies#care-act-statutory-guidance-case-studies

[24] Under Section 42 of the Care Act, the safeguarding duties apply to an adult 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,
- 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.

[25] Section 42(1c) of the Care Act 2014

[26] Revised September 2024

- Ensure that all adult safeguarding concerns accepted by Greater Manchester Police are investigated thoroughly (taking positive action against offenders), and those which do not require initial police intervention, are signpost to a more appropriate agency.
- Contribute to the safeguarding of Adults at Risk, by working jointly with partner agencies, sharing information, and identifying risk.
- Adopt a proactive and, wherever possible, multi-agency approach to preventing offences against Adults at Risk.

10.38. The vehicle through which Officers can raise any concerns they have in relation to an individual, is known as a Care Plan. Under the governance of the Adults at Risk policy, Officers are prompted to consider the Vulnerability Assessment Framework when completing a Care Plan and record their views on the following: Appearance; Behaviour; Communication; Danger; Environment; Finances; Gravity; Community Threat; Consent. The Care Plan is then graded by the Officer as either Standard, Medium or High risk and submitted, alongside any other reports that the Officers may have (for example, a crime report or a missing report) to the police District Safeguarding Team.

10.39. Upon receipt, the police Care Plan is triaged using the initial grading decided by the Officer and then reviewed to decide whether further onward referrals are required or a referral to the local authority under safeguarding.

10.40. In addition to the police Care Plan, Police Officers can make direct referrals for onward support (where the individual agrees) at the time of the incident, i.e., there is no requirement for an Officer to wait for the police Care Plan to be triaged by the police safeguarding team. In relation to Officers not referring Steven directly to external support agencies, this is recorded to have been due to Steven not giving his consent.

10.41. This review has learned that it was a directive given in Chief Constable Orders 2020/38 that "*Due to a recent coronial investigation highlighting disparity across Greater Manchester Police, it has been agreed that a Care Plan should be submitted on every occasion where Greater Manchester Police responds to a person presenting with mental health related concerns. You should submit a care plan regardless of whether the person presenting mental health problems is transferred to the North West Ambulance Service, taken into a health setting or neither*".

10.42. However there have been three instances identified during the scoping period of this review whereby a police Care Plan for Steven was missed, and Greater Manchester Police has acknowledged that this is not in line with policy or the above directive. As such all front-line Officers (including the individual Officers involved with Steven) have since been reminded of the policy (and its reasons) and this communication has specifically reminded Officers that when an individual is taken to hospital, there is still a police duty to record a Care Plan.

10.43. As well as the frontline Officers missing a Care Plan, there is evidence of Officers within the District Safeguarding Team missing onward referrals to support Steven in instances whereby Officers have taken Steven to healthcare professionals. For example, there was an incident whereby Steven was found in a canal, and before the ambulance service transported him to hospital, he informed Police Officers of fluctuating episodes of psychosis. On this occasion Officers did generate a Care Plan (medium risk) with full updates of the incident, but no onward referrals were made by the District Safeguarding Team; the rationale being that Steven was taken to the Mental Health suite voluntarily and would be safeguarded thereafter with appropriate mental health interventions.

10.44. The appropriate course of action would have been for details of the Greater Manchester Police Care Plan to have been shared with the Local Authority Adult Safeguarding Team (who triage referrals). And, in the event of Greater Manchester Police being informed that Steven wasn't currently open to Mental Health services, consideration should have been had as to whether a professionals' meeting to co-ordinate safeguarding activity was appropriate. The actions taken (and considered) should have been recorded on the police care plan.

10.45. Greater Manchester Police has assured this review that to reinforce that a Care Plan should be submitted and responded to on every occasion where Greater Manchester Police responds to a person presenting with mental health related concerns, the following actions have been taken:

- The Mental Ill Health, Mental Incapacity and Learning Disabilities Policy and procedure has been updated to remind Officers that Multi-Agency Safeguarding Hub teams should refer mental health Care Plans to partner agencies even if a person has been taken to a health care setting or transferred to North West Ambulance Service.
- Training is being delivered by the Serious Case Review Team to District Safeguarding Teams/ Child Protection Investigation Teams/ Domestic Abuse Teams/ Complex Safeguarding Teams which reinforces the necessity for Officers to submit Care Plans when they deal with welfare cases (child or adult).
- This review has been assured that the general issue of Greater Manchester Police not sharing some of the adult welfare Care Plans with partner agencies has been raised with the Public Protection Governance Unit, and it has been identified as an area that forms part of a programme of triage officer training which has been developed and is being delivered to all Officers in triage roles across the force. It is intended that quarterly Continuing Professional Development for these roles utilising the training package will ensure that all future triage officers also receive the same training.
- Furthermore, the Strategic Mental Health Lead for the force has been consulted with, and the non-compliance with the referral policy of Care Plans is being addressed with local Senior Leadership Teams to offer guidance to the Districts on best practice. Additionally, the Mental Ill Health policy has been updated to include this requirement.
- The Greater Manchester Police Mental health App (which was launched in December 2024) has been amended (the amendments go live in July 2025) to now include a Care Plan prompt alongside the force statement reminding Officers that it is mandatory. This App will also provide the Prevention Branch with an audit tool to monitor the submission of care plans related to mental health.

10.46. North West Ambulance Service often submit safeguarding concerns. Their staff raise approximately 1,350 safeguarding concern notifications, and approximately 2,500 requests for Early Help over the North West Regional footprint each calendar month.

10.47. In relation to Steven, staff and crew would not have routinely considered that as an adult who was using drugs recreationally, he had care and support needs, as identified by the Care Act. And the aforementioned lack of case history or the ability to take a social history from Steven at the time of incidents (as previously discussed), hindered recognition of any ongoing or repeated drug use and dependency which may have led staff to consider the need to raise a safeguarding concern notification for Steven.

10.48. However whilst neither a safeguarding concern or a request for Early Help was raised by ambulance staff in relation to Steven, he was transported to the Northern Care Alliance hospital Emergency Departments for medical care with clear explanations of his Acute Behavioural Disturbance presentation, and high-risk behaviours clearly documented on the Electronic Patient Records. This information was then provided to hospital staff on handover. North West Ambulance Service has observed that the receiving hospital would then undertake further exploration of Steven i.e., his mental health needs and drug use, whilst he was being treated and that this would support identity of care and support needs and allow for exploration of any safeguarding.

10.49. Northern Care Alliance has informed that their staff observed Steven to be mobile and independent with his daily activities of living. His needs were recognised as being around housing, mental health, and drug use but these issues were not seen as a safeguarding concern and did not prompt a safeguarding referral. Instead Steven was signposted and referred to onward agencies for support as per the collective responsibility across the agencies to address Steven's safety through alternative support pathways when safeguarding criteria was not deemed to have been met.

10.50. The Housing Options Service didn't identify any safeguarding issues that would require any further intervention from the local authority in relation to safeguarding. When they undertook their homeless

assessment with Steven, he disclosed issues with drugs and alcohol and mental health, but he advised that he was engaged or had been engaged with agencies to support him. Consequently the Housing Options Service only had reason to believe that Steven was vulnerable under the definition of section 189 of the Housing Act[27] (as opposed to the Care Act) and to address this, he was placed in temporary accommodation.

10.51. The Supported Housing Service did not assess Steven as he left the temporary accommodation and did not attend the scheduled appointment.

10.52. Greater Manchester Mental Health has reflected that their Mental Health Liaison Teams may not have recognised the potential need to submit a safeguarding concern because the busy hospital environment equates to time restraints which hinders their ability to consider the third criterion of the three key test.

10.53. This suggests that practitioners might need to be empowered to raise a safeguarding concern even in circumstances where it is not clear whether section 42 (1c) is met - as per the Local Government Association (2020) guidelines.

10.54. Following Steven's presentation at the hospital Emergency Department and the Mental Health Liaison team, a letter would have been sent to his GP Practice, but the Practice has informed this review that it has been noted that via work stream optimisation processes, not all clinical letters are now reviewed by a clinician.

10.55. However, the review has been assured that the administrative team who review such correspondence, do read every letter and are trained to highlight safeguarding issues. Had concerns been highlighted within the correspondence, they would have been discussed directly with Steven's General Practitioner.

10.56. In relation to Steven's direct contacts with the Practice, no safeguarding was identified during the scoping period – though notably his presentations tended to be acute whereby the priority was to refer Steven into secondary care mental health – not explore his current personal circumstances.

10.57. Despite no safeguarding concerns being shared with the local authority, professionals reflected at the Practitioner Reflective Session that Steven did exhibit care and support needs by means of,

- self-neglecting behaviours,
- homelessness,
- repeated drug use,
- inability to maintain engagement with services,
- non-concordance with medication.

And that whilst all of this was 'knowable' information at the time, focus appears to have been on his addiction - the other concerns were considered to be consequential.

10.58. As such, there are two considerations within this section of the report:

10.58.1. The fact that Steven wasn't ever subject of a safeguarding concern raises the question as to whether further emphasis is required within training and policies in relation to enhancing practitioners' comprehension of how an adult's care and support needs may include for example, an individual who misuses substances[28] to the extent that it impacts their ability to manage daily living and influences self-neglecting behaviours.

[27] Priority need for accommodation.
(1) The following have a priority need for accommodation—
(a)a pregnant woman or a person with whom she resides or might reasonably be expected to reside.
(b)a person with whom dependent children reside or might reasonably be expected to reside.
(c)a person who is vulnerable as a result of old age, mental illness or handicap or physical disability or other special reason, or with whom such a person resides or might reasonably be expected to reside.
(d)a person who is homeless or threatened with homelessness as a result of an emergency such as flood, fire or other disaster.
(e)a person who is homeless as a result of that person being a victim of domestic abuse.
(2) The Secretary of State may by order—
(a)specify further descriptions of persons as having a priority need for accommodation, and
(b)amend or repeal any part of subsection (1).
(3) Before making such an order the Secretary of State shall consult such associations representing relevant authorities, and such other persons, as he considers appropriate.
(4) No such order shall be made unless a draft of it has been approved by resolution of each House of Parliament.

[28] This aligns with professionals' understanding the power of addiction which can affect one's ability to keep themselves safe and is discussed in more detail later in this report.

Learning 3: *The multi-agency safeguarding policy and procedures on the Salford Safeguarding Adults Board website are known to practitioners working in Salford but are they effectively supporting practitioners to fully understand care and support needs.*

Question 1: How can Salford Safeguarding Adults Board and partner agencies evidence that they have reviewed, and where appropriate amended, their training and policies to ensure that they support practitioners to understand that an adult's care and support needs may include for example, an individual who uses substances to the extent that it impacts their ability to manage daily living and influences self-neglecting behaviours.

And,

10.58.2. Do Practitioners understand that they should raise a safeguarding concern even if they are unclear in relation to the criteria at section 42 (1c) of the Care Act having been met? This review has been informed that Salford Safeguarding Adults Board is currently producing a seven minute briefing in relation to the role and responsibility of a referrer which could include something about recognising the section 42 (1c) criteria.

Learning 4: *Practitioners are sometimes unsure whether to raise a safeguarding concern when they are uncertain about whether the criteria in section 42 (1c) of the Care Act have been met?*

Question 2: How can Salford Safeguarding Adults Board review their multi-agency safeguarding procedures to ensure that it supports professionals who are unsure whether section 42 (1c) of the Care Act has been satisfied, in line with the Local Government Association (2020) guidelines.

10.59. Additionally, the above analysis suggests that practitioners treated Steven's presentation as isolated incidents rather than recognising the escalating risks. This is understandable in relation to agencies such as the ambulance service who do not carry case notes or individual records but raises questions around the professional curiosity of those agencies who have access to previous incidents/concerns. Are those agencies referring to case notes, and/or triangulating information; or are they taking information at face value and making their safeguarding decisions based upon current and immediate presentations.

Learning 5: *Professionals must look beyond the isolated presentation of an individual and assess escalating risks when considering safeguarding.*

10.60. Panel members discussed how resources and the demands on services, mandates that practitioners focus upon their main priorities, for example, a professional working within the Emergency Department of a hospital will focus upon preserving life. But practitioners must be supported to step outside of their individual role and remember the responsibilities under the six principles of safeguarding in day to day practice.

Question 3: How can partner agencies assure Salford Safeguarding Adults Board that they are prompting and supporting their professionals to step outside of their individual role and remember the responsibilities of safeguarding and to look beyond the isolated presentation of an individual when considering care and support needs.

10.61. Additionally practitioners must be supported to recognise when an individual is accessing services more frequently as this could represent an increase in vulnerabilities and a need for safeguarding.

10.62. This review has been assured that there are already systems in place to do this, for example,

- To support repeat users of the hospital Emergency Department there is a multi-professional group called the High Intensity User Group. It consists of a variety of accountable multi-agency professionals who work in partnership as a multi-disciplinary team to share intelligence and agree person-centred care plans that meet the core needs of high intensity users of the department. Unfortunately because discussions are not recorded, it is not clear whether Steven was ever known to this group. However

even if he was brought to the Group's attention at some point, Northern Care Alliance safeguarding team has no knowledge of Steven - which indicates that a safeguarding referral wasn't considered even if he was.

- The police Care Plans support the District Safeguarding Unit to recognise increased vulnerabilities as the unit will look back to see if there have been any previous plans submitted for the individual. However as already mentioned, police Care Plans were not always submitted in Steven's case.
- Additionally recurring police Care Plans could have resulted in Steven being discussed in a Vulnerable Adults Meeting with partner agencies – though it is recognised that such a meeting is concerning triage as opposed to case reflection. (Further discussion around this meeting at the Practitioner Reflective Session established that housing homelessness services are not always included in the process, and arrangements were made to add the service to the mailing list for future attendance as appropriate.)
- Primary Care informed this review that General Practitioners can flag patient records if they recognise that risk is escalating for an individual and individuals can also be discussed with the safeguarding lead/practice meetings. However, during the scoping period of this review, Steven's visits to his GP Practice did not increase or raise any complexity/concern.

10.63. In summary, Steven did not trigger any of the above systems that may have highlighted his vulnerability because although Emergency Services (police and ambulance) when responding to Steven in crisis transported him for necessary medical care, his frequency at hospital fell below a threshold that would raise concern.

Explore the current co-occurring conditions/dual diagnosis pathways and professionals' knowledge/understanding of them.

10.64. Dual diagnosis, also referred to as a co-occurring condition, describes the simultaneous presence of mental health disorders and substance use issues in an individual.

10.65. When these conditions occur concurrently, they can exacerbate each other's effects; untreated mental health disorders can lead to an escalation in substance use problems, whilst increased substance use can further deteriorate mental health.

10.66. Steven experienced mental ill health, and used drugs, throughout most of his adult life. The root cause of either is not known for certain and it is not possible to identify whether Steven's mental health issues arose from substance use, or vice versa. However case notes record a domino effect in that Steven has said that when he used drugs, he was unable to manage his medication and his mental health consequently relapsed. And conversely, when his mental health deteriorated, he would be more likely to use drugs.

10.67. In relation to professionals recognising a co-occurring condition for Steven; the GP Practice has informed that during the scoping period of this review, they wouldn't have - because they believed Steven had ceased using drugs. However the Practice assured that they are aware of co-occurring conditions and dual diagnosis.

10.68. Other agencies assured this review that staff and practitioners are able to recognise the presence of both substance use and mental health and can make onward referrals to the individual support services.

10.69. This is the correct thing to do as there isn't a referral into 'dual diagnosis' – the important thing is that professionals from all agencies know to refer to both mental health and substance support services because in terms of dual diagnosis pathways in Salford; each Community Mental Health Team has a Co-Occurring Conditions Senior Practitioner and Achieve has a Trauma Informed Care and Dual Diagnosis Lead.

10.70. This review has learned that all Greater Manchester Mental Health staff follow a specialist 'Co-occurring Mental Health and Alcohol/Drug Use Conditions (Dual Diagnosis) Policy' (developed in 2020). This policy supports staff to identify service users with co-occurring conditions, and a flow chart assists staff from both Greater Manchester Mental Health substance misuse services and mental health services to decide when

a complex case review meeting is required to agree what intervention is needed and by whom, and the joint working arrangements.

10.71. However, this wasn't used for Steven because he was only ever 'assessed' by Greater Manchester Mental Health services (had he been found to have a secondary mental health illness that required ongoing support, he possibly would have been considered for complex case review). And Steven didn't engage with support from the substance misuse services because he said he had abstained from use and was going to attend a rehabilitation unit outside of the Salford area.

10.72. In addition to living with co-occurring conditions, Steven was further frustrated by his housing situation.

10.73. When this became known, Steven was referred to the Housing Options Service whose focus of intervention was to support Steven in relation with his homelessness - other support needs are picked up thereafter by the Supported Housing Service who then further link an individual into the appropriate teams within their own service.

10.74. For example, Steven could have been referred to what was then known as the Salford Dual Diagnosis Homeless Team[29] (commissioned in April 2021[30]) but which is now referred to as the Inclusion Health Homeless Team – Salford (IHHT-S). The team consists of individuals from various services (including housing, drug and alcohol outreach and specialist NHS practitioners) and is commissioned to work with people who are rough sleeping, or at risk of rough sleeping, and who have mental health, and/or substance misuse problems. The aim is to support people into housing and link them into services to help them to retain accommodation and meet their health and social care needs.

10.75. Once an individual is referred to the Inclusion Health Homeless Team – Salford, their staff conduct their own assessments in order to understand the individuals current mental health; substance-use needs and personal history and recognise how these may impact them.

10.76. If an individual is already receiving mental health or substance-use services, they continue with their current teams, but the Inclusion Health Homeless Team – Salford can coordinate with these teams, offer short-term joint-working, and provide advice to keep individuals engaged.

10.77. The Inclusion Health Homeless Team – Salford only accept referrals directly from housing workers[31] and Steven could have therefore been referred by Supported Housing Service. However a referral wasn't done because Steven had left the temporary accommodation provided to him before his scheduled assessment with the Supported Housing Service and he did not attend the appointment. Practitioners have discussed how had Steven been identified as more vulnerable than the other individuals who were also awaiting assessment, he could have been prioritised and offered an assessment sooner (and consequently possibly been referred). However when the team sought to assess his vulnerabilities, they were informed by a member of the Community Mental Health Team admin that Steven was not open to the team and no context was provided in relation to the previous incidents which had led to Steven being seen by the Mental Health Liaison Team in the Emergency Department at hospital.

10.78. The Inclusion Health Homeless Team – Salford work in tandem with the Rough Sleeper Drug and Alcohol Team[32], (who can also refer directly to Inclusion Health Homeless Team – Salford). Notably a major part of both teams service comes from delivering assertive outreach – not waiting for referrals from other agencies.

[29] The Salford Dual Diagnosis Homeless team (now known as Inclusion Health Homeless Team - Salford) is commissioned by Salford City Council through a grant from the Ministry of Housing, Communities and Local Government to address rough sleeping in the area. This team works alongside the Rough Sleeper Drug and Alcohol service.

[30] Through funding to Salford City Council under the Rough Sleeper Initiative grant from the Ministry of Housing Communities and Local Government. This flowed from a previous funding stream, the 'Protect Programme', which had been made available to a limited number of local authorities to support the most vulnerable rough sleepers during the winter, under COVID-19 restrictions. In Salford, a joint housing and Greater Manchester Mental Health mental health team was commissioned to support a small, identified cohort (30) of very vulnerable homeless individuals, whose needs were not being fully met through universal adult services. This proved very successful, and the decision was made to carry on with commissioning a homelessness mental health team, with a referral pathway via the Supported Housing Service, who fund the team.

[31] 194 referrals were made to the Homeless Dual Diagnosis Team in 2023 and 114 in 2014.

[32] In 2022, funding was made available to Salford, via the Office for Health Improvement and Disparities, to commission a Rough Sleeper Drug and Alcohol service.

10.79. The Rough Sleeper Drug and Alcohol team is a multi-disciplinary team of practitioners who specialise in engaging individuals who have drug and alcohol issues and are experiencing challenges in engaging with mainstream addiction services. They use a trauma informed assertive outreach approach to overcome barriers to individuals accessing treatment services. Although they cannot offer accommodation they facilitate engagement with housing services.

10.80. In relation to the Rough Sleeper Drug and Alcohol team, any agency can refer an individual who is sleeping rough, or is at risk of sleeping rough, into the team.

10.81. Missed opportunities to refer Steven to the Rough Sleeper Drug and Alcohol team during the scoping period have been identified:

- **10.81.1.** Achieve could have transferred Steven to the team when he self-referred to their service[33]. Professionals at the Practitioner Reflective Session mooted whether - because the Rough Sleeper Drug and Alcohol team don't usually pick up if an individual is already under services, it could have been anticipated that Steven would not meet the threshold having reached out to Achieve and abstained drugs for a period of time – albeit a short period of time.
- **10.81.2.** The Community Mental Health Team could have referred Steven to the team when it was established during their assessment[34] that Steven was homeless, and using drugs, and experiencing mental ill health.
- **10.81.3.** Police Officers could have referred Steven when he was reported to be sleeping in a bus station.

10.82. Both Achieve and the Community Mental Health Team offered onward support for Steven's issues in isolation as opposed to considering his circumstances holistically. And the police advised Steven to present at Housing Options for support.

10.83. Consequently the onus remained on Steven to seek drug support, mental health support and to address his homelessness independently.

Learning 6: Steven was left to seek support independently when he was not referred to the Rough Sleeper Drug and Alcohol team.

10.84. Question 6 later in the report should support this learning to be addressed, but this review has also been assured that issues around referrals are currently being debated within the Rough Sleeper Drug and Alcohol steering group who are in the process of liaising with Achieve.

10.85. Given that Steven wasn't referred onto any co-occurring condition pathway, it is difficult for this review to explore the pathways effectiveness.

How do professionals include family in healthcare plans?

10.86. Sophie has informed this review of her frustrations in trying to get support and help for Steven. She described how she would beg for help at the hospital and said that she felt that no one was listening to her. Yet, she knew Steven best. She had lived with him for a number of years, and she had first-hand experience of his mental health and addiction and had learned of his lived experiences from childhood to adulthood.

10.87. In line with Sophie's experience, Greater Manchester Mental Health has identified that there is evidence that practitioners did contact members of Steven's family/associates, but it is agreed that it does not appear that they were consulted as part of the risk management/safety plan when Steven presented to hospital in crisis.

[33] Instead Steven was referred to the Psychosocial Intervention Team with the rationale that the team would gauge his motivation with a view to rehabilitation - Steven had spoken of rehabilitation programmes and said that he had already started to abstain from drug use.

[34] There was no evidence of a severe enduring mental illness which would require treatment from any community mental health. It was felt that Steven's presentations at the time were the result of substance abuse, and that Steven was presenting with psychotic symptoms which would resolve when he was no longer under the influence of drugs. Instead, the practitioner separated Steven's concerns and advised him to consider the Living Well scheme, a referral to improving access to psychological therapist program, and to present for housing support. Onward drug support was not offered because Steven had said that he was going to work with Emerging Futures who offer community-based support for individuals affected by addiction.

10.88. As such an action from the Greater Manchester Mental Health Trust Internal investigation is to review Carer Contact as part of the Quality Assurance Framework.

10.89. Additionally this review has learned that Clinical Risk Assessment and Safety Planning has replaced the former STAR V2 risk assessment form[35] and there is now a greater emphasis on the involvement of family and carers to express their views on risk factors as part of risk assessment and safety planning. It is recognised that many professionals may worry that collecting and recording risks identified by carers and families will breach the right to patient confidentiality, but it does not - and to enhance staff knowledge in relation to this, there is an increased training offer which will better support staff completing risk assessments.

10.90. In relation to other agencies, it is clear from Steven's case notes that Steven was sometimes asked (and did) provide Sophie's phone number as a means of contact, but the case notes do not evidence whether Steven's consent to share his information with her was ever sought. It is therefore not possible to review whether professionals did consider including Steven's family in his care planning - but were not given his consent, or whether it was overlooked.

Learning 7: Professionals do not always record whether consent has been sought to include family/associates within an individual's care planning and risk assessment.

10.91. Neither conversation with professionals who attended the Practitioner Reflective Session, nor consultation of the agency reports, could further confirm whether Steven's consent had been sought - but practitioners did indicate that whilst they are confident to routinely record next of kin, they would be wary of including family in health plans and/or risk assessment without the individual's consent.

Question 4: How can partner agencies evidence to Salford Safeguarding Adults Board that they are prompting their professionals to record whether consent has been sought (and achieved) to include a family member or associate within an individual's care planning and risk assessment.

10.92. Additionally it is not easy to identify Steven's support network from case notes. Records often refer to Steven's associates as simply *friend* or *ex-girlfriend*, and not by name. This would make it harder for a practitioner to know who to contact.

10.93. Conversations with professionals has concluded that even though professionals understand that from a safeguarding stance, and to better inform clinical assessments and safety planning, it is important that the names of individuals are captured, they are wary to record details without the individual's consent due to concerns around breaching the Data protection Act 2018 (which is the United Kingdom's implementation of the European General Data Protection Regulation).

Learning 8: *Professionals remain concerned about breaching data protection when recording personal information.*

10.94. Salford Safeguarding Adults Board has assured this review of guidance on their website to support professionals in relation to this learning point. There is an information sharing and confidentiality page[36] that informs of the legislation seven golden rules, and the first one is that the General Data Protection Regulation is not a barrier. There is a flowchart to support practitioners when they can and cannot share information and there are links to a seven minute briefing[37].

10.95. Additionally the Board has held two Bite Size Briefings in 2024.

Question 5: How can the Salford Safeguarding Adults Board enhance and evaluate their information sharing training offer, and how can partner agencies assure the Board that the links to the information provided on the Board's website is integrated into their own guidance and training for practitioners

[35] The STAR (Strategic Tool for Assessing Risks) v2 is a comprehensive framework developed by WHO to facilitate evidence-based assessments

[36] Information Sharing and Confidentiality | Salford Safeguarding Adults Board

[37] information-sharing-002.pdf

What pathways were available to professionals to support Steven with his homelessness - taking into account his care and support needs and the local authority's duty to safeguard.

10.96. To support readers of this report, the review will begin this section of analysis with an explanation of the housing homelessness services in Salford[38].

10.97. The Housing Options Service is the front door into homelessness services delivered by the council. It performs the statutory functions of the local authority in relation to homelessness – assessments, prevention work, referrals into temporary accommodation (statutory and non-statutory), and where appropriate, referrals into other services.

10.98. If an individual or household is currently homeless, or likely to be homeless within 48 hours, they can go in person to the Housing Options Service for a homeless assessment under the relief duty. (The relief duty requires an authority to 'take reasonable steps to help[39] the applicant to secure that suitable accommodation becomes available for the applicant's occupation' for at least six months.) A short initial assessment will confirm immediate homelessness and if confirmed, a full assessment by a Homeless Prevention Officer will be offered for the same day.

10.99. The Homelessness Reduction Act 2017 introduced a duty on certain public authorities to refer individuals who they think they may be homeless or are threatened with homelessness to a housing authority.

10.100. As such if an individual or household is at risk of homelessness in the future, a referral for an appointment can be made to the Housing Options Service using the duty to refer process[40] . People can also self-refer to this service or someone can refer on their behalf with their permission[41].

10.101. When the referral is submitted the person being referred will be allocated a Homelessness Prevention Officer who will contact them within three working days to discuss their situation, provide advice and arrange an assessment where necessary. Following a homeless assessment, an internal referral is then made to the Supported Housing Service which has a number of teams that provide support to homeless individuals/households.

10.102. In the case of an individual or household requiring emergency accommodation outside opening hours, there is a telephone Out of Hours service.

10.103. The GP Practice has informed this review that they were unaware that Steven was homeless, but it is recorded in case notes that Steven disclosed that he was sofa surfing. This review recognises that the term 'sofa surfing' is ambiguous and does not capture the complexity of Steven's situation but professional curiosity into the causes and drivers of Steven's sofa surfing could have assisted a better understanding of his care and support needs at that time. Further exploration could have highlighted the need for a referral and for a flag to be added to his records to highlight his homeless status.

10.104. The Practice does note that Steven was later asked to confirm his address by means of the standard text message being sent. The message informs individuals of homeless services and how to access them. The text also offers the Practice address as a safe place for correspondence to go. However it is not clear from case notes whether Steven responded and a barrier to the effectiveness of this procedure is that Steven, when homeless, may not have always had access to a charged mobile phone and/or the credit to respond.

10.105. Though Steven was advised to present to Housing Options in person when the police were called to a report of him sleeping in the bus station, there was a missed opportunity to refer him for a homeless assessment. Additionally this review has learned that the police could have brought Steven to the attention of the rough sleeper services via the StreetLink national reporting mechanism www.thestreetlink.org.uk. The advantage of this mechanism for the police is that the correct local services are contacted from the reported location, and a response with the outcome is expected within 10 working days.

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[38] Further information can be found on the services and teams at the following link: https://www.salford.gov.uk/housing/safeguarding-in-housing/salford-city-council-housing-services-and-safeguarding/

[39] 'Help to secure' does not mean that the authority has to source and provide accommodation, but that it should try to agree reasonable steps for itself and the applicant which could result in accommodation being found. There is, however, a power for authorities to provide accommodation as one of those reasonable steps.

[40] The Homelessness Reduction Act 2017 places a legal duty on public services to refer those who are homeless or threatened with homelessness to housing services, with the applicants consent. This is often referred to as the Duty to Refer process.

[41] Worried about keeping your home, homeless or may become homeless?•Salford City Council

10.106. Furthermore on this occasion Officers did not record a police Care Plan – had a plan be submitted it is possible that the District Safeguarding Unit may have made the onward referrals.
10.107. This review has learned that Officers could have used the "Making Difference Toolkit" which holds contact details for numerous supporting agencies and can readily be accessed on the police Intranet. On this occasion use of the toolkit could have prompted Officers to consider making their own referral in addition to signposting Steven to the Salford Housing Options Service, as it would have highlighted the public Duty to Refer homelessness (or those threatened with homelessness).
10.108. It was a week after Steven had been found in the bus station that the hospital Emergency Department contacted the Housing Options advisor (who is part of the admissions avoidance team), based with the hospital discharge team, on behalf of Steven after he had disclosed to them during a presentation that housing was his primary concern.
10.109. The Housing Options advisor informed of the Out of Hours number and Steven contacted the service himself. It is recorded that Steven said that he had some drug and alcohol issues and mental health issues, but that he had been discharged from hospital without medication or referrals. This was true but did not reflect that he had been offered referrals but had declined[42].
10.110. Following the call, Steven told hospital staff that he had not met the criteria for the 'A Bed Every Night' scheme[43]. The notes on the Out of Hours system corroborate that Steven would not be placed that night but the rationale for the decision is not clear. However Steven's hospital discharge notes evidence that he told hospital staff he was going to stay with a friend for the night.
10.111. Whilst Steven was advised by Out of Hours to present for housing assessment the following day (Steven did not), there was a missed opportunity to have notified the Rough Sleeper Services that Steven was potentially homeless.
10.112. Steven had no further contact with housing services until he presented to the homelessness service seven months later and completed an assessment with the Homeless Prevention Officer.
10.113. Because during this assessment, Steven said he was open to the Community Mental Health Team (and the Housing Services are dependent on partner agencies providing relevant and significant information to corroborate self-reported information) the Homeless Prevention Officer began enquiries in relation to mental health. However as previously mentioned, it appears that a member of the Community Mental Health Team admin may have disclosed that Steven was not open to the team without providing any context in relation to the previous incidents which had led to Steven being seen by the Mental Health Liaison Team in the Emergency Department at hospital. Consequently in the absence of this background information being shared with housing services, Steven was not deemed to be any more vulnerable or at risk than anyone else being placed at this time and standard procedures were followed. No safeguarding concerns had been identified other than needing temporary accommodation, and an internal referral was made to the Supported Housing Service whose Temporary Accommodation team identified suitable accommodation for Steven at a hotel.
10.114. A housing assessment was scheduled for Steven at the Supported Accommodation within two weeks. This review has been told that this is a typical timescale from being placed to starting an assessment given there was no indication that Steven needed to be seen as a priority.
10.115. Steven did not attend the assessment, and the Supported Housing Service team were informed by the hotel that Steven had left. This review has learned that it is commonplace for people to leave temporary accommodation with all their belongings, and therefore the information gave no specific cause for concern. It appeared Steven had chosen to leave and so no further follow up was made by the Supported Housing Service at this time - although the Homeless Prevention Officer did attempt to contact Steven to tell him about the homeless assessment/decision to end the interim accommodation but couldn't reach him.

[42] No professional shared any information in relation to Steven's history with the service, and due to it being out of working hours, it was not possible for the duty officer to undertake any checks.
[43] A Greater Manchester Scheme set up by the Greater Manchester Mayor. Anyone who the City Council doesn't have a statutory housing duty to, but who will be street homeless will be accommodated under 'A Bed Every Night'. Salford has 179 funded bed spaces to accommodate people under 'A Bed Every Night'. Due to demand these bed spaces are always filled, and each person must have had a homeless assessment first by Housing Options.

10.116. Hospital Emergency Department staff could have re-referred Steven to housing two months later when Steven mentioned sofa surfing at a friend's house, but like when Steven had informed his General Practitioner that he was sofa surfing, there was insufficient professional curiosity into Steven's circumstances to establish the need for a referral.

10.117. Soon after this presentation, Steven again attended the Emergency Department with thoughts to end his life. He now disclosed that he was 'living rough' and that his homelessness was affecting his mood. Staff signpost him to Salford City Council and booked Steven a taxi to Loaves and Fishes where Steven would be able to access:

- Hot food and drinks
- Clothing and toiletries
- Dental Surgery
- GP surgery and Practice Nurse
- Citizens Advice Bureau
- Community Alcohol Team, Drugs Clinic and Needle Exchange
- Support and Advice
- Smoking reduction/support

10.118. Loaves and Fishes is an excellent charity which offers valuable support for homeless and vulnerable individuals but given Steven's crisis, he should have been taken to the Housing Options Service for a homeless assessment instead. This alternative action indicates that not all staff may be aware of the Duty to Refer or understand that Loaves and Fishes is an add on voluntary, community and social enterprise service to statutory intervention and services.

Learning 9: Professionals are not consistently exploring their legal Duty to Refer those who are homeless or threatened with homelessness to housing services.

Question 6: How can agencies provide assurance to Salford Safeguarding Adults Board that their practitioners are supported to understand and remember their Duty to Refer, along with knowledge of StreetLink for rough sleepers when they are working with an individual who is at risk of or threatened with homelessness, and evidence that it is being done.

Learning 10: The layers of teams within the housing service is complicated to those working outside of it and a better understanding of the homelessness service could support an improved understanding of the referral process.

10.119. This learning has already been recognised by housing services, and this review has been informed that consequently a representative from the Rough Sleeper Initiative team has met with appropriate staff from the Northern Care Alliance NHS Foundation Trust to discuss referral processes.

10.120. Panel members discussed whether this offer could be extended to other agencies but wondered how the information should thereafter be cascaded to all units/teams within a service and embedded into guidelines.

10.121. Additionally to support agencies to understand housing, Salford City Council has updated their website pages[44] to better detail how the housing service is structured and the different services that are available. The pages now include seven minute briefings about the housing options service or and a fact sheet about support housing and all the different teams. And they contain the names of designated safeguarding officers across all of housing sector across the registered providers and across council services.

[44] Housing•Salford City Council and https://www.salford.gov.uk/housing/safeguarding-in-housing/

Question 7: How can Salford Safeguarding Adults Board and Salford City Council promote their 'housing' website pages and support partner agencies and organisations to embed links within their guidance.

10.122. However it must be recognised that the issue around why Steven was not always referred to Housing Options runs deeper than a lack of understanding of the service and some professionals engaging with this review were aware of the Housing Options Service yet still did not refer Steven.

10.123. In relation to these missed opportunities it has been concluded that whilst it is possible that some professionals saw Steven's homelessness as a consequence of his drug use/mental health and therefore primarily offered onward support to address this, his homelessness issue was complicated further by the aforementioned use of terms such as 'sofa surfing' and 'staying with friends' and from the knowledge that sometimes Steven could and would return to his family home address.

10.124. The preliminary findings of the Systems-wide evaluation of homelessness and rough sleeping[45] published in February 2025[46] notes that: *While there is no universal or consistent definition of homelessness, it is generally understood to encompass individuals and families living in unsuitable or inadequate housing, as well as those who are sleeping rough. In England, homelessness is defined legally as when "a person or a household does not have accommodation that is available for them to occupy, that they have a legal right to occupy and that is reasonable for them to continue to occupy". This includes people experiencing rough sleeping, people living in hostels and refuges, and hidden homelessness such as sofa surfing.*

10.125. Steven did have a home legally available to him, and this potentially frustrated professionals recognition of his circumstances. Improved professional curiosity into Steven's living arrangements could have assisted professionals to recognise when a referral was needed and/or what support he needed in order to attend Housing options in person when he was surviving in such chaotic circumstances.

10.126. Also in relation to Steven returning 'home', there is a notable absence of curiosity or safeguarding concern in regard to the effect his addiction and/or mental ill health could have had upon his family - which includes a young child.

Do professionals recognise/understand the power of addiction?

10.127. Steven has described his childhood as being traumatic, and chaotic and has disclosed that he was introduced to drugs at a young age. At times throughout his life, Steven successfully abstained and it is to his credit that despite his trauma and addiction, he achieved educationally, learned a trade and owned a business. Prior to the scoping period of this review Steven had a home; a marriage and his wife describes him as a good father to their young child. It is highly unlikely that Steven wanted to lose all that he had worked to achieve: his home, business, family and ultimately, his life.

10.128. On its website, the NHS describes addiction as a treatable condition for which there are lots of way to seek help. To example, the United Kingdom offers both private and public NHS treatment services for addiction recovery which ranges from addiction counselling to medically supervised detoxifications and rehabilitations.

10.129. However to put the demand of such services into context; there were 310,863 adults aged 18 and over in contact with drug and alcohol treatment services between April 2023 and March 2024. This is a 7% rise compared to the previous year (290,635), the largest rise in adults in treatment since 2008 to 2009, and the highest number of adults in treatment since 2009 to 2010[47].

10.130. It is clear that professionals saw Steven's addiction and did ask him to consent to referrals to support services, but this review has learned that Steven would often decline. On one occasion he declined stating that he wanted to address his housing situation first, on other occasions Steven said that he would self-refer - and in May 2023, Steven did self-refer to Achieve.

[45] Systems-wide evaluation of homelessness and rough sleeping: preliminary findings - GOV.UK

[46] The objective of which is to identify potential improvements to the homelessness and rough sleeping system, to ensure it delivers optimal outcomes for individuals who require the services

[47] Adult substance misuse treatment statistics 2023 to 2024: report - GOV.UK

10.131. Only Steven will understand how hard it was for him to take those steps of self-referral, and it is important to acknowledge that prior to him doing this, he had told professionals many times that he would. This was taken at face value, but this review would respectfully ask whether professionals could have recognised the pattern wherein Steven would say he was going to self-refer but then, for unknown reasons, was unable to do so, and could professionals have taken the onus off Steven by overriding his consent with a referral? At what point should professionals intervene?

10.132. During the initial telephone assessment with Achieve, Steven said that he had a bed secured at Emerging Futures, but that because he had 'used' before admission, his bed had been withdrawn. He was encouraged to re-contact Emerging Futures to explore re-allocation. Case notes also record that Steven said he had contacted the Abstinence Based Supported Accommodation project[48] which runs its own recovery placement. He said he had to wait to hear back from them because he couldn't be considered for placement until a peer had moved through treatment. It is also recorded that Steven said that he had contacted other rehabilitation providers all of which had advised for funding to be in place. Steven was signpost to look at the Well Communities in Cumbria[49] - a supported accommodation project that delivers a recovery programme.

10.133. Steven was allocated a Recovery Coordinator within Achieve and a face to face appointment was scheduled for the next day.

10.134. During the face to face assessment, Steven self-reported a third day clean from crack cocaine (uranalysis confirmed this to a degree) and said that he had previously attended rehabilitation programmes on three or four occasions and so understood how the services functioned. He said he wanted to be clean within a month (which the practitioner challenged as an unrealistic goal) and that he was exploring other rehabilitation options. It was decided that Steven would be referred to relapse prevention with the Psychosocial Intervention Team to gauge his motivation and with a view to a rehabilitation placement.

10.135. Steven was accepted by the Psychosocial Intervention Team and contact was attempted in order to invite him to the First Step group. However Steven could not be reached and contact with his wife established that Steven was now in rehabilitation with Transforming Choice in Liverpool and would be there for three months. A couple of months later Achieve further contacted Steven who said that he had now completed his rehabilitation and was drug free, sharing that he had 'one slip' but had refrained since. Steven also said he had now secured accommodation out of the Salford area

10.136. The chronology evidences that during the time Steven was reportedly in rehabilitation, drug-induced incidents continued in Salford which led on one occasion to his GP Practice referring him for mental health support, and on another occasion, Sophie contacting the police for support. Consequently this review has contacted Transforming Choice who have confirmed that they have no records of any contact with Steven or of him having attended rehabilitation.

10.137. However in contrast, Sophie has informed this review that Steven did attend Transforming Choice and was there for just under a week. Sophie said that it wasn't what he had expected, and he told her that it was somewhere he could stay and attend meetings but that he wasn't having any 1:1 sessions or mental health assessment. He had therefore asked Sophie if he could return home and Sophie agreed on the condition that he consulted with mental health support.

10.138. This review has been unable to unpick this discrepancy in the information.

10.139. Clearly around this time within the scoping period, Steven was displaying behaviours in line with him seeking support. He had

- spoken with the Out of Hours housing services,
- self-referred to Achieve,
- abstained from drugs and

[48] The SASH project which offers supported accommodation for males and females over 18 years of age.

[49] The Well Communities supports and accommodates people recovering from drug and alcohol addiction through therapy counselling peer mentoring employment training and social activities.

- visited his General Practitioner in relation to his mental health and agreed to a referral (Steven was accepted for assessment with the Community Mental Health Team but it concluded that there was no evidence of a severe enduring mental illness which would require treatment from any community mental health, and he was advised to consider the Living Well scheme, and a referral to the Improving Access to Psychological Therapist program.)

10.140. But something prevented Steven from being able to maintain this pathway to recovery and/or re-seeking support. And that is - the power of addiction.

10.141. Sophie has told this review that Steven would say to her:

- Do you think I'm having fun
- Do you think I want to be like this
- Do you think I'm happy
- Do you think I want to leave our son
- Do you think I want to lose my business

10.142. Without doubt she knew the answer was no.

10.143. This review has learned that whilst staff within Achieve fully understand the power of addiction, and the physical and mental health and social factors that link to it[50], most professionals working outside addiction support services – though able to recognise addiction, have no specific training in relation to its impact and power.

10.144. Consequently there is a risk that whilst professionals are trained to know and understand drugs, the power of addiction could be at risk of professional unconscious bias.

10.145. Panel members discussed how professionals can have varying degrees of understanding and compassion for individuals experiencing addiction. Some may have lived experiences of addiction within their own families or circle of friends and consequently be more aware. Whereas others may hold a moralistic view.

10.146. Regardless of professionals' personal experiences or views, effective practice in addiction treatment requires a holistic multi-agency assessment. This approach can be achieved only if practitioners collaborate to compile individual pieces of information about the person, thereby constructing a comprehensive understanding of their situation.

10.147. Panel members concurred that professionals do not need to be addiction experts or possess detailed knowledge of various drugs. The crucial aspect is for them to

- have the skills to listen empathetically,
- make an effort to understand, and
- approach the situation with curiosity.

It is vital to get to know the individual, as only they can provide insight into the nature of their addiction. By achieving such understanding, professionals will be able to overcome any unconscious biases.

10.148. Salford Safeguarding Adults Board noted that they have commissioned a number of Safeguarding Adults Reviews in recent years that have considered addiction, and unconscious bias has been a recurring theme.

Learning 11: Unconscious bias is a recurring theme within Safeguarding Adults Reviews which look at how professionals support individuals experiencing addiction.

10.149. This review has learned that to help professionals break down the wall of stigma and think about attitudes, actions and beliefs, the Addictions Provider Alliance has produced an anti-stigma campaign[51]. This would be a useful resource to share with Salford agencies and organisations.

[50] This experience/understanding may be from previous employment, current roles, voluntary work or having lived experience be that themselves or a loved one. Additionally on joining Achieve services, staff are inducted, and access relevant training as required. To support staff and volunteers, the Trust has its own dedicated Specialist Service Network, Occupational Development and Training Team whose role is to support occupational development; develop and deliver learning and development activities and, to support and promote access to training.

[51] Stigma Kills | NHS Addictions Provider Alliance

Question 8: In what ways can the Salford Safeguarding Adults Board consolidate the insights gained from their Safeguarding Adults Reviews regarding unconscious bias related to addiction, in order to enhance practitioners' ability to engage in more effective conversations with individuals about addiction?

10.150. A further consideration in relation to the understanding of addiction is drug induced psychosis.
10.151. Drug-induced psychosis occurs when substance abuse leads to episodes of delusions or hallucinations. This condition can worsen or trigger mental illness and is often caused by toxic levels of a drug, mixing substances, or withdrawal.
10.152. Psychosis is marked by delusions or hallucinations. Delusions are irrational beliefs held despite contradictory evidence. Hallucinations involve vivid sensory experiences of things that aren't real, such as feeling, seeing, smelling, or hearing non-existent phenomena.
10.153. Steven experienced drug-induced psychosis during several incidents within the scoping period and records evidence that Emergency Services such as the ambulance service, the police and medical professionals responded professionally and effectively.
10.154. Outside of crisis, this review has learned that the management of drug induced psychosis forms part of the Greater Manchester Mental Health practitioners' holistic assessment - with practitioners affording consideration of referrals to services (including dual diagnosis/co-occurring conditions team) for additional support[52].
10.155. This review is assured that there is little need for any other agencies to fully understand the condition - other than to know that it poses a real risk and is further reason to ensure that referrals are made as appropriate to substance use and mental health services.

Identify areas of positive practice
10.156. Professional discussion around Steven has highlighted examples of positive practice[53]. Some are included within the body of the report, but it is also important to highlight:

10.156.1. There were multiple attempts made by housing services to verify self-reported information in relation to Steven's mental health issues.
10.156.2. On many occasion whereby Steven was in dangerous situations, for example on high buildings, bridges, roof tops and in the canal, police with assistance of the North West Ambulance Service and Greater Manchester Fire and Rescue Services were able to bring him to safety.
10.156.3. The ambulance service staff recognised Acute Behavioural Disturbance swiftly as a critical medical emergency and followed appropriate pathways to transport Steven to hospital.
10.156.4. An assessment undertaken by Greater Manchester Mental Health pre the scoping period of this review, captured the lived experience of Steven which informed future assessments.
10.156.5. At the incident in which Steven tragically died, the ambulance service had provided senior staff to the scene which, when he fell from height, meant he was able to be assessed instantly at the point of the fall, provided with appropriate care, and a clear rationale recorded for the decision to terminate resuscitation at an appropriate point.

11. Conclusions

11.1. The lessons learned from this Safeguarding Adults Review commissioned by Salford Safeguarding Adult Board are highlighted in bold text throughout this report, but for reference, are repeated here alongside the relevant question if the learning has not been already addressed:

[52] In some circumstances professionals may consider admission under the Mental Health Act so that someone can have a period of "drug free assessment," however this is a contentious issue and not always an appropriate option; but would be considered as part of the holistic assessment and safety plan if required.
[53] Positive practice in this report includes both expected practice and what is done beyond what is expected.

	Learning	Has this learning been addressed?		Question to address outstanding learning
1	Time constraints can affect the standard of assessment and consequently affect practitioner's ability to learn of an individual's lived experience.			Recommendation: Salford Safeguarding Adults Board should highlight practitioners' concerns regarding the impact of time constraints on assessment to members of the Directorate Management Group.
2	It is crucial that practitioners from all agencies are aware of the importance of trauma-informed practice and utilise any opportunity to seek to understand (and record) an individual's lived experience.	All agencies can find support for their professionals in relation to adopting a trauma-responsive approach on the Salford Safeguarding Adults Board website[54]. This review has also been made aware of free Psychologically Informed Environment Training[55], and that Salford Health and Well-being Board has been awarded a contract for trauma training with Dignifi Ltd.		
3	The multi-agency safeguarding policy and procedures on the Salford Safeguarding Adults Board website are known to practitioners working in Salford but are they effectively supporting practitioners to fully understand care and support needs.		1	How can Salford Safeguarding Adults Board and partner agencies evidence that they have reviewed, and where appropriate amended, their training and policies to ensure that they support practitioners to understand that an adult's care and support needs may include for example, an individual who uses substances to the extent that it impacts their ability to manage daily living and influences self-neglecting behaviours.
4	Practitioners are sometimes unsure whether to raise a safeguarding concern when they are uncertain about whether the criteria in section 42 (1c) of the Care Act have been met?		2	How can Salford Safeguarding Adults Board review their multi-agency safeguarding procedures to ensure that it supports professionals who are unsure whether section 42 (1c) of the Care Act has been satisfied, in line with the Local Government Association (2020) guidelines.
5	Professionals must look beyond the isolated presentation of an individual and		3	How can partner agencies assure Salford Safeguarding Adults Board that they are prompting and supporting their professionals to

[54] Trauma Responsive | Salford Safeguarding Adults Board
[55] FREE Spring 2025 Homeless PIE Training Course - Manchester Safeguarding Partnership

	assess escalating risks when considering safeguarding.			step outside of their individual role and remember the responsibilities of safeguarding and to look beyond the isolated presentation of an individual when considering care and support needs.
6	Steven was left to seek support independently when he was not referred to the Rough Sleeper Drug and Alcohol team.	Question 6 later in the report should support this learning to be addressed.		
7	Professionals do not always record whether consent has been sought to include family/associates within an individual's care planning and risk assessment.		4	How can partner agencies evidence to Salford Safeguarding Adults Board that they are prompting their professionals to record whether consent has been sought (and achieved) to include a family member or associate within an individual's care planning and risk assessment.
8	Professionals remain concerned about breaching data protection when recording personal information.		5	How can the Salford Safeguarding Adults Board enhance and evaluate their information sharing training offer, and how can partner agencies assure the Board that the links to the information provided on the Board's website is integrated into their own guidance and training for practitioners
9	Professionals are not consistently exploring their legal Duty to Refer those who are homeless or threatened with homelessness to housing services.		6	How can agencies provide assurance to Salford Safeguarding Adults Board that their practitioners are supported to understand and remember their Duty to Refer, along with knowledge of StreetLink for rough sleepers when they are working with an individual who is at risk of or threatened with homelessness, and evidence that it is being done.
10	The layers of teams within the housing service is complicated to those working outside of it and a better understanding of the homelessness service could support an improved understanding of the referral process.		7	How can Salford Safeguarding Adults Board and Salford City Council promote their 'housing' website pages and support partner agencies and organisations to embed links within their guidance.

11	Unconscious bias is a recurring theme within Safeguarding Adults Reviews which look at how professionals support individuals experiencing addiction.		8	In what ways can the Salford Safeguarding Adults Board consolidate the insights gained from their Safeguarding Adults Reviews regarding unconscious bias related to addiction, in order to enhance practitioners' ability to engage in more effective conversations with individuals about addiction.

12. Appendix 1

The Review Panel Members

- Independent Chair, Salford Safeguarding Adult Board
- Board Manager, Salford Safeguarding Adults Board
- Independent Reviewer

A representative from

- North West Ambulance Service
- Northern Care Alliance
- Salford City Council Rough Sleepers Initiative Team
- Greater Manchester Police
- Greater Manchester Mental Health
- Salford City Council Housing options
- NHS GM
- Salford City Council Housing

13. Appendix 2

Further (SMART) actions required to make improvements in the issues identified as affecting care and/or service delivery				
What is the identified concern/gap	**What needs to happen?** What change is required to make an improvement, and which services are likely to be affected?	**By whom**	**By when**	**Evidence of Completion**
When Steven presented reporting that he was homeless, there appears to have no consideration given to referring to Dual Diagnosis Homeless Team.	Training session with MHLT and SMS to be arranged to enhance staffs understanding of services available	Operational Manager	30/08/2024	Training session.
Does not seem to be any carer contact at any point	Carer contact to be reviewed as part of the QAF. Actions to be developed from findings.	Operational Manager	30/08/2024	Audit to be completed and feed into QAF and actions developed.
Potential for EUPD diagnosis not explored.	CERN training to capture differences in presentations for male patients with EUPD traits/ diagnosis.	CERN Clinical Lead	30/08/2024	Training Slides
A referral letter was completed by MHLT in November 2023 however this was not actioned by CMHT.	Reducing access to generic inboxes for admins whose duties do not require them to have access would reduce the room for human errors to be made.	Operational Manager	15/07/2024	Email access list

	All seniors add to their agenda in their next admin meetings to do a piece around concentrating in, what can be a busy office.			Team meeting minutes

14. Appendix 3

Single Agency Learning undertaken or identified by agencies before or during the course of this review:

Greater Manchester Mental Health
Missed opportunities to enact safeguarding procedures. Steven had care and support needs and was experiencing self-neglecting behaviours including homelessness, drug use and non-engagement with services (not self-referring to ACHIEVE, non-concordance with medication). Following an assessment in the Emergency Department in November 2023 Steven was reported to be referred to the Community Mental Health Team. This does not appear to be followed up and he was not seen before his death in February 2024. A letter was completed by the liaison team and printed suggesting that the referral was sent. However, no referral to the Community Mental Health Team has been generated for that period on Paris. Investigation into this has confirmed that Cromwell House were copied into the email sent to the General Practitioner requesting the referral to Cromwell House from Liaison. The referral has been found in the subheading folder "Referrals" in the generic Cromwell House email inbox, but this doesn't appear to have been actioned by the admin team. It wasn't uploaded to Paris, forwarded on to a practitioner or discussed with any clinical member of staff. The process is not felt to be the issue; this is felt to be a human error. There is no documented carer/family contact either during or following the assessments from many services. On discussion with his partner, she stated that she was "not allowed" to speak to anyone or that she never received any telephone calls to ask for information or to discuss discharge plans. No consideration to a referral to Dual diagnosis team given he was homeless.
Greater Manchester Police
Greater Manchester Police are required to submit a care plan regarding all incidents where there is an immediate danger to a person. Incidents are graded using the THRIVE model. It can be seen that due to the gravity of concern for Steven's safety and well-being, Police have been dispatched to assist him down from great heights, in order to prevent death or serious harm. Other emergency services have also assisted at the scenes. In Steven's case, Officers have attended and once he has been secured into safety, he has been taken to hospital to be assessed by the mental health teams. On two of the contacts in the relevant time period, Officers have recorded a care plan and made the relevant referrals. However, on three of the police contacts no care plans have been recorded, which is not in line with policy for adult welfare cases (one of these incidents did not relate to him climbing up into dangerous positions, he was found sleeping rough in a bus station). When in some instances mental health patients are transported to hospital and left within their care, Officers still have to record a care plan and make the necessary referrals. It is important to reiterate to Officers that the use of the care plans allows for accurate recording of what occurred during the incident and action taken. Information Officers have gathered during the incident is important to understand the risk to that individual or others, and for making appropriate decisions on what further action may need to be taken. Officers are advised to use the Vulnerability Assessment Framework (A-G model) to record relevant information about the person and incident, and document information from other partners which has informed the officer's decision making. Sharing of information between agencies makes for informed actions plans and a multi-disciplinary response to tackle the issues. Work is already ongoing by the PPGU

to address the requirements of Officers to submit care plans, with subsequent triage processes and appropriate referrals to safeguarding agencies.
Northern Care Alliance
Needs to be better understanding on the mental capacity act and its application when young people and adults present with mental health, drug and alcohol challenges and who are homeless.