

Safeguarding Adult Review 'Bobby' Overview Report

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Approved by Board:
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1. Introduction

- 1.1 In January 2025, a Safeguarding Adult Review referral was made by Shropshire Council in respect of 'Bobby', who died whilst of no fixed abode in December 2024. A further referral was made by Midlands Partnership Foundation Trust shortly afterwards. Bobby lived with complex mental health and drug dependency needs and was at risk of self-neglect and financial abuse.
- 1.2 The pseudonym 'Bobby' has been selected, and agreed by loved ones, to protect the identity of the deceased and the privacy of his family.
- 1.3 The SAR referral was discussed by the Shropshire SAR Subgroup, and it was agreed the mandatory criteria under Section 44 Care Act (2014) had been met. Gill Taylor, an Independent Reviewer with over twenty years subject matter expertise in homelessness and multiple disadvantage, was commissioned by the Shropshire Safeguarding Community Partnership (SSCP) in June 2025.
- 1.4 The Reviewer and Shropshire Safeguarding Adult Board wish to share their deepest condolences with Bobby's family for their loss, and the distressing circumstances in which his death occurred.
- 1.5 The reviewer also wishes to extend gratitude to the frontline practitioners and clinicians who worked with Bobby, for sharing their insights sensitively and conscientiously throughout the Review.

2. Pen Portrait

- 2.1 This review relates to Bobby, a 45-year-old white British man who died in Shropshire whilst of no fixed abode in December 2024, shortly after being discharged from the local mental health hospital.
- 2.2 Bobby was a much-loved brother, son, and uncle. He kept in touch with his family even when things were difficult for him. His brothers were clearly a huge source of comfort and care, as he was for them when he was able to be. They have happy memories of their childhood together having adventures in the local countryside, as well as playing computer games, dancing and debating various topics in later years.
- 2.3 Bobby loved music, with a particular fondness for techno and had enjoyed going out clubbing with his brothers in his early adulthood. He loved walking and spending time outdoors, and professionals shared that he enjoyed the companionship of dogs. Bobby was also a talented and keen juggler, something he remained focussed and engaged with throughout his life even when circumstances were especially difficult for him. His brothers shared that when Bobby died, he didn't have many possessions left, but he did still have a set of juggling balls.
- 2.4 Bobby was a highly intelligent man who greatly enjoyed energetic debate, often engaging others in conversations about scientific and philosophical ideas. Bobby had lots of friends and enjoyed socialising and having a good time; on the last day of his life, he was with friends who cared for him when he became ill. He valued relationships with professionals where he felt heard and respected, and his best connections were with practitioners who took the time to genuinely listen to him and engage in meaningful discussion. Practitioners reflected that Bobby understandably took time to build trust, but when he did, he was funny, wise and motivated. Bobby had used his

experiences of mental health care to work as a Peer Support Worker in 2013, when he had achieved a period of stability for a few years. It's said that he really enjoyed this work.

- 2.5 Strongly independent by nature, Bobby was deeply uncomfortable with the level of control he felt agencies had over his life. As a result, he rejected many offers of support and was often reluctant to engage with services on their terms. He frequently refused his depot injection treatment, although he actively sought out inhalers to manage the discomfort of his asthma, something that was made more difficult by requirements for him to attend the GP to access new prescriptions.
- 2.6 Bobby lived with schizophrenia and antisocial personality disorder, had a long history of drug and alcohol use, and had been under the care of mental health services since his early twenties. He made at least three attempts to take his own life during adulthood. He experienced a traumatic brain injury in 2013 after a suicide attempt involving a road traffic accident. Bobby also lived with asthma and COPD (Chronic Obstructive Pulmonary Disease).
- 2.7 Bobby was vulnerable to physical and financial abuse by others and to self-neglect. His mental health needs and cognitive difficulties meant he was often unable to protect himself or recognise risks and his use of drugs was understood to be both a problematic coping mechanism for Bobby and, at other times, a source of fun and joy.
- 2.8 In the days leading up to his death, Bobby asked Ark¹ staff if he could make Christmas cards for two of his brothers and their families. Sadly, the cards arrived on the day his brothers were told of Bobby's passing, but they serve as a lasting reminder of his deep love for them even as he was struggling personally.

Protected Characteristics

- 2.9 Bobby was a working age white British man who had lived experience of inpatient psychiatric care, chronic mental ill-health, homelessness and drug use and dependency. Documentation and reflections from practitioners suggest that agencies were not formally aware of his sexuality or religious beliefs, although he is known to have had girlfriends and was not known to attend a place of worship.
- 2.10 Bobby's 'protected characteristics', such as gender, age, sexuality and religion, as defined by Equality Act (2010), are not documented in agency decisions related to his care and support needs, homelessness or health concerns, nor in how the risk and vulnerability he experienced was understood and responded to.
- 2.11 Bobby's mental health and drug and alcohol use were central features in agency responses towards him. According to the social model of disability², Bobby could be considered a disabled man due to these needs and the cognitive impairments resulting from his brain injury. However, it is unclear from the documentation provided if he understood himself to be disabled and what it meant to him if he did. Documentation provided does not identify if and how the social model of

¹ Shrewsbury Ark is a local voluntary and community sector organisation, offering outreach and daycentre support to people experiencing homelessness and social exclusion.

² The social model of disability is a way of viewing the world, developed by disabled people. The model says that people are disabled by barriers in society, not by their impairment or difference. Barriers can be physical, like buildings not having accessible toilets. Or they can be caused by people's attitudes to difference, like assuming disabled people can't do certain things. Read more here: [Social model of disability | Disability charity Scope UK](#)

disability was applied by agencies, when considering the barriers he faced in accessing services, achieving goals and protecting himself.

3. Approach to Review

Purpose of a Safeguarding Adult Review

- 3.1 The purpose of a SAR is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died. The purpose of a Safeguarding Adult Review (SAR) is to establish whether there are lessons to be learned, from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults and the factors that enable and constrain this. This typically involves reviewing the effectiveness of practices and procedures (both multi agency and those of individual organisations) in order to inform the improvement of interagency practice and strategic planning.
- 3.2 There is a strong focus on understanding the underlying issues that informed professional actions and what, if anything, prevented them from being able to help and protect Bobby from harm. As well as local factors, it is good practice to highlight the impact of national policy and legislation on effective single and multi-agency practice as part of this, which can be found at [Section 5.5](#). The learning produced through a SAR concerns 'systems-findings' as well as local direct practice. Systems findings identify legal, political, social and organisational factors that make it harder or easier for practitioners to provide quality care and support that meets the needs of the people they work with.

Key Lines of Enquiry

- 3.3 The review considered the period December 2023 to December 2024, the final year of Bobby's life. Given the long-term nature of Bobby's relationship with statutory and voluntary agencies in Shropshire, and the particular impact of Bobby losing his tenancy in 2021, information from prior to the review period was considered and discussed where it relates to the key lines of enquiry described below.
- 3.4 A SAR Panel, made up of key local agencies, was established to support the Review. The Panel agreed the following four key lines of enquiry, each with a series of guiding sub-elements to be explored as relevant:

1. Application of legal duties and statutory guidance:

- Mental Capacity Act 2005, with a focus on consideration of fluctuating capacity
- Community Treatment Orders (Section 17A Mental Health Act 1983, as amended by Mental Health Act 2007)
- Aftercare arrangements (Section 117 Mental Health Act 1983)
- Adult safeguarding (Section 42 Care Act 2014)

2. Engagement that is 'Difficult or Not Working':

- Barriers to support related to overlapping health, housing and care needs (multiple disadvantage)
- Dynamics that resulted in reducing support when needs were escalating
- 'Risk normalisation' and 'unfounded professional optimism'
- Planning and decision-making around service withdrawal
- Trauma-informed care

- Rapport building and trusted professional relationships

3. Multi-Agency Working Arrangements:

- 'Lead professional' arrangements and information sharing
- Hospital discharge planning
- Multi-agency risk management and escalation meetings
- 'Dual diagnosis' pathways, specifically around the risk of drug-related deaths for mental health patients
- Working collaboratively with family and next of kin

4. Homelessness Prevention:

- Application of Housing Act and Homelessness Reduction Act duties and powers in respect of adults with enduring mental health needs
- Tenancy sustainment and eviction prevention for vulnerable tenants
- Effectiveness of pathways from street homelessness into accommodation
- Assessing and managing risks around rough sleeping and in accommodation services

Methodology

- 3.5 On reviewing the summary information provided by relevant agencies from this period, the Panel agreed that SAR Bobby should adopt a hybrid methodology, drawing on the Appreciative Inquiry³ (AI) approach alongside SCIE's 'Learning Together'⁴ and 'Whole System Understanding'⁵ tools.
- 3.6 Appreciative Inquiry (AI) does not negate problems or ignore systemic issues. However, it recognises that by shifting the frame of reference away from defining "what's wrong" and towards "what's working" and "what do we want to strengthen" opportunities for change can expand. Appreciative Inquiry is a process of generating new knowledge, through dialogue that is provocative, future-focussed and resistant to hopelessness.
- 3.7 This methodology co-created multi-agency learning with practitioners and local agencies who support adults living with multiple disadvantage⁶, which is sometimes referred to as multiple exclusion homelessness⁷. These terms relate to the experiences of people living severely marginalised lives defined by deprivation, inequality, abuse and trauma that result in cycling experiences of at least three of the following experiences: homelessness, mental ill-health, domestic abuse, criminal justice involvement and drug/alcohol dependency.
- 3.8 The following agencies were represented on the SAR Panel, provided documentation to support the SAR and/or provided representatives to join learning events:
- Connexus Housing Association
 - Midlands Partnership University Foundation NHS Trust - Redwoods Centre

³ https://www.researchinpractice.org.uk/media/hpsba3z3/developing-effective-safeguarding-adult-review-learning-events_pt_web.pdf and <https://www.iriss.org.uk/resources/insights/forming-new-futures-through-appreciative-inquiry>

⁴ <https://www.scie.org.uk/safeguarding/children/case-reviews/learningtogether/>

⁵ Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews.' Journal of Adult Protection, 17 (1), 3-18.

⁶ The most commonly used definition can be found here: <http://meam.org.uk/multiple-needs-and-exclusions/>

⁷ A useful summary of this term and research about it can be found here: <https://www.communitycare.co.uk/2011/11/17/research-multiple-exclusion-homelessness/>

- Midlands Partnership University Foundation NHS Trust - Rough Sleepers Mental Health Team
- Midlands Partnership University Foundation NHS Trust - Shropshire Central East Community Mental Health Team
- NHS Shropshire, Telford and Wrekin Integrated Care Board
- Shrewsbury Ark
- Shropshire Council – Housing, Homelessness and Rough Sleeping Services
- Shropshire Council – Adult Social Care - Adult Safeguarding and Mental Health Social Work Services
- We Are With You - Shropshire Recovery Partnership
- West Mercia Police Constabulary

Involvement of Family and Friends

- 3.9 The Reviewer made initial contact with two of Bobby's brothers in August 2025. In an initial discussion they spoke about their deep love for their brother, sharing memories of their life together, of times when he was well and of their concerns about his deteriorating health and wellbeing in the years since he lost his tenancy. They shared concerns about their brother's care and expressed their dissatisfaction with how agencies worked together around his discharge from hospital in November 2024. They felt strongly that they had advocated for Bobby but had not been listened to and were deeply concerned about the decision to discharge Bobby without accommodation or a Community Treatment Order in place.
- 3.10 The Reviewer shared an update on review progress in January 2026 and in May 2026 invited them to contribute to the pen portrait in this report and the pseudonym chosen, which they kindly did.

SAR Process

- 3.11 This SAR took place over a 10-month period, with a delay at the start of the process related to staff sickness. It was a highly engaged review, with contributions from voluntary and statutory agencies and a meaningful commitment to practice improvement demonstrated by all involved.
- 3.12 It is notable that the practitioner learning event was especially well attended, including by frontline practitioners who had known Bobby well before the review period, whose attendance was not required. As such, it was a moving and candid discussion, that showed significant respect and care for Bobby as well as a commitment to learning and improvement in his memory.

Parallel Processes

- 3.13 A Coroner's inquest was opened in February 2025. An inquest hearing is set for October 2026.
- 3.14 An After-Action Review was completed by the Midlands Partnership University NHS Foundation Trust (herein after called MPFT or Midlands Partnership Foundation Trust) in March 2025. The report describing this investigation has been made available to the SAR author to inform this review.

4. Research & Best Practice

- 4.1 Safeguarding Adult Reviews draw on research and best practice to identify relevant themes and practice issues that may be related to the individual who is the focus of the review. The purpose

of including is to draw attention to best practice and also to highlight what is known about the wider systemic and structural factors that influence and impact the provision of relevant care and support beyond the local context.

- 4.2 Michael Preston-Shoot (2019) posits that *“drawing on existing evidence about effective practice would mean that reviewers are not starting out with a blank canvas. What is proposed here is that SARs begin explicitly with the available evidence-base, using it as a lens with which to scrutinise...what facilitates good practice and what presents barriers to effective practice”*. The advantage of this approach is that reflection and systemic analysis is foregrounded within the SAR process.
- 4.3 Research into safeguarding practice around homelessness, self-neglect and substance dependency has underlined the need for a holistic whole-systems approach for people who may fall outside of statutory thresholds and eligibility criterion. As such, review findings and recommendations will consider four domains of effective practice outlined by the Local Government Association⁸:
- Direct Practice with Individuals
 - Multi-Agency Team Around the Person
 - Organisations Supporting the Team
 - Strategic Governance
- 4.4 Given the vast array of relevant research and practice concerned with the experiences and needs Bobby lived with, it is not possible or useful to include all the information considered as part of the Review in this report. The sections below attempt to draw out research and practice findings in key areas.

Wellbeing & Prevention

- 4.5 The wellbeing principle and safeguarding obligation to adults with care and support needs was deliberately widely defined in the Care Act 2014 by Parliament. Since April 2015, Section 1 Care Act requires local authorities to promote an individual's wellbeing whenever it is carrying out any care and support function; this is a general duty applying to all residents within a local authority area as well as a specific responsibility that local authority officers should uphold when carrying out duties under the Care Act. Considerations of wellbeing need to consider the suitability of accommodation, a person's ability to make choices and the quality of their relationships with others.
- 4.6 Section 2 of the Care Act obligates local authorities and relevant partners⁹ to provide services or take other steps it considers will prevent or delay the development of care and support needs by adults in its area. The Care and Support Statutory Guidance, which accompanies the Care Act, dictates an early response to emerging harm is essential to stop risks from escalating. It also clarifies that local authorities have duties when the adult's needs for care and support are due to a physical or mental impairment or illness and that they are not caused by other circumstantial factors. This includes *‘physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury. The authority should base their judgment on the assessment of*

⁸ Michael Preston Shoot (2021) 'Adult Safeguarding and Homelessness: A briefing on positive practice', Local Government Association. Available at: <https://www.local.gov.uk/publications/adult-safeguarding-and-homelessness-experience-informed-practice>

⁹ Section 6 and 7 of the Care Act 2014 obligates relevant partners (police, NHS, district or county councils, prison, probation, department of work and pensions and providers of health or social care services) to cooperate in the delivery of respective functions to adults with care and support needs and their carers.

*the adult and a formal diagnosis of the condition should not be required.*¹⁰ Section 11(2) provides an enduring duty to offer an assessment when an adult with care and support needs has experienced, or is at risk of abuse or neglect, including sexual exploitation.

- 4.7 Finally, Section 42 of the Care Act 2014 requires that each local authority must make (or cause others to make) enquiries, decide what must be done and by whom whenever an adult with care and support needs is at risk of, or experiencing, abuse or neglect. This includes taking action to prevent abuse and neglect and to working with people at risk of abuse and neglect in accordance with [Making Safeguarding Personal](#) principles.

Self-Neglect

- 4.8 Research about self-neglect and people who've experienced homelessness and multiple disadvantage concludes that there are uncertainties within contemporary social work, including whether people fall under the 'umbrella' of Adult Social Care and adult safeguarding (Harris et al, 2022). Learning from practice also concludes that narratives of 'lifestyle choice' and mental capacity sometimes derail responses to referred adult safeguarding concerns (Preston-Shoot, 2021) which indicates the need to reshape attitudes of professionals and the structures that enable successful multi-disciplinary support for adults who self-neglect but who may appear not to fall easily into established definitions and categories.
- 4.9 Self-neglect in adults who've experienced homelessness and exclusion may be harder to detect and may less easily fall within established adult safeguarding responses and interventions than other forms of abuse and neglect. There may be particular challenges in identifying if self-neglecting behaviour is about 'unwillingness' or 'inability', which can be further complicated by drug and alcohol use, executive functioning concerns and the impact of life circumstances.
- 4.10 SSCP has a robust [self-neglect best practice guide](#) in place that outlines how self-neglect can be associated with care and support needs, trauma, health concerns and other personal factors. The guide advises that social and environmental factors are taken into consideration when identifying and responding to self-neglect and includes case examples, legal information and practice guidelines to support agencies and practitioners to consider if a multi-agency response, including through Care Act adult safeguarding duties & powers, is needed to support people who are self-neglecting. The guide draws on a range of sector-led research and best practice guidance to ensure that:
- Adults who are self-neglecting are empowered, as far as possible, to understand the implications of their self-neglecting behaviours with a focus on Making Safeguarding Personal principles
 - A shared, multi-agency understanding and recognition of the issues involved in working with adults who self-neglect.
 - Effective multi-agency working and practice, whether this falls within a Section 42 safeguarding enquiry or outside of this. Decisions will be made on a case-by-case basis as to whether the lead agency will be the local authority or another agency.
 - Agencies and organisations uphold their legal and organisational duties of care.
- 4.11 Importantly, self-neglect guidance emphasises the role of relational approaches; get to know the person, act with integrity and honesty and work in personalised and iterative ways that accord with the adult's mental capacity, personal priorities and their desired pace of change. It

¹⁰ Paragraph 6.104 Care and Support guidance, DHSC

draws on Social Care Institute for Excellence (SCIE) guidance¹¹ to encourage a 'Knowing, Being, Doing' approach:

- **Knowing**, in the sense of understanding the person, their history and the significance of their self-neglect, along with all the knowledge resources that underpin professional practice.
- **Being**, in the sense of showing personal and professional qualities of respect, empathy, honesty, reliability, care, being present, staying alongside and keeping company.
- **Doing**, in the sense of balancing hands-on and hands-off approaches, seeking the tiny opportunity for agreement, doing things that will make a small difference while negotiating for the bigger things, and deciding with others when the risks are so great that some intervention must take place.

Mental Health

- 4.12 People experiencing homelessness face systemic barriers when seeking access to mental health services. In real terms, this means that many people who rough sleep or stay in hostels are living through acute episodes of emotional and mental disturbance as well as enduring distress, resulting in high rates of suicide, acute hospital admissions, interactions with criminal justice agencies and without the ongoing therapeutic input they need to regain a sense of stability¹².
- 4.13 People experiencing homelessness are disproportionately affected by adverse childhood experiences, such as neglect, exposure to violence, unexpected bereavements, poverty, and physical or emotional abuse¹³, which may go some way to explaining the high prevalence of personality disorder traits and diagnoses amongst homeless populations¹⁴.
- 4.14 Research highlights social and professional stigma towards people whose behaviours are characterised as 'Personality Disorder' (Mind, 2022). A Royal College of Psychiatry (2018) study identified the negative attitudes of clinical staff towards patients with diagnosis of personality disorder. The study specifically referenced nurses as scoring lowest, using self-rating scales, on caring attitude towards patients. Professional attitudes influence care planning and responses to risky behaviour and distress; people diagnosed with personality disorder experience high levels of criminalisation, excessive detention and containment, and disproportionate deaths by suicide¹⁵ compared with people living with other diagnoses. This prevails despite more than twenty years of intentional government policy to 'break the cycle of rejection' where personality disorder is a diagnosis of exclusion¹⁶. Whilst it is not clear from the information shared as part of this review if Bobby experienced direct stigma, reflections from practitioners surrounding how he was perceived and how agencies responded to his experiences of victimisation, suggest that it would be valuable for all agencies to reflect on how stigma and unconscious bias plays a role in their work supporting adults with complex experiences commonly associated with personality disorder and substance use dependency.

¹¹ <https://www.scie.org.uk/app/uploads/2024/06/report69.pdf>

¹² <https://www.england.nhs.uk/wp-content/uploads/2016/07/stop-the-scandal.pdf>

¹³ Herman D. B., Susser E. S., Struening E. L., Link B. L. (1997). Adverse childhood experiences: Are they risk factors for adult homelessness? *American Journal of Public Health*, 87(2), 249–255. <https://doi.org/10.2105/AJPH.87.2.249> and Koegel P., Melamid E., Burnam M. A. (1995). Childhood risk factors for homelessness among homeless adults. *American Journal of Public Health*, 85(12), 1642–1649. <https://doi.org/10.2105/AJPH.85.12.1642>

¹⁴ Fazel S., Khosla V., Doll H., Geddes J. (2008). The prevalence of mental disorders among the homeless in western countries: Systematic review and meta-regression analysis. *PLoS Medicine*, 5(12), e225. <https://doi.org/10.1371/journal.pmed.0050225>

¹⁵ <https://www.nhsconfed.org/events/watch-personality-disorder-no-longer-diagnosis-exclusion-call-action>

¹⁶ Department of Health (2003) Available at: https://www.candi.nhs.uk/sites/default/files/Documents/pd_no_longer_a_diagnosis_of_exclusion.pdf

- 4.15 There are examples of innovative practice around personality disorder stigma from Scotland, where attempts to improve responses to people living with personality disorder through the provision of multi-agency training and learning spaces for practitioners have been effective in improving care¹⁷. Given the prevalence of personality disorder diagnoses in the population of people living with multiple disadvantages and homelessness, as well as its clear links with trauma and social exclusion, there is value in exploring local policy and practice in this area further.

Multiple Disadvantage

- 4.16 According to the Making Every Adult Matter coalition:

“People facing multiple disadvantage experience a combination of problems. For many, their current circumstances are shaped by long-term experiences of poverty, deprivation, trauma, abuse and neglect. Many also face racism, sexism and homophobia. These structural inequalities intersect in different ways, manifesting in a combination of experiences including homelessness, substance misuse, domestic violence, contact with the criminal justice system and mental ill health.

Multiple disadvantage is a systemic, not an individual issue. People facing multiple disadvantages live in every area of the country. They are often failed by services and systems that focus on singular issues. This makes it harder for individuals to address their problems, lead fulfilling lives and contribute fully to their communities.”

- 4.17 The **Hard Edges** report (2015) estimated that 58,000 people face problems of homelessness, substance misuse and offending in any one year. When the research was expanded to considered gendered violence and mental health, in a report called [Gender Matters](#) (2020) this figure rose to an estimated 336,000 people.
- 4.18 Research exploring multiple disadvantage is growing, and with it the evidence base of effective practice. One of the most comprehensive and relevant considerations of effective practice with people living with multiple disadvantage arose from the Fulfilling Lives programme, which worked between 2014 and 2021 in twelve areas of the country. Their evaluation¹⁸ made clear the following foundations for effective work with people living with the effects of multiple deprivation, trauma and co-occurring conditions:
- Removing arbitrary barriers to accessing support services
 - Co-production of new and changed services, with the people who use them
 - Improving the training and learning opportunities available for frontline practitioners, and giving them the flexibility to use it in their practice
 - Improving access to mental health services
 - Improving transitions between services and settings

Hospital Discharge

¹⁷

<https://blogs.iriss.org.uk/homelessness/personality-disorder/>

¹⁸

<https://www.tnlcommunityfund.org.uk/media/insights/documents/Summary-of-programme-achievements-evaluation-findings-learning-and-resources-2022.pdf?mtime=20221128143121&focal=none>

- 4.19 National policy is clear that people should not be discharged from hospital into homelessness, and that discharge planning for people who are homeless or at risk of homelessness must start early, be coordinated and involve local authority and voluntary sector housing partners. This expectation is set out in the joint Department of Health and Social Care (DHSC) and Department for Levelling Up, Housing and Communities (DLUHC) guidance *Discharging people at risk of or experiencing homelessness*¹⁹, published in 2024. The guidance stresses that admission to hospital should be seen as a “window of opportunity” to identify and address health, housing and safeguarding needs, rather than focusing solely on clinical readiness for discharge.
- 4.20 “Duty to Refer” requirements outlined in the Homelessness Reduction Act 2017²⁰ are highly relevant to effective discharge planning. Hospitals, emergency departments and NHS trusts providing inpatient care have a legal duty to refer anyone they believe is homeless or threatened with homelessness within 56 days to a local housing authority, with the individual's consent. Guidance²¹ emphasises that this duty should be embedded into hospital discharge processes, not treated as an administrative add-on, and that referrals should be made as early as possible to allow homelessness prevention or relief activity to take place before discharge.
- 4.21 NHS England²² and NICE guidance²³ reinforces that safe hospital discharge requires multi-agency collaboration and must extend beyond meeting immediate clinical criteria. The NHS England Emergency Department pathway, checklist and toolkit recommends early identification, holistic assessment and coordinated discharge planning, including liaison with housing, primary care, mental health, substance misuse and voluntary sector services. Policy documents also emphasise safeguarding and person-centred practice. The 2024 DHSC/DLUHC guidance²⁴ explicitly links homelessness with self-neglect, trauma, mental ill health, substance use and brain injury and makes clear that adult safeguarding processes should be considered where risks are high or persistent. Making Safeguarding Personal principles²⁵ apply at discharge, requiring practitioners to involve the individual in decisions, consider their wishes and strengths, and coordinate support that reduces the risk of harm. Good practice includes identifying a lead professional or coordinator for discharge, involving family members where appropriate, and ensuring continuity of support after discharge, rather than reliance on crisis-driven responses.
- 4.22 Taken together, statutory and practice guidance establishes a clear expectation: hospital discharge for people experiencing homelessness must be planned, lawful and multi-agency, with housing and safeguarding considerations treated as integral to health care, not as secondary concerns.

¹⁹ <https://www.gov.uk/government/publications/discharging-people-at-risk-of-or-experiencing-homelessness/discharging-people-at-risk-of-or-experiencing-homelessness>

²⁰ <https://www.legislation.gov.uk/ukpga/2017/13/section/10>

²¹ <https://www.gov.uk/government/publications/homelessness-duty-to-refer/a-guide-to-the-duty-to-refer>

²² <https://www.england.nhs.uk/publication/supporting-people-experiencing-homelessness-and-rough-sleeping/>

²³ <https://www.nice.org.uk/guidance/ng214>

²⁴ <https://www.gov.uk/government/publications/discharging-people-at-risk-of-or-experiencing-homelessness/discharging-people-at-risk-of-or-experiencing-homelessness>

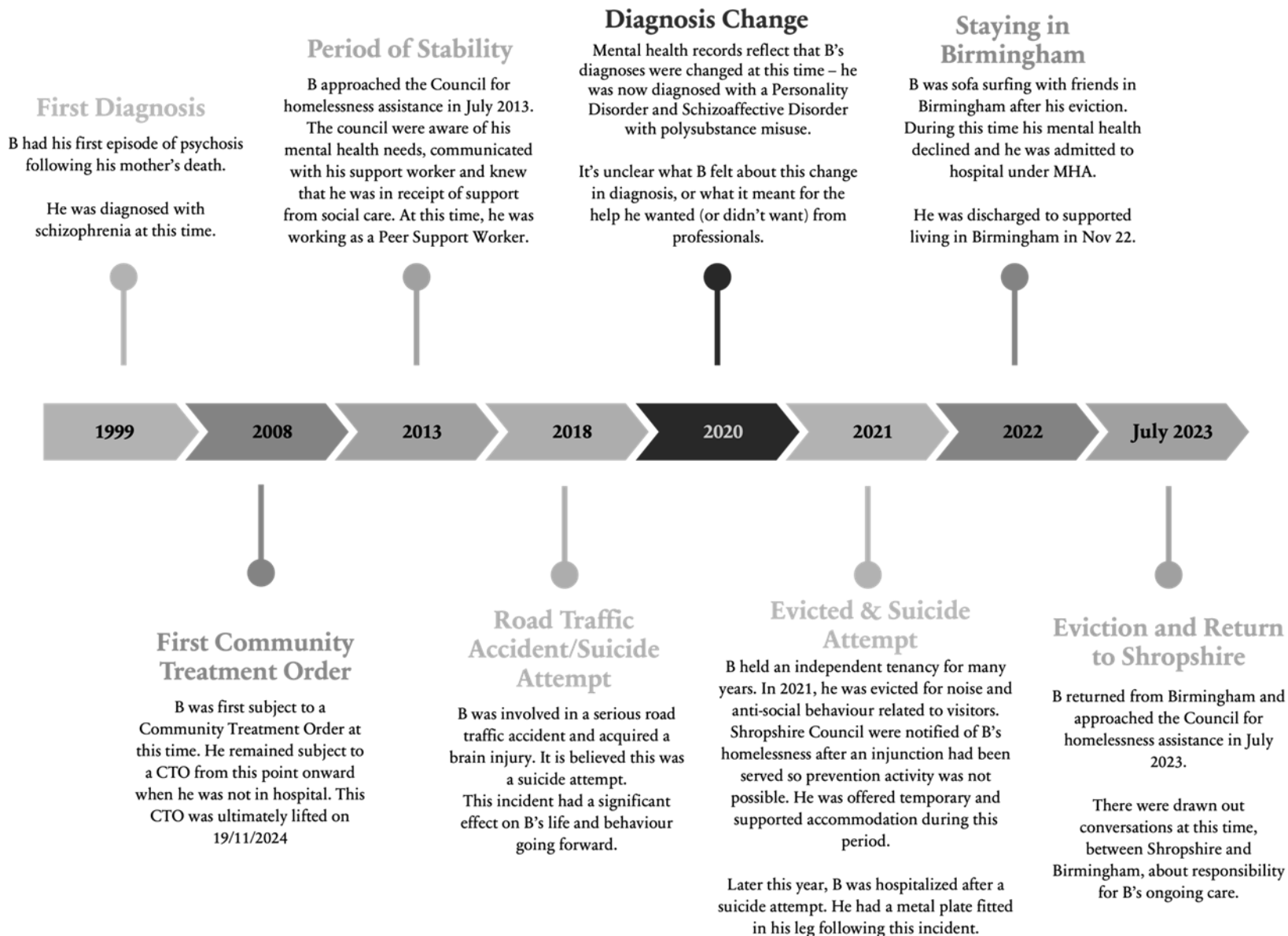
²⁵ See local guidance on MSP here: <https://www.shropshiresafeguardingcommunitypartnership.co.uk/useful-links/keeping-communities-safe-resources/making-safeguarding-personal/>

5. Analysis and Findings

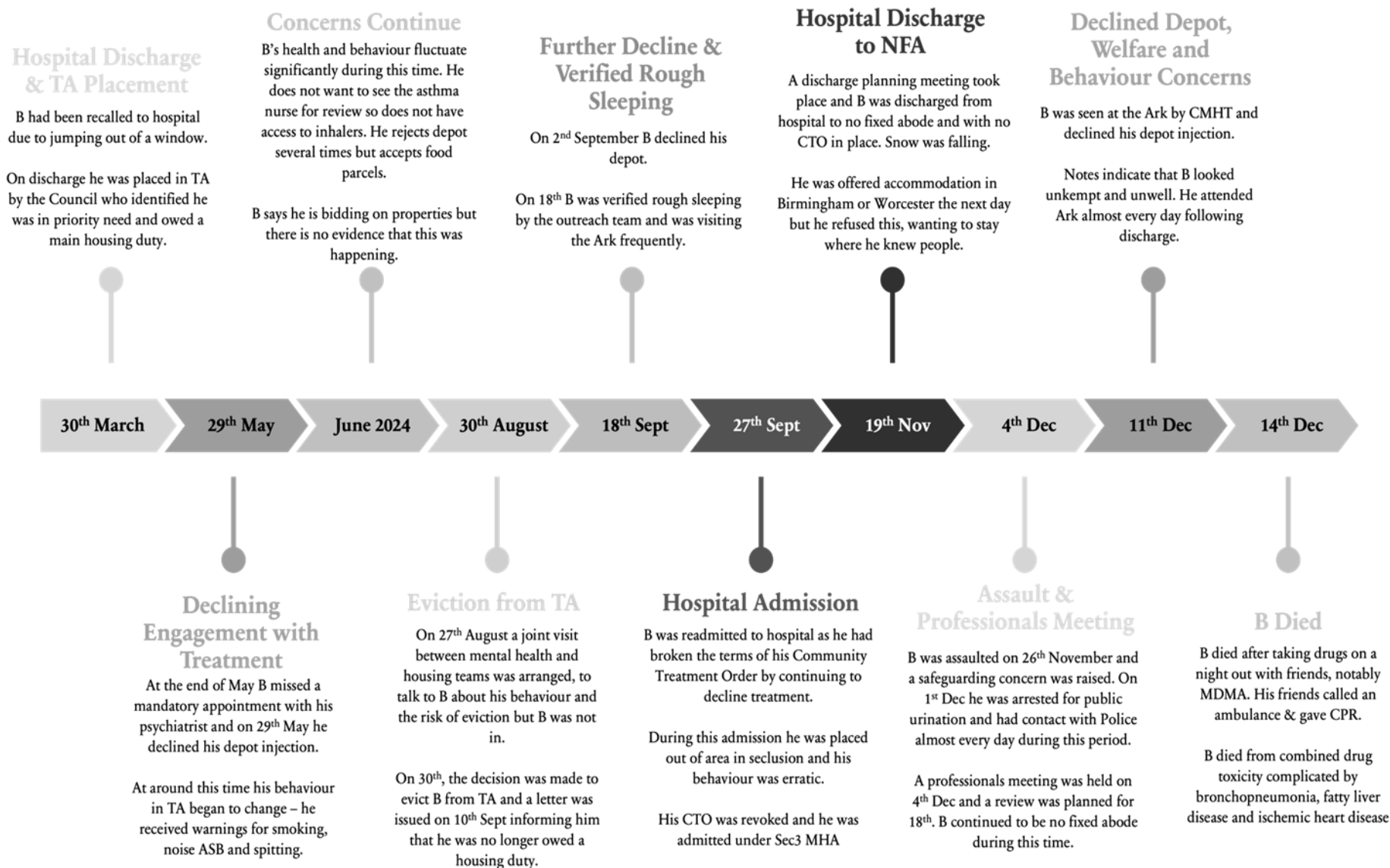
- 5.0.1 The following sections of the report explore each of the Key Lines of Enquiry thematically rather than chronologically. Each section draws on written documentation provided by agencies, reflections from practitioners, managers and Bobby's loved ones and on evidence from research and practice, to identify and contextualise areas for learning and improvement.
- 5.0.2 Although the analysis is thematic, it's important to understand what is explored in the context of Bobby's lived experience. As such, the following two diagrams provide a high-level timeline of relevant events during Bobby's contact with agencies in the years before he died, and a more a detailed, albeit still high level, timeline of events during the review period of 2024.

CHRONOLOGY

(Pre-Review Period)



CHRONOLOGY 2024



KLOE1: Application of legal duties and statutory guidance:

- 5.1.1 The purpose of a Safeguarding Adult Review is to consider how the application of legal duties, powers and decisions impacted on Bobby's exposure to abuse and neglect, including self-neglect and what can be learnt from how agencies worked together to improve multi-agency practice going forward. Therefore, it is appropriate to consider how safeguarding and risk issues were identified, explored and mitigated as part of the application of a range of legal duties and statutory guidance relevant to Bobby. This section will not look at housing duties and decisions, which are explored in KLOE 4.
- 5.1.2 It is not the purpose of a Safeguarding Adult Review to draw conclusions about the lawfulness of decisions made by Midlands Partnership Foundation Trust in respect of making a new application for Bobby's Community Treatment Order. An After-Action Review has been conducted by MPFT in this respect, with the outcome shared with the SAR Author and with Bobby's brothers. This review notes that Bobby's brothers are dissatisfied with the outcome of the After-Action Review, sharing that they felt that professionals made decisions that best suited them rather than what would keep Bobby safe. They also pointed to administrative errors (acknowledged in the AAR) that resulted in their not being appropriately notified of the decision to rescind Bobby's CTO and therefore to offer him additional support or to challenge the decision. They submitted a formal complaint sharing their concerns, which has been responded to separately and not shared as part of this review.
- 5.1.3 In respect of mental capacity, the review brought forward a range of complex discussions about a person's ability to make "unwise decisions", as described in section 1 (4) of the Mental Capacity Act, as well as the difficulties of assessing capacity in people who use drugs and alcohol where capacity and capability naturally fluctuate. The After-Action Review also includes observations, discussion and assumptions about Bobby's capacity to make decisions, principally about his housing situation and use of drugs, but there is no reflection about fluctuating capacity or executive functioning in this report. It is important to respect Bobby's clearly articulated desire to continue to use drugs and to note that in the past he clearly had been able to manage a tenancy, because he had done so successfully for many years. Practitioners were very conscious of the need to respect Bobby's wishes and decisions. However, this does not negate the need for agencies to assure themselves that unwise decisions are capacitous, especially in the circumstances where there are concerns about self-neglect and treatment compliance, especially where a person has a range of complex vulnerabilities is being discharged from hospital without safe accommodation.
- 5.1.4 Although this is a challenging area of mental health and social care practice, learning from SAR's and evidence from research and practice is widely available in respect of the capacity and execution issues facing adults with brain injuries and those who are dependent on, or 'problematically' using drugs and alcohol. However, the House of Lords Select Committee, in its post-legislative scrutiny of the MCA 2005 in 2014, concluded that "*The presumption of capacity, in particular, is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm. In some cases, this is because professionals struggle to understand how to apply the principle in practice. In other cases, the evidence suggests the principle has been deliberately misappropriated to avoid taking responsibility for a vulnerable adult. (para 105)*"²⁶. This review concludes that there is no

evidence that Mental Capacity Act principles were deliberately misappropriated, but rather that presumptions about capacity meant that a comprehensive assessment of Bobby's mental capacity, particularly but not exclusively to understand his executive functioning capabilities, was missing from his care. As a result, he was exposed to additional risks when discharged from hospital to no fixed abode and was subject to decisions around his housing and care that may have been different, had it been concluded that he was unable to make and execute such decisions without support.

- 5.1.5 Community Treatment Orders (CTOs) are set out in Section 17²⁷ of the Mental Health Act 1983, as amended by the Mental Health Act 2007. A CTO allows someone who has previously been detained in hospital under the Mental Health Act, to leave hospital and live in the community subject to specific conditions, such as engaging with treatment and attending appointments. An individual can be recalled to hospital if those conditions are not met or if their mental health deteriorates. The purpose of a CTO is to support people for whom ongoing hospital admission is not necessary or considered therapeutic, but where continued treatment and oversight are still important and there are concerns about patterns of disengagement from services and subsequent relapses.
- 5.1.6 Bobby had been subject to a CTO for almost 20 years, during which time he had frequently not engaged with the conditions of the order and had been recalled on numerous occasions for treatment and stabilisation. CTOs are 'less restrictive' than being in hospital, in legal terms and in respect of the experience of the individual, although in Bobby's case he experienced his CTO as restrictive because he didn't want to engage with his mental health treatment nor be under the control (as he saw it) of mental health services. In his case records a pattern of 'disguised compliance' is evident where Bobby agrees to a lesser or lower form of treatment or intervention, to satisfy the clinician/worker in front of him that treatment he didn't want was not needed or helpful, and then he would immediately disengage with the newly negotiated treatment regimen or agreement. This happened on multiple occasions, often coinciding with being allocated new workers who didn't know him or his history well, most recently in 2024 when his care was transferred from one community mental health team to another after Bobby changed his GP. There is learning for agencies in applying a greater degree of professional curiosity when an individual has a pattern of disengaging from support and not following through with actions they agree to, something explored in more detail in KLOE 2.
- 5.1.7 In respect of safeguarding, although the decision not to reinstate a CTO is concluded by the AAR to have been legally compliant, this review concludes that the immediate and longer-term risks to Bobby, especially in respect of self-neglect concerns or of the risks he had been known to pose to others when he was not compliant with his medication, were not thoroughly explored at this stage. Practitioners and managers involved in this SAR reflected that concerns about the lawfulness of decision-making overtook considerations about Bobby's wellbeing, safety and exposure to risk. They were candid about their discomfort with the decision made to discharge Bobby without housing or with his known history of disengagement, although they expressed that having explored the situation with all agencies present that 'their hands were tied' as accommodation wasn't available. It is noted as good practice that the Operational Lead for Shrewsbury East Central Community Mental Health Service escalated concerns about the circumstances around Bobby's discharge to the Care Group Clinical and Care Director. This meeting was not documented and as such it's not possible to draw conclusions, although findings in the AAR suggests this discussion was primarily about legal duties rather than about how to

alleviate concerns about Bobby's safety or wellbeing. MPFT state that it would not necessarily be expected that this type of meeting be recorded; learning from this review indicates that all decisions and escalations made about individuals being discharged from hospital to no fixed abode should be documented to ensure transparency and clarity.

- 5.1.8 In reaching their decision at the discharge planning/s117 aftercare meeting on 19th November 2024, there was some uncertainty within MPFT whether a CTO could be put in place for someone with no fixed abode. It's good practice that legal advice was sought to clarify this, which was confirmed in the After-Action Review. This concern does not appear to have been explored when Bobby was of no fixed abode and on a CTO in September 2024, before being recalled to hospital, which would have been helpful. In the same meeting, also documented in the AAR, a Mental Health Social Worker is said to have explained "*that they were very limited in how they could support [Bobby] without having an address due to the transient lifestyle*". There is no reference to how the Mental Health Social Work Team would commit to working with the Housing Options Service to mitigate the perceived limitation to meet his needs whilst homeless, and although it is likely Bobby would have declined care, his living situation in the years prior was certainly not transient – he had lived for long periods in his own tenancy, supported living accommodation and temporary accommodation. Irrespective, there is nothing in the Care Act that requires an individual to have an address in order to receive care, indeed Bobby's needs were noted as being about connecting with his community and maintaining a home, both outcomes that social work could have had a significant input in, whether Bobby did or did not have a secure home at the time. There is learning for the Council and MPFT, to invest in the legal and practice literacy of frontline social work and ward teams in respect of homelessness and its interaction with CTO and Care Act duties and ways of working. This would ensure that formal and informal decisions related to adults with mental health and care and support needs are made with comprehensive legal and practice knowledge, including of Making Safeguarding Personal principles.
- 5.1.9 The After-Action Review states Bobby was offered a tent and clothing, but this did not actually happen until the next day – Bobby left hospital in sandals, which he continued to wear for over a week despite being offered shoes the day after discharge. It is hard to see from case records or practitioner reflections how Bobby's wellbeing was considered in the discussions and decisions made around his discharge, and despite the statement that "a clear plan was in place", there is no information about what was put in place, who was identified to ensure agreed actions were followed-up or how known risks would be mitigated, such as ensuring Bobby had access to his inhalers prior to discharge. There was no clarity about where Bobby was going when he left hospital, with records changing from no fixed abode, to staying with family to staying with friends. Whilst Bobby was free to go wherever he wanted without letting staff know, those involved in the review (and the discharge planning process) reflected that in hindsight more time was spent determining the legality of decisions than on making sure Bobby had somewhere safe to spend the night, access to his medication and with a clear and urgent plan to secure accommodation as soon as possible.
- 5.1.10 Bobby had been in receipt of 17hrs of support each week from adult social care for many years before the review period. He is documented as living with chronic and severe mental health needs, a brain injury, a metal plate in his leg, long-term drug and alcohol use, asthma and COPD. It is documented at various points by several agencies that he was unable to care for himself, although it is unclear if this related to self-neglect, to executive functioning and mental capacity issues or, to choices he was making about how he wanted to live. During the review period, the involvement of Adults Social Care was limited, although they confirmed that his care and support

needs were assessed during his final inpatient admission. They reflected that Bobby's needs were primarily related to housing and accessing services in the community, and that he consistently declined their support and as such their role was limited. It is not clear if adult social care, or any other agency involved, sought information or diagnostic information about the impact of his brain injury.

- 5.1.11 It is unclear, as social care specialists, why self-neglect was not raised by the Mental Health Social Work Team as part of the discharge planning/s117 aftercare meeting, and comments recorded in the AAR about Bobby's "lifestyle" indicate that evidence from research and practice about self-neglect and its relationship with mental capacity, i.e. that one can be determined as having mental capacity and still be facing self-neglect, may not have been fully understood. Self-neglect is a challenging area of safeguarding practice, but one where the evidence points strongly to the role of relationships and to rebuilding of self-esteem – which were indicated in Bobby's assessed need to connect with services in the community. Learning from this review points to the importance of strong legal literacy across all agencies, and perhaps a review of the role of the Self-Neglect Multi-Agency Risk Meeting (MARM) in supporting adults with complex presentations of self-neglect. This activity should be supplemented by training about the role of stigma and unconscious bias when working with people living with dual diagnosis and homelessness.
- 5.1.12 Similarly, despite the escalating concerns about Bobby it is notable that very few safeguarding concerns were submitted to the local authority. There were missed opportunities when Bobby was discharged from hospital in March 2024 and in November 2024, when he was evicted from temporary accommodation in August 2024 and when he was found to be rough sleeping shortly after that. It is good practice that the Rough Sleepers Quality Lead raised a concern with the Safeguarding Team when Bobby was assaulted shortly after being discharged from hospital in November 2024 and it is also noted as good practice that Shrewsbury Ark have regular informal meetings/conversations with the safeguarding team when they are concerned about people who visit their service. Although self-neglect was a documented cause for concern this does not appear to have been explored in any formal meeting or discussion during the review period. There is learning for all agencies about ensuring adequate safeguarding training and ongoing professional development around self-neglect, and for this to consider the particular and discrete risks facing adults who are homeless or living with multiple disadvantage.
- 5.1.13 This review concludes that although legal duties were applied appropriately, they were not applied consistently nor in a person-centred way. As such Bobby was lost amongst the decisions made about him rather than at the heart of them. Whilst the lawfulness of decision-making is crucial to effective practice, so too is person-centred and trauma-informed care²⁸. The latter was much less evident than the former in this case, something that agencies should learn from and prioritise going forward.

KLOE 2: Engagement that is Difficult or Not Working

- 5.2.1 Practitioners who knew Bobby spoke about him with warmth, respect and genuine affection. The practitioners' learning event brought together staff from a wide range of services and periods in Bobby's life. Their collective insights, grounded in both professional experience and personal reflection, have informed this section of the report.

²⁸

<https://www.gov.uk/government/publications/discharge-from-mental-health-inpatient-settings/discharge-from-mental-health-inpatient-settings#considerations-for-particular-people-in-hospital>

- 5.2.2 Bobby needed time to build trust, and practitioners needed the time and organisational permission to allow that trust to develop. Research consistently shows that trust-building is central when working with adults who self-neglect or who have long histories of contact with services, as repeated experiences of intervention, coercion or perceived failure can erode confidence in professionals. Relationship-based practice emphasises persistence and consistency over time, recognising that engagement may be slow and non-linear. In Bobby's case, time pressures and service thresholds appear to have limited the ability of frontline workers to work at the pace he required. As such he experienced most professionals with suspicion and resisted what he felt was their control over his life.
- 5.2.3 Mental health treatment can be experienced as traumatic, isolating and restrictive, particularly where detention, hospitalisation and compulsory treatment are involved. Bobby described his experiences in terms of feeling controlled. Trauma-informed practice highlights the importance of recognising how past trauma, including institutional trauma, can shape a person's responses to services, leading to avoidance, resistance or disengagement. There is limited evidence that these dynamics were fully recognised in Bobby's care, and it is unclear how trauma-informed principles - such as choice, collaboration, empowerment and emotional safety - were consistently applied.
- 5.2.4 'Unfounded professional optimism' is a recurring theme in agency records, with repeated assumptions that Bobby's engagement or stability would be sustained without sufficient contingency planning for when it, predictably, broke down. While optimism can be useful and motivating, and certainly practitioners and agencies had hopes for a brighter future for Bobby, research into self-neglect and multiple disadvantage highlights the risks of overly positive assumptions where there is a known pattern of disengagement. In Bobby's case, this pattern does not appear to have been formally recognised by agencies at the time, and therefore plans to anticipate, mitigate or respond to his (predictable) withdrawal from services were not adequately developed. This was especially the case at times when the risks around disengagement were especially high, such as when he was not taking his medication or when he was at risk of homelessness.
- 5.2.5 The staff at Shrewsbury Ark worked exceptionally well with Bobby, offering a clear example of effective trauma-informed and person-centred practice. Staff gave him space, listened and talked with him, made few demands and prioritised his sense of safety. They focused on building a relationship, getting to know Bobby as a person, and meeting his small, everyday needs such as charging his phone, and making sure he had a good meal. Their notes describe instances where they remind him of his strengths, thank him for his kindness and accept his apologies. Research highlights this type of low-threshold relational approach is highly effective for people with histories of exclusion and mistrust, because they allow the person to test what feels safe on their own terms and in their own time. The impact of this approach was evident: Bobby attended the service almost every day whilst rough sleeping, was very rarely aggressive or rude, and proactively asked for help when he needed it – a stark contrast to his engagement with other services.
- 5.2.6 Although practitioners were aware that drugs were important to Bobby and something he described enjoying, this was not explored as a way of understanding his life, coping strategies and unmet needs. Whilst drug use is common across all population groups, for people experiencing homelessness and instability it is often linked to attempts to manage emotional pain, trauma or distress. Evidence suggests that asking curious, non-judgemental questions can help professionals understand what taking drugs offers for an individual and what they are seeking to

feel, or avoid feeling. Bobby began using drugs heavily after his mother died; it may have been helpful for agencies to gently approach this with him, understanding his feelings of grief and giving him the opportunity to talk about how drugs or other behaviours soothed those feelings, without judgement or expectation of change. There is little evidence that such exploration took place with Bobby, or that services sought to understand what mattered to him in this respect, instead focussing on their own priorities and outcomes. This understandable given the extreme resource and demand pressures most agencies are experiencing, but nevertheless it was insufficient to give Bobby space to be himself and to feel like what he wanted for his life mattered to others.

- 5.2.7 Bobby had a wide range of interests and talents, including in music, nature and science. While his substance use and challenging behaviour may have made these more difficult to explore, there is limited evidence that practitioners were meaningfully able to build these strengths into his support planning. Strengths-based practice emphasises the importance of recognising interests and abilities as protective factors that can support identity, connection and motivation. Practitioners reflected that time and budget constraints and high caseloads often mean this type of support is hard to offer in practice, although all recognised that both they and the people they support would benefit from time together focussing on their strengths and not only on their needs and issues.
- 5.2.8 Bobby also had much to offer others, having previously worked as a Peer Support Worker for a mental health service. It's unclear whether and how this was explored in respect of opportunities such as volunteering, peer support roles or contributing through music or community activities. Research into homelessness and recovery consistently highlights the importance of purpose, self-worth and social contribution. Feeling needed and valued can be central to rebuilding identity and connection. For Bobby, it remains unclear where he felt a sense of purpose or belonging, suggesting that there is learning for agencies about asking and then supporting people experiencing homelessness to find meaning, purpose and connection that encourages future-thinking and self-worth.
- 5.2.9 No information was provided as part of the review to indicate that Bobby was offered advocacy, either formal or informal, to support him in articulating his wishes, goals and priorities. Advocacy is a key component of Making Safeguarding Personal, ensuring that the individual's voice remains central even when engagement is difficult or outcomes are uncertain. While it was positive that Bobby had some good and growing relationships with local services, there is limited evidence of an ongoing, non-familial relationship that existed solely to support Bobby and ensure he felt heard. This might have taken the form of independent mental health advocacy or peer support, both of which are recognised as effective in building confidence, ensuring rights and entitlements and exploring future goals.

KLOE 3: Multi-Agency Working Arrangements

- 5.3.1 There is strong evidence of willingness across agencies to work collaboratively, alongside a shared recognition that multi-agency working has improved significantly since Bobby's death. Practitioners demonstrated insight into the importance of joint working, shared responsibility and mutual accountability, and the review identified several examples of effective collaboration, including joint working between Housing Options and the Community Mental Health Team, and the consistently positive partnership between Shrewsbury Ark and a wide range of services. Research into adult safeguarding and homelessness consistently shows that trust and outcomes improve where agencies genuinely work together, rather than operating in silos, particularly for adults experiencing multiple disadvantage.

- 5.3.2 However, in practice, much of the joint working that did occur was reactive and crisis-driven, rather than proactive or sustained as part of a planned package of support around Bobby. Despite the involvement of numerous agencies and the presence of statutory duties across housing, health and safeguarding, it remains unclear who was leading Bobby's overall care and support. There is no evidence of a clearly identified lead professional or coordinated care lead, no MDTs were called in respect of Bobby until the day of discharge from hospital, and there is limited evidence of shared decision-making at key moments, such as when he was at imminent risk of eviction in summer 2024. Research and guidance on integrated care models emphasise the importance of clear leadership, shared ownership and continuity, particularly for people with complex needs who struggle to navigate fragmented systems.
- 5.3.3 Shropshire has a MARM Framework in place, to support adults whose needs and risks are deemed to sit outside statutory frameworks and there is a view that a multiagency approach would be helpful. A monthly MARM meeting for self-neglect and hoarding is in place, the purpose of which is to agree a multiagency risk management plan. If the risks are assessed as being moderate or high, then the expectation as laid out in the 'Responding to Self-Neglect in Shropshire: Local Procedure and Good Practice Guidance'²⁹ are that an MDT would be arranged. The Co-Chair of this meeting stated that *"due [to] the complexity of Bobby's needs, I would not deem a MARM to be appropriate but an MDT"*. However, this did not occur, and practitioners reflected that they were unsure about who would call a MARM or MDT or when these would be appropriate, indicating a need to promote information about these forums and processes more widely. There is evidence that concerns were escalated following the decision to discharge Bobby to no fixed abode in November 2024. However, there is little evidence of earlier escalation or the use or consideration of adult safeguarding or MARM frameworks prior to this point, despite ongoing indicators of self-neglect, homelessness and disengagement. Research highlights the role of safeguarding processes, including Multi-Agency Risk Management (MARM/MARAM), in creating shared oversight and coordinated responses for adults at high risk. Earlier engagement with adult safeguarding teams may have provided additional structure, challenge and support to the multi-agency network working with Bobby.
- 5.3.4 The absence of effective multi-disciplinary team (MDT) working is consistently identified as a systemic issue in Safeguarding Adult Reviews nationally, especially in cases involving homelessness, mental ill health and substance use. MDTs provide a structured way to bring together professional perspectives, share risk, challenge assumptions and develop coordinated, longer-term plans. Council-wide efforts are now underway to strengthen this approach, including the establishment of the RESET MDT, which brings together housing, health, outreach, substance misuse and voluntary sector partners to support people who are rough sleeping. This represents good practice aligned with evidence from national multiple disadvantage initiatives, such as Changing Futures, but this case management forum was not in place during Bobby's lifetime.
- 5.3.5 It is positive that the section 117 aftercare and discharge planning meeting was well attended by statutory agencies, reflecting recognition of shared responsibilities and the specific complexities around Bobby's housing and care. However, this was the first and only meeting, held on the day of discharge, which limited opportunities for proactive planning, meaningful collaboration and risk mitigation. Best practice and research consistently emphasise that discharge planning should

begin at admission, include early Duty to Refer³⁰ applications, proactive consideration of safeguarding concerns, and active involvement of housing, community services and family members wherever possible. While the final meeting demonstrates some good practice, this collaborative approach needs to be embedded across the whole inpatient journey. Improvements in this area have since been initiated through the Cultures of Care Quality Improvement programme, which is described in more detail in [Section 6](#).

- 5.3.6 During the review period, Shrewsbury Ark were not consistently included in multi-agency discussions and email threads sharing relevant information about Bobby, including as part of discharge planning in November 2024. This was a missed opportunity to involve a voluntary agency with knowledge about Bobby and resulted in documented misunderstandings about the support they could offer him, which is daycentre provision rather than accommodation. As a frontline voluntary sector organisation with regular, everyday contact with people experiencing rough sleeping, Shrewsbury Ark held valuable relational knowledge and insight into Bobby's presentation and needs as well as maintaining regular contact which was especially crucial when he was rough sleeping and his whereabouts uncertain. Their reflection that voluntary sector voices are not always afforded equal weight to statutory partners echoes learning from Safeguarding Adult Reviews across the country, pointing to the need to strengthen cross-sector relationships and to enable and encourage voluntary sector leadership, especially in homelessness where their support is a crucial part of the support system for many people. Encouragingly, relationships and inclusion have improved since Bobby's death, with Shrewsbury Ark now active contributors to RESET and other partnership forums, aligning local practice with evidence that inclusive, multi-sector collaboration leads to more effective support for people experiencing multiple exclusion homelessness and rough sleeping³¹.
- 5.3.7 The involvement of Bobby's brothers was not prioritised in care and support planning during the review period, despite their consistent concern, ongoing contact and willingness to be involved. Research and safeguarding practice highlight the importance of family and informal networks as protective factors, particularly for adults experiencing social isolation and homelessness. Family members can offer continuity, insight and advocacy that statutory systems often lack. While consent is a key consideration, Bobby had broadly given consent for his brothers to be involved, and this opportunity could have been better utilised within multi-agency planning, particularly when managing and mitigating risk. Even where information-sharing needed to be limited to respect Bobby's privacy, agencies could have engaged more actively with his brothers to listen, acknowledge their concerns and maintain relationships. This reinforces the importance of broadening traditional child-focussed Think Family approaches³² and Making Safeguarding Personal principles³³, ensuring that adults are supported within their wider social and familial context where possible and meaningful to them.

KLOE 4: Homelessness Prevention

- 5.4.1 Bobby's housing situation fluctuated significantly during the review period and in the years prior. This is in stark contrast to a long period of housing stability prior to 2021, when Bobby held an independent tenancy in Ludlow for many years. In the practitioner event, participants reflected on the impact of the Covid-19 pandemic on loneliness and isolation, and on agencies ability to identify and intervene in the situations that may have placed Bobby at risk of eviction, principally

³⁰ <https://www.gov.uk/government/publications/homelessness-duty-to-refer/a-guide-to-the-duty-to-refer>

³¹ <https://www.local.gov.uk/publications/adult-safeguarding-and-homelessness-experience-informed-practice#further-learning-for-the-team-around-the-person>

³² <https://www.shropshiresafeguardingcommunitypartnership.co.uk/media/n4oj2pot/02-think-family.pdf>

³³ <https://www.local.gov.uk/msp-toolkit>

the possibility that he was being cuckooed. Unfortunately, whilst a chronology was provided by Connexus to support the review, they did not attend learning events and therefore a discussion about how the decision to evict Bobby was reached and what action was taken to prevent this was limited to what other agencies were able to share.

- 5.4.2 Although not within the scope of this review, the Housing Options Service contributed a number of meaningful and candid reflections on their practice with Bobby in 2021 that are valuable to share. There was a 3-week delay between the initial notification to the Housing Options Team that Bobby was being made homeless in June 2021 and when the case was allocated. The Housing Options team recognise this falls short of practice expectations and point to a backlog within the service that has since been resolved. Despite this, the notification was submitted when an injunction and formal eviction notice were already in place, which meant that prevention action by the Council's HOT would not have been possible anyway. This identifies a learning point about the knowledge that housing providers have about the homelessness prevention support the local authority can offer, and that this can be sought 56 days prior to the likely date of homelessness, and earlier where appropriate. At this time Bobby was offered temporary accommodation, which he left voluntarily for accommodation secured for him elsewhere. This accommodation subsequently broken down, at which time Bobby moved to Birmingham to stay with friends, returning in 2023.
- 5.4.3 During the review period, 2024, Bobby was homeless, with periods of time in temporary accommodation and rough sleeping, as well as two stays in hospital. Due to his mental and physical health needs, Bobby met the criteria for 'priority need' status under Part VII Housing Act 1996 and as such he was owed a 'main duty' by the local authority when he was discharged from hospital in March 2024. The local authority met this duty in accordance with law and guidance, conducting an assessment, offering temporary accommodation and initiating planning for longer-term housing options.
- 5.4.4 The availability of suitable accommodation was a significant factor in the challenges facing professionals at this time. There were shortcomings identified in the housing needs assessments conducted on behalf of Bobby, which should have explored accommodation suitability in more detail and potentially triggered a multi-disciplinary discussion with the mental health trust and adult social care. This has since been identified as an area for improvement in the 2025 Systems Review of the Housing Options Service completed by Shelter, which is explored further in [Section 6](#). Agencies reflected that Bobby may have been better suited to self-contained accommodation, although at the time there was highly limited provision of this nature available and typically only for adults with significant mobility needs. The Council now works more closely with its Arm's Length Management Organisation (ALMO), STAR Housing, to identify self-contained temporary accommodation units where required, although these are still a scarce resource and are not always immediately available or located in an applicant's preferred area.
- 5.4.5 Notwithstanding the practice shortcomings around suitability in the housing needs assessment, securing accommodation was extremely difficult due to Bobby's history of challenging behaviour and non-compliance with tenancy conditions. At the time, there was no specialist supported accommodation available locally that could meet Bobby's needs. Several temporary and supported housing providers refused to offer accommodation to Bobby due to concerns about risk, and as such Bobby was placed in unsupported temporary accommodation in March 2024 after leaving hospital. This accommodation housed a range of single homeless adults, including much younger and older people with varying needs and vulnerabilities. In May 2024, coinciding

with Bobby refusing his depot injection, this placement began to break down, and Bobby's behaviour began to cause problems for other residents. There are documented incidents of aggression towards other residents, spitting and excessive noise at unsocial hours. His brothers expressed concern that Bobby's vulnerability in these settings was not recognised; his refusal to take his medication, his escalating drug use and aggressive behaviour could, and in their view should, have been considered through the lens of mental ill health including relapse, which necessitated a multi-agency review during his time in temporary accommodation in 2024. They report that they alerted professionals that he had his possessions stolen on several occasions and was unable to manage his behaviour in settings where there were other people using drugs, but this does not appear to have been followed up in discussions between the Mental Health Trust and the Housing Options Service.

- 5.4.6 It is good practice that Housing Options Team officers made several attempts (both successful and unsuccessful) to visit Bobby in this placement and to liaise with the temporary accommodation provider and Bobby's mental health support workers in an attempt to put additional support in place. Bobby was generally unreceptive to these interventions and was unwilling to engage with much of the support offered, although he did accept food parcels and it may have been beneficial to reflect on this as an opportunity for building a relationship (see KLOE 2). As discussed in KLOE 3, given Bobby's known needs, previous history of eviction and concerns about challenging behaviour whilst in temporary accommodation it was a significant missed opportunity that multi-disciplinary planning and coordination was not effectively and proactively utilised to prevent what was a predictable eviction, and the rough sleeping that followed.
- 5.4.7 The Housing Options Service recognised that there were specific missed opportunities to work proactively with Bobby, by making referrals for assessment, seeking advice and/or raising safeguarding concerns. However, given that Bobby was well known to ASC and to the Mental Health Trust, receiving support from both during the review period, action to safeguard Bobby and to explore accommodation related to his care and support needs, should reasonably have been led by these teams and not by the Housing service. It is notable that Bobby's mental health support worker did not raise a safeguarding concern when he was evicted, nor convene an MDT review of his mental health needs when he was uncontactable in the weeks that followed. The Housing Options Service did suggest that raising a safeguarding concern might be a good idea, but they did not action the suggestion when the mental health support worker didn't take this up. A quality and practice improvement project has been undertaken by the Housing Options Service in 2025 which has included commissioning joint Care Act and Housing Act training, developing a Senior Officer-led approach to auditing case files, and implementing regular team discussions to share practice.
- 5.4.8 Related to the analysis in KLOE 1, it is stated in the After-Action Review that Housing Services were of the belief that Bobby had the capacity to make a homeless application and therefore to accept or refuse housing assistance as he wished. It's unclear from the records how this determination was reached and by whom and it's important to note the distinction between a formal assessment of an individual's mental capacity as determined by the Mental Capacity Act (2005), and capacity to make an application for homelessness assistance, as described in 18.8 of the Homelessness Code of Guidance³⁴ and in case law related to housing³⁵. As a person

³⁴ MHCLG (2026) Chapter 18: Applications, decisions and notifications. Available at: <https://www.gov.uk/guidance/homelessness-code-of-guidance-for-local-authorities/chapter-18-applications-decisions-and-notifications>

³⁵ R v Tower Hamlets LBC ex parte Ferdous Begum (1993) 25 HLR 3019, HL; R (Uddin) v Southwark LBC (2019) EQHC 180.

deemed to have capacity to make a homeless application and understand the conditions of a tenancy, the “intentionally homeless” decision made about Bobby in August 2024 is the logical conclusion of repeated instances of disruptive, aggressive and non-compliant behaviour that were, ultimately, his choices. However, when this behaviour is understood in the context of his recall to hospital just a few weeks later, because he was increasingly mentally unwell, had not been complying with medication for several months and presented a risk to self and others it is difficult to see how a decision that he was responsible for his actions, and therefore intentionally homeless, could have been reached. The Homelessness Code of Guidance 9.17(c) is clear that the act or omission causing homelessness should not be considered deliberate if it was “*the result of limited mental capacity; or a temporary aberration or aberrations caused by mental illness, frailty, or an assessed substance misuse problem*”. This review concludes that insufficient attention was paid to Bobby’s capacity to meet the requirements of a tenancy, and to understand the implications of refusing accommodation. There is learning for agencies to approach decisions that prevent adults with care and support needs from accessing homelessness assistance with diligence and rigour. It is vital to be assured that an individual has, or does not have, mental capacity by requesting a formal assessment specific to the decision and the context it will be made in, with support from other agencies in the person’s support network.

- 5.4.9 Representatives from the Housing Options Service reflected as part of the review that the intentionally homeless decision would likely have been overturned had Bobby sought a review, but it is a practice shortcoming that this decision wasn’t reached prior to Bobby’s discharge from hospital in November given the information available and their own significant efforts to engage with partners around his deteriorating mental health. At this juncture, it was determined that he would be discharged without accommodation because he was no longer owed a main housing duty following the previous intentionally homeless decision. The After-Action Review describes a conversation in the discharge planning meeting, held on the day Bobby was discharged from hospital, where this intentionally homeless decision was explored. It is stated that the decision remained in place because Bobby’s circumstances had not changed, which is a requirement that must be met in order for a review of the decision to take place. However, it does not appear that the basis on which that decision was reached was questioned i.e. that the assumption of capacity was directly contradicted by his recall to hospital under his CTO. It is a point of learning for the Housing Service that they ensure that intentionally homeless decisions regarding adults with care and support needs, are only reached after seeking comprehensive information about the factors that may be influencing behaviour, such as the relapse in mental ill-health in Bobby’s case.
- 5.4.10 Bobby experienced two brief episodes of rough sleeping during the review period. The first episode followed immediately after he was evicted from temporary accommodation in August/September 2024 and the second after being discharged from hospital in November. There does not appear to have been a process in place for escalating safeguarding and welfare concerns about adults with care and support needs who are or are likely to be rough sleeping, and this is a learning point for agencies. As well as Bobby’s mental health needs, he was known to live with asthma and COPD, something he regularly spoke to professionals about and that was exacerbated by inhaling drugs; the Housing Service should work with the outreach and RESET Teams to explore an approach to ‘flagging’ individual risk factors relevant to rough sleeping, such as respiratory and circulatory conditions, affecting people rough sleeping in the area. This could be used to inform multi-agency discussions and prioritisation for limited supported accommodation.

- 5.4.11 Bobby's second episode of rough sleeping followed a hospital discharge planning meeting that all agencies were in attendance for on 19th November. From the perspective of adult safeguarding practice, it is concerning that agencies agreed that it was appropriate to discharge Bobby from hospital without accommodation on a day where it was snowing outside³⁶, SWEP was activated and it was expected that he would rough sleep. This practice episode is explored in more detail in KLOE 1.
- 5.4.12 It is documented in the Shrewsbury Ark case records that Bobby was very motivated to sort out his housing situation, working on this with staff on most occasions he accessed the service in the three weeks after he was discharged. It is also noted in the AAR that Bobby said he was bidding on properties, but this was not the case according to the Housing Options Service. It is documented that Bobby was advised during the discharge meeting that he would be able to access housing assistance once he had been 'verified'³⁷ as rough sleeping by the outreach team but when this offer was made (believed to be within two days of discharge) it was out of area in either Birmingham or Worcester, which Bobby did not feel able to accept. It is acknowledged that securing suitable accommodation for Bobby was very difficult and that an offer had been which is good practice. However, given his ongoing needs and release from hospital without the protections of a CTO, the collective agreement that he could be discharged without housing, and without a comprehensive forward plan that attempted to mitigate the risks of rough sleeping was unduly optimistic, poorly explored and far from the person-centred care that is expected.
- 5.4.13 Whilst no one could have predicted Bobby's death shortly afterwards, there is learning for agencies about addressing the housing needs of adults with care and support needs who are being discharged from hospital, especially where there is ample time for proactive planning to take place. Midland Partnership Foundation Trust acknowledged a number of gaps around meeting the housing needs of their patients, which have been taken forward through a nationwide 'Cultures of Care' quality improvement programme, described in more detail in Section 6.

National Context

- 5.5.1 The first and second national analyses of SAR's³⁸ concluded that insufficient attention was given in SARs to the national, legal, financial and policy context that shapes local practice.
- 5.5.2 During practitioners' events the national context of acute resource pressures, short-term funding cycles and the severe lack of appropriate and affordable housing were highlighted as major challenges in supporting vulnerable adults in Shropshire. Specifically, agencies highlighted the specific challenges of meeting Bobby's need for supported accommodation, although this has now eased slightly with the developments described in the next Section.
- 5.5.3 Agencies also pointed to intense resource pressures impacting NHS services in the community and in hospitals, pointing to a greater reliance on out of area placements and the challenges these can bring, as well as to concerns about the impact of recent staffing reductions in the Integrated Care Board. Managers also reflected on both the challenges and opportunities brought

³⁶ The Reviewer did a comprehensive search of national weather agency information. It was snowing across the West Midlands on 19th November 2024, one source confirming such is the BBC, available here: <https://www.bbc.com/news/live/cpvzxk14pxdt>

³⁷ 'Verification' describes the formal documenting of an individual as rough sleeping by an outreach team. This takes place when an outreach team has met the individual 'bedded down' outside. It is a contested area of practice, more about which can be read in this Homeless Link blogpost: <https://homeless.org.uk/news/spotlight-on-rough-sleeper-verification/>

³⁸ Braye, S. and Preston-Shoot, M. (2024) Final report: Stage 2 analysis, Analysis of learning in Second national analysis of safeguarding adult reviews. Local Government Association, London, UK. Available at: <https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023>

forward by the NHS 10-Year Health Plan³⁹, reflecting that homeless patients and those from other 'inclusion health' populations appear to have been 'forgotten' despite their significant over-representation in acute and inpatient settings, with funding priorities and strategic commitments seeming to turn away from addressing inequalities after several years where this has been a priority.

- 5.5.4 As well as situating challenges in local practice within the context of national funding pressures, agencies pointed to gaps and uncertainties within the law around self-neglect, mental capacity and adult safeguarding. In particular, agencies felt that the interaction between self-neglect and mental capacity is challenging to assess and determine, especially when someone is known to use drugs and alcohol. Agencies involved in this review welcomed further training and practice guidance but pointed to the specific challenges of applying the legislation to adults whose needs and decision-making abilities are not sufficiently considered by the Act, specifically adults living with the effects of alcohol and drug use and trauma. Furthermore, agencies were unclear about how duties and powers related to mental capacity and adult safeguarding interact and felt that this was a gap in national guidance for practitioners.
- 5.5.5 In Autumn 2025, the Ministry of Housing Communities and Local Government published the National Plan to End Homelessness⁴⁰. This new national strategy places significant emphasis on the role of health and adult safeguarding in addressing homelessness and recognises the impact of resource pressures and funding cuts on the ability to provide suitable and safe accommodation for those with needs like Bobby's. Whilst the plan is only in its early stages of delivery, it provides a hopeful and evidence-led foundation for positive action to tackle the causes and consequences of rough sleeping and multiple exclusion homelessness.

6. Changes Since Bobby's Death

- 6.1 A strong positive aspect of this review lies in the demonstrable commitment to continuous development around support for adults experiencing multiple exclusion homelessness and multiple disadvantage. There are several examples described throughout the report, but this section takes particular note of two initiatives which were not in place during Bobby's life but that have subsequently been implemented with positive effect.
- 6.2 The Culture of Care programme is part of a national NHS improvement initiative aimed at transforming the experience of mental health, learning disability and autism inpatient care by strengthening culture, relationships and therapeutic practice. Co-produced with people with lived experience, families and frontline staff, the programme promotes care that is trauma-informed, autism-informed and culturally competent, while balancing safety with the least restrictive approach. Key principles include valuing lived experience, prioritising relationships, avoiding harm, supporting staff wellbeing and ensuring people have meaningful choice, activity and therapeutic support during admission. Within MPFT, the programme has been delivered through structured quality improvement work on selected wards, supported by national coaching, and has led to multiple practical changes shaped directly by patient and staff feedback. These include improved sensory and therapeutic environments, increased peer support and advocacy, stronger family liaison, a shift away from narrow risk assessment tools towards holistic formulation, and a clearer focus on continuity, dignity and emotional safety throughout a person's inpatient journey.

³⁹ <https://www.england.nhs.uk/long-term-plan/>

⁴⁰ <https://www.gov.uk/government/publications/a-national-plan-to-end-homelessness/a-national-plan-to-end-homelessness>

- 6.3 In Shropshire, improvements as part of the Culture of Care programme have drawn on wider local learning to strengthen discharge planning, housing and homelessness pathways, family liaison and multi-agency working. Discharge processes are increasingly recognised as needing to begin at admission, with earlier involvement of housing services, clearer duty-to-refer activity, attention to safeguarding concerns and better preparation for transitions back into the community. There has been greater emphasis on collaboration between inpatient services, Housing Options, homelessness outreach, community mental health teams and voluntary sector partners, alongside improved recognition of the value of family involvement wherever consent allows. The introduction of clearer family liaison roles, expanded peer and advocacy support, and multi-agency forums such as RESET for people who are rough sleeping, has improved coordination and shared ownership of complex cases. Together, these developments reflect a move towards more integrated, preventative and relationship-based practice for adults experiencing homelessness and multiple disadvantage, addressing gaps identified in past practice and aiming to reduce reliance on crisis-driven responses.
- 6.4 Since April 2025, following a systems review undertaken with Shelter, the Housing Options Team has eliminated its backlog and worked to address a number of practice gaps and areas for improvement. This included the introduction of prompt templates for assessments, audits of case files by a Senior Officer to identify training needs, and regular discussion of assessment quality in team meetings. Homelessness and Duty to Refer cases are now allocated on the day they are received, either to the Prevention Team or to a Homeless Duty Officer, with contact made the same day (or the next working day where the person is not roofless). This represents a substantial improvement on earlier practice, though it would not have altered the limited scope for prevention once legal action against Bobby was already well advanced.
- 6.5 Additionally, in 2025 Shropshire Council opened a number of new temporary accommodation services. These include both self-contained units and accommodation with shared kitchen facilities, backed by 24-hour staffing and intensive housing support for people experiencing rough sleeping with complex health and care needs. This has significantly strengthened the provision available for people whose behaviour and needs are considered complex, like Bobby, and mark a significant positive development in the availability of suitable accommodation for those who need supported environments.

7. Conclusion

- 7.1. This Safeguarding Adult Review highlights the profound challenges faced by Bobby, living with the overlapping effects of multiple disadvantage and, the significant challenges faced by the local system in meeting his needs. His experiences underline how the chronic shortage of specialist accommodation, pressures on mental health trusts and uncertainties in practice around self-neglect intersect with engagement that is difficult or not working and drug related co-morbidities to create and exacerbate barriers to accessing stability and recovery. The review has shown that while there were dedicated and engaged professionals involved in supporting Bobby, there were significant gaps in multi-agency coordination and missed opportunities to work collaboratively to reduce risk. There is learning in this regard for individual agencies and the system as a whole.
- 7.2. The absence of clear lead professional arrangements and missed opportunities to look beyond legal duties and towards person-centred care, meant that responsibility shifted between agencies, leaving gaps in housing, support and care during moments of acute vulnerability. These gaps were particularly significant for someone whose experiences of homelessness, substance

use, and mental ill-health had resulted in significant professional mistrust and suspicion as well as patterns of disguised compliance to create distance from professionals. During the review period, Bobby did not have a consistent trusted professional relationship to help him navigate his needs, experiences and goals for the future.

- 7.3. As a result, interactions between Bobby and agencies sometimes inadvertently reinforced feelings of mistrust and resentment. Decisions too often focussed on lawfulness rather than Bobby's needs and wishes, professional interactions were too frequently focussed on their priorities rather than his, and his strong desire to secure a stable and permanent home for himself again did not come to fruition, albeit that this was of course in part due to Bobby's own behaviour. Although Bobby was clearly loved, it was reflected by practitioners that he probably felt quite isolated and alone a lot of the time.
- 7.4. Bobby's death has created an opportunity to reflect on the consequences for individuals when systems are unable to meet need or to work in coordinated and person-centred ways, especially where there is a need for specialist supported accommodation that is in short supply locally and nationally. It is also a reminder of the challenges of supporting people whose needs do not fit neatly into traditional service models, legal definitions or expectations around behaviour. Whilst more creativity, flexibility and permission are needed in the local system, so too are robust commissioning strategies around supported housing, and policy frameworks that prioritise preventing rough sleeping and hospital discharges to the streets.

8. Recommendations

- 8.1 The key lines of enquiry explored as part of this Review have identified a number of systems learning points as well as areas of strength and emergent good practice. The aim of the following nine recommendations is to enable Shropshire Safeguarding Adults Board, and key partner agencies, to continue to improve the quality and outcome of health, social care and safeguarding activity for people living with the effects of multiple disadvantage/multiple exclusion homelessness.
- 8.2 A number of relevant SAR's have been completed in Shropshire exploring homelessness, challenging behaviour and multiple disadvantage, the most relevant of which being SAR Kim (2022)⁴¹. The recommendations made in SAR Kim are highly relevant and to avoid duplication, progress on recommendations from this SAR should be reviewed by the Shropshire Safeguarding Community Partnership, for assurance that learning and recommendations were implemented and that their impacts, expected and unexpected, are understood by key partners.
- **Recommendation 1:** SSCP to commission/develop a new training module and briefing note about adult safeguarding in the context of homelessness/multiple disadvantage, a feature of this should be stigma/risk normalisation. Promote widely across all partners and commissioned and non-commissioned providers.
 - **Recommendation 2:** SSCP to review local training and guidance around Mental Capacity, ensuring that learning opportunities and resources about best practice approaches to working with people likely to experience fluctuating capacity/executive functioning issues are available and widely promoted.

- **Recommendation 3:** SSCP to strengthen access to effective and rapid advice and information for professionals, specifically on topics such as mental capacity, self-neglect, homelessness, adult safeguarding and substance and alcohol use and dependency. A briefing note should be shared with the Safeguarding Adult Board making key partners aware of the advice and information offer, with a request to promote widely within their agencies.
- **Recommendation 4:** Shropshire Housing Options Service to revisit the commitments in the Shropshire Homelessness and Rough Sleeping Strategy 2024-2029 and develop a hospital discharge protocol for adults at risk of rough sleeping with a target of zero discharges to the street. Once completed, the protocol to be presented to SSCP and promoted widely with partners.
- **Recommendation 5:** SSCP, Housing and Mental Health Social Work Team to create a digital resource about local MDT's and multi-agency forums relevant to adult safeguarding, their referral processes, escalation pathways and chairing arrangements. This should be published on the SSCP website and promoted widely to partners.
- **Recommendation 6:** SSCP and Mental Health Social Work Team to promote information about MARM and issue a note to key partners promoting its use when supporting adults living with unmanaged or escalating risks, self-neglect and multiple exclusion homelessness
- **Recommendation 7:** Relevant Housing, Community and Voluntary Sector commissioners and VCS leads should engage with providers and partner agencies operating in this area to explore potential funding opportunities and other support for the revenue sustainability and capital aspirations of services. The Council will remain mindful of opportunities to work collaboratively with all providers to support the commissioning of services more generally, recognising that any future commitments must be considered in the context of competing priorities and finite resources.
- **Recommendation 8:** SSCP Independent Safeguarding Adult Board Chair and Directors of Housing and Social Care to meet to review the implementation of recommendations made in the joint ministerial letter of May 2024. This should be followed by a note to staff and partners about safeguarding expectations and notifications of deaths.
- **Recommendation 9:** SSCP Independent Safeguarding Adult Board Chair and Director of Health Inequalities and Shropshire, Telford and Wrekin ICB to meet to discuss the Implementation of recommendations in NHSE Framework for Action on Inclusion Health, specifically a named Inclusion Health/Health Inequalities lead on SSCP. This should be followed by a note to partners promoting local services and specialist practitioners/clinicians.

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