Safeguarding Adult Review – ‘Raymond’

Systems Findings Report

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Introduction

A SAR referral in respect of a 68-year-old man, 'Raymond', who died whilst residing in interim bed & breakfast accommodation, was discussed by the Somerset Safeguarding Adults Board in June 2025. It was agreed that the criteria for a mandatory Safeguarding Adult Review had been met, as outlined in Section 44(1) Care Act 2014.

Gill Taylor was commissioned as independent author. She has more than twenty years subject matter expertise in homelessness, multiple disadvantage and social exclusion, including senior leadership experience in statutory and voluntary sectors.

The Reviewer would like to share her heartfelt condolences with Raymond's family and loved ones, and to thank all involved in this review for their generous and candid participation.

Pen Portrait

Raymond died in December 2024 at the age of 68, having lived in Somerset for many years but with ties to Kent. He had previously been married and was the father of six children, though his relationships with them were distant. The traumatic deaths of his two sons, and the childhood loss of his mother, left an indelible mark on Raymond; these experiences of bereavement threaded through his later years and influenced his sense of self-worth, drug and alcohol use and his goals for the future.

Despite this, Raymond was widely known as a *cheeky chap* with a warm, caring presence. Many described him as a *gentle giant* who acted as an informal father figure within the local street community. He was both cared for by others and deeply caring in return, often watering the plants in his temporary accommodation and finding comfort in home-cooked meals. In the years before he was known to agencies in Somerset, he had worked as a bricklayer, painter and decorator and liked to be busy and to use his skills to help others.

Professionals who worked with Raymond were increasingly concerned about the deterioration in his memory, cognitive functioning and general frailty. He had undergone a hip replacement and lived with vascular eczema, chronic pain, and suspected cardiac issues. His long-standing alcohol and drug dependency significantly affected his mental and physical health; seizures, accidental overdoses, and blackouts occurred frequently, placing him at continual risk. His health needs made managing his personal hygiene, nutrition and home environment difficult and he knew he was vulnerable to financial abuse from others but felt shame about this and did not want his money to be managed by professionals. In his younger years he enjoyed boxing and was a strong

and fit man; during the review period agencies reflected that he struggled to recognise himself as frail and unable to protect himself without support.

Raymond was well known, respected and genuinely liked by professionals across multiple agencies. He sought help repeatedly and clearly wanted support, even when his memory difficulties, frailty or intoxication made engagement challenging. Those who knew him spoke of his humour, his kindness, his routines, and the way he brought a sense of companionship to others experiencing homelessness. His life was shaped by loss, hardship and vulnerability—but equally by resilience, warmth and the affection he inspired in people around him.

In respect of protected characteristics, as defined by Equality Act (2010), Raymond was an older, white British man living with chronic and disabling physical, mental and cognitive health conditions. Neither his sexuality nor religion were formally recorded, although he had been married to a woman and was not known to attend a place of worship.

Methodology & SAR Process

A Terms of Reference was established and agreed by the Panel brought together for this SAR. The review adopted a hybrid methodology, drawing on elements of the SAR in Rapid Time[1] and SCIE 'Learning Together[2]' approaches, alongside Appreciative Inquiry principles. This approach aimed to facilitate a collaborative and focussed review that would build on, rather than duplicate, the findings and recommendations of the thematic review exploring the street homelessness experiences of three Somerset men, which was published in Summer 2025 and written by the same independent author.

The Terms of Reference describes a slightly atypical approach to the outputs of this review. The aim was to undertake a review focussed on generating and disseminating new knowledge that can be readily incorporated into strategic and direct practice. As such, review outputs will differ slightly from the standard approach of SARs. The Panel agreed that these would be:

- a 'Systems Findings Report' which may include a small number of recommendations and/or assurance questions.
- five 'Brief Practice Guides' intended to share learning generated by this review and supplement existing local resources with best practice tools, guidance and resources relevant to Raymond's experiences.

1 https://www.scie.org.uk/safeguarding/adults/reviews/in-rapid-time/
2 https://www.scie.org.uk/safeguarding/children/case-reviews/learningtogether/

The review considered case information from a two-year period prior to Raymond's death in December 2024. This review period was selected in recognition of the long-term nature of Raymond's interactions and relationships with local services, also to capture the reality of system barriers, bureaucratic delays and professional differences that led to the decision to commission this review.

The review adopted the following five key lines of enquiry (KLOEs) to steer discussion and reflection of the multi-agency practice around Raymond:

1. Accommodation for adults with care and support needs alongside/including drug and alcohol dependency and challenging behaviour
2. Assessment and support for adults experiencing 'fluctuating capacity' and cognitive impairment related to drug and alcohol use/dependency.
3. Identification and intervention for adults living with atypical presentations of frailty
4. Risk assessment and management around financial abuse/exploitation
5. Trauma-informed practice, especially in relation to recognising and responding to challenging behaviour and distress in older men.

The aim of the review was to identify systemic issues, and opportunities for practice improvement, through case analysis and reflective discussions with relevant practitioners and senior managers. This report is presented for consideration by the Somerset Safeguarding Adults Board with the goal of providing actionable learning that supports existing efforts to improve multi-agency practice and system coordination around adults experiencing multiple exclusion homelessness and multiple disadvantage.

This was a highly engaged and emotional review, with practitioners and managers candidly sharing the sense of loss felt by Raymond's passing. Almost everyone involved had a personal memory or anecdote about Raymond to share, and the candour and energy in review discussions reflects a local system committed to improving practice, to tackling barriers and to championing the rights and personal interests of people experiencing homelessness.

Relevant Literature

There is a growing body of evidence exploring the needs and experiences of people living with multiple disadvantage; some of this will be introduced in the Brief Practice Guides produced as part of this review. What follows is a high-level summary of key findings from research and

practice about multiple disadvantage, relational care, brain injury, stigma and a consideration of the impact of the wider national operating environment on local practice.

Evidence from research[3] and lived-experience testimony[4] concludes that people experiencing multiple disadvantage face a range of interconnected vulnerabilities that impact their health, wellbeing and exposure to risk. These vulnerabilities arise from overlapping experiences of homelessness, trauma and abuse, drug and alcohol dependency, mental ill-health and criminal justice involvement and how these are responded to by professionals.

Coordinated and personalised multi-agency support that centres rapport and trust building has been identified as best practice[5]. One impact of complex trauma and multiple disadvantage, that can create further barriers to positive outcomes, is behaviour that challenges professionals. This can range from issues with maintaining contact and building relationships to serious acts of self-harm, aggression and violence and requires flexible support and trauma-informed practice beyond standard operating models and service thresholds. Evidence from research and practice identifies professional curiosity, persistence, creativity and the prioritisation of psychological safety; long-term relational support, positive risk-taking and a strong understanding of the personal and environmental factors that activate and escalate distress. This is challenging for services managing high levels of demand, competing priorities and unwieldy statutory duties, but with supportive leadership and robust organisational support, mechanisms can be established to enable creative and person-centred practice on the individual's own terms.

Evidence from research and practice consistently identifies a strong association between acquired or traumatic brain injury (ABI/TBI), reduced cognitive functioning, and homelessness. Cognitive impairments, including difficulties with organisation, impulse control, concentration, and risk assessment, are "hidden disabilities" that reduce a person's ability to maintain housing, follow support plans, or navigate complex service systems. Research by the Disabilities Trust Foundation[6] found that almost half of people experiencing homelessness (48%) had a history of traumatic brain injury, more than double the rate found in the general population. 90% of these injuries occurred *before* the individual became homeless, suggesting an important causal pathway into homelessness

[3] University of Sheffield (2022) The Fulfilling Lives programme: supporting people experiencing multiple disadvantage A summary of programme achievements, evaluation findings, learning and resources. Available at: https://www.tnlcommunityfund.org.uk/media/insights/documents/Summary-of-programme-achievements-evaluation-findings-learning-and-resources-2022.pdf?mtime=20221128143121&focal=none

[4] Taylor, G., Clint, G., and Price, C. (2022) 'Seen but not heard: why challenging your assumptions about homelessness is a matter of life and death' in Preston-Shoot, M. and Cooper, A. (eds), in *Adult Safeguarding and Homelessness: Understanding Good Practice,* pp. 40-58. London; Jessica Kingsley Publishing

[5] **https://assets.publishing.service.gov.uk/media/642af3507de82b000c31350c/Changing_Futures_Evaluation_-_Frontline_support_models_REA.pdf**

[6] **https://committees.parliament.uk/writtenevidence/64314/pdf/** and https://brainkind.org/wp-content/uploads/2023/10/dtfoundation-briefing-2pp_web.pdf

linked to impaired executive functioning, memory, planning, and emotional regulation. Frontline homelessness services may misinterpret these neurocognitive symptoms as non-engagement, intoxication and aggression, leading to avoidable evictions or exclusion from support. To address these challenges, guidance increasingly emphasises trauma-informed and brain-injury-aware practice: for example, the Groundswell Homelessness and Brain Injury Toolkit[7] highlights the need for early identification, adjustment of communication approaches, and collaboration between homelessness and neurorehabilitation specialists. Homeless Link further recommends adapting services to accommodate cognitive difficulties, avoiding punitive and judgemental responses to memory lapses and missed appointments, and ensuring more flexible engagement strategies that aim to prevent repeat homelessness[8]. Together, this evidence supports a good-practice approach in which homelessness services routinely screen for brain injury and cognitive functioning issues, modify support plans to match cognitive capacity, and collaborate closely with clinical partners, helping to break the cycle between injury, impairment, and housing instability.

The presence of stigma has been highlighted as a factor in professional decision-making about homeless adults with care and support needs, as part of national analyses of Safeguarding Adult Reviews where homelessness is a feature[9], and in in research about mental health[10] and drug and alcohol dependency[11]. Pervasive negative attitudes about drug use and rough sleeping mean that people who experience them are more likely to face barriers when accessing help, less likely to have their behaviour understood in the context of violence and exploitation, and more likely to have their health concerns dismissed as 'lifestyle' related without proper investigation. In short, the evidence suggests that people living with multiple disadvantage are more likely to be seen as a risk to self and others, and not as vulnerable individuals caught in cycles of harm, violence and self-neglecting behaviours, often exacerbated by actions and attitudes that shift responsibility for harm towards those with the least power to protect themselves.

Best practice can be challenging to achieve and sustain due to the wider national context. The conditionality of legal rights and entitlements, short-term funding models for homelessness and

7 **https://groundswell.org.uk/wp-content/uploads/2020/10/Brain-injury-Toolkit-June-2024.pdf**

8 **https://homeless.org.uk/knowledge-hub/brain-injury-and-homelessness/**

9 Martineau, S. J., Cornes, M., Manthorpe, J., Ornelas, B., & Fuller, J. (2019). Safeguarding, homelessness and rough sleeping: Ali analysis of Safeguarding Adults Reviews. NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London. https://doi.org/10.18742/pub01-006

10 Eylem, O., de Wit, L., van Straten, A. *et al* (2020) Stigma for common mental disorders in racial minorities and majorities a systematic review and meta-analysis. *BMC Public Health* 20, 879. https://doi.org/10.1186/s12889-020-08964-3 and Kapadia, D. (2023). Stigma, mental illness & ethnicity: Time to centre racism and structural stigma. *Sociology of Health & Illness*, 45(4), 1–17. https://doi.org/10.1111/1467-9566.13615

11 Lloyd, C. (2010). Sinning and Sinned Against: The Stigmatisation of Problem Drug Users. London: UK Drug Policy Commission. Available at: http://www.ukdpc.org.uk/resources/Stigma_Expert_Commentary_final2.pdf and Page S, Fedorowicz S, McCormack F, Whitehead S. (2024) Women, Addictions, Mental Health, Dishonesty, and Crime Stigma: Solutions to Reduce the Social Harms of Stigma. *International Journal of Environmental Research and Public Health*. 2024; 21(1):63. https://doi.org/10.3390/ijerph21010063

inclusion health services, rigid eligibility criteria of key services and overwhelming demand for highly stretched local housing, social care and mental health services all play a role in the outcomes for individuals. Local efforts to respond to the needs of people with multiple disadvantage occur within this context and whilst there are clear areas for practice development, influencing national law and policy is also a crucial area of opportunity. Locally, significant efforts have already been made by establishing the Somerset Homelessness Partnership[12], a cross-sector strategic partnership made up of the Strategic Homelessness Board, Homelessness and Rough Sleeping Forum and a Homelessness Reduction Operations Group. This work was initially brought together during the county's Covid-19 'Everyone In' efforts and now work together to deliver the Somerset Homelessness Charter[13] and Homelessness and Rough Sleeper Strategy 2025-30[14].

Case Analysis

Summary Activity

The following timelines provide a summary chronology of Raymond's life, with a focus on safeguarding, risk & multi-agency practice, during the review period 2022-2024.

Although not described here, detailed single agency chronologies, case review reports, case management documents, meeting minutes, a range of local policy and strategy documents and reflections from learning events and 1:1 meetings with local agencies have informed the system findings that follow.

12 **https://www.somerset.gov.uk/housing-support/homelessness-and-prevention/somerset-homelessness-reduction-board/**

13 https://www.somerset.gov.uk/housing-support/homelessness-and-prevention/homelessness-reduction-board-homelessness-charter/

14 https://somersetcc.sharepoint.com/sites/SCCPublic/Housing%20Support/Forms/AllItems.aspx?id=%2Fsites%2FSCCPublic%2FHousing%20Support%2FSomerset%20Homelessness%20and%20Rough%20Sleeping%2FSomerset%20Homelessness%20and%20Rough%20Sleeper%20Strategy%202025%2D2030%2Epdf&parent=%2Fsites%2FSCCPublic%2FHousing%20Support%2FSomerset%20Homelessness%20and%20Rough%20Sleeping&p=true&ga=1

CHRONOLOGY 2022/3



Service Closure & Recognition of Trauma

Referred by BCHA to Step Together as accommodation due to close; desired outcome included trauma/bereavement support.

Assessments Continue & Offer of Property

Memory clinic notes *mild cognitive disorder* exacerbated by alcohol/drug use; SDAS prescribing moved to supervised daily collection; several failed contacts; several falls and ED/ambulance contacts. Offer of property in Yeovil.

Health Declines, Frailty Emerges

ED attendances (leg swelling, head wound); assault in town (money stolen)all agencies note increasing frailty & physical health issues. ASC logged 'info only"

Concerns Escalate

Falls continue; Korskoff's indicated; found unresponsive &; admitted to ICU (possible opiate overdose); safeguarding alerts raised; multi-agency meeting (MAM) planning; financial vulnerability noted.

Assessments & 1st MARM

Memory clinic assess & significant cognitive difficulties documented; MARM held after significant delay; residential or intensive supported living discussed; ASC peer forum sought funding but declined .

Multiple Street Contacts

Multiple contacts with BCHA & homeless health but difficulties engaging (left clinic mid-bloods; drinking at appointments). Lots of comms between agencies to update Care Act assess and to support medication management.

Property Rescinded & ASC close case

Housing offer withdrawn (historic rent arrears/eviction); ASC record no care & support needs & **close case.**

Accommodation Change

Raymond moves to 189 Sherborne Road; safeguarding referrals begin to accumulate due to falls, assaults & memory concerns.

Multi-Agency Coordination Evident

Concerns continue, increase in emotional distress; significant knee & hip pain; social worker allocated (10mth delay); MDT confirms cognitive impairment and exploitation risk; memory clinic support delayed by blood tests.

Concerns Escalate

Risk of self-neglect noted; GP shifts to daily dispensing due to misuse concerns; continued ED attendances; plan for residential/supported housing move keeps stalling, Raymond due to be evicted.

CHRONOLOGY 2024



Jan 2024 — High-risk Harm Events

Opiate overdose (Naloxone administered); multiple ED visits for injuries/falls; ongoing ASB case management. Care Act Assessment takes place.

Feb-Mar 24 — Situation Stalls, Harm Increases

Cluster of overdoses, falls & assaults with police action; dementia noted by SDAS; heart monitor and sleep study failed/declined (equipment); fibroscan shows significant liver fibrosis.

April 2024 — Concerns Continue but Care Home Denied

Multiple assaults & blackout incidents; safeguarding concerns ongoing; specialist care home identified but declined at Peer Forum (reason unclear). Concerns raised by agencies about delays. Protection Plan started.

May-June 24 — Situation Stagnates

Ongoing falls & assaults; respiratory clinic unable to conclude sleep study; Care Home costed with shortfall & arrears stated as blocking progress; multiple street contacts & welfare checks; ASB continues.

June-July 24 — Raymond in Distress

R opens up about bereavement trauma; multiple overdoses & discussion of ending life. Older Persons dual-diagnosis referral accepted; capacity tests discussed. Protection Plan completed by ASC.

August 2024 — Multi-Agency Action & Eviction

Several overdoses; police safeguarding BRAG; OPMH joint visit with dual-diagnosis; confirms R has capacity to decide accommodation; emergency MARM convened; 189 issues eviction notice due to escalating aggression.

Sept 2024 — Hotel Stay

Eviction executed; Council places Raymond at Globe & Crown; ASC delays continue & agencies escalate concerns; DoLS assess requested but rejected re: finances; aggressive behaviour continues & agencies are very concerned about death.

Sept 2024 — ASC Withdraws

Protection planning meeting held;; further overdoses/collapses; MARM cancelled; street community raise concerns;

Resolving Professional Differences meetings held about working relationships in ASC.

Oct-Nov 24 — Further Delays, Raymond at Risk

ASC refuse to fund additional welfare checks but agree 3wks later; no progress on sourcing suitable accom or on providing homecare; assaults & thefts increase and behaviour change is noticeable; several head injuries. No MARM.

4th Dec — Raymond Died

Raymond was found in his room, suspected to have died of an overdose.

MARM meeting went ahead to inform agencies.

Street community grieving; daughter makes complaint of suspicious death (unsubstantiated).

System Finding 1: There are significant practice gaps around supporting people experiencing financial abuse/exploitation and homelessness.

Raymond was vulnerable to financial abuse and exploitation, which often included physical assaults, with risks persistent, visible, and escalating during the review period**.** Raymond's cognitive difficulties, frailty and memory loss made him highly vulnerable to this form of abuse, especially in the community whilst intoxicated, which also created challenges for agencies in intervening in harm. **https://groundswelluk-my.sharepoint.com/personal/gill_taylor_groundswell_org_uk/_layouts/15/Doc.aspx?sourcedoc={2BE3340F-8683-426A-8123-2A4865ABE23C}&file=SAR RB - Managers Event 05.02.26.pptx&action=edit&mobileredirect=true**

Agency chronologies and discussions during learning events highlighted repeated patterns: money stolen in town, street associates coercing Raymond to withdraw money, peers charging vastly inflated prices for drugs, and Raymond speaking about giving away money or alcohol to "keep the peace." Raymond was frequently robbed whilst intoxicated, and his rigid daily routine made him highly targetable and his intoxication leaving him unsure of what happened and who to trust. Understandably, after such incidents Raymond's behaviour notably changed; he became irritable, angry and often downplayed or dismissed what had happened. Practitioners shared that he clearly experienced a lot of shame about his victimisation, not wanting to acknowledge or address what was happening out of embarrassment.

During the review, practitioners were able to identify the pattern of financial harm and abuse Raymond experienced, although it was reflected that the pattern is much easier to see in retrospect, in particular how it impacted Raymond's behaviour. Agencies expressed uncertainty about how to intervene in financial abuse and exploitation affecting adults experiencing homelessness and drug dependency, especially where there are professional differences about mental capacity and where the individual states that they don't want to report individual incidents of harm. These discussions illustrate how financial exploitation can become normalised and overlooked, especially for those with complex peer relationships and for whom the accusation of being a 'snitch' is a barrier to reporting harm. Ethical considerations about consent and restrictive practice were also raised, with professionals unsure about how to support Raymond to reduce financial abuse risks without implementing deputyship practices that, even if granted by the Court of Protection, could restrict Raymond's agency and independence which were important to him.

Making Safeguarding Personal guidance is clear about the need to involve the adult in decisions about their safety, by listening to their wishes, respecting their choices and working with them to

explore and manage risks. The Local Government Association toolkit provides a range of tools and resources to support practitioners to meaningfully involve people in safeguarding practice. Agency chronologies and post-incident reviews point to the absence of Raymond's voice in discussions and decision-making about his safety and vulnerability to abuse and neglect.

Discussions during the Senior Managers' Event noted that training and guidance around identifying, exploring and intervening in financial abuse was insufficient to support frontline staff working with Raymond. Somerset Safeguarding Adult Board has not published specific guidance about financial abuse, and the guidance about vulnerable dependent drinkers does not offer meaningful practice input about assessing and managing these risks. Managers also identified that the interaction between financial abuse and frailty, cognitive decline and substance use, as well as clear risk ownership and escalation pathways, is an area for development.

Self-neglect was identified in a small number of concerns raised about Raymond, although this was under-explored in practice and guidance around identifying and intervening in self-neglect was not considered. Raymond's presenting behaviours, and his life course experiences, clearly indicate self-neglect and it may have been useful to consider financial abuse and exploitation alongside self-neglect, to understand the underlying causes of vulnerability and Raymond's views on his own self-worth and entitlement to safety and wellbeing.

The review confirms that Raymond was experiencing financial and physical abuse at the hands of others in the street homeless community. This was identified by agencies and continuously discussed throughout the review period. However, responses were delayed, largely administrative and absent of Raymond's voice and wishes. Whilst an individual's willingness and readiness to accept help will always shape the outcome of safeguarding activity, such high-risk harm affecting a frail older person should have resulted in an assertive and holistic exploration of risks and mitigations, drawing on the support available from all agencies involved in his care and exploring creative and person-centred solutions shaped around the realities of Raymond's life. Achieving this will require greater attention on financial abuse and exploitation in social work practice and the development and promotion of practice guidance to support identification and creative intervention.

Recommendation 1a: By November 2026, the SSAB Learning and Development Subgroup should hold a session to explore existing multi-agency learning opportunities and practice guidance about financial abuse and exploitation. This should inform a refresh of local practice

guidance and training around financial abuse for frontline practitioners across the statutory and voluntary systems[15].

System Finding 2: **Bureaucratic delays, unclear escalation pathways and unresolved professional differences left Raymond at risk.**

The Care Act and its accompanying statutory guidance is clear that effective adult safeguarding is preventative, person-centred and observant. Agencies are expected to implement timely information sharing and robust risk management processes in order to prevent concerns escalating towards crisis, where intervention under safeguarding adult procedures is required. Under the Care and Support Statutory Guidance, local authorities must act promptly where an adult may have needs for care and support, prioritising early intervention, prevention, and proportionate assessment.

A recurrent theme in discussions as part of this review, was the impact of delayed action to meet Raymond's care and support needs and to reduce risk. Delays primarily resulted from professional differences of opinion about accommodation and mental capacity, worsened by unwieldy bureaucratic processes that were inattentive to the risks of not meeting need in a timely manner.

In July 2023, a section 42 safeguarding enquiry was initiated, at which point Raymond was allocated a safeguarding social worker and it was accepted that a care and support needs (re)assessment was needed; a recent assessment had concluded that he did not have care and support needs. Despite accepting a safeguarding duty, a multi-agency meeting to discuss the concerns was not arranged until October, more than 3 months later and after dozens more contacts were made to share and escalate concerns. In the Joint Serious Incident Review conducted by Housing and Adults Social Care after Raymond's death, it was noted that opportunities to reduce risk were missed and third-party reports of escalating harm were not given the attention they warranted. Further, the six-month delay in allocating a social worker for Raymond prevented a full assessment of his needs from being established and agreed by the professional network around him, which would likely have had a positive impact on Raymond's vulnerability to abuse and created a single plan around which all agencies could cohere.

[15] Potentially using the Newcastle Safeguarding Adults Board guidance as a good practice example and template, available here: **https://www.newcastlesafeguarding.org.uk/identifying-preventing-and-responding-to-financial-abuse-guidance/**

Notably, there was a 6-month delay between referral and the completion of a care and support needs assessment in January 2024 and further delays throughout 2024, when a decision to agree funding for specialist accommodation for Raymond was repeatedly delayed at the Peer Forum, resulting in his case returning for presentation at least three times. This delay resulted in accommodation offers being withdrawn or becoming unavailable, a significant blow to multi-agency efforts given the challenges of securing accommodation that could meet Raymond's particular needs. The Stage 1 incident review conducted after Raymond's passing concluded that greater clarity about the expectations for Peer Forum presentations, attention to professional curiosity and the employment of escalation would have been good practice and resulted in better outcomes for Raymond.

Chronologies show that whilst risks escalated social workers too often waited for processes rather than responding dynamically to Raymond's needs and circumstances. E-mail correspondence, case notes and meeting minutes between agencies in 2024 show a pattern of escalating professional concern - urgent multi-agency discussions - process delays and gaps in professional curiosity – and ultimately no change in Raymond's circumstances. During the last year of his life, these delays meant that Raymond did not have a lead professional in place, nor a clear plan for the future, nor suitable accommodation and a support package that was supportive of his goals. A growing sense of hopelessness and futility is evident in case information and practitioner reflections about conversations with Raymond after August 2024, with one record noting that he felt let down by the lack of communication from Adult Social Care and others speaking about a growing ambivalence towards living.

The Stage 1 Review highlights inconsistent recording, unclear decision-rationales, and long periods without direct contact between Raymond and statutory services. Agency chronologies place an increasing focus on inter-professional disagreements, rather than meaningful engagement with Raymond or on how to mitigate the effects of delays on his safety and wellbeing where these were unavoidable. There is very little information recorded about how risk mitigation and harm reduction planning was explored and little evidence of professional curiosity to explore creative solutions with Raymond when the Peer Forum turned down or delayed requests for specialist accommodation.

It is positive that professionals initiated Resolving Professional Differences guidance[16] when it became clear that Adult Social Care teams (Safeguarding and Locality) were unable to reach mutual agreement on a way forward for Raymond. However, prior to this there were other

[16] **https://somersetsafeguardingadults.org.uk/wp-content/uploads/2025/07/SSAB-Resolving-Professional-Differences-June-2025.pdf**

significant professional differences that resulted in delays, chiefly disagreements about mental capacity decisions, which were not addressed using this policy. Review discussions indicate that not all voluntary sector and commissioned providers are aware that they can employ this policy to resolve professional differences of opinion.

Recommendation 2a: By September 2026, SSAB should seek assurance, perhaps via presentation or briefing note to the Board, from the Council's Housing and Adult Social Care Departments about the oversight and implementation of recommendations in their Joint Serious Case Review about Raymond.

Recommendation 2b: By September 2026, the SSAB Independent Chair to seek assurance in writing that key partners have shared the Resolving Professional Differences policy appropriately and proactively within their organisations and, importantly, with commissioned and third sector providers.

Recommendation 2c: By September 2026, SSAB to request a briefing note from the Chair of the Adult Social Care Peer Forum about safeguarding. This should include information about changes to the groups Terms of Reference and in decision-making processes about the sourcing of care and support, ensuring safeguarding concerns are considered and risks mitigated when decisions are delayed or requests for support turned down.

System Finding 3: **Research and guidance about trauma-informed practice has not paid sufficient attention to the relationship between homelessness and grief.**

Written and verbal reflections point to the traumatic impact of Raymond's experiences of bereavement, rejection and abandonment, which were compounded by the coping mechanisms he had adopted in the absence of appropriate bereavement support across his lifetime. Agency chronologies highlight concerns about early traumatic harm (his mother's death when Raymond was a child, paternal abuse in the home and rejection by his step-mother) and later the premature deaths by suicide of his two sons, and estrangement from his daughter. Anniversaries repeatedly triggered emotional deterioration, increased drinking and heightened risk behaviours and at these times Raymond would talk to trusted professionals about his profound and unresolved sense of loss. Professionals connected Raymond's experiences of homelessness, exploitation, substance dependence and deteriorating physical and cognitive health with his inability to reconcile and move on from these experiences of loss, noting how they impacted his sense of self-worth, hope and his ability to consistently accept help.

Raymond's distress resulted in behaviour that challenged professionals, including aggression, withdrawal, hostility, disorientation, threats, agitation, self-neglect, and episodic suicidal ideation. These behaviours often escalated during periods of increased insecurity such as when accommodation was unstable or evictions pending, when he was victim to exploitation and assaults in town and when his pain was particularly unmanaged. Professionals described Raymond as gentle, funny and engaged when regulated, yet aggressive, fearful, confused, and overwhelmed at times when routines and stability were disrupted - patterns that are aligned with evidence about the presentation of trauma.

Review discussions considered the intersectionality of trauma and how behaviours and coping mechanisms are shaped by systemic factors, personal characteristics such as age and gender, and wider social attitudes. It was reflected that responses to different causes of death are also shaped by these factors, with stigma around suicide and drug-related deaths further complicating how grief is felt and expressed. Raymond was an older man, a bereaved and estranged father and a divorced husband, with a long history of social exclusion and homelessness. These factors will have shaped his sense of identity but also how trauma and distress were felt and communicated, how he perceived expressing vulnerability and how he understood these key events in his life. Professionals reflected that trauma-informed care needs to be attentive to personal characteristics, systemic inequalities and social attitudes, especially when considering grief and bereavement.

There is evidence of good trauma-informed practice from frontline agencies, in decisions to delay evictions and to offer additional support at times of particular uncertainty, notably from Bournemouth Churches Housing Association (BCHA), Somerset Drug and Alcohol Service (SDAS) and Second Step. It's clear that professionals recognised the importance of developing and maintaining trust with Raymond, with professionals making significant efforts to maintain regular communication with him, making arrangements to meet him that fit with his daily routines and ensuring that people he trusted were checking in with him regularly to offer support. Agencies in the voluntary and health sectors treated Raymond with continuous positive regard, advocating for him and continuously communicating his needs and wishes in professional discussions, something clearly observable in review activities.

Agencies reflected that applying trauma-informed principles to work with adults experiencing homelessness is a local system priority. It is noted that a multi-agency Community of Practice has been established by Second Step to give professionals the opportunity to share resources, discuss trends and to develop new ways of working together that reflect best practice evidence. However,

there was an overall agreement that there is limited support available in respect of how to respond to grief and bereavement needs for individuals who face barriers to accessing traditional bereavement groups and 1:1 talking therapies. It was noted that there is very limited research and practice evidence about the role of grief and bereavement in causing and exacerbating homelessness and that local guidance would be welcome.

Recommendation 3a: By the end of 2026, the Somerset Public Health team should host a multi-agency discussion with local homelessness and inclusion health services about bereavement support for people experiencing homelessness and multiple disadvantage, with the aim of informing future commissioning decisions and development work with local grief and bereavement organisations.

Recommendation 3b: By the end of 2026, the Trauma-informed Care Community of Practice to host a session on intersectionality in trauma-informed care, using the example of supporting older men with grief and loss as a starting point for discussion. The session should produce a briefing note to be shared by SSAB with key partners, and by Somerset Council with homelessness teams and commissioned providers.

Systems Finding 4: Gaps in suitable accommodation for adults with care and support needs related to drugs and alcohol is exposing individuals to undue and unmitigated risks

Foregrounding this review, and the circumstances of Raymond's final months, are the deepening challenges facing individuals who seek homelessness assistance from English local authorities. The context of a deepening national housing emergency and the significant pressure on universal and specialist accommodation were central to the challenges professionals faced in securing suitable accommodation for Raymond. A significant gap in available accommodation for adults with overlapping health, housing and care needs is acknowledged in The National Plan to End Homelessness[17] and the findings of the Second National Analysis of Safeguarding Adult Reviews[18]. All those engaged in the review reflected these issues as growing and urgent locally, often at the heart of professional tensions and, being largely market driven, not always within the control of the local authority. Notwithstanding this important broader context, there are notable learning points from the review of Raymond's experience.

17 https://www.gov.uk/government/publications/a-national-plan-to-end-homelessness/a-national-plan-to-end-homelessness#pillar-3--preventing-crisis

18 https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023-executive

Raymond had lived in multiple supported and temporary housing services in the county over the previous ten years, some that he sustained for long periods but all ultimately ending because he was unable to adhere to license conditions around behaviour and substance use. During the review period it's notable that BCHA made significant efforts to prolong their decision to evict Raymond in Summer 2024 after they concluded that they could no longer meet his needs, extending his tenancy on at least two occasions in the hope that alternative accommodation would be sourced to prevent Raymond rough sleeping. They repeatedly highlighted to the local authority that Raymond was at imminent risk of eviction and that they were deeply concerned about the impact of inappropriate accommodation on his wellbeing and vulnerability, concerns echoed by all agencies involved. This urgency is not reflected in local authority action, and voluntary sector agencies shared that they felt "left to hold the risk for years" with limited communication or interim support from adult social care whilst accommodation was sourced. This reflection is supported by the joint review by Adults and Housing, that reflects candidly on the impact of delays and professional disagreements around Raymond's housing on other professionals involved in his care.

Although Raymond's accommodation needs were a challenge to meet, chronologies suggest that sourcing was slow, lacking urgency, creativity or advocacy. A number of accommodation options were explored by Housing and Adult Social Care during the review period, including Extra Care and two specialist residential care facilities. A sheltered housing option was rescinded by the landlord due to previous rent arrears and 'anti-social behaviour' in a previous tenancy. This decision was made and communicated whilst Raymond was in the car with a support worker on his way to sign-up for the tenancy. This was understandably a huge disappointment for him and marked a turning point in his behaviours and sense of hope for the future. Practitioners reflected on the impact of professional decisions and how they are communicated and also on the failure of agencies to advocate for Raymond around that decision, particularly given the information the landlord had was from at least five years prior, and they were misinformed about Raymond being the perpetrator of anti-social behaviour. Senior managers from the Housing Dept reflected on the action they could have taken to negotiate with the landlord, to advocate for Raymond and to offer support to enable them to take a positive risk and noted this as broader learning.

It was good practice that Somerset County Council's Housing Department took action to secure temporary accommodation for Raymond when he was evicted by BCHA in September 2024, using their statutory discretionary powers to offer interim accommodation. However, the only accommodation they were able to secure was in a pub in the town centre, without cooking facilities or self-contained bathroom and with no support on-site. The pub was providing

accommodation to a number of other adults experiencing homelessness and related struggles, which presented additional risks and challenges to Raymond. He was repeatedly targeted for financial and physical abuse by those he lived alongside and others, frequently robbed or assaulted, and often unable to protect himself or remember exactly what had happened to him due to intoxication, narcolepsy and short-term memory issues. As incidents of harm increased, so too did changes in his behaviour—aggression and hostility were signs of a man overwhelmed by shame, risk, declining health and a deepening sense of hopelessness. He remained in this highly unsuitable housing for several months, until the end of his life. Urgent concerns raised by professionals were recorded but not acted on, and the local authority failed to act in a position of leadership despite a clear duty of care.

Integration between adult social care and housing departments is a requirement of the Care Act, which should include joint planning, proactive activity to identify appropriate legal duties around accommodation in order to promote wellbeing. Adults with care and support needs and experiences of homelessness require mature joint working and creative use of services and resources, which unfortunately was not evident in practice around Raymond. Senior leaders reflected candidly on challenges created by two-tier local authority systems at the time, and of cultures in both departments of siloed working, that have a particular impact on adults experiencing homelessness and on strained relationships between frontline practitioners. They were also able to reflect that the absence of clear escalation pathways to senior managers contributed significantly to delays, and the yo-yoing between the two departments in respect of the legal duty to provide accommodation.

As part of the review, the Author met with the Chair of a recently established Accommodation and Support Working Group, governed by the Somerset Homelessness Partnership and contributing to the priorities of the county's Homelessness and Rough Sleeper Strategy. This group has established an intention to conduct a review and mapping exercise of the county's accommodation and support for people experiencing homelessness, recognising that much of the county's provision is independent and not commissioned by the local authority. This piece of work will be important to understanding current provision, gaps and opportunities to meet need.

Recommendation 4a: By year end 2026/27, the Executive Directors of Housing and Adult Social Care to support the Accommodation and Support Working Group of the Somerset Homelessness Partnership, in their aim to conduct a mapping and gaps analysis exercise about the availability of specialist and supported accommodation (commissioned and non-commissioned) for people experiencing homelessness across the county.

Recommendation 4b: By year end 2026/27, with support from SSAB Board Manager, Somerset Council Housing and Social Care to establish a senior manager panel (suggested name in review discussions was a Complex Case Panel) to escalate cases of concern where multi-agency action has stalled or failed to reduce harm. Assurance to be provided to SSAB about arrangements and implementation.

Recommendation 4c: By year end 2026/27, Somerset Council's Adult Social Care and Housing commissioning team to develop a business case for a homecare service to support adults living in hostels, temporary or supported accommodation where regulated personal care activities are not offered. The business case should be presented to the Strategic Homelessness Board for consideration and discussion in Summer 2027.

Systems Finding 5: Cognitive functioning and mental capacity concerns were treated with suspicion and stigma, leaving an older disabled man at risk in the community

In its post-legislative scrutiny of the Mental Capacity Act 2005, the House of Lords Select Committee stated 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*[19]". Raymond's experiences appear to reflect these practice and legal literacy uncertainties and further, learning event and 1:1 discussions, agency chronologies and post-incident reviews highlighted the added complexity of unconscious bias in the ways that Raymond's needs and experiences were understood and responded to.

Agencies reflected that although overt stigma and discrimination are uncommon, unconscious bias affects everyone and, in retrospect, decisions to rescind housing offers based on historic and inaccurate information, the use of language such as 'anti-social behaviour' to describe how Raymond spent his time, and the normalisation and lack of urgency around incidents of harm and violence were undoubtedly shaped by unconscious attitudes about substance use and homelessness.

Frontline practitioners reflected that social attitudes and lack of expertise about substance use and homelessness experiences, alongside practice uncertainties about fluctuating capacity and self-

[19] **https://publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/13907.htm**

neglect, are likely to have shaped understandings of Raymond's cognitive capacities and executive functioning. They reflected, in various ways, on the 'illusion of choice' that foregrounds understandings of mental capacity for people living highly excluded lives, noting that decisions perceived as 'unwise' by assessors occur in a context where genuine choice is extremely limited and 'healthy' choices are often far out of reach.

Agencies involved in this review described how uncertainties and biases around the application of the Mental Capacity Act principles collided in different and contested ways, so that Raymond's behaviours were misunderstood by professionals and he wasn't offered support to make decisions about his safety, particularly related to his finances, use of substances and engagement with healthcare. Those who knew him well, largely professionals working in the homelessness, substance use and inclusion health fields, were able to draw on their expertise with this population of adults to discern fluctuating capacity concerns in the complex coping mechanisms, trauma responses and cognitive decline Raymond was navigating. In contrast, professionals conducting mental capacity assessments with Raymond were non-specialists, who didn't know him well and who may have been more likely to assess Raymond's behaviour as 'unwise decisions', rather than as the behaviours of a highly vulnerable man living with complex co-morbidities and cognitive decline related to long-term drug and alcohol use. Whilst enhancing opportunities to apply professional curiosity in mental capacity assessments would be meaningful here, so would developing a more collaborative approach to complex mental capacity assessments that routinely consider third-party information where there are co-occurring factors that might be impacting capacitous decision-making.

Lastly, voluntary sector professionals reflected on the hierarchy of authority between different professionals in the local system. Voluntary sector organisations were the bedrock of Raymond's support network and employed a diverse array of practice approaches to engage and build rapport with him. At times of risk escalation, voluntary sector organisations were coordinating and delivering support to Raymond without meaningful statutory involvement; without the expertise and dynamism of their direct support and agency coordination Raymond would certainly have been at higher risk, with increased likelihood of acute hospital admissions, criminal victimisation on the streets and eviction from his temporary accommodation placement. However, they reflected that their insights and observations were not given the same weight as their statutory counterparts, in particular in relation to mental capacity concerns. They expressed frustration about the degree of advocacy required to secure a capacity assessment for Raymond and then at assessment decisions which were made and then changed without discussion (Sept 24). These reflections point to the presence of unconscious bias, not only in how adults with care and support

needs are understood, but also in how the expertise of non-statutory practitioners is valued in the local system. This mirrors observations made as part of the Thematic Review of Street Homelessness that concluded last year[20], and points to opportunities to strengthen system coordination by improving the equity of voice and authority between professionals in different sectors working with adults experiencing homelessness and multiple disadvantage.

Recommendation 5a: By autumn 2026, Somerset Council Adult Social Care to provide assurance, via a presentation to the Safeguarding Adult Board, about the approach to mental capacity assessments with adults who use drugs and alcohol, including how third-party information is considered and how contested decisions are reviewed and communicated. The presentation should be made available to local system partners to promote awareness of the local approach and key contacts.

Recommendation 5b: By September 2026, SSAB to promote the existing unconscious bias training offer to system partners, and the Learning Subgroup should schedule an agenda item to consider the development of a training module about stigma and social attitudes around homelessness, drug dependency and unusual behaviour. Uptake of the multi-agency training offer (including from Recommendation 1a) should be monitored for a year and promotion targeted to service areas and specialism where uptake is low.

Changes Since Raymond's Death

Since Raymond's death in December 2024, there have been several significant and meaningful developments in Somerset's approach to safeguarding, homelessness, and system coordination.

One of the most important steps has been the approval and publication of the 2024/25 Thematic Safeguarding Adult Review into the street homelessness experiences of three Somerset men. Work is now underway to implement its recommendations, signalling a positive commitment to learning and improvement. As part of this, a Homelessness and Safeguarding Summit took place in October 2025, which brought system partners together to strengthen understanding, accountability and joint working around this group of adults. Discussions and learning from that event were evident during this SAR which is an encouraging sign of improved relationships and the increased 'visibility' of people experiencing homelessness as a multi-agency priority.

[20] **https://somersetsafeguardingadults.org.uk/wp-content/uploads/2025/12/Homelessness-Review-Executive-Summary.pdf**

Alongside this, Somerset introduced the Homelessness and Rough Sleeper Strategy for 2025–2030. The strategy marks a shift towards a more coordinated and strategic approach, including the establishment of a Homelessness Charter to set shared expectations and standards. It also introduces stronger governance arrangements and more focused working groups, such as the Accommodation and Support group mentioned in this report, designed to ensure that strategic planning, commissioning and decision-making around housing enables timely, person-centred frontline practice. It is positive that the local authority is now taking a more visible leadership and governance role around homelessness, whilst the expertise of the local voluntary sector remains at the heart of this work.

The notable leadership of the county's voluntary sector continues to grow. Second Step have recently been commissioned to provide a Trauma-Informed Service for Adults Experiencing Homelessness and Multiple Disadvantage. This service builds on the Step Together service which has been supporting the homeless community in Somerset since 2019. This service now has a trauma-informed training offer for staff which has been formally commissioned following a 2-year pilot. Importantly, although the service has been commissioned by adult social care, it will work across adult social care and housing/homelessness systems, which is a crucial step towards improved system integration.

Local government reorganisation has also played a role in reshaping how homelessness and safeguarding are addressed locally. The merging of Somerset councils is now complete and the move to a single directorate for housing and adult social care has been widely seen as positive, with hopes for closer alignment, both strategically and operationally. A new director of Adults and Housing has recently been appointed, and it is hoped that learning from this review will be informative and supportive of strategic priority setting.

Local progress is mirrored nationally by the publication of the National Ending Homelessness Plan, which places greater emphasis on the role of adult social care and health in responding to homelessness, and includes a commitment to review and refresh the statutory guidance on safeguarding in respect of multiple exclusion homelessness. Together, these changes represent a significant shift in local and national policy and practice since December 2024, with a stronger focus on integration, prevention and safeguarding for people experiencing homelessness with significant social care and health need.

Conclusion

Raymond's death highlights the profound vulnerabilities experienced by older men living with multiple disadvantage and the critical importance of coordinated, trauma-informed, legally-literate multi-agency practice.

Across the review period, professionals were asked to navigate a complex landscape of risk, statutory duties and housing challenges, under time pressures imposed by impending evictions and escalating concerns about Raymond's health and wellbeing. However, case analysis and reflective discussions identified that efforts were fragmented, constrained by lethargic action from the local authority and lacking Raymond's voice at their heart. Collectively, these system barriers limited the ability of agencies to intervene effectively at moments when coordinated, proactive safeguarding activity was needed to reduce risk and improve Raymond's wellbeing. Ultimately, Raymond's voice, wellbeing and personal goals were somewhat lost amidst this.

Raymond's experiences highlight the impact of the wider context in which safeguarding and homelessness systems operate: a national housing emergency, limited specialist accommodation for adults with complex care and support needs, and gaps in national policy and practice guidance around grief, financial abuse and fluctuating mental capacity. Despite this context, Somerset's commitments outlined in the Homelessness and Rough Sleeping Strategy 2025-30 provide a strong foundation from which to embed learning from this review and strengthen local responses. The learning emerging from this review provides an opportunity to address discrete practice gaps, and to embed deeper cultural and structural change as new local authority structures embed—ensuring that adults with multiple disadvantage are met with curiosity, empathy, and coordinated support that recognises their vulnerabilities, strengths and hopes for the future.

The recommendations made in this report aim to build on existing good practice and multi-agency working arrangements, to remedy local practice gaps and to make use of opportunities to strengthen training, guidance and service delivery. The SSAB Board is invited to develop a SMART action plan to implement the findings and recommendations here, aligned with existing Board and partner activity and priorities.