

**Safeguarding Adults Review**

**Tower Hamlets Safeguarding Adults Board**

**Title**: Executive Summary of Ms H and Ms I – Thematic Safeguarding Adult Review

**Author**: Professor Michael Preston-Shoot (Emeritus Professor of Social Work, University of Bedfordshire and Independent Adult Safeguarding Consultant)

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# Introduction

* 1. Tower Hamlets Safeguarding Adults Board (THSAB) received two referrals for consideration as Safeguarding Adult Reviews (SARs) in early 2019. The THSAB SAR sub-group considered both referrals and concluded that the mandatory criteria for SARs had been met in both cases. In May 2019 it decided upon a thematic review methodology[[1]](#footnote-1). This decision was informed by the apparent similarities between the two cases, namely self-neglect, homelessness, substance misuse and multiple physical health needs.
	2. Ms H, a White British woman, died aged 52 on 1st April 2018, in accommodation belonging to a friend where she had been staying. She was found unresponsive by a care worker who called the London Ambulance Service. She was pronounced deceased at the scene. The Coroner established cause of death as due to morphine and gabapentin[[2]](#footnote-2) toxicity, a drug-related conclusion. The Coroner did not issue a Regulation 28 notice[[3]](#footnote-3) in this case.
	3. Ms I, died in hospital aged 33 on 2nd June 2018. Her ethnicity is not recorded on the SAR referral form but in other records she is listed as White British. The Coroner recorded cause of death as a methadone overdose. The Coroner found that she had taken illicit drugs whilst an inpatient on top of prescribed medication, including methadone, unintentionally causing her death. Her presence on the floor in her room under a pile of clothes and surrounded by drug paraphernalia went undetected for approximately ten hours, during which time she was believed to be off hospital premises. Hospital CCTV was not checked. The Coroner was unable to determine whether earlier detection of Ms I in her ward room would have saved her life.
	4. In this case the Coroner issued a Regulation 28 notice on 16th November 2018. The Coroner listed several concerns, namely that:

1.4.1 there was no nursing plan to address the likelihood of Ms I taking illicit drugs when in and out of hospital;

1.4.2 there was a lack of awareness amongst some staff about Ms I going off ward to take drugs;

1.4.3 a drug chart was missing;

1.4.4 she was thought to have left the ward to smoke but no-one had seen her leaving;

1.4.5 hospital security personnel had not been notified that she was missing and that there was confusion amongst staff about when the missing person policy should be followed.

* 1. The NHS Trust replied to the Coroner on 15th January 2019. It accepted that, although medical and nursing staff had advised Ms I against taking illicit drugs, the nursing plan should have been more explicit about this risk so that all nursing staff were aware of her behaviour. Staff have been reminded of the importance of documenting suspected drug misuse and including such risks in nursing handovers. The Hospital has reviewed the controlled drug registers and is able to account for the doses of methadone given. However, it accepted that the missing drug charts was a “serious failure” for which it apologised. A move to electronic prescribing is envisaged to eliminate risk of loss of paper charts.

1.6 The Hospital observed that her room was crowded with possessions such that a search was difficult. It accepted, however, that well-meaning tolerance of the state of her room was not in her best interests and staff have been reminded of the need to ensure that rooms are tidy and organised. It accepted that the room checks had not been adequate and staff have been reminded of the danger of making assumptions, in this instance that patients have left hospital premises. Finally, the Hospital stated to the Coroner that Ms I was judged to have capacity to decide to leave hospital premises and therefore they did not have powers to prevent this. Accordingly, she would not have been classified as a missing person but as a self-absenting patient. Hospital policy in that instance is that security staff would not be called. The Hospital added, however, that if there was concern that she as missing on the premises, then security staff should have been notified. Again, staff have been reminded of the dangers of making assumptions.

1.7 THSAB agreed that a themed approach would be taken. Rather than a traditional review that would concentrate on a detailed chronology of a single case, this thematic review would look across the two cases for learning from recurring themes that would indicate systemic issues to be addressed. The thematic review was commenced in May 2019 and concluded in January 2020.

1.8 From the SAR referrals and initial chronologies, the following themes were identified as the initial terms of reference:

Work with adults with multiple health and care needs;

Barriers to information-sharing;

Commissioning of care and support;

Responses when adults are homeless or threatened with homelessness;

Responses when adults are engaged in long-term substance misuse;

Work with adults who self-neglect;

Partnership and collaborative working.

1.9 The information made available by the agencies involved was compared and contrasted with the evidence-base for working with adults who self-neglect[[4]](#footnote-4). This evidence-base has been extended to incorporate what is known about best practice with adults who misuse substances and/or are homeless, and adopts a whole system perspective. The terms of reference therefore included a requirement to analyse the degree to which practice and policy in these two cases corresponded with “what good looks like”.

1.10 It was agreed that the chronologies and independent management reviews would report in detail contact with Ms H or Ms I from 1st April 2017 whilst also highlighting significant events prior to that date. Completed section 42 (Care Act 2014) enquiries were also submitted as part of the review process.

1.11 A learning event with practitioners and managers involved in the cases, or in the strategic development and/or delivery of services, explored key themes that had been extracted from the combined chronologies and other material submitted for the purposes of the review. The learning event offered an opportunity for those involved in working with homeless people, with individuals who misuse substances and/or self-neglect and with adult safeguarding more generally to comment on what they believed was working effectively in Tower Hamlets and on where they felt that improvements were required.

1.12 Ms H’s mother and Ms I’s partner participated in the review.

1. Two Cases
	1. Ms H was well-known to agencies for many years. Her children had been removed from her care when she was living in another London Borough. She experienced multiple health problems. Although details are sparse, it appears that she had a difficult relationship with her parents. Her mother is recorded as stating in 2010 that her daughter had a diagnosis of bipolar disorder.
	2. Her history included drug and alcohol misuse, suicidal ideation, self-neglect, housing crises, self-discharges from hospital and non-engagement with services. She had been a victim of domestic violence and had a variety of convictions dating back to 1995. She appeared unable to maintain a habitable environment. She had a history of insecure accommodation and homelessness. She was at risk of homelessness at the time of her death.
	3. During the period under review, essentially the last year of her life, when not in hospital she stayed in a friend’s flat. It appears that this was because she had been evicted from her own accommodation due to significant rent arrears. This friend died in February 2018, after which efforts were made to find Ms H accommodation or a placement. She rejected the placement and died before the threat of homelessness had been averted.
	4. Throughout the period under review she continued to misuse drugs and alcohol, including when in hospital. She had three admissions, the longest between June and September 2017 when there were concerns at the involvement of friends in relation to her continued substance misuse. She took her own discharge in September 2017 having refused the offer of a placement. During this particular hospital stay Deprivation of Liberty Safeguards were applied for twice. In the first instance the application had not been authorised. In the second instance, Ms H regained mental capacity.
	5. There were at least four safeguarding referrals during the period under review, one referral for advocacy and at least one safeguarding planning meeting. Nonetheless, her erratic engagement with services continued, including with the care agency commissioned to assist her with activities of daily living, as did her self-neglect and substance misuse.
	6. Ms I was also well-known to agencies for many years. There is evidence that she had been sleeping rough since 2000 (aged 16) and she had a long history of homelessness. Details of her family background are also patchy but include reports of childhood trauma. She had a history of depression and had been diagnosed as having an emotionally unstable personality disorder. She could be challenging and difficult to support, aggressive and non-compliant with hostel rules and/or medical treatment.
	7. Ms I’s partner reflected that he did not know much about her traumatic childhood as she would not easily talk about her family. She had also been abused by a previous partner. He agreed that, as a consequence, her “real self” was often “hidden.”
	8. Ms I’s partner described her as a very complex person. She could be cheeky and charming, sometimes almost child-like, but he also described her ability to manipulate people and to let people know when she was unhappy with them. Ms I and her partner had been together for about seven years.
	9. Her engagement with services varied between erratic and poor. She had a history of overdoses and was the subject of a suicide marker periodically. She had a longstanding history of alcohol and drug misuse. She experienced considerable physical health problems.
	10. Ms I had been imprisoned for assault and been arrested and/or convicted for various offences. During the period under review there was one use of section 136, Mental Health Act 1983, and four hospital admissions. The high risk of serious harm, including death, non-engagement and self-neglect prompted at least one safeguarding alert, in November 2017, but this did not result in a safeguarding plan. In 2017 there were two professionals’ meetings but Adult Social Care was not invited to either meeting. There was a case conference in April 2018.
	11. Initially in the period under review Ms I resided in a hostel but was often missing, sometimes to sleep rough with her partner because there was nowhere where they could stay together. Her hostel place was withdrawn in November 2017 because she was not using the room, which by then was unkempt. She was effectively homeless until May 2018, except when accessing severe weather provision. Before the final hospital admission, when she died, she was using a temporary assessment hostel bed, although perhaps erratically.
	12. These cases exemplify multiple exclusion homelessness. This comprises extreme marginalisation that includes childhood trauma, physical and mental ill-health, substance misuse and experiences of institutional care[[5]](#footnote-5). Adverse experiences in childhood can include abuse and neglect, domestic violence, poverty and parental mental illness or substance misuse[[6]](#footnote-6). These cases demonstrate again that, for many, street sleeping is a long-term experience and associated with tri-morbidity (impairments arising from a combination of mental ill-health, physical ill-health and drug and/or alcohol misuse) and premature mortality[[7]](#footnote-7).
	13. This thematic review also presents a rare opportunity to explore the experiences of women who experience multiple exclusion homelessness. The majority of reviews have concerned men[[8]](#footnote-8). Research[[9]](#footnote-9) has found that the causes of homelessness are multi-faceted and impact differently on men and women.
2. Themed Analysis
	1. From the domain of direct practice with individuals, five themes were apparent from the review of the chronologies and IMRs, namely:
		1. *Professional curiosity in response to service refusal*. In line with Making Safeguarding Personal, best practice indicates the importance of finding out about the person, their life experiences and history, and their hopes and desired outcomes. Whilst some practitioners did attempt to “stay alongside” Ms H and/or Ms I, the chronologies and IMRs do not give a sense of exploration, inquiry and challenge regarding what lay behind suicidal ideation and/or substance misuse, or whether either woman could envisage a different life trajectory than the one into which they had become locked. Service refusal and non-engagement or disengagement appears often to have been seen as a lifestyle choice, however unwise, rather than a response occasioned by substance misuse, physical disability, mental ill-health or trauma. Equally, when people lead chaotic lives indicative of complex personal challenges, it may be unrealistic to rely on engagement as expected by services. Important then become assertive outreach and support to engage, proactive rather than reactive responses and case closures. Underpinning the questioning of how practitioners responded to Ms H and Ms I is how addiction is regarded and whether staff have confidence to explore difficult issues.
		2. *Involving family and friends*. In both cases there were concerns about the friends keeping Ms H and Ms I company. The degree to which they were challenged about their relationships and interactions with Ms H or Ms I appears to have been limited. Equally, there does not appear to have been any sustained examination of whether and how any friends or partners could prove a circle of support. There was some limited contact with Ms H’s mother. Ms I’s partner was known to services. Might more information have been elicited from family and friends? Were there concerns about sharing information?
		3. *Recognising, assessing and responding to risk*. Documentation supplied by the agencies involved raises questions about the degree to which risks were recognised and assessed in a holistic, person-centred manner. Repeating patterns do not seem to have been addressed. Responses to risks involving drug and alcohol misuse, homelessness, mental health and neglect of care and support needs were not addressed in an integrated, coordinated way. Thus, there are questions about the scope of risk assessment, planning and review. There are also questions about when risks prompt consideration of section 42 enquiries or multi-agency high risk panels.
		4. *Assessing mental capacity*. The chronologies and IMRs provide evidence in both cases of the challenges of responding to cases where capacity fluctuates. The cases also raise the question of whether the impact of trauma and longstanding substance misuse on mind or brain is recognised and assessed, and most particularly whether executive capacity is considered. Neither the High Court nor the Court of Protection appear to have been considered as legal routes in either case.
		5. *Hospital discharge*. There were several hospital admissions in both cases and key episodes relating to self-discharge. Taking their own self-discharge cut across attempts to resolve homelessness or to embed treatment for substance misuse. The chronologies raise a question, therefore, of how agencies might best respond when patients self-discharge against advice.
	2. From the domain of the team around the individual, four themes were apparent from an analysis of the chronologies and IMRs, namely:
		1. Multi-agency working. Several issues have arisen in this thematic review. Firstly, limited use of multi-agency risk management meetings, high risk panels, multi-disciplinary meetings and section 42 enquiries. Secondly, lack of involvement of service users/patients in meetings to discuss risk management and safeguarding. Thirdly, whether there are pathways for whole system and integrated working with multiple exclusion homeless people (homelessness + substance misuse + offending + mental and physical ill-health). In neither case does there seem to have been a lead agency or keyworker. Use, monitoring and review of plans in response to risk and safeguarding concerns were variable. Given the repetitive pattern of non-engagement or non-compliance, there was an absence of contingency planning. There was information-sharing but arguably an absence of coordination between hospital and community provision, mental health and drug/alcohol services, and between statutory and third sector staff. There appears to have been an absence of parity of esteem of voices between statutory and third sector professionals.
		2. *Safeguarding literacy*. The review has highlighted concerns about awareness and use of safeguarding pathways within and across agencies, and questions about the thresholds in use for safeguarding referrals and enquiries. Finally, there are questions too about the use of escalation when there are concerns about risk and working together that appear to be overlooked.
		3. *Legal literacy*. In both cases legal powers were used in the form of mental capacity assessments, best interest decisions, Deprivation of Liberty Safeguards and sections within the Mental Health Act 1983. However, there appears to be insufficient knowledge of legal options, confidence in using powers and duties, and consideration of options for responding to complex cases, fluctuating capacity and extreme risk of self-neglect.
		4. *Recording*. Some recording was poor, limited and/or delayed. It was not always clear how, why and by whom decisions are reached. Defensible decision-making requires that recording of risk, needs and capacity assessment is clear. That was not always the case here.
	3. From the domain of organisations around the team, two themes were discussed at the learning event, namely:
		1. *Management oversight*. Both cases raise questions about management oversight and supervision of complex, high risk cases. Embedded in these two cases are concerns about unconscious bias in the form of how addiction, homelessness, non-compliance and self-neglect are viewed. A view was also expressed at the learning event that staff were not following agreed policies and procedures, and that this was not being challenged.
			1. *Workforce and workplace issues*. Both cases raise questions about the resources available for responding to cases where needs are complex and risks high. In a context of high demand for services, there is a question about whether workloads are manageable and staff suitably qualified and experienced. Some participants at the learning event were of the view that agencies were service-driven because of the pressures under which they were working. Limited resources were seen as negating longer-term involvement with individuals with complex health, housing and social care needs. However, it was also recognised that there was a lack of knowledge about substance misuse, addiction and self-neglect across the workforce as a whole. Staff skill-sets were sometimes limited, and staff attitudes and working styles could cut across a person-centred approach.
3. Conclusion: Revisiting the Terms of Reference
	1. In both cases it is possible to discern good practice, most especially in attempts by individual practitioners to remain alongside or to reach out to Ms H and/or Ms I, and in the use of discretion by services to meet their care and support needs. For instance, the RLH IMR observes that a pathway homelessness team worked with Ms I for some time.
	2. It is also clear that the agencies involved have already begun to learn lessons from the two cases. A summit about working with adults who self-neglect has been held. The policy and procedures regarding people missing from hospital wards have been reviewed. A homeless pathway for patients in secondary care settings, as part of a multi-disciplinary team approach, is being developed.
	3. However, in examining practice against the evidence-base for working with adults who self-neglect and/or experience multiple exclusion homelessness, as required of this thematic review, it is also possible to identify learning. To begin with, practice with respect to individuals who self-neglect and/or who experience multiple exclusion homelessness was taking place in a policy and procedure vacuum. Locally agreed procedures, which draw on the evidence-base for best practice, would clearly locate THSAB expectations of multi-agency partners. Such procedures and expectations would, for instance, clarify the need for professional curiosity about a person’s self-neglect and/or substance misuse rather than relying on assumptions about lifestyle choice.
	4. The terms of reference included a focus on partnership and collaborative working. It is clear from comments at the learning event and within the chronologies and IMRs that there are lessons to be learned here. They include the apparent absence of case coordination, especially but not just at points of transition, and the advisability of appointing keyworkers for complex cases, and uncertainty about pathways for referral and escalation of concerns. Agencies must know what other services are doing and research on best practice advises system-wide integrated working[[10]](#footnote-10). Commendably a number of panels have been established, including Community MARAC, Self-Neglect and Hoarding, and High Risk. Clarity of when to refer to which panel would be helpful for practitioners across the statutory and third sector. Work also appears necessary to ensure parity of esteem across the different workforces, so that all those with a contribution to make are present at multi-agency and multi-disciplinary meetings. Finally, there may be a case for reviewing whether the development of additional procedures locally would be helpful, for example on self-discharge, led by THSAB.
	5. One key interface where partnership working is required is that of Housing and Adult Social Care. Section 23 Care Act 2014 covers the boundary between care and support and housing legislation. The statutory guidance[[11]](#footnote-11) that accompanies the Act, Chapter 15, provides further detail. The lack of suitable accommodation puts health and wellbeing at risk. Suitable accommodation is one way of meeting a person’s care and support needs. However, where a local authority is required to meet a person’s accommodation needs under the Housing Act 1996, it must do so. Where housing is part of the solution to meet a person’s care and support needs, or prevent them, then the care and support plan may include this, even though the housing element is provided under housing legislation. Any care and support required to supplement housing is covered by the Care Act 2014.
	6. However, homeless people experience difficulties accessing personalised support through Adult Social Care[[12]](#footnote-12). There is also evidence[[13]](#footnote-13) that Social Workers may see homelessness purely as a housing problem to be dealt with under housing legislation and not as an issue involving social care. Social Workers and Social Care staff may also be uncertain how wellbeing and the criteria regarding eligible needs are to be applied, for example to promote homeless people’s social inclusion[[14]](#footnote-14). Case law[[15]](#footnote-15) has also established that local authorities must consider if care and support needs are accommodation related and must involve an advocate in assessment and care planning. It is difficult to conceive of situations in which homelessness does not have a significant impact on an individual’s wellbeing. All of which would suggest a required focus on how the provisions in the Care Act 2014 relating to care and support are being implemented with respect to homeless people.
	7. The terms of reference also directed attention towards work with and responses towards adults with multiple health and care needs, adults who self-neglect, individuals who are homeless and individuals who have long-term issues with substance misuse. Feedback from the learning event and analysis of the chronologies and IMRs would suggest that substance misuse is not always recognised as a form of self-neglect and that the possible drivers underpinning long-term substance misuse may not be fully appreciated or explored over time. There are no quick fixes here and workloads will need to be adjusted to allow for long-term relationship-building work as a precursor to addressing causes rather than or as well as symptoms of self-neglect and substance misuse. There is certainly a need to understand patterns of behaviour and the influence of a person’s history on current behaviour. What also emerges in this thematic review is the question of confidence and scope of mental capacity assessments, including executive capacity and the impact of long-term substance misuse and of trauma and adverse life experiences on decision-making. Finally, a renewed focus on risk assessment, including the use of tools and templates to assist consideration of the likelihood and significance of diverse risks would assist with multi-agency risk management.
	8. Barriers to information-sharing also featured in the terms of reference. At times, judging by the content of the chronologies and IMRs, this was poor. Holding regular multi-agency meetings for complex cases may help to overcome such barriers, as well as an expectation that a keyworker is informed of significant developments, such as self-discharge or relapse. Integrated recording systems would also be helpful.
	9. The terms of reference also referred to commissioning of care and support. There does appear to be justification for an analysis of gaps in provision, highlighted by the two cases, but also consideration of how commissioning can be used to achieve greater integrated, whole system working.
	10. There was considerable investment from diverse agencies in attempting to meet the needs of Ms H and Ms I. However, it is arguable that much of this took place on parallel lines. It was also suggested at the learning event that the pathway for cases of dual diagnosis could be clarified and that perhaps more could be done to establish “wrap-around” support when people are housed away from the street.
	11. Members of the review panel have also commented that the shortage of registered care homes for people who misuse substances is a gap in service provision, and have noted the absence of a dual diagnosis service.
4. Recommendations
	1. Arising from the analysis undertaken within this review, the SAR review panel and independent reviewer recommend that the Tower Hamlets Safeguarding Adults Board:
		1. produce and disseminate multi-agency procedures for working with people who self-neglect, such procedures to include clear pathways for convening multi-agency panel meetings and for escalation of concerns, and arrangements for agreeing on lead agency and key worker to coordinate practice;
		2. produce and disseminate best practice guidance for working with people who experience multiple exclusion homelessness, such guidance to include clear pathways into mental health support and a protocol for the management of cases of dual diagnosis;
		3. commission multi-agency training on self-neglect, legal literacy (including information-sharing), unconscious bias, trauma-informed practice, mental health and mental capacity assessments (including a focus on executive capacity), and risk assessment;
		4. commission regular audits of the effectiveness of multi-agency high risk panels;
		5. convene a multi-agency summit to review commissioning of services in response to the needs of people experiencing multiple exclusion homelessness, concluding with proposals for further service development where gaps in provision are identified;
		6. convene a multi-agency summit to plan development of a more trauma-informed approach to practice;
		7. request that senior managers in Children’s Social Care and Adult Social Care discuss the learning from this report as it impacts on current cases where there are a combination of children’s safeguarding and adult safeguarding factors that require a think family approach, and disseminate guidance about best practice;
		8. audit progress on learning from this SAR after one year from publication.
1. Section 44, Care Act 2014; DHSC (2018) Care and Support Statutory Guidance: issued under the Care Act 2014. London: The Stationery office. [↑](#footnote-ref-1)
2. An anticonvulsant medication used to treat seizures and neuropathic pain. [↑](#footnote-ref-2)
3. Schedule 5 (7) Coroners and Justice Act 2009; The Coroners (Investigations) Regulations 2013, Regulations 28 and 29. [↑](#footnote-ref-3)
4. Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence. Preston-Shoot, M. (2019) ‘Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.’ *Journal of Adult Protection*, 21 (4), 219-234. [↑](#footnote-ref-4)
5. Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) ‘Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.’ *Research, Policy and Planning*, 33 (1), 3-14. [↑](#footnote-ref-5)
6. Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping)*. London: Public Health England. [↑](#footnote-ref-6)
7. Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) ‘Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.’ *Research, Policy and Planning*, 33 (1), 3-14. [↑](#footnote-ref-7)
8. Martineau, S., Cornes, M., Manthorpe, J., Ornelas, B. and Fuller, J. (2019) *Safeguarding, Homelessness and Rough Sleeping: An Analysis of Safeguarding Adult Reviews*. London: Kings College London. [↑](#footnote-ref-8)
9. Cameron, A., Abrahams, H., Morgan, K., Williamson, E. and Henry, L. (2016) ‘From pillar to post: homeless women’s experiences of social care.’ *Health and Social Care in the Community*, 24 93), 345-352. [↑](#footnote-ref-9)
10. Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping)*. London: Public Health England. [↑](#footnote-ref-10)
11. Department of Health and Social Care (2018) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office. [↑](#footnote-ref-11)
12. Cornes, M., Joly, L., Manthorpe, J., O’Halloran, S. and Smythe, R. (2011) ‘Working together to address Multiple Exclusion Homelessness.’ *Social Policy and Society*, 10 (4), 513-522. Cameron, A., Abrahams, H., Morgan, K., Williamson, E. and Henry, L. (2016) ‘From pillar to post: homeless women’s experiences of social care.’ *Health and Social Care in the Community*, 24 93), 345-352. [↑](#footnote-ref-12)
13. Whiteford, M. and Simpson, G. (2015) ‘Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.’ *Housing, Care and Support*, 18 (3/4), 125-135. Maeseele, T., Roose, R., Bouverne-De Bie, M. and Roets, G. (2014) ‘From vagrancy to homelessness: the value of a welfare approach to homelessness.’ *British Journal of Social Work*, 44 (7), 1717-1734. [↑](#footnote-ref-13)
14. Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) ‘Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.’ *Research, Policy and Planning*, 33 (1), 3-14. [↑](#footnote-ref-14)
15. R (SG) v Haringey LBC [2015] EWHC 2579 (Admin). [↑](#footnote-ref-15)