Reviewing the deaths of people facing multiple disadvantage.

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Introduction

People experiencing multiple disadvantage are among the most vulnerable individuals in society. Due to a combination of structural disadvantage, poor health outcomes and personal circumstances, they are consistently at a higher risk of premature death than the general population.

Despite this, there remains a limited focus, both locally and nationally, on investigating and reviewing premature deaths when they occur. As a result, opportunities to learn from deaths and proactively identify changes that might help prevent others are missed.

This briefing encourages national and local government to take clear steps to ensure there is greater learning from the premature deaths of people facing multiple disadvantage. It highlights the benefits that a review of these deaths can bring and the methods and processes that can be adopted to improve current practices and minimise future loss of life. The briefing draws on work happening across the MEAM Approach and Fulfilling Lives networks and covers the following:

- In section 1, we explore the reasons why so many people facing multiple disadvantage are at risk of premature death.
- In section 2, we examine why local areas should review premature deaths and the potential benefits this can bring to local areas, staff, relatives, friends and people using services.
- In section 3, we look at Safeguarding Adult Reviews as a way to review deaths of people facing multiple disadvantage.
- In section 4, we look at how local areas can develop their review processes and the elements that are important in this process.

1. Premature and preventable deaths

A range of evidence[1] indicate that individuals facing multiple disadvantage are more likely to suffer premature death when compared to the general population. This view is reinforced by discussions with frontline staff and strategic leaders within our network.

Sadly, the true scale of the issue is not known. Whilst a range of national statistics related to death are collected, specific information on the number of deaths of people experiencing multiple disadvantage is not recorded locally or centrally by any government body. However, a report from the Fulfilling Lives programme found that the death rate among people supported by the programme was more than five times higher than the equivalent rate in the population of England and Wales in 2016.[2] In addition, the average age of people on the programme who died was 43 for men and 39 for women compared to 76 years for men and 81 years for women across the general population.

Findings from recent research suggest that there can be a 'normalisation of death' within local communities of people facing multiple disadvantage due to the frequency of death within their peer group.[3]

Below we briefly highlight some of the main reasons for this increased risk, and the issues individuals are facing, using data from existing research and discussions with frontline support professionals.

- *Physical and mental health conditions*

People experiencing multiple disadvantage are more likely to suffer from long-term physical and mental health conditions. For example, there are increased cardiovascular issues among rough sleepers[4] and a greater prevalence of respiratory conditions, such as COPD and Hepatitis C, for individuals with substance misuse issues. Additionally, the majority of people facing multiple disadvantage suffer from severe and long-term mental health problems[5], which in itself can substantially impact on the likelihood of premature death.[6]

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[1] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31869-X/fulltext
[2] http://www.fulfillinglives-ng.org.uk/wp-content/uploads/2020/11/FLNG-and-Fuse-understanding-high-mortality-rates-research.pdf
[3] https://fuseopenscienceblog.blogspot.com/2020/05/experts-by-experience-challenge-us-to.html
[4] http://www.fulfillinglives-ng.org.uk/wp-content/uploads/2020/11/FLNG-and-Fuse-understanding-high-mortality-rates-research.pdf
[5] Lankelly Chase: Hard Edges https://lankellychase.org.uk/resources/publications/hard-edges/
[6] https://www.ox.ac.uk/news/2014-05-23-many-mental-illnesses-reduce-life-expectancy-more-heavy-smoking

Despite this higher prevalence of severe and long-term health issues, individuals facing multiple disadvantage are often far less likely to have access to both primary and secondary health care services. This may be the result of stigma, a lack of flexibility, accessibility problems, strict eligibility criteria or poor past experiences of treatment. Therefore, individuals may only receive healthcare when they are experiencing a crisis and can be unlikely to attend regular appointments for longer-term conditions. Limited access to health services results in health and wellbeing deteriorating more rapidly.

We are aware that people facing multiple disadvantage are likely to have high rates of suicide and suicide attempts compared to the general population. For example, 40.6% of Opportunity Nottingham beneficiaries, part of the Fulfilling Lives programme, have been recorded as at high or immediate risk in relation to physical safety as a result of deliberate self-harm or suicide attempt, at some point during their support from the project.

- *Substance misuse*

Individuals facing multiple disadvantage frequently have chronic issues with substances. This can lead to both long-term health conditions, for example liver issues as a result of alcohol consumption, and immediate risks to life, such as overdose from opiates.

Drug related deaths have risen dramatically over the past 10 years and a substantial proportion of this increase will include people facing multiple disadvantage. Research has demonstrated that individuals facing substance issues alongside other problems are at elevated risk, for example people with substance issues who are also homeless have seven to nine times the chance of dying from alcohol related diseases and over 20 times the chance of dying from drugs[7] when compared to the general public.

People facing multiple disadvantage will frequently enter prison for short periods of time and a substantial but smaller group will be placed in inpatient care, often as a result of applications of the Mental Health Act. For these individuals, discharge can place them at elevated risks of overdose as their tolerance levels will have reduced while in prison or hospital.

- *Rough sleeping*

The average age of death of someone rough sleeping is 45.9 years for men and 43.4 years for women, significantly younger than the general population.[8] Routine

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[7] https://www.crisis.org.uk/media/236798/crisis_homelessness_kills2012.pdf

[8]https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2019registrations
There were an estimated 778 deaths of homeless people in England and Wales registered in 2019, an increase of 7.2% from 2018 when there were 726 estimated.

activities that people carry out day-to-day are far more difficult when living in inappropriate accommodation or when rough sleeping. For example, the ability to stay clean and to keep wounds and other abrasions free from infection is exceptionally difficult. Staying warm and dry is problematic, particularly during the winter and this can cause health conditions to deteriorate rapidly. People sleeping rough are also at increased risk from general contractible illnesses and diseases. This increased risk was recognised as part of the government's decision to launch 'Everyone In' at the start of the first national lockdown in March 2020.

Access to basic nutrition can be extremely difficult for homeless people as a result of limited or no income. Even when individuals are on benefits they may struggle to afford sufficient food to sustain healthy diets. There are regular examples of individuals having to resort to begging or stealing to eat or relying on voluntary sector services.

- *Criminal justice involvement*

As mentioned above, a large proportion of people facing multiple disadvantage will spend short periods of time in prison on a regular basis.

The physical health of the prison population, across a broad range of conditions, is much poorer than that of the general population. Incidences of blood borne viruses are particularly more prevalent among the prison population. Cases of tuberculosis per 100,000 are over five times higher among the prison population. Hepatitis C is more prevalent among people in prison, especially women in prison, compared to the general population.[9] It is thought many older people in prison have a physical health status ten years older than their contemporaries in the community.[10]

Studies have found rates of psychosis and common mental health problems in prison far exceed the prevalence rates found in the general population.[11] Rates of self-harm and self-inflicted deaths in prison remain very high, and research has shown that men in prison in England are 3.7 times more likely to take their own life than men in the general population.[12]

The point at which people facing multiple disadvantage leave prison presents a large number of risks, particularly where people are released from prison homeless or with little continuity of care. The number of people who are dying while under the supervision of probation within the community has increased substantially over the past few years. Of the 1,002 deaths of people under the supervision of the probation service in the year to March 2020, 35% were recorded as self-inflicted and 22%

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[9] 13% of female prisoners and 7% of male prisoners are diagnosed with hepatitis C compared to 0.4% of the general population https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/963/963.pdf

[10] https://publications.parliament.uk/pa/cm5801/cmselect/cmjust/304/30405.htm

[11] https://www.clinks.org/sites/default/files/2019-04/clinks_whole-prison-mh_V4.pdf

[12] https://www.ons.gov.uk/news/news/maleprisonersare37timesmorelikelytodiefromsuicidethanthepublic

remain unclassified. 66 people died on post-release supervision within just 28 days of release from prison.[13]

- *Violent and sexual abuse*

The experience of violence, trauma and abuse is common among people facing multiple disadvantage. The vast majority of women facing multiple disadvantage will have experienced substantial violence and sexual/domestic abuse in their past. According to recent research this can place women at higher risk of self-harm and suicide and of course domestic homicide.[14]

In conclusion, each of these issues taken individually can significantly affect the average age of death. Unfortunately, people facing multiple disadvantage will experience many or all of these issues simultaneously, along with other issues. This can drastically increase the chances of a premature death.

2. Reasons to review deaths

In too many local areas, not enough is being done to review the deaths of vulnerable individuals experiencing multiple disadvantage. This is a lost opportunity to develop valuable learning at an individual and wider cohort level.

At its worst, the lack of reviews can suggest that insufficient value is being placed on the lives of individuals who have passed away and the feelings and thoughts of their friends, family and staff who were supporting them. As one respondent we spoke to said, these individuals are 'neglected during their lives and neglected when they die'.

Below we outline some of the most important reasons to review deaths of individuals experiencing multiple disadvantage, appreciating that the scope and detail of any review will vary according to the specific individual and local circumstances.

- *Reduce preventable deaths*

Only by exploring and reviewing the specific circumstances of deaths of individuals facing multiple disadvantage can areas understand and appreciate the full set of factors involved and take action across services and systems to reduce the likelihood of future deaths.

Carrying out individual reviews will often uncover issues or experiences of which local services and systems are not aware. For example, in one area where a review of several deaths was completed it became apparent that park/city wardens often

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[13] https://www.gov.uk/government/statistics/deaths-of-offenders-in-the-community-annual-update-to-march-2020
[14] https://www.nspa.org.uk/wp-content/uploads/2021/04/New-Suicide-Report2c-Refuge-and-University-of-Warwick.pdf

had regular contact with the individuals and were aware of their needs. Yet they were rarely involved in developing support plans or invited to contribute towards referral pathways.

Where review processes are implemented successfully, they can help focus work across local partnerships, leading to a more systems-orientated and collaborative approach. As we were told by one local area, reviewing deaths gives services a chance to understand each other's limitations and ways of working. It allows systems to collectively take responsibility for the death and to develop actions together than can prevent more deaths in the future.

Reviews can also help identify trends in local areas where several deaths occur each year. Combining the result of reviews and identifying themes helps local areas to develop a better understanding of longstanding systemic causes of deaths and the need for them to be addressed.

- *Support frontline staff*

Staff turnover and 'burnout' can be a serious problem for local support services. Carrying out reviews of deaths and building processes for future reviews helps create spaces for frontline practitioners to share their grief, acknowledge their feelings and support colleagues. Several frontline staff across our network reported deep-rooted frustration with the internal and local area processes for when people facing multiple disadvantage passed away, stating they were too simplistic and focused too much on trying to negate fault as opposed to developing learning.

Developing review processes and opportunities for staff to discuss their thoughts and wellbeing when an individual has passed away can help make them feel supported and present an opportunity for them to offer suggestions on how to improve systems and services to prevent future deaths.

- *Support service users affected by death*

Fulfilling Lives Newcastle Gateshead alongside The Centre for Translational Research in Public Health, carried out peer research exploring the reasons for high death rates among people facing multiple disadvantage.[15] The research found that members of the local Experts Network are passionate about better understanding the reasons for deaths and also identified the normalisation of death within the expert by experience community.

Developing a review process for deaths can help peers in dealing with deaths of those close to them. It can help identify individuals whose wellbeing might potentially have been negatively impacted by the death. It can also provide a space

[15] http://www.fulfillinglives-ng.org.uk/wp-content/uploads/2020/11/FLNG-and-Fuse-understanding-high-mortality-rates-research.pdf

for people to voice their own thoughts on deaths, what might be learned from them and actions that need to be taken.

3. Safeguarding Adult Reviews

In this section, we look at Safeguarding Adult Reviews (SARs) as a process that can be used to review deaths of people facing multiple disadvantage.

Safeguarding Adult Boards (SABs) are responsible for helping to safeguard adults with care and support needs in all local areas. Under the Care Act there must be three core members in every local area; the local authority, clinical commissioning groups (CCGs) and the police. Local authorities are responsible for the establishment of SABs.[16]

Under Section 44 of the Care Act, SABs have a statutory duty to arrange for there to be a review of a case involving an adult in its area with care and support needs[17] (regardless of whether the local authority is meeting those needs) if there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult and;

a) The adult has died, and the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).
b) The adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.[18]

Each member of the SAB must co-operate in and contribute to the carrying out of SARs with a view to identifying the lessons to be learnt from the adult's case, and applying those lessons to future cases. The purpose of SARs is to promote effective learning and improve action to prevent future deaths or serious harm occurring again. While a SAR will seek to establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom, its purpose is not to hold any individual or organisation to account.

Safeguarding Adult Reviews produce detailed chronological accounts of an individual's life in the weeks and months prior to their death, outlining the interactions and engagements they had with local public services. They can be extremely valuable to local areas, helping identify faults and failings in the local system which if addressed can reduce the likelihood of future deaths.

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[16] Under Section 42 of the Act each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect.
[17] This terminology should not be confused with care assessments under the same legislation and the test/criteria set out for eligible needs. Care and support needs under safeguarding have a much wider interpretation and can include conditions linked to physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury.
[18] https://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

Safeguarding Adult Reviews and Multiple Disadvantage

Although it is unclear at the moment how many SARs are commissioned across the country annually for people facing multiple disadvantage we know the figure is quite low. Since 2015-16, NHS Digital has published data giving the overall number of reviews commissioned in each year, including the numbers of people involved, individuals who died and individuals who suffered harm. However, no breakdown is provided for people facing multiple disadvantage by type of abuse and neglect. The total number of reviews commissioned has risen from 90 in 2015-16 to 135 in year 2018-19.[19]

A large proportion of these SARs will be for individuals experiencing multiple disadvantage and will provide local areas with detailed and valuable reports that help to improve systems for this group and reduce the potential for future preventable deaths.

However, we also know there is the potential for more SARs to be carried out in the future for this group of individuals to generate further learning and identify improved practices. For example, over the first five years of Fulfilling Lives programme alone, at least 171 people who were engaged with the programmes died. Those programmes only cover a fraction of the country and do not work with all individuals in local areas experiencing multiple disadvantage. This number exceeds the number of SARs carried out in 2018-19 across the entire country.

Having discussed SARs with numerous experts and front line staff it is clear that further training and support should be provided across local public services around both safeguarding and in particular SAR processes. If there is to be an increase in the number of SARs carried out on the deaths of individuals facing multiple disadvantage, staff and services need to feel more comfortable making referrals to safeguarding teams.

At the moment there can be a lack of trust in existing processes. Some individuals feel that referrals will automatically be rejected and as a result feel there is little point in making them in the first place. More worryingly, some staff reported that they are concerned that others will look unfavourably on them if making referrals, because findings might reflect badly on their organisation.

Increased training on SARs will go some way towards tackling this and hopefully overcome any concerns. It will also position staff to make better referrals, providing

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[19]DHSC funded the establishment of a national library of SARs, hosted by SCIE, which contains reports and summaries provided voluntarily by SABs. However, in the absence of continuation funding, development of the library has stalled; it is incomplete and the search mechanisms are limited. The absence of a national review of SAR learning has been said to deprive SABs and their partner agencies of an easily recognised pathway by which they can locate local learning themes within a national picture.
https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf?dm_i=10XE,76CTJ,RBIR88,T2G3I,

suitable information and justification within their applications and therefore create less potential justification for a rejection.

- *SAR and Homelessness*

The government's 2018 Rough Sleeping Strategy explicitly recommended that SARs be used more frequently when individuals who are rough sleeping pass away, recognising that unfortunately they are rarely used in this situation at present.[20] There is some evidence, mainly anecdotal, that this is beginning to change, with increased use of SARs for this cohort over the past year or two and an increased level of attention to the problem.

A recent report analysed numerous SARs where homelessness was a factor.[21] It found there were reports of poor inter-authority co-operation, poor hospital discharge arrangements, and a lack of supported accommodation provision. There was evidence of a reluctance to see individuals' situations as safeguarding matters, particularly in relation to self-neglect and a reluctance among agencies to look beyond the housing issue and properly assess care and support needs accordingly. This analysis demonstrates the value of reviewing deaths involving multiple disadvantage and the potential it can have to provide learning at both a local and national level.

4. Developing review processes for people facing multiple disadvantage

It is our view that local areas should review all premature deaths of people facing multiple disadvantage to support learning and help prevent future deaths.

We are aware that a SAR will not necessarily be needed in every case. However, there should be a clear process in place in every local area to identify whether a SAR is needed and, where thresholds are met, that the review is carried out. In addition to this, there should be a less rigorous and nimbler review process available for individuals who do not meet SAR thresholds. This process should sit alongside and support the statutory SAR process.

These shorter reviews should be able to produce findings and identify possible actions in a timelier and less resource intensive manner. For example, perhaps the cause of and reasons behind the death are relatively well known, but services and staff would like additional information and a process that can ensure that learning is recorded and acknowledged.

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[20] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733421/Rough-Sleeping-Strategy_WEB.pdf

[21] https://kclpure.kcl.ac.uk/portal/files/116649790/SARs_and_Homelessness_HSCWRU_Report_2019.pdf

Below we highlight some examples from across our network of local areas that have been proactive and progressive in setting up processes to review deaths of people facing multiple disadvantage.

Haringey - Homelessness Fatality Reviews

Following the deaths of 11 people in 2019 who were homeless or vulnerably housed, a review process was initiated to establish whether there was any connection between the circumstances of these deaths. When the review found revealing similarities in how the individuals concerned had fallen through the cracks of services, the council started exploring processes to ensure a formal review of every death of a person experiencing homelessness in the borough.

Led by Gill Taylor, Haringey's Strategic Lead for Single Homelessness & Vulnerable Adults, procedures were drafted in collaboration with colleagues in grassroots organisations, commissioned services, public health and the CCG. The Safeguarding Adults Board approved the establishment of a discrete review process underneath their governance. This gives the new review process status, visibility and protection. The reviews are chaired by Gill Taylor, who delivers an annual thematic report to the SAB, detailing review findings, actions taken and other relevant work.

There are two stages to a full review: a desktop review including contacting people in the person's life to gather the facts of the case, followed by a multi-agency meeting to explore issues and feelings raised in more depth. Friends and family members are involved in the process where possible, though sensitively managing this while maintaining privacy is an ongoing challenge. Every death of a person experiencing homelessness is reviewed and most receive a full two-stage review, including everyone who was sleeping rough and who faced multiple disadvantage.

Faster than a SAR, actions and recommendations from the review are implemented in 'real-time'. The aim is to prevent the premature death of homeless people and to improve multi-disciplinary partnership practice which is central to reducing the inequality affecting homeless people. It is hoped that the process will help recognise the particular vulnerabilities affecting homeless people as they relate to safety and safeguarding and create a 'human portrait of some of the borough's most invisible residents that resists framing people solely by their needs and risks'.

Thanks to the proactive and progressive work of Haringey Council many other local authorities are attempting to adopt similar processes, or at least use them as a template for designing their own.

Westminster – Annual Thematic Review

Westminster has high levels of rough sleeping and has reported relatively high numbers of deaths within this group. The council decided to learn from the Haringey approach and seek to implement their own review process to sit alongside that of SAR.

Where appropriate, referrals are made to the SAB to carry out a SAR. Westminster have implemented a process that allows them to carry out a combination of rapid and more detailed reviews, depending on the individual circumstances. This is determined on a case-by–case basis, after initially screening the case and looking at available information and evidence.

An annual thematic report is produced and presented to the Safeguarding Adults Board. It sets out the causes of deaths, the multi-agency actions that followed the deaths and also analyses any identifiable trends. For example, last year they discovered that a large number of deaths involved spice. However, that is not something that coroners can easily screen for; they have to perform an enhanced screening, which they now routinely do when there is advice provided by local supporting organisations suggesting the individual may have been consuming it.

Developing local review processes

Local areas should look to take proactive steps, learning from other areas such as Haringey and Westminster, to ensure that when someone facing multiple disadvantage dies there is a clear process in place to identify whether a SAR is needed and an alternative review process in place where SAR thresholds are not met. When developing their plans, local areas may wish to consider some of the points below arising from discussions with our network.

- *Where to place the process*

For a process around reviewing deaths of people facing multiple disadvantage to operate successfully, become embedded in the system and remain sustainable, it will need to be officially held and housed somewhere. In both examples above it is held by the local SAB. This helps give structure and governance to the process, provides somewhere to report individual findings, gather thematic analysis and set actions.

- *The process for determining reviews*

A clear mechanism will be needed to determine whether the death of a vulnerable individual experiencing multiple disadvantage requires a SAR or an alternative review. All local staff and support agencies should be able and encouraged to refer into and inform this mechanism, which should take account of the statutory duty to undertake a SAR when thresholds are met.

The process should be as transparent as possible. One of the issues that has been highlighted to us by staff in some local areas is the control over the decision making process for SARs. It was suggested by some, whether fairly or not, that local authorities might have an incentive to reject SAR referrals.

For people who might have fallen through gaps in services, statutory services in particular are less likely to understand the details of the case enough to make a

decision on what kind of review is needed. Involving voluntary sector partners is therefore crucial.

- *Cross sector and multi-agency involvement*

It is important that deaths of people experiencing multiple disadvantage are viewed as a system wide issue. Preventing and reducing deaths should be a goal for all local services to work collaboratively towards, and it is not the responsibility of one single agency. Therefore, processes around reviewing deaths, and the reviews themselves, should involve all local public and voluntary services, with findings and potential activities ensuing from them shared across the system.

The aim of any review (regardless of type) should be to learn what the entire local support system can do to improve, not just individual services. For example, if someone dies as a result of a substance misuse, it should not be seen solely as something for the substance misuse provider to address by themselves. There should be an attempt to understand what other issues the person was facing and what other services they were engaged in.

In order to do this properly, and efficiently, it is important to involve as many public and voluntary sector partners as possible from the beginning of the process. Existing cross-sector partnerships, which will likely have substantial information available, can help with this.

- *Including all people facing multiple disadvantage*

Review processes must cover all vulnerable individuals who experience multiple disadvantage and not just those facing homelessness and rough sleeping. Ideally, the death of any individual experiencing multiple issues should automatically trigger a local review mechanism, even if someone has been living in appropriate housing for a substantial period of time, for example someone who has died as a result of a drug overdose who was known to have mental health issues and was recently released from prison. The engagement and involvement of voluntary organisations in any process is vital as they will often know of vulnerable individuals that statutory agencies may not.

- *Information sharing*

One of the key challenges to setting up review processes such as the examples outlined above is the issue of information sharing across statutory and voluntary organisations. Utilising any existing information-sharing agreements should be prioritised alongside the development of new ones where appropriate. Making sure these are in place will speed up reviews. Being able to gather a wide range of information across organisations quickly will enable relatively swift decisions to be made as to what kind of review is needed. It will also generally improve information sharing between local public services.

- *Staff support*

Any review process and the reviews themselves, will rely on the confidence and trust that frontline support staff place in them. If not, incidents and deaths won't be referred. Creating a new process presents an opportunity to help train staff generally on the importance of reviewing deaths and also how best to make SAR referrals.

Alleviating any concerns staff might have (for example that they will be ignored or might be in some way reprimanded by others for making referrals) should be a priority if the system is going to work well. People should feel encouraged to make referrals. The process must be open and transparent. Nobody should be concerned that it might reflect badly upon them or their organisation for making a referral. Generally, staff should be involved in designing the process.

There should also be appropriate support available for staff that knew the deceased to ensure their wellbeing during the review process.

- *Peer involvement*

Peers should be involved in the design and operation of review process and the reviews themselves. Friends and families will often be best placed to provide information on the death of the individual and any underlying issues. The views of local peers and experts by experience should shape how they are approached and asked for information, supported and kept informed of findings. Review structures must clearly set this out.

Review processes and reviews themselves must also be culturally sensitive to the individual and the peers around them. Recording race and other demographic information should be seen as essential. Only by doing this can evidence emerge on local and national trends and it be determined if specific groups are facing disproportionate risks of death[22].

- *National Government*

Local areas can significantly improve the response to and subsequent learning from the deaths of vulnerable individuals, in particular those experiencing multiple disadvantage. In time this will hopefully lead to actions across local systems that reduce preventable and premature deaths.

However, local areas also need to feel supported by national government, which must continue to improve how it investigates and analyses the deaths of vulnerable people nationally. Government has a vital role to play in collating learning across local areas on trends in the deaths of vulnerable adults and encouraging certain

[22] Numerous national statistics focused on certain deaths such as homelessness and drug related deaths do not provide a breakdown by ethnicity.

local and national actions to be taken. The government should require all local authorities to develop clear processes for reviewing deaths of individuals facing multiple disadvantage. These should be specific to local pressures, needs and circumstances but government should provide best practice guidance, example frameworks and implementation toolkits.

Collating local thematic reports could provide the government with substantial additional analysis to sit alongside national statistics such as drug related or rough sleeping deaths. This should provide a more detailed understanding of what led to those deaths, the experiences of the individuals and those supporting them, allowing for more nuanced policies to be created nationally to try and address the issue and react to developing trends.

Conclusion

The response to Covid has shown that local services and systems can quickly galvanise around the clear goal of protecting the lives of vulnerable groups, particularly those experiencing multiple disadvantage. Across the country concerted efforts were made to reduce the likelihood that this group of individuals would die prematurely, by addressing the risks of viral transmission, whilst still providing individual support.

There is an excellent opportunity to build on this in the future and to ensure that reducing premature death becomes a primary goal of services and systems. One of the first steps local areas can take is to build on and improve current local review processes to make sure they learn as much as possible from each unfortunate and unnecessary death.

Embedding these processes in local systems will demonstrate to staff and individuals how seriously the issue is taken and in time hopefully lead to actions at both the local and national level which can reduce the likelihood of future premature and preventable deaths.