Dying Homeless:
Evidence & Learning for Anti-Oppressive Practice

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HARM AND HOMELESSNESS

- Homelessness exposes people to discrete vulnerabilities as well as exacerbating existing risks
- Experiencing homelessness often means people have significantly less choice in relation to their safety, making them especially vulnerable to self-directed harm and harm from others
- Gender, sexuality, age and race (as well as other protected characteristics) make people additionally vulnerable when homeless
- People with rough sleeping histories have often experienced repeat instances of exploitation, abuse and neglect starting in childhood (ACE's)
- Research evidence points to disproportionate experiences of undiagnosed brain injury, learning disability, neurodivergence and cognitive impairment that make people additionally vulnerable.
- Stigma plays a significant role: people experiencing homelessness are less likely to be believed and to have their wishes respected. As such, they are less likely to disclose experiences of harm..
- Professional 'attitudes of inevitability' can normalize risk and unfounded professional optimism can result in predictable harm.
- People who experience homelessness are at significantly increased risk of a premature death.

Taking Action to Understand the Issue

- The Dying Homeless Project
- Second National Analysis of SARs
- Understanding Local Deaths

DYING HOMELESS PROJECT

- The Dying Homeless Project was initiated by the Bureau of Investigative Journalism in October 2017. In April 2019, the Museum of Homelessness agreed to begin hosting the investigation and memorial. Since the project began in October 2017, we have documented 6,911 deaths.

- The project aims to document and remember with love every person who dies whilst homeless in the United Kingdom.

- Our annual investigation captures information about people who died in the previous calendar year.

- Our annual report presents our findings and shares ongoing attempts to galvanise action to prevent future losses of life.

- **In 2023, the investigation recorded 1,474 people died whilst homeless in the United Kingdom, that's one person every six hours.**

METHODOLOGY

- The Dying Homeless Project collects information year-round; from an FOI request to every local authority, tributes and memorials from bereaved family members and desktop research examining media reports, coronial inquiries and statutory review processes.

- Our definition of homelessness includes all people who are sleeping rough, living in emergency or temporary accommodation, living in short-term supported housing, sofa surfing or squatting.

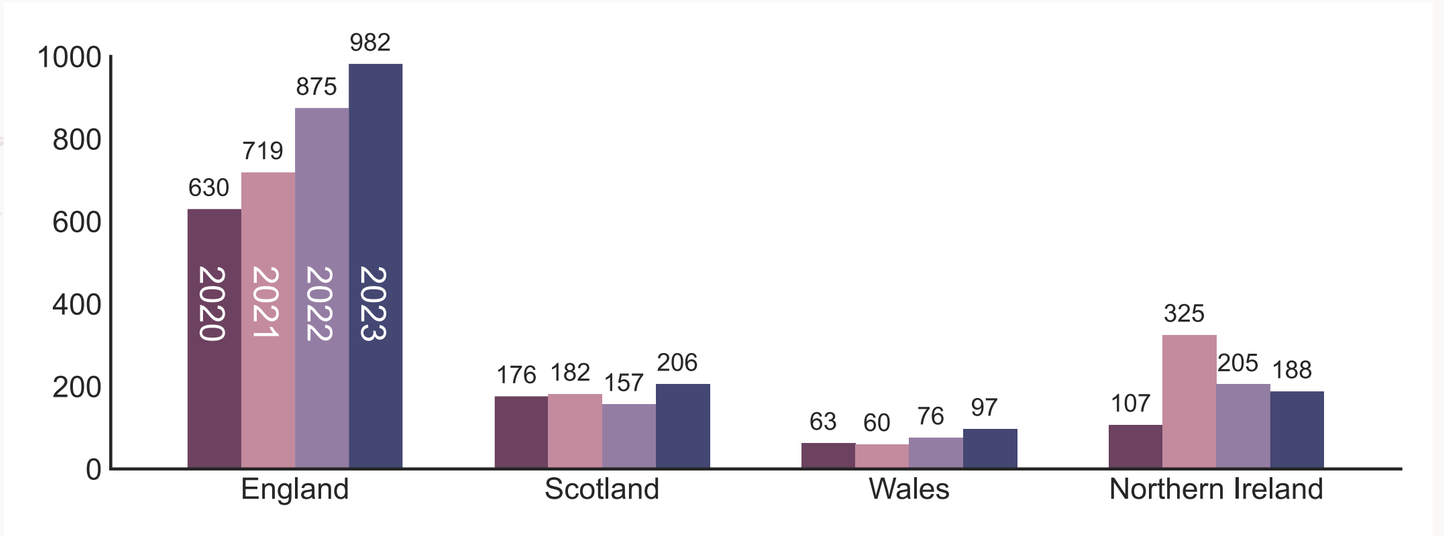
- Unlike official statistics, our investigation counts actual deaths and does not make estimates or projections.

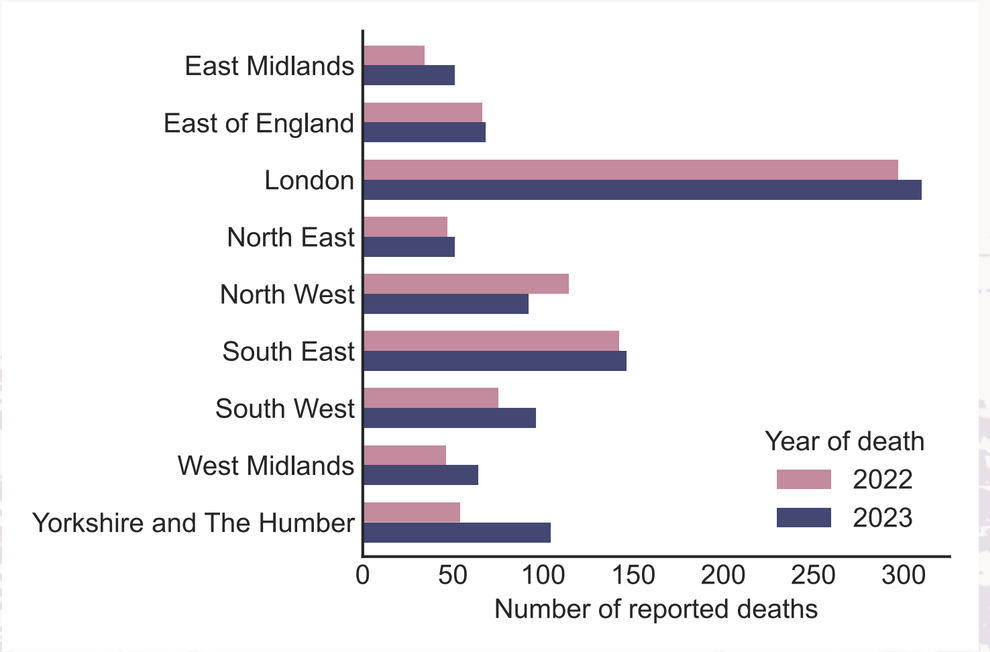
- We have a rigorous de-duplication process to ensure we don't double count someone we were told about by more than one source.

- We worked with Farrer and Co LLP to develop a legal and ethical framework for that reflects data protection law and ethical considerations about privacy.

SUMMARY FINDINGS

- In 2023, there were at least 1,474 deaths of people experiencing homelessness.
- We documented a 12.2% increase in the total number of deaths compared with 2022. The increase was highest in Wales.
- We documented a 42% increase in the number of people who died whilst rough sleeping.
- London had the highest number of deaths (309) while the North East had the equal fewest (51) although when adjusting for population the North East has the second highest rate of deaths.
- The region with the most significant change was Yorkshire and the Humber, with a 93% increase in the number of people dying.

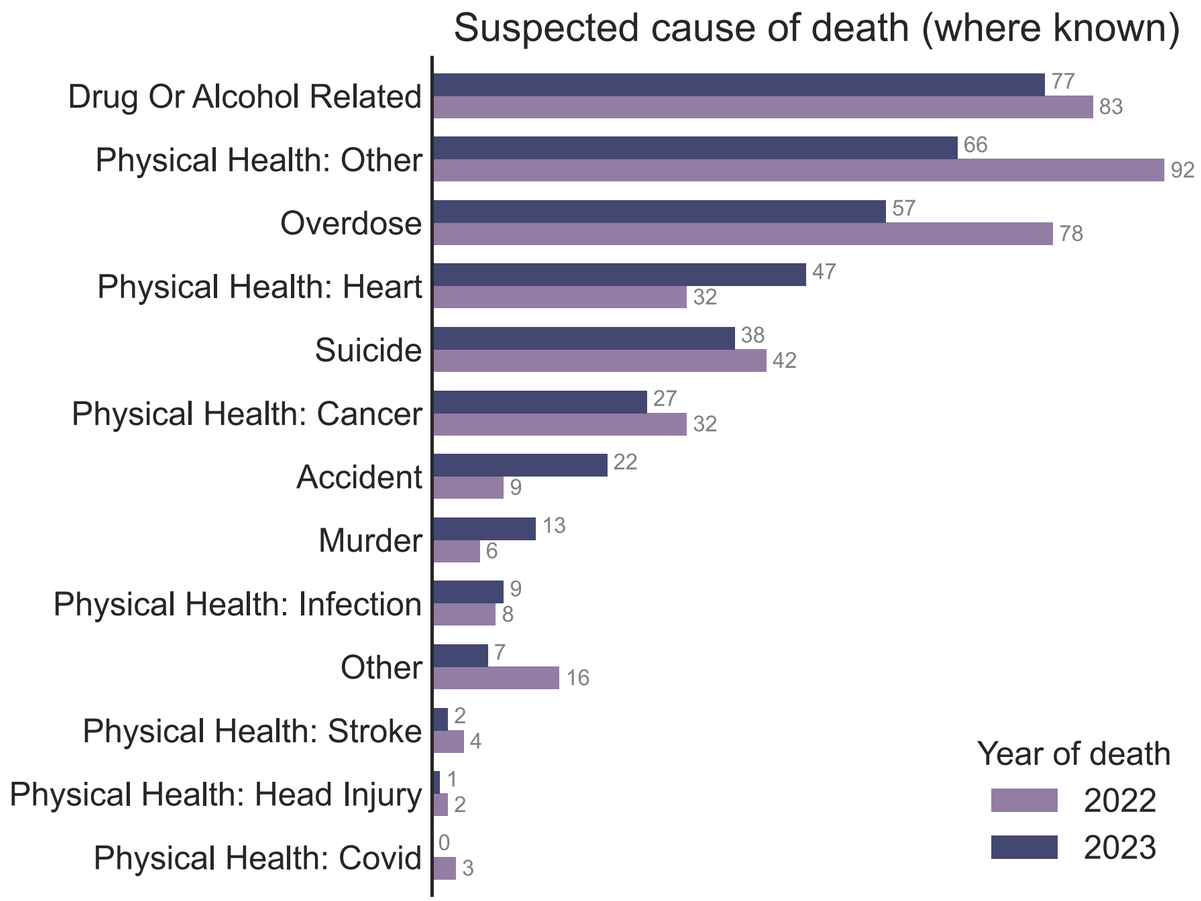




DEMOGRAPHICS

- Our findings do not align with the ONS data on average age at death or gender.
- Our investigation indicates the average age at death is older in England than the rest of the UK.
- There are significant differences in age at death between nations, with people in Wales dying several years younger than other UK countries.
- Women made up 26% of deaths reported to us, much higher than ONS data (12.7%). Women appear to be more likely to die by suicide, and men by accidents, cardiac causes, and cancer.
- The reliability and quality of data related to trans and non-binary folk and Global Majority people is inadequate to draw conclusions. This is an area of priority for this years study (2024/25).
- What we can learn about people is limited by the constraints of FOI law

Age at Death by Country		
	Male	**Female**
England	49	47
Scotland	43	43
Wales	43	39
Northern Ireland	60	60



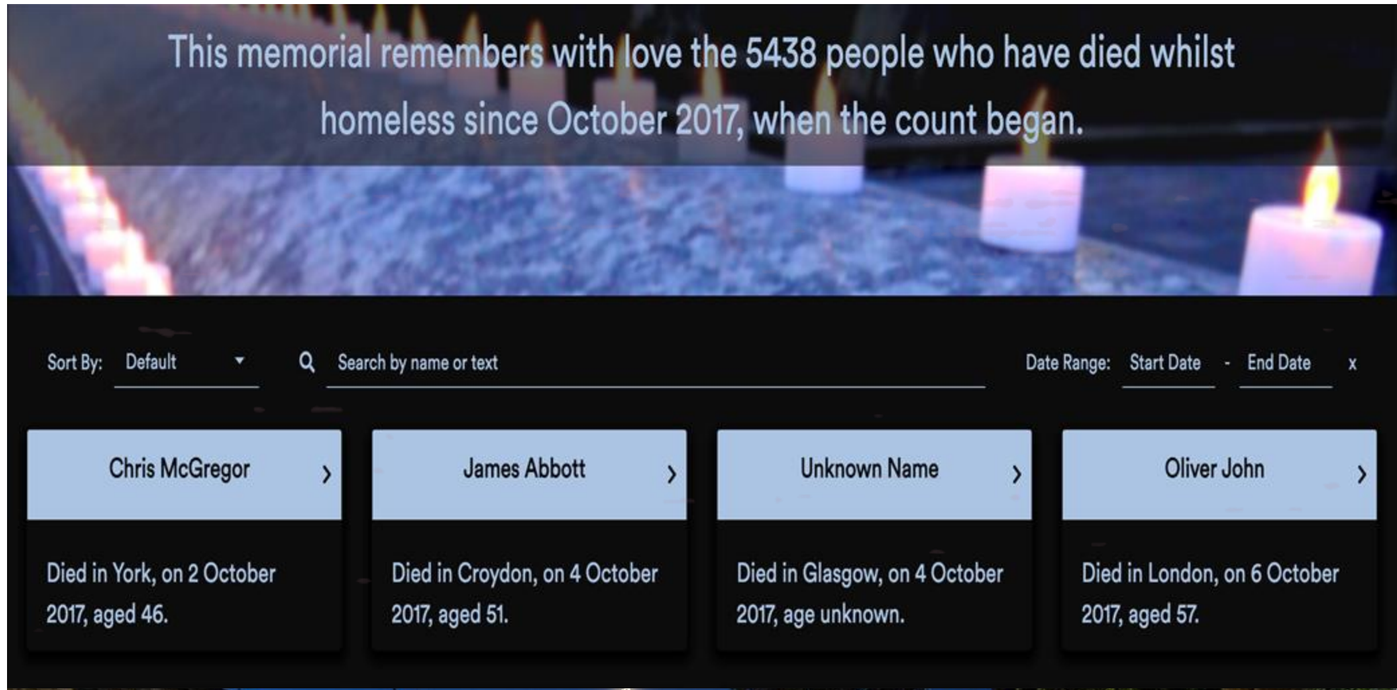
- We have cause of death data for 25% of people.
- Drug and alcohol related deaths (including overdose) make up 37% of all deaths where we know the cause.
- Overdose deaths have increased by 37% since 2022.
- Cardiac-related deaths appear to have increased by 47% since 2022.
- 38 people died by suicide, whilst homeless, in 2023. Their average age at death was 30 years old (women) and 36 years old (men).
- The number of people who were murdered whilst homeless has doubled since 2022.

PEOPLE WHO EXPERIENCE HOMELESSNESS ARE AT LEAST THREE TIMES MORE LIKELY TO BE MURDERED

CAUSE OF DEATH

REMEMBRANCE & MEMORIAL

- The project hosts a digital memorial and an annual vigil outside Downing Street
- Every person counted is remembered, even if their name is unknown
- A memorial garden is being designed called the ‘Sacred Space’.
- We work with organisations across the UK to reflect on and learn from unjust deaths in our communities
- We are currently working with other projects across Europe to remember people and to highlight the parallels and connections between nations.

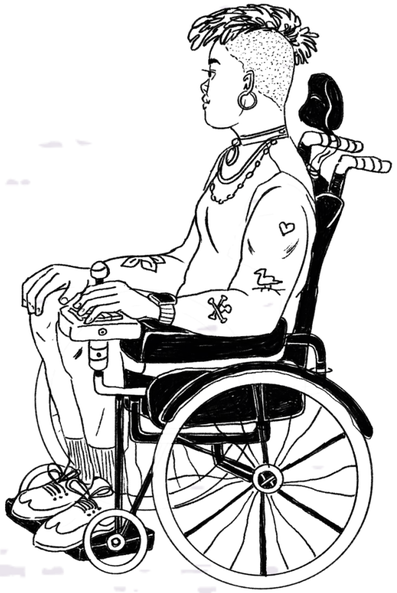


PROMISING PRACTICE

2023

‘A SAFE PLACE TO RECOVER FOR ALL’ CAMPAIGN

Pathway UK, the leading voice on homeless and inclusion health have initiated a powerful campaign to end discharging people from hospital to the streets. Their creative campaign includes in-depth research about out-of hospital care support and a co-produced installation depicting the realities of unsafe discharge. They’ve taken the installation on a roadshow, hoping to draw the attention of policymakers and politicians to this life-threatening issue.



EXETER PARTNERSHIP RESPONSE TO PREVENTING DEATHS

A grassroots, voluntary and public sector coalition in Exeter is taking a holistic approach to homeless deaths, which could be a model for other areas. The city holds a powerful annual memorial service, led by St Petrocks, as well as a prevention partnership between agencies and policymakers who come together to improve data and to learn from deaths. In 2024, the coalition are exploring how public health and NHS data can be better utilised to ensure every death is known about and counted.

THE UK’S FIRST SANCTIONED OVERDOSE PREVENTION CENTRE

Following the hugely important work of Peter Krykant, who delivered an unsanctioned safe injecting service in Glasgow for 10 months, the city has opened the UK’s first sanctioned overdose prevention service, The Thistle. Overdose Prevention Centres provide support and supervision to people who use intravenous drugs and evidence from Peter’s pilot project shows that it saves lives. We hope to see more OPC’s opening in the years to come.

MEMORIAL EVENTS

There are a growing number of memorial events taking place across the country to remember those who died whilst homeless, including in Brighton, Bristol, Exeter, London, Salford and Southampton. These events are an important mark of respect and we are pleased to see more events being planned each year.

2nd NATIONAL SAR ANALYSIS

- First National SAR Analysis concluded in 2020 (2017-2019)
  - 231 SARs in the sample
- Second National SAR Analysis concluded in March 2024 (2019 – 2023)
  - All 136 Safeguarding Adults Boards responded
  - 652 SARs in the sample (+ 23 unpublished reviews)
  - A team of 6 readers completed an analysis of every single SAR
  - Analysis and recommendations were written by Prof Michael Preston-Shoot and Prof Suzy Braye

SUMMARY FINDINGS - homelessness

- There has been a small rise in the number of SARs featuring homelessness, to 13%
- There has been a significant rise in the number of SARs related to drug and alcohol dependence - now accounting for 33% of all SARs commissioned
- Self-neglect is the most common form of abuse and neglect (60% of all reviews, up from 45%)
- There is an overall lack of attention to intersectionality and protected characteristics as described by Equality Act (2010)
- The shortage of all forms of accommodation, and issues with the availability and suitability of specialist support were a frequent feature in SARs about people experiencing homelessness.
- Some SARs positively referenced what was achieved through 'Everyone In'. However, SARs also record the impact of the rolling back of accommodation and integrated ways of working developed during that time.
- Many SARs spoke about the positive direct practice from practitioners and teams, especially around person-centred approaches, recognising abuse & neglect and attempts to communicate and share information across boundaries.

CRITIQUE OF NATIONAL CONTEXT

Covid-19 pandemic	22%
National economic context	8%
Legal powers and duties	7%
National health and social care policy	5%
National commissioning strategy	3%
Statutory guidance on safeguarding	2%
Immigration policy	<1%
Regulation of services	<1%

- 229 SARs highlighted the negative local impact of the national context
- Although Covid had largely positive outcomes for people experiencing homelessness, it severely limited the care others received
- The national economic context was noted as having an impact on the availability of specialist services, of housing and on people's ability to protect themselves
- More could be done in SARs to highlight how national policy and financial decision-making impact the quality and availability of support

TWO (OF MANY) IMPROVEMENT PRIORITIES RECOMMENDED

- [The Westminster government] should convene a whole system summit to begin to develop and resource services that will meet the needs of people experiencing multiple exclusion homelessness. **The lessons learned through "Everyone In" are in danger of being lost.**

- Recommendations in SARs demonstrate that practice development and service improvement require corresponding changes at all levels, a whole system response. **Without a whole system response, including from government departments, recommendations run the risk of being simplistic and repetitive.**

Understanding Local Deaths

- In 2024, National Records Scotland published their annual findings about homeless deaths. They found that 242 people died whilst homeless in Scotland in 2023[1].
- 41% of deaths were considered to be related to 'drug misuse'
- 79% of deaths recorded were of men, 21% were women.
- Half of all deaths affected people under the age of 45.

- There have been a number of high-profile homeless deaths in Scotland in recent years, with particular media attention on those occurring in B&B placements in Glasgow[2].
- Public Health Scotland conducted analysis into the health inequalities affecting people experiencing homelessness in Scotland in 2018[3], establishing a number of priorities for improvement.
- Learning Reviews provide a rich learning opportunity but there appears to be a gap in the commissioning of learning reviews for adults who experience 'multiple exclusion homelessness'[4].

Taking Action to Improve Policy and Practice

- Whole Systems Approach
- Everyone can take action
- Further Reading

THE CASE FOR CHANGE: MORE THAN INDIVIDUAL TRAGEDIES

31% of displaced people are living with PTSD symptoms[1]

At least 1474 people died whilst homeless in the UK in 2023[2]

GRT communities are up to seven times more likely to die by suicide[3]

Living in Temp Accom was a factor in at least 55 child deaths (19-23)[4]

Every year, 48 people die within two weeks of leaving prison[5]

Care leavers are four times more likely to suffer poor health in adulthood[6]

Sex workers are 20 times more likely to experience mental ill-health[7]

Homeless adults in their 40's exhibit frailty scores similar to people in their 80's[8]

At least 60% of homeless women have experienced domestic abuse[9]

Up to 94% of adults who are homeless have experienced trauma[10]

Stigma contributes to poor health outcomes for all conditions and populations

60% of people given short custodial sentences have substance use needs[11]

A WHOLE SYSTEMS APPROACH

- Good frontline practice is legally literate, curious, non-judgemental and person-centred.
- Organisations have to support their staff to do this by providing good training, supervision and physical environments.
- Agencies must work together, and create partnerships where staff can work creatively and flexibly.
- APC's must ensure they are collecting the right data, setting strong strategic priorities and improving needs data about homelessness in their communities.
- Law and policy needs to enable all of this to happen equitably.

EVERYONE CAN TAKE ACTION - Practitioners

- Improve your **legal literacy**
- **Reflect** on your biases; how do your own experiences influence how you see, listen to and respond to others?
- Read everything you can about **self-neglect** & homelessness
- Start a **Community of Practice** or reflective space
- Download and read the ***Radical Safeguarding Toolkit – Homelessness***
- **Pay tribute** to someone on the Dying Homeless Project digital memorial
- **Join** the *National Peer Network For Rough Sleeping Social Workers*
- **Challenge** stigma and prejudice wherever you find it
- If you've got an idea to reduce risk, **share it** with others!

EVERYONE CAN TAKE ACTION - Managers

- Ensure relevant **training** is available to social work staff
- Prioritise 1:1 and group **supervision**
- Safe & welcoming working environments
- **Give permission** for staff to be creative, including a small budget to enable this
- Ensure **policies encourage relationship-building** with service users and with other teams/agencies
- Build good relationships with other team managers to help resolve professional differences
- Enable **peer learning**
- Develop Hospital & Prison **Discharge Protocols**
- Ensure relevant teams understand how to **make a referral for a Learning Review**

EVERYONE CAN TAKE ACTION – Leadership/Governance

- Collect & monitor **data** about harm affecting people who are homeless
- Identify a Homelessness Lead on the APC
- **Commission learning reviews** where homelessness is a feature
- Highlight the national and systemic context of practice gaps
- **Prioritise the learning** to implement changes that will have the greatest impact
- Strengthen/develop risk escalation pathways, especially where professional differences are a challenge (e.g. mental capacity)
- Build adult protection into integrated homelessness commissioning e.g. in service specs, co-location
- Build a focus on homelessness into **Alcohol and Drugs Partnerships, VAWG & Suicide Prevention** strategies

Q&A

- Has anything in this presentation been surprising to you?
- How does the learning shared reflect the challenges and opportunities you experience?
- What opportunities can you see to strengthen the connection between adult protection and homelessness?

Thank You

If you'd like to stay in touch, follow me on Linkedin or e-mail me:
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PRACTICE RESOURCES

- Dying Homeless Project, Museum of Homelessness: https://museumofhomelessness.org/dhp
- Radical Safeguarding Toolkit – Homelessness: https://www.researchinpractice.org.uk/adults/content-pages/open-access-resources/radical-safeguarding-toolkit-for-homelessness/
- Multiple Exclusion Homelessness Toolkit: https://www.kcl.ac.uk/hscwru/assets/news/2023/nov/safeguarding-multiple-exclusion-homelessness-toolkit-2023.pdf
- LNNM Self-Neglect Guidance: https://homelesshealthnetwork.net/wp-content/uploads/2023/07/Self-neglect-guidance-July-2023.pdf
- Little Green Book, Edinburgh Rape Crisis: https://www.ercc.scot/information/little-green-book/
- Deep Dive Episode 5, Museum of Homelessness: https://open.spotify.com/episode/3kApL53KGYjTWvxiSzMiaW?

POLICY RESOURCES

- National SAR Library: https://nationalnetwork.org.uk/search.html
- 2nd National Analysis of SARs: https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023
- Local Govt Association briefings: https://www.local.gov.uk/publications/adult-safeguarding-and-homelessness-briefing-positive-practice and https://www.local.gov.uk/publications/adult-safeguarding-and-homelessness-experience-informed-practice
- NICE Guideline 214: https://www.nice.org.uk/guidance/ng214
- Pathway Policy Papers for Inclusion Health: https://www.pathway.org.uk/resources/pathway-policy-papers/
- Framework for NHS Action on Inclusion Health, NHS England: https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/
- National Peer Network for Rough Sleeping Social Workers: https://www.kcl.ac.uk/research/a-national-peer-network-for-social-workers-specialising-in-homelessness-and-rough-sleeping