STRICTLY CONFIDENTIAL

REPORT OF THE SAFEGUARDING ADULTS REVIEW

REGARDING CHRISTOPHER

CONTENTS

1	INTRODUCTION	P 3
1.1	Background to the SAR	P 3
1.2	The Terms of Reference	P 3
1.3	SAR process	P 3
1.4	Parallel processes	P 4
1.5	Family input to the SAR	P 4
2	SUMMARY OF FACTS	P 4
2.1	Background history	P 4
2.2	Christopher living in YMCA March 2015 – May 2016	P 5
2.3	Christopher homeless and moving around May 2016 – October 2016	P 7
2.4	Christopher living in Newhaven July 2016 – February 2017	P 8
2.5	Christopher returns to Brighton February 2017 – March 2017	P 10
3	ANALYSIS	P 11
4	LESSONS LEARNED	P 18
5	CONCLUSIONS	P 22
6	SAB RECOMMENDATIONS	P 23
Appendix 1	Terms of Reference	P 24
Appendix 2	Glossary of Terms & Abbreviations	P 26
Appendix 3:	Bibliography	P 27

1 INTRODUCTION

1.1 Background to the SAR

1.1.1 This Safeguarding Adults Review (SAR) concerns the death of Christopher, a 39-year old man with a history of anxiety, learning disability and substance misuse. At the time of his death he was living in temporary accommodation and was receiving support from seven local services. He was found dead at his home address on 16th March 2017, he was last known to have been alive in the early hours of the 5th March 2017. The cause of death was heroin toxicity. A referral for a SAR was subsequently made to the SAB in July 2018 and the SAB decided to undertake a SAR on the 24th September 2018. This decision was made as it was considered that the statutory criteria that had been met; namely that an adult had died as a result of abuse or neglect, whether known or suspected, and there was concern that partner agencies could have worked together more effectively to protect the adult.

1.1.2 The review was started in 2019 and an initial report was received in February 2020. The SAB considered this report needed to be summarised in order for learning to be effectively disseminated and the current author was commissioned, in June 2020, to provide a more succinct report.

1.2 The Terms of Reference

1.2.1 The specific terms of reference are attached as appendix 1.

1.2.2 The time frame of the SAR was from 1st March 2015 until the 16th March 2017, Agencies were also asked to report on any significant information prior to 2015.

1.3 SAR process

1.3.1 The report has three main sections: a) 'Summary of facts', a description of the services provided to Christopher explaining how agencies worked together to support him; b) 'Analysis', an appraisal of the practice with, where possible, an explanation of factors that helped or hindered effective service delivery; and c) 'Lessons learned', the ways in which this specific case highlights findings about the safeguarding system as a whole. This is followed by conclusions and recommendations. This report is an analysis of the draft report prepared by the previous Lead Reviewer and a review of documents provided by agencies involved with Christopher. The report author has had no direct contact with any of the front-line staff who worked with Christopher which significantly reduces the possibility of identifying factors that affected practice at the time. Where possible this limitation has been addressed by discussions with members of the Review team (senior managers from the relevant services) who were able to describe usual practice then and now. Another factor that is relevant is that the services were provided to Christopher five years ago and current practice may have changed. In reviewing practice this is acknowledged and where changes have occurred this is acknowledged.

1.3.2 The following agencies contributed to the review and made up the Review Team:-

- Brighton & Hove Adult Social Care Access Point Team
- Brighton & Hove Community Learning Disability Team
- Brighton & Hove CCG
- Brighton & Hove Housing Department
- Sussex Partnership NHS Foundation Trust
- Sussex Police

Information was also received from: Brighton Housing Trust (Fulfilling Lives and First Base), YMCA, Brighton and Sussex University Hospitals NHS Trust, Community Safety Casework Team (CSCT), BHCC, Money Advice Plus, Surrey, and Borders Partnership NHS Foundation Trust (Pavilions Drug and Alcohol Services).

1.3.3 The Lead Reviewer was Fiona Johnson, an independent social work consultant who was Head of Children's Safeguards & Quality Assurance in East Sussex County Council between 2004 and 2010. Fiona qualified as a social worker in 1982 and has been a senior manager in Children's and Adults services since 1997, contributing to the development of strategy and operational services with a focus on safeguarding. She is independent of Brighton & Hove SAB and its partner agencies.

1.4 Parallel Processes

1.4.1 There were no parallel processes as the police criminal investigation and the coronial process were completed prior to the start of the review.

1.5 Family Input to the SAR

1.5.1 Initially it was decided that that, as no agency had contact with his family during his life, and it was thought that Christopher also had no contact, this was not necessary. During the review however it became apparent that Christopher had been in contact with his mother, so it was decided to advise her that the review was taking place and offer her the opportunity to contribute. Letters were sent to Christopher's mother explaining about the review and inviting her to participate but no response was received.

2 SUMMARY OF FACTS – description of the support provided to Christopher

2.1 Background history

2.1.1 Christopher had a turbulent early life and presented in quite a chaotic manner. Christopher reported having learning difficulties at school and being designated as having 'special needs.' Christopher also said that he had a brain injury because of an early bike accident aged 12 years old, where he fractured his jaw. Christopher said his

father was dead and that his mother lived in London but had her own needs so could not care for him. He also said he had a sister who lived abroad.[1]

2.1.2 In his late teens he had a criminal history of shoplifting and drunk and disorderly offences. In adult life Christopher had a history of alcohol and substance misuse. Between August 2009 and March 2015 there were eighteen crimes recorded involving Christopher as a victim, four where he was a suspect, and thirteen where he had some other form of involvement. He was the suspect in two rape allegations and one sexual assault however none of these investigations resulted in charges. Christopher also reported to professionals that he was a victim of rape and in 2014 asked for trauma counselling regarding historic incidents.

2.1.3 Between 2000 and 2009 Christopher was effectively homeless. In 2009 he was detained by the Police under Section 136 of the Mental Health Act 1983 because members of the public described him running 'in and out of traffic' and 'threatening to jump out of a tree'. Following an assessment by a psychiatrist he was released without further intervention as he was not considered to be mentally ill. In March 2010, Christopher was referred to the Mental Health Homeless Team and was assessed as suffering from anxiety which was related to his social situation. In March 2012, Christopher was seen by the Psychiatric Liaison team after claiming to have 'ingested glass following a fall on a bottle when drunk'. At the time there was no evidence of a mental disorder, or suicidal ideation.

2.1.4 In July 2014 Christopher had a cognitive assessment which concluded that his 'Full Scale IQ' was within the 'Extremely Low' range of intellectual functioning. This also identified that there was some significant discrepancy between his 'Verbal Comprehension' which was 'Low Average' and his 'Processing Speed' which was 'Extremely Low'. There was concern that he may have some recent cognitive deterioration and that his history of drug and alcohol use, and/ or traumatic brain injury have either separately or in combination caused some cognitive deterioration.

2.1.5 By 2014 Christopher had tested positive for Hepatitis C probably because of sharing needles when abusing substances. From this point forward Christopher periodically attempted to access treatments for the condition and cited it as a reason for him wanting to cease substance misuse.

2.2 Christopher living in YMCA January 2015 – May 2016

2.2.1 From 2014 onwards Christopher lived in a supported accommodation placement in Hove, run by the YMCA. He had a studio flat and a key worker who assisted him with paperwork and emotional support for two hours a week. At this time Christopher was also assisted by Fulfilling Lives, an organisation that works with services users with multiple and complex needs who have a dual diagnosis of either mental health, substance misuse or risk of homelessness and struggle to engage with services.

[1] It is now known that Christopher's mother lives in Lincolnshire and his sister has returned to the UK>

2.2.2 In January 2015 a safeguarding referral was received by the Mental Health Services after Christopher was the alleged victim of assault. There were follow up discussions between a Mental Health Social Worker and the YMCA manager where concerns of exploitation were raised. Christopher asked for more help managing visitors as there was a female dependent drinker visiting and some concerns of financial exploitation was raised by the YMCA manager. The notes identified that the YMCA manager was to gather further information and to make a safeguarding referral if it was felt that significant harm had occurred. There was no further safeguarding actions identified.

2.2.3 On the 2nd March 2015 the YMCA reported to the police that Christopher was being harassed at his place of residence and was being targeted for his benefits money by another resident at the YMCA accommodation. The same person was said to be 'pushing Heroin on Christopher' and helping him to inject. All the residents involved were too scared to talk to the Police; the suspect was arrested but there was insufficient evidence to prosecute. The Police sent a SCARF[2] to Adult Social Care (ASC) who passed it to West Recovery (MH Services). There was also communication with the staff at the YMCA who were advised to make a safeguarding referral if they felt it was necessary. Christopher contacted the police on seven occasions during March 2015 repeating similar allegations. The Police response was to talk with Christopher's support worker at Hove YMCA and agree an informal response including referring Christopher to the Learning Disability Service for additional support. No further enquiries into the allegations were made and no formal safeguarding enquiries under Section 42 of the Care Act were made.

2.2.4 While Christopher was living at the YMCA hostel he made regular and frequent allegations about theft and that he was being targeted and abused by staff and residents at the accommodation. Most of these allegations were responded to by a police community support worker (PCSW) who made numerous visits to the hostel to liaise with the support workers and to use the support workers as appropriate adults to assist with understanding Christopher when he contacted the police. The visits however were not coordinated, and SCARFs were not submitted, which may have resulted in the correct agencies not being involved.

2.2.5 On the 2nd August 2015 Christopher was arrested for the crime of harassment of a person in their home. The victim was Christopher's ex-partner. There were difficulties in establishing credible evidence. The Police completed a risk assessment and a vulnerable adult at risk (VAAR) form for the victim. This was one of several allegations of sexual assault by Christopher, none of which proceeded to charges. All those who made allegations of sexual assault against Christopher stated that they had had consensual sexual activity before and after the occasions that they alleged were non-consensual.

[2] SCARF - a Single Combined Assessment of Risk Form

2.2.6 From October 2015 Christopher was supported by the Brighton & Hove Community Learning Disability Team (CLDT) following a referral from Hove YMCA who felt he needed additional help. Initially, Christopher was offered both psychological and social care support, but he did not engage and was closed to CLDT psychology in December 2015. As Christopher was being supported by the YMCA it was not felt that he required key worker support but in March 2016 he was referred for an Occupational Therapy assessment. This was not progressed as Christopher left his accommodation in May 2016 and the therapist did not think it was appropriate to continue the assessment until he was in more stable accommodation.

2.2.7 On the 14th November 2015 Christopher reported to his Fulfilling Lives worker that he had been given notice to quit from his accommodation for anti-social behaviour and aggression. A behaviour contract had been drawn up and, if he complied, the notice would be lifted. The issue involved an alleged sexual assault of another resident resulting in a physical fight between them (The incident occurred on the 8th November 2015). The same day Christopher contacted the Police to say that the Trust had taken his money and that other people within his place of residence had bullied him. On the 16th November 2015, a female contacted the Police saying that her friend (Christopher) was having a turn and threatening people in a hostel, she reported that she had locked herself in her room and that he was shouting and swearing. Police attended to find Christopher unwell and appearing to be having a seizure. He went to hospital voluntarily. No SCARF was submitted at this time.

2.2.8 On the 15th January 2016 a three-way meeting took place between the Fulfilling Lives worker, the YMCA hostel worker and Christopher. A further incident had been reported involving Christopher being in a female resident's room breaking his agreed conditions. The meeting decided that Christopher should be given a conditional notice to quit which could be rescinded if he co-operated with the rules.

2.2.9 On the 29th March 2016 a multi-agency meeting was held by Fulfilling Lives. The plan was to provide Christopher with contact details for a counselling service, to consider a move to a smaller house when a vacancy arises, further assessment and support from the Occupational Therapist and Learning Disability Team.

2.2.10 By April 2016 Christopher was unhappy about living in the YMCA accommodation as he felt it was too big, with too many people and too dirty. In May 2016 there was another meeting between the YMCA, Christopher, CLDT, Fulfilling Lives and Speakout Advocacy to discuss his concerns. Christopher was offered a room in another smaller YMCA house in Hove that would give him an opportunity to live in an environment that was quieter and but still receive support from the YMCA. Initially Christopher was happy about this development, however when he went to see the room, he was unhappy as he thought the house to be untidy and dirty. As a result, Christopher decided to leave the YMCA and moved to accommodation at a back-packers hostel in Brighton.

2.3 Christopher homeless and moving around May 2016 – July 2016

2.3.1 During May and June 2016 Christopher was effectively homeless, visiting his mother in Lincolnshire, occasionally staying in hostels, and sometimes sleeping rough. He continued to have regular contact with the police and on occasions reported that he had been the victim of theft. Attempts were made by the police to investigate these allegations, but they were hampered by Christopher being very confused as to dates of events and often withdrawing his allegations. Christopher also accessed services for street homeless people, and he was involved in activities at the First Base drop-in centre on eleven occasions between and the 7th May 2015 and the 13th July 2016.

2.3.2 During this period Fulfilling Lives continued to work closely with Christopher and encouraged him to get support from Pavilion Substance Misuse Services. On 1st July 2016, Christopher was offered a room in a temporary housing accommodation in Grand Parade but on the 19th July 2016 he was asked to leave the hostel as there was drug paraphernalia found in his room. Christopher then moved to temporary accommodation provided by Brighton and Hove Council in Newhaven, where he resided until 9th February 2017.

2.4 Christopher living in Newhaven July 2016 – February 2017

2.4.1 When Christopher was in Newhaven from July 2016 - February 2017, he continued to be supported by Fulfilling Lives. In addition, he received assistance from Homeworks, around housing related issues and attended a drop-in service provided by Together UK, a mental health charity.

2.4.2 Fulfilling Lives continued to support Christopher to access the Pavilions substance misuse services. The focus of their work was on harm minimisation. This included getting support to get a naloxone pen[3] to reduce the risk should he overdose which was issued to Christopher during July – August 2016.

2.4.3 In October 2016 Christopher broke his wrist and needed additional support, it is unclear how this injury occurred. Regular multi-agency meetings were held to support Christopher in attaining an appropriate house and support, finances, safety and risk issues, emotional support, and available services.

2.4.4 On the 30th November 2016 Christopher told his Fulfilling Lives worker that he had been socialising with a female who was financially exploiting him. Christopher did not want police involvement. Christopher's Fulfilling Lives worker liaised with Mental Health services and the Occupational Therapist to get him access to Cognitive Behavioural Therapy and other therapeutic interventions. By December 2016,

[3] Naloxone is a medication designed to rapidly reverse opioid overdose. It is an opioid antagonist—meaning that it binds to opioid receptors and can reverse and block the effects of other opioids. It can very quickly restore normal respiration to a person whose breathing has slowed or stopped as a result of overdosing with heroin or prescription opioid pain medications. https://www.drugabuse.gov/drug-topics/opioids/opioid-overdose-reversal-naloxone-narcan-evzio

Christopher had moved into a new temporary hostel stating that there had been an electricity issue at his accommodation.

24.5 In December 2016 Christopher requested cognitive behavioural therapy from his GP who referred him to Learning Disability services for Social Work support. A statement from the GP identified that Christopher attended the surgery with another patient who was known to fraudulently obtain drugs, so Christopher's prescription was cancelled. The GP considered that the danger of drug overdose for Christopher was considered high because his drug use was intermittent so he had not built up resilience to drugs and if he took a large quantity of drugs then his body may not have the tolerance necessary to manage the amount of toxic substance.

2.4.6 While in Newhaven, Christopher was seen twice by an Occupational Therapist from the East Sussex East Sussex Learning disability team; on 30.11.16, for an initial assessment), and on 18.01.17, for an Assessment of Motor and Process Skills (AMPS) assessment[4]. In these meetings Christopher expressed that he wished for more permanent accommodation as then he would be able to commence Hep C treatment. He stated that his current accommodation was near to people who may tempt him into taking drugs and shared that he attended Narcotics Anonymous in Hove. He also requested access to psychological therapies and said that he had been prescribed anti-depressants by his GP, but he had thrown them away. The AMPS assessment concluded that Christopher would need to live in an environment with 'defined practical support' and that he would benefit from a financial capacity assessment. This OT involvement ceased when Christopher moved back to live in Brighton in February 2017.

2.4.7 The Money Advice Service in Brighton had throughout the review period assisted Christopher with financial matters. From January 2017 they became concerned that he was unable to manage his money and needed an appointee to deal with benefits claims and support with budgeting. As Christopher had declined a money handling service they were liaising with his social worker in CLDT about a capacity assessment to see if the support should be provided anyway in his best interests. The social worker told them in February 2017 that he had changed his mind and had agreed to a full referral to the service to access their support. This was received in March 2017 and they were attempting to organise an initial appointment, at the time of his death.

2.4.8 Whilst Christopher was living in Newhaven he continued to have regular contact with the Police and regularly reported incidents. Most of these were low level offences and Christopher was often not sober when he contacted the police. None of these contacts resulted in charges and most were not reported to Christopher's social worker. The exception to this was an allegation made in December 2016 when Christopher was arrested as a suspect in a rape allegation. This matter was fully investigated but not

[4] The Assessment of Motor and Process Skills (AMPS) is an innovative observational assessment that is used to measure the quality of a person's activities of daily living (ADL) https://www.rcot.co.uk/sites/default/files/AMPS%20application%20form%20-%20May%202017.pdf

progressed because the victim refused to support the police action. It was apparent from the investigation that there had been consensual intercourse at the time of the alleged offence and furthermore both the victim and Christopher had used substances and were not compos mentis. In January 2017 Christopher's worker from the Together for Mental Health service reported to the Fulfilling Lives worker that Christopher is in 'free fall' regarding his mental ill health and anxiety following the rape allegation. It was identified that the person that Christopher was alleged to have raped was the female who had been financially exploiting him.

2.5 Christopher's return to Brighton February 2017 – March 2017

2.5.1 The placement in Newhaven was emergency accommodation and Christopher wanted to move back to Brighton and to live independently. He moved to more settled accommodation in Brighton, sourced by Brighton and Hove Council, on the 9th February 2017. This accommodation was sourced from the temporary accommodation team and the intention was that if the tenancy went well, Christopher would live there up to five years. There were difficulties with the placement from the start, as the Temporary Accommodation team considered that Christopher was not managing his tenancy well and that supported accommodation was required. When Christopher returned to Brighton in February 2017 the plan was for him to receive 4 hours of support per week from Grace Eyre, an organisation that provides outreach support to Learning Disability service users in the city. Support was intended to start at the beginning of March 2017 but was not in place at the time of his death.

2.5.2 On 17th February 2017 Christopher attended the Pavilions Substance Misuse Service with his Fulfilling Lives support worker. He was substance affected and asked for a Naloxone pen – one was issued. The service were aware that Christopher's drug tolerance level may have been lower than he thought, leading to a higher risk of overdose. This risk was discussed with him and the Fulfilling Lives support worker before he was given the Naloxone pen. Christopher attended Pavilions Substance Misuse Service again on 23rd February 2017 and reported large amounts of heroin and crack use in a binge pattern and that he was smoking cannabis regularly and drinking alcohol three times a week. He said however that there was no intravenous use and he tested negative for all substances. Christopher's next appointment was booked for 28th February however he did not attend this or a subsequent appointment on 2nd March. On 7th March 2017, the Fulfilling Lives worker advised the service that 'he no longer wished to engage with Pavilions and to cancel the medical assessment'. It is probable that at this point Christopher was dead from an overdose of heroin taken at some point after the 5th March 2017.

3 ANALYSIS - appraisal of practice against terms of reference with factors that helped or hindered effective service delivery

3.1 Was support appropriate and co-ordinated between relevant agencies including the adequacy of collaboration and communication between agencies? Were safeguarding duties under the Care Act 2014 appropriately considered and documented in this case?

3.1.1 Whilst professionals provided significant levels of support for Christopher and much time was spent on assisting him with services there was limited evidence of professionals considering or undertaking safeguarding duties under the Care Act 2014. There were no formal enquiries or assessments made by any agency that were formally defined as safeguarding. There were also no multi-agency meetings or strategy discussions held during this time. This was despite 13 SCARFs being passed by the Police to professionals in the Local Authority which related to incidents of violence against, or exploitation of, Christopher. During the review period the police created 116 incident logs relating to Christopher, from these there were 20 crimes recorded where he was recorded as the victim and 5 where he was recorded as the suspect.

3.1.2 There was also no evidence of any professional considering whether Christopher was at risk of self-neglect defined as *'The inability (intentional or unintentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well-being of the individual and potentially to their community'.*[5] Throughout the review period there was significant evidence that Christopher was struggling to care for himself effectively and his increasingly chaotic behaviour when stressed had a negative effect on the community within which he was living. This was very evident in both the period when he was living in Hove and then later in Newhaven. It was clear that at both places his behaviour became increasingly problematic for the other residents with whom he was living, and this resulted in him moving in an unplanned way to other accommodation, which was often less secure and more dangerous for him.

3.1.3 The reasons for the absence of safeguarding interventions under the Care Act 2014 are hard to define but probably include several factors. The Access Point Team[6] in Adult Social Care had no direct involvement with Christopher and when they received SCARFs from the Police they appropriately passed them to the other professionals who were working directly with him. Those professionals possibly had less experience of initiating enquiries under the Care Act 2014 and this may have inhibited them from taking this action. The worker who had most direct contact with Christopher was the dual diagnosis worker from Fulfilling Lives. This is a voluntary sector organisation

[5] Sussex Safeguarding Adults Policy and Procedures EDITION 2 • APRIL 2016

[6] Access Point is the main point of contact for Adult Social Care https://new.brighton-hove.gov.uk/adult-social-care/about-adult-social-care/contact-adult-social-care

which would have the least experience of taking a primary role in progressing safeguarding concerns.

3.1.4 The other agency who had very regular and consistent involvement was Sussex Police. When Christopher was living in Hove, most of the police involvement was progressed by a Police Community Support Officer who visited Christopher on numerous occasions and liaised closely with the YMCA staff. Little of her contact was formally followed up with SCARFs and so there was limited communication with ASC or later CLDT. The reasons for this are unclear as the worker is no longer employed by the Police. Another relevant factor however is that much of the police involvement was concerning low level crime and was dealt with on the telephone without further investigation and these matters were not reported to other agencies via SCARFs. This was normal practice at the time if there were no clear lines of investigation which could lead to the recovery of the property or the identification of an offender. Since this time the police have changed and improved their practice with regard to the use of SCARFs. It is now expected that the Vulnerable Adult at Risk (VAAR) section of the SCARF should be completed by an officer or member of police staff for every incident that involves a safeguarding concern relating to a vulnerable adult. This would include matters purely dealt with on the phone. A safeguarding concern is defined as where an adult, who has care and support needs may be experiencing, or is at risk of, abuse or neglect and as a result of their needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect. A further relevant factor is that the nature of policework is that many different individuals undertake the work and it is therefore not possible to identify patterns of interaction or even the level of involvement at the time. However, at no point did any individual event trigger concerns for police officers that indicated a need for an assessment under the Care Act 2014 which may indicate that their thresholds for triggering such a referral are high.

3.1.5 From October 2015 the CLDT were involved with Christopher and they received many of the SCARFs from the Police. Christopher had a learning disability but probably functioned at a significantly higher level than many of the other service users for CLDT which may have affected their response to his behaviour. It is known that Christopher's verbal functioning was better than his processing and reasoning skills which may have masked some of his difficulties and may have meant that the social worker was less responsive to the indicators of self-neglect. It is also apparent that Christopher's behaviour was variable and there were periods when he appeared to be managing which may have further confused the picture. A factor that was never addressed and was a significant safeguarding concern was Christopher's relationships with women. There were repeated allegations made about inappropriate sexual conduct and whilst none of these resulted in charges there was sufficient evidence to indicate concerns about whether Christopher was able to have safe relationships and recognised sexual boundaries in relationships. There is no evidence that any professional addressed these issues with Christopher the reasons for this are not known.

3.1.6 The Fulfilling Lives worker worked extremely hard to involve other agencies in supporting Christopher approaching both substance misuse and mental health services on his behalf. She appeared to be trying to achieve a planned multi-agency response, but without the Local Authority allocating the role of safeguarding enquiry lead (S42 Care Act), it was difficult to get all agencies to become involved in the care planning process. As risks escalated, so did the efforts of the Fulfilling Lives worker and the CLDT Social worker to support Christopher, but there was no safeguarding multi-agency response agreed in one care and support plan across services. There was separate silo working which was not joined up and did not take account of all of Christopher's need. Thus, in March 2017 both Substance Misuse services and Mental Health Services ceased involvement despite Christopher having clear safeguarding needs. The actions of these agencies were logical in the context of their individual service provision but were not effective in terms of Christopher's overall needs.

3.2 How well were professionals equipped to work with clients with a trauma history?

3.2.1 One well-used definition of trauma suggests that *'Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being'.*[7] People who are homeless are more likely to have experienced trauma than the general population. Trauma-informed care (TIC) involves a broad understanding of traumatic stress reactions and common responses to trauma. Services working with people who misuse substances, self-neglect, self-harm, become homeless, hoard, or have other indicators of poor attachment to people and potential trauma in their lives, need to recognise how trauma can affect treatment, presentation, engagement, and the outcome of behavioural health services. A person can be blamed for their substance misuse / homelessness when what they are presenting is coping strategies. The inability to engage fully may also be an indicator of trauma. '*Trauma can affect one's beliefs about the future via loss of hope, limited expectations about life, fear that life will end abruptly or early, or anticipation that normal life events won't occur (e.g., access to education, ability to have a significant and committed relationship, good opportunities for work)'*.[8] Christopher expressed these fears and often contacted services when he believed his life to be in crisis. The priority is to prevent re-traumatisation and to recognise the aspects of care and support that a person who has experienced such trauma might find difficult

3.2.2 There is no evidence that trauma history was considered as a specific factor by the people working with Christopher. He regularly reported to a range of agencies that he had previously experienced traumas including being raped and assaulted. These events were acknowledged and when appropriate investigated but the issue of how and whether this should influence the services he received was not addressed.

[7] https://www.kingsfund.org.uk/blog/2019/11/trauma-informed-care
[8] Trauma Informed Care In Behavioural Health Services https://www.ncbi.nlm.nih.gov/books/NBK207191/

Christopher's coping mechanisms and responses included, substance misuse, homelessness, chaotic presentation, placing demands upon services and regularly presenting to services with allegations of abuse and neglect. Christopher had limited ability to maintain his own safety and well-being but was also fiercely proud and protective of his independence. There is little evidence that professionals understood Christopher's behaviour to be a response to trauma or considered that when deciding how best to provide support. The reasons professionals did not consider trauma as a cause of Christopher's behaviour are unclear however trauma informed practice is an area that requires development in most areas of the country, and this is most likely explanation for this not being explored more fully.

3.3 Were Christopher's particular needs appropriately identified and responded to? How well was Christopher equipped and supported to manage his anxieties?

3.3.1 Christopher found the acceptance of diagnosis difficult when associated with a learning disability or mental ill health and often disengaged with services. Whilst Christopher could appear to be compliant with services and often actively sought support, no agency seemed to have a comprehensive and clear picture of what care and support Christopher needed or wanted. It was often difficult to determine what was reality and what was confabulation[9] in Christopher's life and his manner of communication made it difficult for agencies to fully understand Christopher. Most of the professionals working with Christopher were accepting of his anxieties and accommodated his behaviours. There is evidence that he was often treated with respect and much time was spent in trying to respond to his concerns.

3.3.2 It is probable that Christopher's anxieties related to his past traumas (whether that be the result of the various assaults he reported he had experienced or as likely his experience of long-term homelessness associated with substance misuse). There is evidence that Christopher periodically requested therapeutic services and attempts were made by agencies to respond, he saw a psychologist in 2015 and was on a waiting list for drama therapy in 2017. A difficulty with any therapeutic input was Christopher's capacity to engage and commit to any service for any length of time. It is probable that any therapeutic interventions available would only have been successful if his home environment could have been stabilised and a more secure daily regime established. It is relevant that a psychiatrist in 2017 rejected a request by Christopher for therapy as not being appropriate until he was more settled. Given this was unlikely to be achieved until he had received therapy there is clearly a need for therapeutic treatment services that can be effectively accessed by people such as Christopher when they are in crisis.

[9] **Confabulation** is a symptom of various memory disorders in which made-up stories fill in any gaps in memory. German psychiatrist Karl Bonhoeffer coined the term "**confabulation**" in 1900. He used it to describe when a person gives false answers or answers that sound fantastical or made up. https://www.healthline.com/health/confabulation

3.4 How well were risk and safety plans managed in relation to Christopher's substance misuse? Was risk escalated appropriately?

3.4.1 Christopher was involved with Pavilions Substance Misuse Service for two main periods. The first was from June 2015 to August 2016 when he had intermittent contact with the service. He regularly missed appointments but when challenged about his lack of engagement asked to remain within the programme. He was eventually discharged by mutual agreement from the structured treatment in February 2016 but remained open to Pavilions for post treatment care if he wanted to engage. After his move to Newhaven in July 2016 Christopher seemed to have become more settled and he was seen on three occasions when he was given information about groups, a naloxone pen and risk of overdose was discussed with him. He was discharged from post treatment care at the end of August 2016.

3.4.2 Christopher's second period of involvement with Pavilions Substance Misuse Service was 3 weeks, between 23rd February 2017 and the 6th March 2017. At this time, he reported using heroin, crack cocaine and cannabis in a binge like fashion when spending time with people who also used substances. Christopher presented as nondependent. Upon his self-referral, Christopher was seen for a comprehensive assessment and was given an appointment for a medical assessment on the 6th March 2017 which he did not attend. Christopher had provided a negative Urine Drug Sample, which suggested his tolerance to heroin had lowered. Prior to disengaging from substance misuse services, he had reported not using drugs for nine days and that he was re-engaging with the twelve steps fellowships[10]. A risk assessment was completed on the day of the assessment. The risk rating was assigned as medium for 'Neglect' and high for 'Opiate Overdose' due to Christopher's sporadic use. The risk management plan identified education, naloxone pen, contact with support workers and weekly support from carers. Christopher was given a naloxone pen and his Care Coordinator gave him training to recognise drug overdoses at his assessment. This was conducted in line with the substance misuse services harm minimisation policy. A recovery plan was not completed at assessment. The case notes identify that a plan was made, but it was not recorded on the recovery plan template.

3.4.3 It was known that the Fulfilling Lives worker who attended the assessment appointment with Christopher had been a Pavilions care coordinator in the recent past and that this allowed her to support Christopher with harm minimization regarding his drug use when not engaging with Pavilions. This meant that she would have been able to reiterate the information discussed with Christopher following the assessment. After Christopher's death it was acknowledged that it would have been useful to have been able to provide Christopher with accessible information such as a leaflet using pictograms about overdose risks and naloxone pens. This was a recommendation for action as the service did not have such material.

[10] A support programme offered by Alcoholics anonymous https://www.alcoholics-anonymous.org.uk/about-aa/the-12-steps-of-aa

3.4.4 Review of the actions in response to risks associated with substance misuse would suggest that there was appropriate intervention and that in the main procedures and guidance was followed. There is no evidence of a formal capacity assessment to consider whether Christopher was capable of understanding the risks associated but significant weight was given to the involvement of the Fulfilling Lives worker who knew Christopher well and had considerable expertise in working with people involved in substance misuse.

3.5 How was risk considered in relation to Christopher disengaging with services? How was Christopher's mental capacity considered in relation to Christopher disengaging with services

3.5.1 Throughout the review period there was little evidence of formal capacity assessments being undertaken despite some evidence that, particularly at points of crisis, Christopher may have lacked the ability to make capacitated decisions. Whether a person is prepared to take risks or not is not routinely a concern of professionals, it is a matter for themselves, unless there is concern that the person may not understand enough to make a decision and/or the person is presenting a risk to others, or is committing a crime. If professionals have concerns that a person is unable to make a capacitated decision then that is the point at which it is important that they formally assess the person's capacity to make the concerning decision. This assessment should record that the principles and four domains of the Mental Capacity Act have been considered and applied in weighing the wishes and expectations, identity and preferred outcomes of the person.

3.5.2 In Christopher's case there were gaps in knowledge that needed to be filled via enquiries which should have included undertaking a formal capacity assessment. Professionals needed to be clear who was responsible for the consequences of the actions taken; either Christopher, because he was capable of making the decision and recognised the risks and consequences, or the agency, who then would have made a best interest decision with a defensible rationale. The absence of formal capacity assessments may reflect that professionals generally assumed Christopher to have capacity in relation to his care and support needs but may also indicate that insufficient consideration was given to the issue of his capacity. Another relevant factor was that when Christopher was engaging with professionals he was often making rational decisions and it was when he disengaged that his less safe and more illogical decisions were made.

3.5.3 One reason that self-neglect could not be determined was because it was unclear whether Christopher understood enough to make informed decisions about services, care, and support. Formal consideration of capacity would also have supported decision-making in relation to the need for further safeguarding enquiries about possible abuse. Understanding the wellbeing and safety needs of the individual is particularly important when that person appears to be self-neglecting. One factor that seemed to be overlooked by all the professionals involved with Christopher during this

period were the findings of the psychological assessment undertaken in 2014. This clearly identified that he had a learning disability and that his cognitive functioning and reasoning did not match his verbal presentation. There is no evidence that this was considered by professionals during their interactions.

3.5.4 Disengagement from services by Christopher was routine and was usually followed by him re-engaging at a later stage. It is probable that he withdrew from services when he found it painful to engage or he was unwilling to accept professional's analysis of his difficulties. He was particularly sensitive to any judgements that were made about his cognitive capacity or mental health and this would lead to him withdrawing. Professionals who knew Christopher were accustomed to his responses and this probably meant they did not see his disengagement as necessarily indicating a higher risk for him. Certainly, there is no real evidence that additional risk assessments were undertaken at such times. A significant risk therefore became that there was a normalisation by professionals of his withdrawal that could result in the risks being underestimated. One reason for this may well have been that there are limited options for professionals working with people with Christopher's problems. The statutory options are limited and quite draconian however the absence of a clear assessment of capacity with the reasons detailed explaining why there was no intervention meant that the professionals involved did not have a defensible position if Christopher suffered harm.

3.6 How did Christopher's experience of homelessness (including both temporary and emergency accommodation) impact on his mental health and substance misuse?

3.6.1 It is probable that Christopher's previous experiences of homelessness were fundamentally linked to his mental health and substance misuse. Certainly, there is some suggestion that his mental health problems were reactive and situational, whilst his substance misuse may have been an accommodative strategy. Unfortunately, the traumas resulting from his past homelessness contributed to his substance misuse and mental health difficulties and meant that he found it difficult to achieve stability and security in the accommodation that he was provided. He clearly found it difficult to live in shared accommodation but also lacked the skills necessary for him to live fully independently. His poor understanding around sexual boundaries when combined with substance misuse also meant he was vulnerable to exploitation. Christopher found sustaining a tenancy difficult to achieve and had spells of rough sleeping and homelessness. He could not manage his money or possessions, regularly reporting them as missing, or having been stolen from him. Friendships and relationships were problematic often resulting in aggression, or crime with Christopher as both the victim and the perpetrator.

3.6.2 Professionals working with Christopher understood some of his difficulties and worked hard to get him additional supports that would enable him to achieve stability. The move back to Brighton in 2017 to independent living was in response to Christopher's

express wishes but it was unfortunate that he was not provided with the support from Grace Eyre immediately after the move. It also seemed likely that he would need more than 4 hours a week intervention as the OT assessment undertaken in February 2017 in Newhaven had indicated that he had very limited life skills finding it difficult to prepare a basic lunch of a sandwich.

3.6.3 Despite these limitations there was significant consistency of support provided to Christopher despite his frequent moves of accommodation. He was supported throughout by Fulfilling Lives and had consistent input from his social worker in CLDT and Pavilions Substance Misuse Service even though he was living outside of the Brighton & Hove boundaries.

3.7 Were operational policies and procedures (such as the Sussex Safeguarding Policies and Procedures) applicable to Christopher's support adequate and did staff comply with them?

3.7.1 A significant challenge for this review was the length of time since the death which meant that policy, procedures and practice have changed considerably since the events under review. The Sussex Safeguarding Policy and Procedures have been updated twice since the beginning of the review and whilst the original procedures would have limitations now, the current version is appropriate. As is clear from the preceding paragraphs there were occasions when staff did not fully comply with the policies in place at the time. In particular there was little evidence that the procedures on neglect were utilised particularly around issues of self-neglect.

4 LESSONS LEARNED FROM THE SAR - HOW THIS SPECIFIC CASE HIGHLIGHTS FINDINGS ABOUT THE SAFEGUARDING SYSTEM AS A WHOLE.

4.1 Use and understanding of capacity assessments as part of the safeguarding process – understanding of safeguarding duties across the system

4.1.1 This review has shown that there was no use of safeguarding processes by any professional and that there were no formally recorded capacity assessments. This was despite evidence that on occasions there were clear safeguarding concerns that needed addressing. Moreover, it was also clear that Christopher needed a multi-disciplinary package of support to address his care needs which was co-ordinated by a lead worker. If this had been in place the safeguarding issues may have been resolved without formal safeguarding interventions.

4.1.2 One explanation for the absence of integrated safeguarding intervention was that the workers with most involvement with Christopher were those with least direct experience of undertaking formal safeguarding assessments. These were the worker from Fulfilling Lives, a charity with least power within the safeguarding system and a worker from the BHCC Learning Disabilities Team which has less involvement in formal safeguarding assessments than other parts of Adult Social Care. The worker from Fulfilling Lives put significant effort into helping Christopher access services and furthermore worked hard to enable his engagement. This was however unsuccessful,

in part because Christopher struggled to co-operate with the services offered and the professionals from other agencies ceased their involvement failing to see the disengagement as a safeguarding concern which required more not less input.

4.1.3 A previous Adults Learning Review published on the 3rd January 2019 describes very similar circumstances to those experienced by Christopher including; '*It is evident that whilst all agencies involved, and to whom DMS was known, recognised his vulnerabilities in a broad respect, early opportunities to share information, assess risk and work in a collaborative multi-agency framework were missed.'* This review identified specific limitations in the practice of the BHCC Learning Disabilities Team. There are also similarities with a SAR published in March 2017 which concluded that '…*the procedures that were in place to protect and support X (Multi Agency Procedures for Safeguarding Adults at Risk and Sussex Multi-Agency Neglect Procedures) were for the most part not invoked and as a result an integrated and coordinated multi-agency partnership led approach was not achieved'*[11].

4.1.4 Both these reviews are concerned with events that took place before or at the same time as Christopher's death and there is evidence that since then efforts have been made to improve practice and provide greater support to professionals involved in safeguarding. It is reported that the development of Complex Risk Management Meetings has improved the support available to voluntary sector workers. Until 2018 the major support available to voluntary sector staff working with individuals with complex problems where there are safeguarding concerns was the Multiagency Health Care meeting which provided the opportunity for very brief discussion of safeguarding concerns. Following a learning review it was agreed to develop a supplementary process (the Complex Risk Management Meetings) which would enable a multi-disciplinary meeting to discuss in detail a particular case which would then result in a lead worker and a multi-disciplinary care plan, these meetings may also refer a person for formal safeguarding intervention.

4.1.5 This review is concerned with practice that took place over four years ago and professionals in the Review team considered that there have been changes in practice as a result of work undertaken in statutory agencies to improve awareness and understanding of the importance of undertaking formal capacity assessments and recording those assessments when there are concerns regarding risky decision-making. It was also accepted however that, whilst core professionals undertaking such work routinely may be confident in this work, other professionals who may do it more intermittently are less sure. It is also a fact that professionals find it difficult to assess 'fluctuating capacity' when a person's ability to make safe and rational decisions is intermittent. Christopher did vary in his responses meaning that professionals needed a sophisticated understanding of the issues.

[11] SAR X

4.2 Understanding of Self-neglect – links to mental health and substance misuse

4.2.1 Fundamental to assessment of whether self-neglect is a safeguarding issue is a full consideration of an individual's capacity, which therefore determines whether that person is making an informed choice to live in a certain way or whether they are unable to make a capacitated decision in this respect, and may therefore need support imposed via a formal intervention. The absence of formal capacity assessments with regards to Christopher means that this judgement was never made. There was evidence however from both the psychological assessment and the occupational therapy assessment that he struggled with day to day living and that some of his self-neglect may have been because he was not able to effectively care for himself. That on occasions he presented as more able regarding self-care tasks may have also been an indicator of his fluctuating mental health. It is also likely that his intermittent substance misuse also affected his capacity.

4.2.4 The Review team considered that whilst practice now would have improved professionals still struggled to understand self-neglect and to incorporate it effectively into safeguarding processes. This was particularly true where service users had mental health problems or were involved in substance misuse. It was reported that there had been significant training in recent years about self-neglect and staff within core services now had new tools to use when undertaking assessments. It was felt though that this training and tools may not have been shared as widely as required and that for example staff in the Housing Department may not have access to them. This was also linked to the issue of capacity assessments and it was accepted that whilst there had been improvements professionals outside the core agencies lacked confidence in undertaking capacity assessments. This was particularly true where there was fluctuating capacity associated with substance misuse or mental health issues.

4.3 Relevance of Trauma based practice - links to the homeless experience

4.3.1 Christopher was displaying a number of symptoms typical of someone who had, or was experiencing trauma. There was evidence throughout the review that past events were being re-triggered and that Christopher was feeling judged or blamed for his repeated contact with services. The significance of these repeat trauma experiences was not fully understood in terms of the gravity of impact that this had on his mental and physical wellbeing and safety. Agencies constantly sought to find out 'What was wrong with Christopher', rather than 'What happened to Christopher'. The mental health assessment said that Christopher was responding to social circumstances not suffering from a long-term mental illness. This assessment, in common with others, did not identify his problems (homelessness, substance misuse, self-neglect and self-harm) as possible responses to past trauma. Trauma-informed care (TIC) involves a broad understanding of traumatic stress reactions and common responses to trauma. Services working with people who misuse substances, self-neglect, self-harm, and become homeless need to recognise how trauma can affect treatment, presentation,

engagement, and the outcome of behavioural health services. A person can be blamed for their substance misuse or homelessness when their actions are in fact coping strategies

4.3.2 The understanding of adverse childhood experiences and trauma identification and trauma informed approaches was not well known in the UK during the time period of the review. Trauma informed practice requires professionals to recognise the connections between violence, trauma, negative health outcomes and behaviours. Trauma affects a persons capacity to make specific decisions particularly when associated with self-care and impulse control. Trauma-informed methods of working are based upon key principles are:

- To recognise the connection between trauma and violence and how this manifests in behaviours that impact on wellbeing and safety
- To create emotionally and physically safe environments
- To create opportunities for choice, collaboration and connection
- To provide a stregnths-based, capacity-building approach to support a persons coping and resilience.

Agencies who do not understand the complex and lasting impacts of violence and trauma can unintentionally re-traumatise the person. The approaches are not about 'treating the trauma' but to minise the potential for harm and re-traumatisation. Agencies need to reduce the tendency to judge, or blame people for their psychological, or behavioural reactions to experiences that include threat or violence and consider the cumulative effect of multiple forms of threat or violence.

4.3.3 The Review team considered that whilst there was now improved understanding of trauma informed practice by professionals this was still an area for further development. In Housing the Housing Options Service was remodelled to offer a psychologically informed environment, learning from people with experience of homelessness; ensuring staff are trained and are working in a personalised way with those approaching them for support.[12] This was now being now being rolled out across Housing Options, Temporary Accommodation, Homemove and associated teams. This "...*is an approach to supporting people out of homelessness, in particular those who have experienced complex trauma or are diagnosed with a personality disorder. It also considers the psychological needs of staff: developing skills and knowledge, increasing motivation, job satisfaction and resilience*".[13] Within Sussex Partnership it was felt there was a gap between the specialist psychological provision for people experiencing severe trauma and the wider service response. Adult Social Care commissioned trauma informed practice training for a proportion of frontline staff and consideration is being given to further training being commissioned.

[12] Draft Homelessness and Rough Sleeping Strategy 2020-2025

[13] Briefing for Members Psychologically Informed Environment Implementation across Housing Needs March 2020

4.4 Services for homeless people – reactive not proactive?

4.4.1 At the time of Christopher's review statistics reported in a local newspaper revealed that one in sixty-nine people in Brighton and Hove was homeless. In 2017 there were 4,095 people sleeping rough or in temporary/emergency accommodation and many more hidden homeless people such as those sofa surfing. Currently, Brighton & Hove is the eighteenth highest nationally for numbers in Temporary Accommodation and third highest nationally for numbers rough sleeping. It is probable that many of those people are traumatised and that this affects their safety and wellbeing are affected daily. One aspect that was missing from the support for Christopher was a proactive support service that was able to provide him assistance immediately even if he moved. All too often by the time the assessments were in place he had moved address and the process had to restart or it was felt that it was inappropriate to start a service whilst he was unsettled. This unfortunately meant that he was slow to receive necessary support and lead to a deterioration in his well-being.

4.4.2 The Housing Department was very clear that practice had changed significantly with regard to support for vulnerable homeless people and referenced the implementation of the Housing First Service which is an evidence-based approach to successfully supporting homeless people with high needs and histories of entrenched or repeat homelessness to live in their own homes. The aim being to provide a stable, independent home and intensive personalised support and case management to homeless people with multiple and complex needs. The 2020 Housing strategy is recommending an expansion of the Housing First service from 12 units to a minimum of 40. This development is part of a national programme and has been evaluated to be an effective response. It is less clear however whether there have been similar developments in other services to enable who are chaotic and mobile to access easily and quickly assessments and therapeutic services. If there remains a response that says people cannot receive these supports until they are settled then it is probable that individuals such as Christopher will not receive the therapeutic interventions that they need.

5 CONCLUSIONS

5.1 This review was concerned with the services provided to Christopher, a man who had probably experienced significant trauma in his past. He had a history of homelessness including periods of rough sleeping and had also had periods of poor mental health and substance misuse. He died from a heroin overdose. The significant feature of the support provided to him in the two years prior to his death was the absence of any safeguarding interventions despite evidence of self-neglect and questions about his capacity to care for himself and make safe decisions. During the two years there was significant support provided by a range of agencies to Christopher and lack of resources was not obviously the reason for non-intervention by professionals. Rather

there were assumptions made about his capacity to make safe decisions and a reluctance to intervene or to challenge Christopher's view of the world.

5.2 The review has examined practice from some time ago and it is reported that there have been significant improvements in service delivery since then. There has been significant input in terms of training and changes in service delivery. The challenge is to be confident that this input has resulted in changes in practice and better outcomes for service users.

6 SAB RECOMMENDATIONS

6.1 That the Board as part of its regular audit programme reviews the use of capacity assessments, records of defensible decision-making and identification of self-neglect including how these relate to decisions not to initiate safeguarding procedures.

6.2 That the Board seek assurance from non-statutory agencies that they are confident in relation to the safeguarding procedures contained in the Care Act and how to raise safeguarding concerns under section 42 of the Act.

6.3 That the Board seek assurance from the Brighton and Hove City Council's Community Learning Disability service that they have the structure, policies and procedures to undertake safeguarding enquiries under section 42 of the Care Act where safeguarding concerns are received and the threshold is met.

6.4 That the Board seek assurance from agencies about how they have incorporated 'trauma-informed practice' where service users are identified as having complex and multiple needs and are likely to have experienced trauma.

6.5 That the Board acknowledges the progress made in enabling services for homeless people to be more proactive, in particular within Housing, but asks all agencies to report on how they can ensure that homeless and transient people are able to access support and services in a timely fashion and that this provision is not deferred until they are in more settled accommodation.

Fiona Johnson

17th September 2020

APPENDIX 1

Terms of Reference

Brighton & Hove SAB Safeguarding Adults Board

AW Safeguarding Adults Review (SAR)

Christopher

DOB 1977 **Date of Death** 2017

This independent review is commissioned by Brighton and Hove Adults Safeguarding Board.

Terms of Reference in conjunction with the Safeguarding Adult Review Process

1. To review and analyse the individual agency management reports.
2. To examine the agency interaction and support of Christopher from 1st March 2015 until 16th March 2017, in particular, whether his support was appropriate and co-ordinated between relevant agencies.
3. To identify key episodes for agencies to intervene and affect a positive outcome.
4. To form a view as to whether Christopher's particular needs were appropriately identified and responded to.
5. To examine the adequacy of the operational policies and procedures applicable to his support, such as the Sussex Safeguarding Policy and Procedures and/or Self Neglect Procedures or guidance (in place during the time period being reviewed), and whether staff complied with them.
6. To examine the adequacy of collaboration and communication between all of the agencies involved.
7. Any other matters that the reviewer considers arise out of the matters above.
8. To prepare a written report that includes recommendations to be put to the Safeguarding Adults Board for future learning.
9. To prepare an anonymised Executive Summary that could be made public.

Additional information to be made available to the reviewer:

- SI (significant Incident) – NHS report for AW
- DRD (drug related death) Panel Review AW
- DMS (Learning Review)
- SAR X final report and action plan

Areas to be considered:

10. The referrer stated that there was a 'lack of consideration around safeguarding'. Were safeguarding duties under the Care Act 2014 appropriately considered and documented in this case?
11. How well were professionals equipped to work with clients with a trauma history?
12. How well was Christopher equipped and supported to manage his anxieties?
13. How well were risk and safety plans managed in relation to Christopher's substance misuse? Was risk escalated appropriately?
14. How was risk considered in relation to Christopher disengaging with services? How was Christopher's mental capacity considered in relation to Christopher disengaging with services?
15. Christopher experienced multiple housing placements. He often requested to be moved from placements he did not like. Christopher died within a week of moving back to Brighton from Newhaven. How did Christopher's experience of homelessness (including both temporary and emergency accommodation) impact on his mental health and substance misuse?

Appendix 2 – Glossary of Terms & Abbreviations

ASC	**Adult Social Care -** services provided by
CQC	**Care Quality Commission** - The independent regulator of health and social care in England
GP	A doctor based in the community who treats patients with minor or chronic illnesses and refers those with serious conditions to a hospital.
MSP	**Making Safeguarding Personal** is a national approach to promote responses to safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing, and safety
SAB	**Safeguarding Adults Boards** - The Care Act 2014 places adult safeguarding on a legal footing. From April 2015 each local authority must: set up a Safeguarding Adults Board (SAB) with core membership from the local authority, the police, and the NHS (specifically the local Clinical Commissioning Groups) and the power to include other relevant bodies.
SAR	**Safeguarding Adult Review** - Safeguarding Adults Boards must arrange a SAR when an adult in its area dies as a result of, or has experienced, serious abuse or neglect (known or suspected) and there is concern that partner agencies could have worked more effectively together. The aim of the SAR is to identify and implement learning from this.
SCARF	**Single Combined Assessment of Risk Form** – this is the mechanism by which the Police share information with other relevant agencies particularly Adult social care.
SECAmb	**The South East Coast Ambulance Service** NHS Foundation Trust is the NHS Ambulance Services Trust for south-eastern England, covering Kent (including Medway), Surrey, West Sussex and East Sussex (including Brighton and Hove).
VAAR	The **Vulnerable Adult at Risk** section of the SCARF should be completed by an officer or member of police staff for every incident that involves a safeguarding concern relating to a vulnerable adult.

APPENDIX 3: BIBLIOGRAPHY

The Mental Capacity Act (MCA) 2005 https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance

The Care Act 2014 Sections 44(1) – (3), Care Act 2014
http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

Making Safeguarding Personal
http://sussexsafeguardingadults.procedures.org.uk/ykoss/sussex-safeguarding-adults-policy/sussex-safeguarding-adults-policy

The Mental Capacity Act 2005 https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance

Pan Sussex Child Protection and Safeguarding Procedures Manual
https://sussexchildprotection.procedures.org.uk/search?kw=child+death