Safeguarding Adults Review

Thematic Learning Review into the deaths of three local women

Report Author: Christine Graham
January 2023

Foreword

The Brighton and Hove Safeguarding Adults Board and East Sussex Safeguarding Adults Board wishes at the outset to express their deepest sympathy to the family and friends of Mairead, Amy and Miss C.

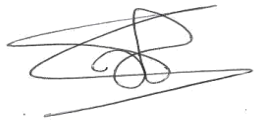
The purpose of a Safeguarding Adults Review (SAR) is to identify how lessons can be learned, and services improved for those who use them, and for their families and carers. This Thematic Review looked at the circumstances prior to the deaths of Mairead, Amy, and Miss C, similarities in their experiences, and the actions of agencies.

The similarities in the wider experiences of their lives included challenges in childhood and as they became adults. Mairead was a 24-year-old woman who had grown up in care and experienced a traumatic childhood before moving to Brighton with her partner whilst pregnant with her third child. Amy was a 41-year-old woman with a history of mental health issues who had a child adopted and experienced substance misuse as well as unstable housing issues. Miss C was a 41-year-old woman who had a history of mental health issues and substance misuse. There were several similar themes in the circumstances of Mairead, Amy, and Miss C that included the domestic abuse they experienced.

This has been a wide-ranging and comprehensive discretionary review that has been carried out in an open and constructive manner with the Independent Reviewers noting that all agencies, both voluntary and statutory, engaged positively. They added that this has enabled them to consider the circumstances culminating in these deaths in a meaningful way and address with candour the issues that it has raised.

The review identifies key findings in relation to a range of areas that includes multiple and compound need and multi-agency risk management, trauma-informed practice, domestic abuse, dual diagnosis, transitions, as well as housing and supported accommodation.

Agencies do not wait for the outcome of a review to consider their own learning and are fully engaged in taking forward the recommendations together. The Board will monitor progress on the implementation of the recommendations made and ensure that learning from this Review is widely shared and that the outcomes lead to improved services in Brighton and Hove.



Annie Callanan
Independent Chair, Brighton and Hove Safeguarding Adults Board

This Overview Report has been compiled as follows:

Section 1 will set out the **process and methodology** of the Review

Section 2 of this report will **introduce the subjects** of the Review

Section 3 will **analyse** the key issues

Section 4 will answer the questions in the **Terms of Reference**

Section 5 lists the **learning points** identified.

Section 6 brings together **the recommendations made**

Section 7 sets out the **conclusions of the review**

Where the review has identified that an opportunity to intervene has not been taken, this has been noted in a text box.

Examples of good practice are highlighted in italic type

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Section One – Process and Methodology

1.1 Background

1.1.1 Under Section 44 of the Care Act 2014 there is a duty for Safeguarding Adult Boards (SABs) to arrange a Safeguarding Adult Review (SAR) when an adult in its area with care and support needs dies or experiences serious harm because of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult. SABs can also arrange a SAR on a discretionary basis in situations where it believes there will be value in doing so.

1.1.2 The Brighton and Hove Safeguarding Adults Board (BHSAB) identified similarities in two Safeguarding Adults Review (SAR) referrals that they received, as well as in a SAR recently published by a neighbouring Safeguarding Adults Board. All were cases of young women who had sadly passed away.

1.1.3 A Serious Incident Review, a Mortality Review and a Drugs Related Death Review had already been variously undertaken by organisations. Whilst it was not considered that the criteria for a SAR had been met in either of the two referrals it was identified that partner agencies may have been able to work together more effectively to protect these individuals. The reviews previously completed were individual desktop exercises and it was considered there remained the opportunity for multi-agency learning to take place.

1.1.4 Whilst the SAR eligibility criteria was not considered to have been clearly met in the two referrals submitted, there were concerns that there are several recurring themes, which echo those of the SAR undertaken by the East Sussex Safeguarding Adults Board in relation to Miss C.

1.1.5 Consequently, the BHSAB decided to commission a discretionary SAR in the form of a thematic review to consider the two referrals received and whether agencies could have done more to protect these women. It was agreed with the neighbouring East Sussex SAB that the review would incorporate findings and learning from their published SAR to explore the similar themes that appear to be evident and consider if there is further learning for local professionals and agencies in seeking to prevent similar situations occurring again in the future.

1.2 Chair and Report Author

1.2.1 Gary Goose served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector, his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary served on the national Family Liaison Executive and led the police response to the families of the Soham murder victims. From 2011 Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility as well as substance misuse and housing services. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework.

1.2.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. As well as delivering training in relation to tackling anti-social behaviour, Christine has worked with a number of organisations to review their approach to community safety. Christine served for seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA, which involved her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews. Christine chairs her local Safer off the Streets Partnership.

1.2.3 Gary and Christine have completed, or are currently engaged upon, more than fifty domestic homicide reviews across the county in the capacity of Chair and Overview Author. Previous domestic homicide reviews have included a variety of different scenarios including male victims, suicide, murder/suicide, familial domestic homicide, a number which involve mental ill health on the part of the offender and/or victim and reviews involving foreign nationals. In several reviews they have developed good working relationships with parallel investigations/inquiries such as those undertaken by the IOPC, NHS England and Adult Care Reviews.

1.2.4 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[1]

1.3 Methodology

1.3.1 Agencies were asked to review their engagement with the two women, who are referred to as Mairead and Amy for the purposes of this review.

1.3.2 Following this the scope for involvement with each woman was agreed as follows:

- Mairead: 1st August 2017 – 1st August 2019
- Amy: 1st December 2018 – 31st May 2020

1.3.3 The SAR had already been published in relation to the woman known as Miss C and the scope of this review was December 2016 – December 2017.

1.3.4 The terms of reference for this review were agreed by a meeting of the SAR Sub-Group on 24th September 2020.

1.3.5 Following this, the following organisations were asked to provide an Individual Management Review:

[1] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

- Arch Healthcare
- Brighton and Hove City Council – Families, Children and Learning (FCL)
- Brighton and Hove City Council – Health and Adult Social Care (HASC)
- Brighton and Hove City Council – Housing Department
- Multi-Agency Risk Assessment Conference (MARAC)
- Pavilions Drug and Alcohol Services (now known as Change Grow Live)
- South-East Coast Ambulance Service (SECAMB)
- Sussex Partnership Foundation NHS Trust (SPFT)
- Sussex Police

1.3.6 A generic IMR template was circulated, and it would have been more helpful to this review if the IMR had covered the specific questions set out in the Terms of Reference. This, coupled with the quality of some of the IMRs received, has made it difficult for the reviewers to answer specific questions in relation to some of the organisations.

Learning point

In future reviews the IMR template should specifically focus on the Terms of Reference set for the review.

1.3.7 **Practitioner workshops**

1.3.8 Two virtual practitioner workshops were held in October 2021. The delegate names were provided by the Safeguarding Adults Board and included frontline practitioners and those who had undertaken frontline work in the past.

1.3.9 There were seventeen delegates across the two sessions and nine organisations were represented. The issues raised in these workshops are discussed later throughout the report.

1.3.10 The workshops focused on three main areas:

- The current position
- If money were no object
- Impact on you

1.3.11 The following questions were posed to delegates ahead of the workshop:

Current position

- What are the challenges you face when working with women with complex needs?
- How are these challenges different to the challenges faced by men with complex needs?
- What are the barriers to these women getting the help and support that they need?
- Are they able to access refuge when needed? Are their complex needs a barrier?
- Are the women perceived by some services as 'deserving' or 'undeserving' of services?

If money were no object

- If money were no object, what would you like to see on offer for these women?

- Can you rank these suggestions in order of priority? Which is the absolutely *must* do? What would be nice to do?

Impact on you

- What part do vicarious trauma/secondary trauma, compassion fatigue or burnout play in your day-to-day work?
- Does this come from your work with women with complex needs? In what way?
- How does this impact on how you respond to women with complex needs? What support is given by your organisation?

1.3.12 The workshops did not go through the questions in turn. The main points of discussion are included throughout the report. The workshops acknowledged that there will be men, within the services, who have complex needs, but the focus was on women as their experience will be different to that of men and is the focus of this review.

1.3.13 **Strategic Representatives Event**

1.3.14 A strategic representatives' meeting was held in January 2022. This was arranged by the Safeguarding Adults Board and was held virtually, with the terms of reference for the review sent to delegates in advance.

1.3.15 This meeting was attended by eleven delegates, working in senior or strategic roles within a range of statutory and non-statutory organisations that support women with complex needs. It included organisations that had worked directly with Mairead and/or Amy, as well as organisations with more general involvement in supporting women with complex needs locally.

1.3.16 There was a focus on two main areas:

- The current system, policies, and processes that are in place to support women with complex needs.
- Safeguarding processes and whether safeguarding concerns are appropriately identified and responded to in supporting women with complex needs. During the discussions the term *complex* needs was thought, by some, to be an organisational phrase and whether the term compound needs was more appropriate. This is discussed in more detail at 1.4.3.4

The Independent Reviewers would like to take this opportunity to commend the honesty, professionalism, dedication, and energy demonstrated by all those who attended both the Practitioner and Strategic Representatives events that were held. The desire to work in partnership to identify, and to enable, meaningful change that improves the lives of those they work with was evident throughout both processes.

1.4 Language and terminology

1.4.1 VICTIM BLAMING LANGUAGE

1.4.1.1 The review has noted that there are similarities in the way in which these women are perceived or described. They are described as having a 'chaotic lifestyle', being a persistent caller, engaging in challenging interpersonal relationships or being difficult to engage with but what they all have in common is that **they have been exploited**, mostly by men.

1.4.1.2 The reviewers observed, in reading the IMRs submitted, language that could be perceived as victim blaming. This caused concern, not only for the reviewers, but also for another IMR author who highlighted in their report, concerns about language used by practitioners in meetings and referrals.

1.4.1.3 Whilst it could be argued that this is just an issue of language and semantics this may be indicative of the underlying thinking.

The review believes that a simple change of language can have a substantial effect upon thinking – if we refer to them as 'women who have been exploited' then the fact that they have a chaotic lifestyle, or may be difficult to engage with, comes into the correct context or disappears altogether. This then changes the way in which we view the support that they need.

1.4.1.4 Below is a table that was used at a seminar given by Standing Together and provides examples of phrases used in MARAC meetings (these are general and not drawn specifically from the IMRs.)

Changing the language from	**To**
'She keeps changing her accounts to services, so we don't know what actually happened	There is a risk of coercive control due to the variety of accounts given by the victim/survivor to agencies
There is no evidence to corroborate her account	There is insufficient evidence against the perpetrator for further action to be taken
These are just allegations	The victim/survivor has disclosed abuse
The onus is on the victim/survivor to engage with us	Does anyone have any suggestions on how to safely engage with the victim/survivor?
She let him in, despite there being bail conditions in place	The perpetrator broke his bail conditions by attending the address
The victim/survivor failed to engage	Our agency was unable to engage with the victim/survivor
The victim/survivor is continuing to have contact with the perpetrator despite the risks	There is a risk due to the perpetrator continuing to have contact with the victim/survivor
She has placed herself at serious risk of abuse because of her substance use	The victim/survivor has substance use issues which increases her vulnerability

Learning Point

Language change amongst all professionals and agencies will positively alter mindsets and make a huge difference to the way engagement with and support for women with multiple needs is considered and delivered.

1.4.2 **DESERVING OR UNDESERVING?**

1.4.2.1 The review sought to explore with the workshop delegates if they felt there was a sense of some people being 'undeserving' of support.

1.4.2.2 One view was that, whilst practitioners would not *consciously* make this distinction there is a danger that it is made unknowingly. This may be because one of the barriers to accessing support is a client's apparent willingness to engage with the support being offered. There is a sense that if support is offered and is not accepted by a client, there is a pressure to 'move on' and offer the support to someone else.

1.4.2.3 Another view was that it was not so much that they had a label of 'undeserving' but that they had a label of 'not willing to engage'. Services are not flexible and responsive to the needs of service users so there might be a sense of 'we tried this before and it did not work' and this needs to be balanced against the possibility that someone may be now in a position to engage and, if not this time, maybe next time.

1.4.2.4 Systems are so overworked that there is a tendency if a client is not willing to engage then services are moved to someone who will.

1.4.2.5 There is a danger that if people do not 'get better' that we consider them undeserving of services. It was suggested that because services are under pressure, we can look for reasons *not* to support them and a lack of understanding of trauma informed care can exacerbate this.

1.4.2.6 It was felt that legislation can force people into a box of 'deserving' or 'undeserving', but the box has a more 'professional' name such as eligible/ineligible for services. Examples were given from housing legislation such as the terms 'intentionally homeless' and 'no local connection' which feed this idea of being undeserving. This requires a change at a national level.

1.4.2.7 These views were supported by delegates at the Strategic Representative's event. The system as a whole is seen as being risk focused rather than need focused.

1.4.2.8 The review was told that 'unconscious bias' against women is also a significant factor. Women are penalised more harshly than men for similar actions, or marginalised when they discuss their experiences or express maladaptive coping behaviours.

1.4.2.9 There are also differing expectations as to transitional maturity levels and decision-making between young men and women. Whilst young men are still seen as developing, and therefore allowances made around decision-making, young women are not viewed in the same way and are expected to act as adults at a much earlier point.

1.4.2.10 The intersectional elements of race, ethnicity and cultural diversity were also identified as further barriers in this respect.

1.4.3 UNDERSTANDING LOCAL POLICIES, PROCEDURES AND TERMINOLOGY

1.4.3.1 Complex and multiple needs

1.4.3.2 The terms of reference for this review refer to the three subjects of the review as being 'women with complex and multiple needs'. It is important to explore what is meant by this terminology and to ensure that there is a locally shared definition of what this means.

1.4.3.3 Whilst the term 'multiple needs' is more straightforward to understand, it has long been noted that there is no clear definition of 'complex needs' (Rosengard et al, 2007; Rankin and Regan, 2004[2]). One definition considers it as a hierarchy of need based on how individuals use services and the challenges experienced by those services (Rosengard et al, 2007)[3]. The term 'severe and multiple disadvantage' is now used to explain things that happen to people because of society's actions, or where individual's experiences exceed a service provider's capability to provide meaningful and effective support (Bramley et al, 2015; Lankelly Chase, 2015)[4].

1.4.3.4 At the strategic representative's event it was identified that the term 'complex needs' itself may not be helpful. The point was made that it may not be the individuals themselves who are complex, rather it is the systems that we ask them to navigate that are complex. In considering these multiple and intersecting needs one alternative term that was put forward was that these women had 'compound needs'.

The word compound can be defined as 'to form by combining things' and underlying this review is the question of whether the needs of these three women were beyond the system's ability to provide support that made a difference. Were their needs so complex or was it rather a combination of needs in a complex system? The review aims to make recommendations to improve the system locally and places the focus away from being entirely on the individual's responsibility for their engagement with services and their behaviours.

1.4.3.5 Intersectionality is a term now widely used to describe the interdependent nature of women's multiple and intersecting experiences. The way that these women sought help can be complicated by their intersecting experiences, which create different contexts in which they seek help and support. A failure to understand the intersecting nature of their experiences can limit their access to services (Thiara et al, 2012)[5].

The three women in this review all had multiple and intersecting, or compound, experiences of domestic abuse, mental health, and substance misuse and these all impacted upon their access to

[2] Cited in Harris, L. and Hodges, K. (2019) Responding to complexity: improving service provision for survivors of domestic abuse with 'complex needs', Journal of Gender-Based Violence, vol 3, no 2, 167–184, DOI: 10.1332/239868019X15538587319964
[3] Ibid
[4] Ibid
[5] Cited in Harris, L. and Hodges, K. (2019) Responding to complexity: improving service provision for survivors of domestic abuse with 'complex needs', Journal of Gender-Based Violence, vol 3, no 2, 167–184, DOI: 10.1332/239868019X15538587319964

support and services. To align with local workstreams the term multiple and compound needs will be used in this report.

1.4.3.6 This review acknowledges that, as set out by AVA (2013, 10), 'The experience of domestic or sexual violence can lead to mental health problems and substance abuse. In turn, people struggling with mental health problems and substance abuse are more vulnerable to further violence' and as Trevillion et al (2012) point out 'it is impossible to separate cause and effect'[6].

1.4.3.7 It is important that this review acknowledges that, due to their multiple and compound needs these women could, at times, present to services as problematic or difficult. For example, Amy was flagged as a 'persistent caller' by the police. On 14th May 2019 she had used the 999 system because she was bored and wanted someone to chat to and this will be discussed in more detail later in the report. The study undertaken by Harris and Hodges[7] found that women with complex needs seeking to access services were 'non-compliant'. It was noted that whilst they *were* non-compliant there were reasons for this non-compliance and that this could become a stumbling block to them accessing other services.

1.4.3.8 Hodges points out that there can be an assumption by service providers and policy makers that women with complex needs understand their experiences as needs for which they are entitled to receive support (Hodges, 2018)[8].

Recommendation

The SAB work with partner agencies (including neighbouring Sussex SABs) to develop an agreed definition, and accompanying terminology, in respect of multiple and compound needs on a pan-Sussex basis.

1.4.4 Single Combined Assessment of Risk Form (SCARF)

1.4.4.1 The SCARF is a vital document in the accurate assessment, recording of risk and maximising outcomes of vulnerable people. It contains the following risk assessments:

- Domestic Abuse, Stalking and Harassment and Honour Base Abuse (DASH)
- Child to Notice
- Vulnerable Adult at Risk (VAAR)
- Hate & ASB Risk Assessment (HARA)
- Operation Signature (vulnerable victims of fraud)

1.4.4.2 The SCARF is for officers and staff to highlight all risks and observations of any vulnerable adult and/or child. SCARFs are shared with partner agencies, an imperative aspect of

[6] Ibid

[7] Harris, L. and Hodges, K. (2019) Responding to complexity: improving service provision for survivors of domestic abuse with 'complex needs', Journal of Gender-Based Violence, vol 3, no 2, 167–184, DOI: 10.1332/239868019X15538587319964

[8] Cited in Harris, L. and Hodges, K. (2019) Responding to complexity: improving service provision for survivors of domestic abuse with 'complex needs', Journal of Gender-Based Violence, vol 3, no 2, 167–184, DOI: 10.1332/239868019X15538587319964

safeguarding; thereby helping partners build a complete picture and identify any concerns or emerging problems which may require intervention.

1.4.5 **Vulnerable Adult at Risk (VAAR)**

1.4.5.1 This is a section of the SCARF and should be completed by an officer or member of police staff for every incident that involves a safeguarding concern relating to a vulnerable adult. A safeguarding concern is where an adult, who has care and support needs may be experiencing, or is at risk of, abuse or neglect and because of their needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

1.4.5.2 It is important when completing the VAAR to ensure that sufficient and accurate detail is included, allowing specialist teams and Adult Social Care to take appropriate action.

- The officer account within the SCARF should give full circumstances of the incident. It should identify whether it is an isolated incident or if it has happened before.
- Record the decisions made and provide a rationale as to why these have been made.
- Consider any additional needs the adult may have such as medical conditions, communication problems, a physical or learning disability, a mental health condition, do they have mental capacity or are they hard of hearing? Is the adult pregnant? If so, include their due date. Record these and how these impact on their ability to protect themselves.
- Are there any circumstances which may affect an adult's vulnerability? For example, their immigration status, are they socially isolated or reliant on others for care and support? Remember to provide details of any support that the adult may have including family, friends, a key worker, or care worker. Is the suspected abuser a person in a position of trust such as a paid or voluntary carer or a nurse or doctor?
- Record the thoughts and feelings of the adult involved. Capture the impact this is having on them and what intervention or help would they like.
- Record the name of their GP, if possible, plus any other services that are already involved with the adult.

1.4.5.3 Once completed, wherever possible and if it is safe to do so, officers/staff should inform the person that concerns will be referred to Adult Social Care and other partner agencies as appropriate. It would not be safe to inform them if the suspected abuser is present or is likely to be made aware by the vulnerable adult or any other person. Preferably the vulnerable adult should be informed alone.

1.4.5.4 Following completion of the VAAR, this must be work flowed immediately to the appropriate Multi-agency Safeguarding Hub (MASH) for where the adult is living and following the usual process on Niche (the IT system that is used). Officers/staff should consult supervisors and local Safeguarding Investigation Units should any immediate safeguarding concerns be identified following attendance at an incident.

Section Two – The subjects of the review

2.1 **Mairead**

2.1.1 Mairead was a 24-year-old woman who had experienced a traumatic childhood, being a victim of sexual and physical abuse, and had spent many years in care. She spoke of having 'behavioural issues', which had culminated in an inpatient admission to a mental health unit, and she had been diagnosed with emotional instability, anxiety, and depression as well as polysubstance misuse.

2.1.2 She and her partner arrived in Brighton in August 2018 and after initially sleeping rough they were placed in emergency accommodation due to her being pregnant with her third child. Mairead disclosed that she had previously given birth to two children in London, who had been immediately taken into care and adopted.

2.1.3 Mairead was supported by a range of statutory and non-statutory services across both Children's and Adult's services. She and her partner moved from emergency accommodation to temporary accommodation in May 2019 and she gave birth to a child in May 2019, who was taken into care.

2.1.4 Concerns were identified by several agencies in relation to (a) domestic violence occurring between Mairead and her partner, (b) potential coercion and control by her partner, (c) Mairead disclosing suicidal thoughts to professionals and (d) their housing environment. It is recorded that Mairead took two separate drug overdoses that both led to hospital admission in the months before her death.

2.1.5 On 18th July 2019 Mairead's partner called emergency services reporting that he had come into her room and found her unresponsive after taking drugs the night before. Sadly, Mairead died after suffering a cardiac arrest. The inquest concluded that the cause of Mairead's death was due to GHB toxicity/overdose and a finding of 'death by misadventure' was recorded.

2.2 **Amy**

2.2.1 Amy was a 41-year-old woman who had a longstanding diagnosis of paranoid schizophrenia, had been diagnosed as having borderline learning difficulties as well as a history of substance misuse. It is also reported she had a previous history of significant trauma.

2.2.2 She had been supported by Children's Services previously as she had a child who had been adopted. Her involvement with Adult Services commenced in 2015 when she was sectioned under the Mental Health Act, whilst in London, and she was supported by Mental Health services following this.

2.2.3 Amy was identified in assessments as having high level care and support needs and concerns were raised in relation to her chaotic lifestyle. She had been evicted from two hostels and was living with her partner, but she was pregnant at this time and there were significant concerns in relation to domestic violence as well as increased substance misuse.

2.2.4 Emergency accommodation was arranged for Amy, but it appears she returned to stay with her partner again as in December 2018 she alleged that he had physically assaulted her. She was very distressed, had visible cuts and bruises and stated this had been occurring since their child had been adopted. Several safeguarding concerns were raised in the months following this in relation to differing issues, including theft as well as sexual assault by a previous partner.

2.2.5 An alternative emergency placement was arranged for Amy at a supported living setting. On 2nd May 2020 Amy was sadly found deceased at this placement following a drugs overdose.

2.3 Miss C

2.3.1 Miss C was a 41-year-old woman who had a history of chronic trauma, fragile mental health, drug, and alcohol dependencies. In her mid-thirties, drug and alcohol dependency resumed, with criminal activities to fund her addictions. She sought alternative care arrangements for her children. Patterns of self-harm and suicide attempts emerged.

2.3.2 In 2015 she was referred into mental health services. During this time, she became involved with a new partner, who was volatile and violent, and she had alcohol and drug misuse issues. In 2016, as her accommodation options became more limited, she experienced increasing periods of homelessness and rough sleeping.

2.3.3 Two safeguarding enquiries were undertaken during this period and Miss C was frequently referred to MARAC. In 2017 she was given a short custodial sentence and served six weeks in prison. It is reported that she hit 'rock bottom' at this time and following two extremely violent assaults, her partner was remanded to prison towards the end of the year, which resulted in charges against him.

2.3.4 The situation appeared to then improve with alternative accommodation identified for Miss C and she was given a 12-month community order. However, her new address details were published in the press, and this led to Miss C being very fearful of reprisals.

2.3.5 In December 2017 Miss C spent the day with a friend, drinking alcohol and taking drugs. She was sadly found dead the following morning following a drugs overdose. The cause of her death is recorded as 'hypoxic brain injury, secondary to a drugs overdose.

2.4 Similarities between the subjects of the review

2.4.1 After analysing the information provided by agencies, there are several pertinent issues that were experienced by both Mairead, Amy and Miss C. Namely:

- Trauma
- Domestic abuse
- Substance misuse
- Mental health
- Dual diagnosis

- Unstable housing
- Children in care

Section Three – Analysis of key issues

3.1 TRAUMA

3.1.1 Trauma is a broad and varied concept but is broadly described as a severely distressing or disturbing experience that has an impact on an individual or their broader social network (Mind, 2020, Substance Abuse and Mental Health Services Administration, 2014[9]). It can be a one-off event or a series of similar events or, as we see in women with multiple and compound needs, a combination of a series of diverse events.

3.1.2 Research[10] indicates that trauma can rewire the brain structure through conditioning resulting in a permanent state of arousal i.e., fight, flight, freeze and so on. The impact of trauma may not be evident until months or years later.

3.1.3 The Substance Misuse and Mental Health Services Administration (2014)[11] says that trauma may impact differently on the individual with outcomes including, but not limited to:

- Addiction (including substance abuse or alcoholism)
- Sexual problems
- Inability to maintain healthy close relationships, friendship, and social interactions
- Hostility and/or anti-social behaviour
- Social withdrawal
- Self-destructive behaviours
- Impulsive behaviours
- Reactive thoughts
- Feelings of depression, shame, hopelessness, or despair

3.1.4 It is important to note that the effect of trauma is not cumulative (i.e., the more trauma that you experience, the more you are impacted) or type dependent (the more severe the trauma, the more severe the impact).

3.1.5 When we look at the lives of Mairead and Amy we see trauma in their lives, and this underpins all the factors that made up their multiple and compound needs. This is also supported by the learning from the Miss C review.

3.1.6 Mairead had experienced considerable trauma dating back to her childhood. She had been a victim of both sexual and physical abuse and had spent many years in care. She spoke of 'behavioural issues' that culminated in a stay as an inpatient on a mental health unit. When she moved to the area, she had previously given birth to two children who had both been taken into care.

3.1.7 Amy was recorded as having previous history of significant trauma the details of which are not known to the review. She had a child who had been adopted.

[9] Cited in Trauma-informed practice, Her Majesty's Inspectorate of Probation, July 2020
[10] Fox et al, 2014 cited in Ibid
[11] Ibid

3.1.8 There is good evidence of the strong link between traumatic experiences and poor mental health. For women, trauma is frequently associated with experiences of abuse and violence. More than half the women who have experienced extensive abuse and violence across their lives have a common mental health condition like depression or anxiety[12].

3.1.9 It is vital to remember that trauma may be a warning sign that an individual needs help and support to enable them to move forward in a healthy way and therefore the impact of trauma can be reduced through effective and appropriate interventions (Rowlands and McCartan, 2019)[13].

3.1.10 There has been increased emphasis over the past few years on services becoming 'trauma-informed'. This review believes that key to being a trauma-informed service is moving from asking 'what is wrong with you?' to asking, 'what has happened to you?' This is a shift not only in policies and procedures but, more importantly, a shift in mindset by all involved. When we read the chronology of the engagement with both women with services it is too easy to get a sense of the problems that they present and lose sight of what has happened to them in the past that has brought them to the place where they were. The trauma that Mairead and Amy experienced led them to develop coping strategies and behaviours that may appear to be harmful and dangerous[14].

3.1.11 **Understanding trauma-informed practice – the views from the workshops and strategic representative's event**

3.1.12 It was agreed that whilst many practitioners seek to work in a 'trauma-informed' way and it is an expression that will be used, it is not always understood and implemented across all services. There was a real sense that the understanding varies across agencies with some having a good understanding and others demonstrating no understanding at all. The quality of the understanding does not only vary across services but *within* services with practice and understanding varying from one practitioner to another in the same service.

3.1.13 There was a sense of people using the term 'trauma informed' as though this were sufficient without going further to explore what interventions would be needed. All these women had experienced trauma and there is a need for a better understanding of trauma and its impact on a woman's capability to move forward.

3.1.14 A number of delegates talked about working hard to practice in a trauma informed way but that there were times when capacity and workloads affected this. One person said that when they are working well, they recognise that clients may be presenting as they do because of trauma they have experienced but, when they are under pressure' this can slip and they 'revert to type'.

3.1.15 The strategic representative's event concurred with the views expressed by practitioners. Individual practitioners, and some organisations, seek to adopt a trauma-informed approach and to be creative but the system is not trauma-informed. A frequent point was that services

[12] A sense of safety, Centre for Mental Health, November 2019
[13] Cited in Trauma-informed practice, Her Majesty's Inspectorate of Probation, July 2020
[14] Sweeney et al, 2018 cited in A sense of safety, Centre for Mental Health, 2019

are felt to work in silos that are informed by separate legislative frameworks and focus on eligibility and acute organisational risk.

3.1.16 The long-term and repeat trauma that occurs for women from being in care or having children taken into care was raised. This may not manifest immediately but creates a lack of trust over a sustained period and contributes to a subsequent lack of engagement. The pressure on resources results in services ceasing their involvement with these individuals. The point was made that those who do not engage are most in need of engagement.

There is a sense of the term 'trauma informed' being used by both commissioners and practitioners without a shared understanding of what this means, and without a multi-agency framework or support processes. Even for those who believe that they understand trauma informed care, there is a sense that is not yet something that comes naturally and automatically but is still something that must be given specific focus. The review believes that this is a critical area of development moving forward.

Learning point

There is a need to improve the local understanding of, and response to, trauma across all services so that the system is trauma informed. It is accepted that this will take time to embed into everyday practice.

Recommendation

The SAB link in with work being undertaken through the Health and Wellbeing Board, Changing Futures, and other workstreams, to support the development of benchmarked trauma informed approaches to enable further standardisation, commissioning arrangements and assessments of quality[15].

3.1.17 Some time was spent discussing the diagnosis of Emotionally Unstable Personality Disorder (EUPD) for women with multiple and compound needs. Practitioners felt that there is a move towards not using a label such as this but a greater emphasis on talking about complex psychological trauma, but this has not yet been adopted by all services. It was felt that the label of EUPD can be a barrier to women receiving help from mental health services because services have concentrated on those that they feel are best suited to the help available.

3.1.18 Strategic representatives also identified this point noting that with diagnoses of EUPD, or other forms of personality disorders, used as a reason for some services to disengage because personality disorders are not seen as 'treatable'.

3.1.19 **Preventative work**

3.1.20 Throughout the workshops delegates expressed concern that for women with multiple and compound needs currently in the system any changes will be too late. They have experienced trauma years earlier and are carrying the burden of this because the appropriate support was not available, offered or accepted.

[15] A sense of safety, Centre for Mental Health, November 2019

3.1.21 One delegate said that they are only doing 'crisis' work and do not have the capacity to engage in preventative work. The point was made that if services had begun to work with these women six months earlier than they actually did, they may have prevented the women ending up in crisis, but that legislation does not encourage/allow services to work in this way.

3.1.22 To quote Bishop Desmond Tutu, 'there comes a point where we need to stop just pulling people out of the river. We need to go upstream and find out why they're falling in'.

The system should be intervening in a therapeutic way much earlier with those who have experienced trauma. This should be offered in their teenage years. The review accepts that this is not possible for the local area to resolve alone – it requires an allocation of increased resources from central government.

3.2 DOMESTIC ABUSE

3.2.1 Domestic abuse was experienced by Mairead and Amy, as well as by Miss C. Mairead had disclosed domestic abuse, including coercion and control, by her partner. There are incidents reported by her partner that suggest that there may have been situational couple violence in the relationship. On one occasion in August 2018 the police were called as Mairead, and her partner were arguing in a tent. He had a cut to his head, and she agreed to sleep elsewhere whilst things calmed down. Only two weeks later, police attended as Mairead's partner had been seen holding her face down on the pavement. She was hitting her partner in the face. On this occasion, both were charged with assault on each other, but the cases were discharged as no evidence was offered. Amy had experienced domestic abuse from several previous partners. The review into Miss C describes her as having experienced domestic abuse on multiple occasions from her partner, including one assault described as being 'particularly violent'.

3.2.2 It is important when supporting those who are in an abusive relationship that the opportunities to intervene are clearly understood and taken by all agencies. There is a danger that, whilst the perpetrator is in custody, professionals breathe a sigh of relief because the victim is now safe. This is the time, however, when more resources, not less, should be directed to supporting the victim and helping her to exit the relationship permanently.

3.2.3 For women in abusive relationships the barriers will be accommodation, safety, and their relationship with the perpetrator. Many women feel that it is safer for them to stay with the perpetrator than to risk abuse from those on the street or in services.

3.2.4 It would be a huge mistake to underestimate the power of the 'trauma bond'. It is impossible for abused women to imagine being anywhere else. The importance of reliable consistent professionals with whom abused women can develop a relationship of trust cannot be overestimated.

3.2.5 **Routine questioning**

3.2.6 The review has considered whether professionals took the opportunity to routinely ask either woman about domestic abuse or if they felt safe in their relationships. The IMRs submitted have not covered this issue in detail but, it is possible to see that there were some occasions when the opportunity was taken. For example,

- When Mairead was taken to hospital by ambulance in March 2019 the safeguarding referral that Ambulance staff (SECAMB) submitted indicated that they had probed about bruises on Mairead, but it was not clear if she had been spoken to alone.
- Hospital staff had cause to ask her partner to leave when Mairead was admitted. They then took the opportunity to ask her if she felt safe and if anyone was hurting her.

These are examples of good practice.

3.2.7 There are examples, however, where it appears that the opportunity to ask about domestic abuse was not taken. For example, when Mairead registered with her GP in August 2018 the IMR has noted several issues discussed with her. Domestic abuse does not appear and therefore it is fair to assume that it was not asked. This is particularly concerning given that it is noted that she was pregnant. Mairead was then seen three times in October 2018 and there is no record of domestic abuse being asked about. Amy registered at the same GP practice and again there is no record of domestic abuse having been explored in any of her interactions.

3.2.8 When the Ambulance Service attended Mairead there is no indication that any questions about domestic abuse were asked.

3.2.9 In interactions both Mairead and Amy had with Sussex Partnership Foundation NHS Trust (Mental Health services) and BHCC Health and Adult Social Care (Adult Social Care). This is explored in more detail in section 4.5.

Learning point

All agencies and departments need to have up-to-date policies and procedures relating to the identification of domestic abuse, processes to be followed in raising this, and actions undertaken in response.

3.2.10 **MARAC (Multi-Agency Risk Assessment Conference) used to safeguard these women**

3.2.11 It is possible to observe attempts to safeguard Amy from domestic abuse through the use of MARAC.

3.2.12 Amy was discussed at MARAC in Brighton in November 2017 under the criteria of a repeat victim. At this meeting there was liaison with a neighbouring MARAC as Amy was planning to move out of Brighton. The case was heard at the neighbouring MARAC on 4th December where it had been referred under the criteria of professional judgement. At a subsequent meeting on 11th December the Chair stated that the case should be heard in full at Brighton MARAC as Amy was living most of the time at the perpetrator's address in Brighton.

3.2.13 After a number of emails, a MARAC-to-MARAC referral was done, and the case was listed for full discussion at Brighton MARAC on 17th January 2018.

3.2.14 A further referral to MARAC was made by Sussex Police on 22nd May 2019. On this occasion, the case was then transferred to the neighbouring MARAC as Amy was at a temporary address in Eastbourne. The case was discussed there on 4th June.

3.2.15 On 27th February 2020 Amy was discussed at the neighbouring MARAC having been referred by Sussex Partnership Foundation Trust under the criteria of professional judgement after Amy had answered yes to 19 questions on the DASH risk assessment. A good discussion took place, and a summary of the decisions was shared with the Brighton MARAC, but the case was not transferred.

3.2.16 Amy was then discussed by Brighton MARAC on 30th April following a referral by Sussex Police under the criteria of a repeat case.

3.2.17 Amy reported to police in December 2018 that her partner had assaulted her and damaged her mobile phone. At this point there was a history of domestic incidents going back over the previous 15 months. This incident was assessed as medium risk. The case was then heard at the neighbouring MARAC.

This review notes that in January 2020 MARAC Chair summaries were introduced to the process. These give an overview of the safety plan for each victim. It is noted that this has improved the record keeping and enables a reviewer to understand the 'thinking' of the panel. *This is an example of good practice.*

3.2.18 There were numerous discussions about where this case should be held – in Brighton or the neighbouring MARAC as the case crossed the boundaries of Brighton and East Sussex. Consequently, previous decisions were not always built upon and shared.

3.2.19 In the Miss C review it is stated that she was discussed at both the Eastbourne MARAC and the Hastings MARAC on 19 occasions. This noted the challenge for agencies to provide an effective and joined-up response for women with multiple disadvantages and need.

The MARAC case management system could have been used, and a flag added to confirm that all referrals should go to Brighton MARAC, but this was not used. There was confusion about where the case should be heard, and this would have been resolved by escalating the matter to managers, but this did not happen. The referrals to MARAC from the police were made by the different Safeguarding Investigation Unit (SIU) teams in Brighton and East Sussex. There was no sense of senior level co-ordination between the two SIU teams as can be seen, not only the referrals going to the different MARACs but also the fact that there were incidents reported on SCARFS that did not result in re-referrals to MARAC (between 17th January 2019 and 27th February 2020).

Recommendation

The MARAC Operating Protocol needs to be reviewed, and updated as necessary, to ensure there is clear guidance on how to manage cases that frequently cross local authority boundaries and when cases should be escalated to senior managers within the MARAC Support Team.

3.2.20 The role of MARAC was discussed at one of the practitioners' workshops and there was a concern raised that, at MARAC, it is hard for agencies to think about how they might work differently to safeguard a woman. For women who have experienced trauma, the standard action may not necessarily work. Agencies need to be more creative in considering opportunities to support and safeguard vulnerable women.

3.2.21 **Refuge**

3.2.22 Practitioners expressed concerns that there is not sufficient access to refuge spaces which could lead to vulnerable women being placed in emergency accommodation where there is a risk that they will be further abused.

3.2.23 Some women were not able to access refuge as they had substance misuse issues. By having to be abstinent from substances before being able to access refuge suggest that some are more deserving of support. It was felt that there is a need to provide, in refuges, not just support workers but *specialist* workers who are able to provide wrap around care.

3.2.24 Since these events occurred the review is advised that there have been changes in the local commissioning and provision of refuge to support those with multiple and compound needs. There is also advised to be ongoing work in this area and future developments will need to incorporate requirements in the Domestic Abuse Act 2021.

3.3 **SUBSTANCE MISUSE**

3.3.1 Both women had a history of substance misuse and died of a drugs overdose. It should also be noted that Miss C died of mixed drugs toxicity.

3.3.2 When Mairead was screened for alcohol use by her GP she scored 39/40 signifying high levels of alcohol intake, daily drinking in a dependent pattern (over 10 units each day, with loss of control). On 12th October 2018 she disclosed to her GP that she was also using cannabis, along with cocaine when she could afford it.

3.3.3 Mairead was offered community alcohol detoxification by her GP but was not happy about the need to attend daily and engage with group work. She and her partner became upset and said that they just wanted the medication. The offer of community detox was kept open. By the time her baby was born, Mairead was drinking heavily and smoking cannabis daily.

3.3.4 When Amy registered with her GP in August 2019, she reported that she did not drink alcohol or smoke. She used heroin, cannabis, and cocaine.

3.3.5 It is well-known that substances are often used as a form of self-medication – to blot out unwanted thoughts and emotions. Both women had life traumas that, understandably, they would wish to block out.

3.4 MENTAL HEALTH

3.4.1 Research has demonstrated that, for at least some conditions, there is a bidirectional causal association between mental disorders and domestic abuse[16]. One systematic review reported a three-times increase in the likelihood of depressive disorders, a four-times increase in the likelihood of anxiety disorders and a seven-times increase in the likelihood of post-traumatic stress disorder (PTSD) for women who have experienced domestic abuse. Significant associations between intimate partner violence and symptoms of psychosis, substance misuse and eating disorders have been reported[17]. Research suggests that women who experience more than one form of abuse are at an increased risk of mental disorder and comorbidity[18].

3.4.2 For all the women in this review, mental health was a significant factor. Mairead informed her GP when registering that she had a history of depression, borderline personality disorder and anxiety. She was referred to the perinatal mental health service and was seen by a psychiatrist in November 2018. Mairead had a longstanding history of suicidal thoughts and self-harm to reduce tension. She was prescribed an increased dose of antidepressants and was given information about how to contact the Mental Health Rapid Response Service (MHRRS) in an emergency.

3.4.3 In February 2019 Mairead called her GP saying she was feeling low and suicidal. There were no GP appointments available, so she was given the MHRRS number. Two weeks later, when 28 weeks pregnant Mairead was admitted to hospital having taken an overdose. She was assessed by the Mental Health Liaison Team at the hospital and for liaison with the perinatal team. The Perinatal Mental Health Service implemented a care plan on 6th March. It identified a working diagnosis of Emotionally Unstable Personality Disorder and Mairead was offered one to one sessions and Cognitive Behaviour Therapy (CBT). Her GP was advised to increase her medication.

3.4.4 On 10th April Mairead was admitted to hospital having taken an overdose of GHB. The GP was advised that the Assessment and Treatment Service (ATS) within Sussex Partnership Foundation Trust (SPFT) had taken over her care. However, the next day Mairead did not attend her appointment and said that she did not wish to have contact from them, and she was discharged from the service.

3.4.5 After Mairead's baby was born and then fostered she received support from ATS, she was offered 1-1 support and advised to engage with substance misuse services. At a multi-disciplinary team (MDT) meeting it was noted that her mental health was deteriorating, and it was agreed to suggest to ATS that they bring forward her review and offer 1-1 support.

3.4.6 Amy had a number of diagnoses over the years:

[16] Devries KM, Mak JY, Bacchus LJ, et al. Intimate partner violence and incident depressive symptoms and suicide attempts: a systematic review of longitudinal studies. PLoS Med 2013; 10: e1001439. Cited in Violence against women and mental health, Oram et al, The Lancet, 2017

[17] Oram et al, The Lancet, 2017

[18] Romito P, Turan JM, Marchi MD. The impact of current and past interpersonal violence on women's mental health. Soc Sci Med 2005;60: 1717–28 cited in Violence against women and mental health, Oram et al, The Lancet, 2017

- 1997 Schizophrenia
- 1998 Paranoid psychosis
- 2006 Psychosis
- 2016 Depressed mood
- 2018 Depression

3.4.7 At the end of August 2019 Amy was seen by an out of hours GP for low mood. Amy then contacted the Out of Hours (OOH) service about her low mood and anxiety seventeen times between September and 12th December. On 12th December Amy was seen by the Mental Health Liaison Team (MHLT) at the emergency department at Eastbourne Hospital. She was feeling suicidal and isolated. A request was made for the lead practitioner to contact Amy and engage with her.

3.4.8 From 13th December to 12th January 2020 Amy called OOH service six times. The last contact that the OOH service had with Amy was on 16th April when she was confused and anxious.

3.4.9 There was no concerns identified by agencies who supported Mairead and Amy regarding their decision-making, and mental capacity. However, the impact of trauma, substance misuse, and coercion and control on decision-making can often be overlooked. This has been identified in previous reviews, including locally in SAR James that was published by the BHSAB in May 2021.

3.4.10 The review heard from the strategic representatives that mental capacity is frequently used as a basis for service disengagement. Individuals are identified as making unwise decisions, and services ceased on that basis, without sufficient consideration of the factors that may be unduly influencing the decision-making process.

3.4.11 The review into Miss C describes her as also having experienced poor mental health and suicidal ideation. Whilst there was felt to be a good initial response to this deterioration by services it did not lead to any specialist support from mental health services, due to the presence of her violent partner.

3.4.12 When we consider the struggles faced by the women in this review, we are drawn back to the World Health Organisation definition of mental health. They describe it as a 'state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to contribute to his or her community'[19]. Sadly, this is not a definition that can be applied to these women with multiple and compound needs.

3.5 DUAL DIAGNOSIS

3.5.1 Dual diagnosis is a term used to describe someone who has both mental health and substance misuse issues. Both women had dual diagnosis. One of the challenges in supporting and treating those with dual diagnosis is to work through the conundrum of:

[19] World Health Organisation, 2018, https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

- To address a person's mental health issues, they must first deal with their substance misuse
- A person's substance misuse cannot be addressed without treating the underlying mental health issues

3.5.2 Those with co-existing mental health and substance misuse issues are at higher risk of relapse, hospital admission and suicide.

3.5.3 Since 2002 the Department of Health has been clear that the primary responsibility for those with dual diagnosis sits with mental health services who must work closely with substance misuse services to establish an appropriate pathway.

3.5.4 The problems for those experiencing dual diagnosis were discussed in the practitioners' workshop. It was said that the system is under pressure and is considerably worse than it was 10 years ago. Practitioners felt that, as the contract for dual diagnosis services has reduced, the psychiatrists have been removed from the system as they are more expensive and the underlying mental health needs of clients are not being met.

3.5.5 Practitioners felt that it was detrimental to the long-term outcomes for clients if the only available option for detoxification is in Essex. It was felt that services should be available locally.

3.5.6 The workshop was told about a private, local Residential recovery service that works with people who find it hard to engage with mental health services. It was said that clients have thrived well there because there is support on site for their mental health and substance misuse issues. Clients who attend there, the workshop was told, are more likely to engage with services in the community when they leave***. This is an example of good practice.***

3.5.7 There is evidence that in March 2019 Mairead was offered an appointment for a dual diagnosis assessment, but she did not attend. This demonstrates that her dual diagnosis was considered by practitioners.

3.5.8 The IMR completed by SPFT identifies that Mairead had co-existing needs and, on reflection, note that she didn't 'fit' into one service. This is reflected in decisions made during periods of input with secondary mental health services and substance misuse services. This may have created barriers for Mairead in accessing services in a timely way.

The review is advised that there is currently a pilot scheme in place where a Service Manager sits across services provided by CLG and ATS (within SPFT) to help build better relationships and support service users who sit between these two services.

Recommendation

The SAB ask the Integrated Care System (ICS) commissioners to explore how the underlying mental health needs of people with dual diagnosis are being met, including the psychiatry element of dual diagnosis treatment.

Recommendation

Whilst recognising recent changes in commissioning and service provision to provide refuge to people who require detoxification support, or who have ongoing substance misuse needs, the SAB ask relevant commissioners to consider the wide variety of accommodation-based models being used elsewhere in continuing to develop refuge provision locally for those with multiple and compound needs and fleeing domestic abuse.

3.6 UNSTABLE HOUSING

3.6.1 For women experiencing domestic abuse, home may be the most dangerous place for them. Safe and stable housing is vital for those living with domestic abuse. Each of the women in this review relocated to the local area from another part of the country and looked to the local authority for support with housing.

3.6.2 Shelter identifies that, since 1980, the number of social housing households has declined by 26%. They state in 2018/19 only 6,287 new social rent homes were delivered nationally whilst the sale and demolition of social housing totalled 23,740 resulting in a shortfall of at least 17,000 social homes in a single year[20]. The current housing crisis includes:

- A shortage of affordable and social housing stock
- Long waiting lists for social housing
- High cost of private rented accommodation

3.6.3 One of the options for women fleeing domestic abuse is to move into refuge. Unfortunately, these services are overstretched and cannot meet the high demand. In 2018-19 64% of referrals to refuge were being declined[21]. Women with additional needs often find accessing refuge even more difficult. The barriers to refuge lead to women remaining in unsafe, unstable accommodation.

3.6.4 When presenting to a new area, the local authority must decide if they have a duty to provide housing to the person presenting. Demand for social housing far exceeds the supply of accommodation available. Under the Choice Based Lettings Scheme, called Homemove, those who are eligible and qualifying applicants are placed into one of four bands that will take account of their housing need according to their circumstances.

3.6.5 Someone is deemed to be eligible and qualifying under the criteria set out in the Housing Act 1996. It is unlawful for the council to allocate housing to a person prescribed as ineligible in the Act, but the council has the power to classify if a person is a qualifying person.

3.6.6 To be accepted onto the council register a person must have lived in the Brighton and Hove area continuously for the five years immediately preceding the date of application *unless* they are homeless, and the council has accepted a full duty to them under the Housing Act 1996 Section 193 (2) that has not yet ceased.

[20] www.blog.shelter.org.uk/2020/01/new-data-makes-the-case-for-a-new-generation-of-social-homes cited in Locked Out: Barriers to housing for people facing social injustice, Commonweal Housing, 2020

[21] Women's Aid (2020). The Domestic Abuse Report 2020: The Annual Audit, Bristol: Women's Aid.

3.6.7 Applicants will not qualify for social housing and be registered on the housing register if they have refused two offers of suitable accommodation within the last two years made or arranged by the council.

3.6.8 Applicants will be placed in Band A (highest priority) if, in exceptional circumstances, they cannot remain in their current accommodation due to insurmountable problems and there is imminent risk to them if they remain. This may include, but is not limited to, domestic abuse, racial harassment, homophobic, transphobic, bi-phobic abuse, or harassment.

3.6.9 When a person presents to the council as homeless, their application will be considered. If the council considers that they have a duty under the Housing Act they will be offered accommodation. This will usually be, initially, emergency accommodation such as a B&B or short-term temporary accommodation, before moving into longer term temporary accommodation.

3.6.10 Amy was placed in temporary accommodation from 11th October 2018[22] but in December she returned to live with her partner again and was assaulted by him. At the time of her death, Amy was in an emergency placement in a supported living setting.

3.6.11 Mairead and her partner presented to the council in October 2018 when she was six weeks pregnant. They had been rough sleeping in the city having moved to the area from London. She was identified as being in priority need due to her pregnancy and they were placed in emergency accommodation whilst the homeless application was made and assessed. In May 2019 the offer of temporary accommodation was made, and they moved on 15th May. At this point, as accommodation had been provided, the council's homelessness duty was discharged.

3.6.12 Unstable housing was also a key element of the Miss C review. She experienced periods of homelessness, spent time in temporary accommodation but was also deemed not eligible for housing at certain points. She was denied access to refuge because of the risk posed by her violent partner and to private rental accommodation because of her ongoing substance misuse.

The housing department has identified that they experience ongoing issues with information sharing between agencies, particularly in relation to safeguarding. Staff are often not included in multi-agency meetings, and they do not have access to the Adult Social Care IT systems.

Learning point

In order to support people with multiple and compound needs all relevant roles in housing need a point of access to Adult Social Care IT systems.

3.6.13 Staff in the homelessness department have identified that there is a lack of understanding across agencies about the housing provision is available locally and what this includes. For example, emergency and temporary accommodation is just that, a roof in an emergency,

[22] Due to historical data not being able to be accessed there is no further information about this housing application

and does not provide support to the clients. This can lead to unrealistic expectations of the support that the client will receive and lead to clients being placed in housing that does not meet their complex needs.

Recommendation

A clear explanation of the role of housing and the services that are provided is prepared and made available to all agencies in the Brighton and Hove area. This will enable greater shared understanding and additional support arrangements to be put in place to meet individual need as required.

3.6.14 The review has noted that Mairead was accommodated in the city as soon as she presented to Housing Options. There was good communication between her support workers and the Homelessness Prevention Team. There is evidence that, even when Mairead was reluctant to engage with the Temporary Accommodation Team, they were persistent and ensured that she moved into temporary accommodation before the birth of her child. ***This is an example of good practice.***

3.6.15 Practitioners described housing as an area where it is particularly difficult to deal with the challenging behaviour of clients who have experienced trauma within their policies and procedures. It was well acknowledged that the challenging behaviours that are being displayed are a breach of a tenancy agreement and may well be impacting on other residents.

3.6.16 There was a sense of frustration with certain aspects of the housing provision. For example,

- That clients are, on occasion, evicted without engagement with those working with the person
- That clients are moved out of area due to lack of availability locally.

3.6.17 It was also recognised that housing practitioners, in many cases, understand that the behaviour is a consequence of the trauma that has been experienced but when a tenant is unable to engage with the support being offered it poses a real dilemma. The housing provider is unable to manage the behaviour in that setting and so the client is moved on – with all the inherent issues that this brings.

3.6.18 The number of providers of emergency accommodation locally are limited and, it was felt by practitioners, that their expectations about how those who have experienced trauma will behave are unrealistic.

3.6.19 There was a concern that private providers, where many women with multiple and compound needs are housed, can act unilaterally. If a person is evicted from one provider, at short notice and with no support, it is likely that they will continue to present in the same way at the next provider and be evicted from there also.

3.6.20 Practitioners were concerned that once a person is barred from emergency accommodation there is no way back for them regardless of if their need and behaviour changes in the future.

3.6.21 Conversely, there was a sense that housing providers are, often, providing support over and above that which they are commissioned to provide to support vulnerable tenants. The example was shared of a tenant who takes an overdose but refuses to go to hospital and housing staff are providing a constant watch to keep them safe.

The review was left with the impression that the availability of emergency and supported accommodation for those with multiple and compound needs is not sufficient to meet the local need.

This raises a question about how we deal with women experiencing trauma who are not able to engage with support at that time. The workshop was told about the *Emergency Accommodation Charter,* that is being developed. This needs to include a focus on providing stable accommodation and support for those who have experienced trauma.

3.6.22 Practitioners felt strongly that supported accommodation is currently 'papering over the cracks'. The need has grown but the provision has reduced. There are large buildings that are not safe for people with multiple and compound needs.

3.6.23 Workshop delegates identified that during the first phase of the COVID-19 national lockdown, Brighton operated (along with all local authorities) the Everyone In[23] initiative. Whilst acknowledging that the views expressed were anecdotal, it was felt that the provision for vulnerable people improved because, regardless of housing status and local connection, the view was 'house first and then ask questions' rather than expecting people to get well before they are accommodated.

3.6.24 Practitioners said that their clients felt safe in the Everyone In accommodation and that they had not felt safe in emergency accommodation previously.

The review was advised that supported accommodation provision is due to be reviewed but practitioners felt that a timelier fix is needed.

3.6.25 Those attending the workshops felt that, for women with multiple and compound needs, there is a need for women only spaces and services, particularly in the homeless sector. Many delegates talked about women avoiding services for fear of assault/abuse or meeting their perpetrator. Vulnerable women need to build trusting relationships.

3.6.26 The delegates felt very strongly that the answer is not to just develop women only spaces. It was felt that it would be relatively easy to take a hotel and decide that it will operate as a women only space but that, whilst this may be protecting women from external factors, if the services are not commissioned correctly the women will be placed in even more risk.

3.6.27 The experience of women in the Everyone In initiative during COVID-19 was positive. As a result of women being placed in hotels they had, some for the first time, a door that they could lock along with a private shower and bathroom. Women were given phones and

[23] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/928780/Letter_from_Minister_Hall_to_Local_Authorities.pdf

tablets to allow them to maintain contact with services and they were better protected from exploitation. Over time visible improvements were seen in women's presentation and self-esteem and they began to make progress. Unfortunately, there is now a move back to hostel accommodation and, for some women, things are unravelling again. That said, the Equinox hostel was commended as a place where women have a real opportunity to take a breath and move forwards.

The review acknowledges that placing a number of women with multiple and compound needs together in one place is not without its challenges and the capacity needs to be built into the service to manage the dynamics between clients.

Recommendation

Whilst accepting the inherent challenges, that the SAB ask community safety and integrated care system commissioners to explore the feasibility of providing supported accommodation for women with multiple and compound needs, with consideration given to the cost benefit analysis over time of more expensive crisis driven interventions.

3.7 CHILDREN IN CARE

3.7.1 Mairead, prior to moving the Brighton, had lived in London where she had two children who were both immediately taken into care. During the scope of this review, Mairead gave birth to another child who was also taken into care.

3.7.2 Amy had her child taken into care in February 2019.

3.7.3 Research by Lancaster University found that over 11,000 women had more than one child removed between 2007 and 2014. One in four women who has a child removed through the family courts is likely to have another removed and that number increases to one in three if they are a teenage mother. Four out of ten women who have had multiple children removed have been in care themselves. A further 14% lived away from their parents, in private or informal arrangements, while many more have experienced disruptive or chaotic childhoods[24].

3.7.4 Where the state intervenes to remove children, birth mothers experience loss but this is magnified where this is repeated yet there has been little research into understanding the experiences of these women. Broadbent's research found that, for birth mothers who have their children removed from their care, the interval between one set of care proceedings and the next may constitute a vital window for recovery. However, the timeframes were out of sync with what is known about realistic recovery from problems such as mental health or addiction – the problems that frequently characterise the lives of women whose children are removed (Sidebotham and Heron, 2006; Brandon et al, 2008; Bockting et al, 2015[25]). Broadhurst et al noted that a sizeable percentage of women reappear in the family court, sometimes multiple times, because their problems are *repeated* not *resolved.*

[24] https://www.pause.org.uk/why-pause/the-data/

[25] Cited in Connecting Events in Time to Identify a Hidden Population: Birth Mothers and Their Children in Recurrent Care Proceedings in England, Broadhurst et al, 2015

3.7.5 When a child is taken into care, there is no statutory obligation for support to be offered to the mother and, as has been suggested by some, once the child has been removed the mother's need does not meet adult services threshold for intervention and support (Ashley, 2015[26]). Interviews undertaken by Dr Karen Broadhurst, of Manchester University, with over 60 birth mothers in five local authority areas in a study for the Nuffield Foundation, found that 'mothers feel completely abandoned after their child has been removed. There would be more attention paid to your rehabilitation if you were a criminal'[27].

3.7.6 Practitioners felt that for women who were involved with Children's Social Care services (known as Families, Children and Learning or FCL locally), interaction required them engage with an administrative system that thrusts them into meetings that can, in themselves, be retraumatising. One person said, 'you work at the point where very powerful organisations meet very powerless people'.

3.7.7 The delegates felt that trauma informed practice is embedded in FCL, but, on the other hand they said that it will depend on individual practitioners' experience. It was felt that there is a sense of victim blaming of women at a very deep level. Women are made entirely responsible for the wellbeing of their children even when the father is being abusive. Women will internalise this victim blaming and will carry this burden for many years. It can then take time and support to unpick this internalised victim blaming in women.

3.7.8 The review was told about the existence of 'Looking Forward', a service delivered by Oasis Project in partnership with Fulfilling Lives. This supports women who have had children removed and can also enable access to mental health and drug and alcohol services. It is viewed as a positive example of a preventative service. However, the service only having a single full-time practitioner and with the funding for the service due to end this year can be seen as reflecting both the lack of resources as well as the lack of priority given to preventative services.

Recommendation

As part of their future audit programme the SAB consider undertaking a review of the transitional approach taken towards transitional safeguarding between Children's and Adult services, focusing for example on the identification of trauma and support provided for mothers whose children are taken into care.

[26] https://www.theguardian.com/society/2015/apr/25/are-we-failing-parents-whose-children-are-taken-into-care

[27] IConnecting Events in Time to Identify a Hidden Population: Birth Mothers and Their Children in Recurrent Care Proceedings in England, Broadhurst et al, 2015

Section Four - Answering the questions posed in the Terms of Reference

4.1 As the questions posed in the Terms of Reference were not specifically asked in the IMR template provided to agencies the review has sought to glean the answers from the IMRs submitted, as well as through the strategic representative's event. There was an element of overlap between the questions and evidence found therefore the review has sought to avoid duplication across the questions.

4.2 **COULD THERE HAVE BEEN INCREASED CO-ORDINATION AND OVERSIGHT ACROSS AND WITHIN THE AGENCIES?**

4.2.1 The number of agencies involved with each of the women in this review demonstrates the complexity for service providers in meeting the needs of women with multiple and compound needs. Survivors interviewed in the Harris and Hodges (see 3.2.7) evaluation said that they became frustrated in having to repeat their story to every agency and this view has been replicated across many studies over the years. The survivors said that the support of a dedicated keyworker facilitated the trust needed to build relationships and access services. It is not clear in either Mairead or Amy's chronology that either had a keyworker or lead professional who liaised between the different agencies.

4.2.2 The way in which services are commissioned can unintentionally create a labyrinth of services that women must navigate[28].

4.2.3 It is clear from reading the individual management reviews that there were numerous organisations involved with both Mairead and Amy but what is not evident is clear, joined up working with one agency being identified as the lead.

4.2.4 The Housing IMR identifies what the author describes as 'ongoing issues with information sharing between agencies – particularly in relation to safeguarding'. This suggests that this is not an isolated issue with this review. Housing cite that they are often not included in multi-agency meetings and do not have access to the Adult Social Care Information Technology (IT) system.

Learning point

The Adult Social Care IT system should be accessible to identified representatives from other statutory agencies working in partnership to safeguard and support people with multiple and compound needs.

4.2.5 SPFT also identify that they were aware Mairead was known to several other services and that there appeared to be an absence of co-ordinated, person-centred support planning.

4.2.6 The chronology shows that Mairead came to the notice of Sussex Police in August 2018 and a SCARF was completed. This suggests that all agencies were advised of her presence in

[28] Harris, L. and Hodges, K. (2019) Responding to complexity: improving service provision for survivors of domestic abuse with 'complex needs', Journal of Gender-Based Violence, vol 3, no 2, 167–184, DOI: 10.1332/239868019X15538587319964

Brighton and ***is an example of good practice***. She then registered with her GP in October when she advised that she was pregnant and was referred to specialist midwife at the hospital. At this point, according to housing, Mairead was known to St Mungo's, Anti-freeze, Justlife, Arch Surgery and midwifery services, Sussex Police and Families, Children and Learning services (FCL). In November a review was undertaken of Mairead by SPFT with the One Stop Clinic and Pavilions. In February 2019 a Child Protection Conference was held in relation to the unborn child but at no point were there any multi-agency meetings to discuss Mairead and her needs.

Whilst reviewing the case with hindsight, it is clear that there was no multi-agency discussions about Mairead and her needs, it is unclear to the review where these discussions might have taken place and who would have initiated them. The police, in their IMR, advise that they did not refer Mairead to MARAC as the domestic abuse incidents were 'all of a fairly low-level nature' and twice featured Mairead as the perpetrator.

4.2.7 Whist Amy was discussed, on a number of occasions at MARAC it is not clear that this provided any additional safeguarding input, and this is discussed in more detail in a previous section.

4.2.8 The review was advised that there are several local multi-agency forums in place currently. In addition to MARAC and a multi-agency safeguarding hub (MASH) there is also a monthly Operation Cuckoo meeting (for victims of cuckooing), a Complex Risk Management (CRM) process for people who are homeless or where there are housing issues. There has also been a homeless mortality review process, although both this and the CRM meetings have been paused during the pandemic.

4.2.9 The Operation Cuckoo, CRM and Homeless mortality review meeting processes were all viewed as positive, multi-agency processes that are preventative in approach. ***This is an example of good practice.***

4.2.10 However, these processes all consider individuals or situations where there is a singular or specific need or issue. Delegates at the strategic representative's event meeting advised that they were not aware of any relationship that connects these processes, or that considers need or risk in a broader form.

4.2.11 The need for there to be a multi-agency framework, or forum, to support individuals with non-specific multiple and compound needs, and where there is felt to be significant risk, was identified. Delegates discussed this supporting the development of a shared understanding of service legislative frameworks, processes and language and acting as a preventative mechanism.

Recommendation

The SAB to work with partner agencies to develop the framework for a multi-agency risk management (MARM) process for presentation to board members. This will enable women (as well as men) with multiple and compound needs to be referred and discussed as a key element in developing a preventative multi-agency response to adult safeguarding, in line with arrangements already in place elsewhere in Sussex.

4.3 DO PROFESSIONALS AND AGENCIES HAVE THE KNOWLEDGE, SKILLS, AND EXPERIENCE TO SUPPORT PEOPLE WITH COMPLEX AND MULTIPLE NEEDS?

4.3.1 The IMR template had a section headed Staff knowledge and awareness which asked, 'Were staff sensitive to the needs of the individual(s) in their work; knowledgeable about potential indicators of abuse and neglect; and aware of how to share and raise concerns?

4.3.2 Sussex Police

4.3.2.1 In 2018, 250 Domestic Abuse mentors were introduced across the organisation to ensure that good practice is embedded.

4.3.2.2 The IMR identified that there were 10 SCARFs completed in relation to interactions with Mairead. Whilst the quality is much improved, there were still inconsistencies in relation to VAAR submission. This is now a theme that is quality assured by DASP so that learning, and recommendations are embedded into working practice across the organisation. For this reason, the review does not make a recommendation in relation to this.

4.3.2.3 There is evidence that first responders used their professional curiosity on several occasions. For example, on 23rd March 2019 Mairead made an 'abandoned call' to the police. The caller was heard to say, 'get out' before the call ended. Officers were able to trace the number to Mairead and attended the address. The officers advised FCL of the dirty state of the flat and that she had a glass of cider by her bed (she was pregnant at the time).

4.3.3 MARAC

4.3.3.1 It was identified, by the IMR author, that MARAC representatives and MARAC chairs could usefully receive training specifically on working with victims with multiple and compound needs.

Learning point
MARAC representatives and MARAC chairs would benefit from training in working with victims with multiple and compound needs.

4.3.4 Sussex Partnership Foundation NHS Trust (SPFT)

4.3.4.1 Mairead struggled to engage with the support that she was offered. It does appear that when she was referred to Assessment and Treatment Services the Lead Practitioner was sensitive to her needs and Mairead engaged well with support. ***This is an example of good practice.***

4.3.4.2 SPFT felt that having reviewed the case notes, it appeared that a trauma informed approach to working with Amy was adopted.

4.3.4.3 OTHER ORGANISATIONS

4.3.4.4 There were some organisations that provided little or no information in their IMR that allowed this question to be answered. This has been fed back to the BHSAB for further consideration.

4.3.4.5 There was additional consideration of this area during the strategic representatives' event meeting. The pressure on services, and therefore on professionals, was acknowledged with caseloads being seen to have significantly increased. This has led to some organisations experiencing severe challenges in the retainment (and recruitment) of staff, with a clear and direct impact on knowledge, skills, and experience.

4.3.4.6 The review heard that the impact of austerity has also contributed to a reduced overall number of professionals working directly with individuals. However, it was recognised that this is not the sole reason and is exacerbated by an overall lack of consistency across the system in areas such as trauma and exploitation.

4.3.4.7 Whilst there are 'pockets of good practice' much of the current arrangements rely on individual practitioners, networking and established professional relationships.

Learning point

As it has not been possible to fully reassure the SAB that from an organisational perspective professionals have the necessary skills, knowledge, and experience within their workforce to meet the needs of women with multiple needs this area may require further consideration.

4.3.4.8 Professionals recognise that clients with multiple and compound needs are difficult to work with. They can present as unreliable, reluctant, and difficult to treat and support. What are described as 'chaotic lifestyles' can go hand in hand with these needs, some of which may be undiagnosed. This can impact upon a client attending for appointments and engaging with services. Consequently, those with multiple and compound needs can be vulnerable to reaching a crisis point.

4.3.4.9 There is evidence to suggest that it could, at times, be difficult to work with both women. For example, the GP surgery records an incident in December 2018 when Mairead was seen with her partner. The practitioner was discussing community rehabilitation and Mairead and her partner both became upset and said that they just wanted medication. They left saying the doctor and nurse were not good at their jobs. On another occasion, Mairead was issued with a warning letter by the GP surgery after she became abusive towards staff.

4.3.4.10 There is no escaping the fact that working with women with multiple and compound needs is draining and will take its toll on staff. They may experience vicarious or secondary trauma, compassion fatigue or burnout. This is an area that was specifically explored in the practitioner workshops.

4.3.4.11 During these discussions it became clear that the quality of the services that vulnerable women receive is based, not only on the services commissioned, but more importantly on those who are delivering the frontline service.

4.3.4.12 One person said that the current caseloads are not sustainable. People are on their knees and excellent staff are leaving in droves. The point was made that, the more robust a person

is, the more likely they are to leave because they will see how unhealthy and unsustainable their situation is. The responsibility for vulnerable women weighs heavily on workers. One person said, 'this is not the way I want to work; I want to do this right, and we want to focus upon people'.

4.3.4.13 Research published recently in The Lancet discussed the effects of moral injury on mental health[29]. Moral injury is understood to be the strong cognitive and emotional response that can occur when events violate a person's moral or ethical code such as someone's workload resulting in them delivering a standard of service that falls below what they would consider to be good enough. Whilst moral injury does not necessarily involve a threat to life it threatens one's deeply held beliefs and trust. Whilst it is not considered a mental illness, it can cause profound feelings of shame and guilt and maladaptive coping responses such as substance misuse or social withdrawal. Attendees had seen the impact of moral injury on colleagues.

4.3.4.14 The review was advised that prior to the COVID pandemic there were opportunities for workers to come together for peer support. The review was pleased to hear that these were beginning again at the end of October. One practitioner said that this ability to share their experiences with their 'community' was particularly valuable.

4.3.4.15 More concerningly, some practitioners expressed the view that organisations talk about building resilience but that they don't necessarily put this into practice. Practitioners felt that clinical supervision should be mandatory in organisations.

4.3.4.16 Some organisations offer a series (usually six) sessions of counselling, but it was felt that this was not sufficient for extreme circumstances such as a client taking their own life. It was felt that the support provided depends upon your own ability to advocate for support and the support of your manager.

4.3.4.17 The picture was, however, mixed with one organisation referring to a clinical psychologist and chaplain to support the service through individual and group work.

Learning point

In recognising the findings from this review agencies should consider reviewing the supervision and support that is being provided to professionals working directly with people across the system, ensuring improvements are made where necessary.

4.4 ARE CURRENT SYSTEMS, POLICIES AND PROCESSES THAT ARE IN PLACE TO ASSESS AND MANAGE RISK PRESENTED TO WOMEN WITH COMPLEX AND MULTIPLE NEEDS SUFFICIENT AND WELL ADOPTED?

4.4.1 Sussex Police

[29] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(21)00113-9/fulltext

4.4.1.1 In 2020, Sussex Police introduced the Domestic Abuse Scrutiny Panel (DASP). This is a monthly meeting chaired by the Head of Public Protection to ensure that frontline investigations are delivering effective and efficient outcomes for vulnerable victims. The Panel examines many of the themes, which due to non-compliance issues have historically featured amongst safeguarding review recommendations. The purpose of the DASP is to provide a forum for sharing best practice, learning and problem solving by way of auditing and analysing compliance regarding the completion of safeguarding templates, effectiveness of safeguarding measures implemented, support service referrals, supervisory oversight, and quality of investigations.

4.4.1.2 The quality of Vulnerable Adults at Risk (VAAR) section of the Single Combined Assessment of Risk Form (SCARF) is quality assured by the DASP.

4.4.1.3 The Evidence Led Prosecution Domestic Abuse Scrutiny Panel (ELP DASP) has also been recently established as a separate entity to DASP and with similar objectives focussing on improving outcomes in relation to cases where there are evidential difficulties or proactive collection of third-party evidence is required.

4.4.1.4 April 2020 saw a revised NICHE safeguarding template being introduced, together with the introduction of a Safeguarding Guidance Booklet by Sussex Police, which is based around the assessment of risk principles (RARA-Remove, Avoid, Reduce and Accept) when determining the necessary safeguarding action taken and required. It is intended that this template will continue to be completed for every DA incident and will further improve the management of risk and protection of the vulnerable.

4.4.1.5 After the investigation on 24th June 2019 when officers attended Mairead's flat in response to a violent domestic incident, it was recorded that markers were placed on the address, along with mobile numbers attributed to Mairead and her partner. These markers alert first responders to her vulnerability, levels of risk and domestic abuse. However, the IMR author established that these markers were not in place. This had the potential to reduce the information that was available to first responders. The IMR author states that, despite this, NICHE checks were completed so officers were made aware of 'warning markers' prior to attending. The review does consider that this omission potentially reduced the information about Mairead's vulnerability that was available.

4.4.1.6 There were 16 SCARFs, 11 DASHs and 6 VAARs submitted in relation to incidents involving Amy. The IMR author notes that there 6 additional incidents when SCARF submissions could have been considered and four where the SCARF should definitely have been completed. This is an issue that is being reviewed on an ongoing basis by DASP.

4.4.1.7 In November and December 2019 Amy made several calls to the police when she was bored and could not sleep. Despite this, and officers contacted the hostel to request a welfare check on her and SCARF and VAAR submissions were made to ensure that mental health partners were aware. ***This is an example of good practice.***

4.4.2 **MARAC**

4.4.2.1 In a conscious effort to ensure that agencies were aware of continued risks to Amy there were numerous re-referrals to MARAC. However, Amy had several long-term vulnerabilities and support that Amy needed. These were not always the key focus of MARAC discussions, and they were discharged to SPFT to manage.

4.4.2.2 There is a danger that, in an effort to provide a forum for risks to be managed, MARAC has become a default for agencies. There is a sense that, having identified a risk, this is discharged by a referral to MARAC with MARAC then discharging it back to the agency.

4.4.2.3 The review accepts the challenges for the SAB and agencies in having a system that manages risk in a multi-agency way and adds value but does not then become a 'dumping ground' and leading to agencies, possibly unconsciously, absolving themselves of responsibility.

4.4.2.4 Another question that is raised is whether the SAB is confident that referral processes are working appropriately and whose responsibility it is to monitor this. For example, the police NICHE record in relation to the incident of domestic abuse on 24th June 2019 shows that a request was made for the safeguarding plan in relation to Mairead and her partner to be reviewed, and that history markers were placed on all addresses and phone number. A referral to Rise (a Brighton-based charity for people affected by domestic abuse) was made and both adult and children's services were made aware of her current mental health issues.

4.4.2.5 The review does not have the information to know what happened when these referrals were received in these other agencies. Was action taken? If so, what action was taken? More importantly at this point is the question about the responsibility of the agency making the referral. Is there an expectation that the police would follow up with the agencies to ensure that their referral was acted upon? If not, how can the system be certain that referrals are acted upon in an appropriate way?

Learning point

The way in which risk is managed both within agencies and between agencies needs to be effective and there needs to be the means to identify and to respond to escalating risk.

4.4.3 IS THE SUPPORT AND SERVICES THAT ARE AVAILABLE TO HOMELESS WOMEN WITH COMPLEX AND MULTIPLE NEEDS ACCESSIBLE AND MEETING THEIR NEEDS?

4.4.3.1 Harris and Hodges argue that if individuals must seek support from a wide range of services it reflects a failure of the helping services to respond to the range and severity of individual needs[30].

4.4.3.2 These cases have highlighted the complexity of the needs of these clients and the lack of support for them when in emergency or temporary accommodation. This is discussed in more detail earlier in the report.

[30]Harris, L. and Hodges, K. (2019) Responding to complexity: improving service provision for survivors of domestic abuse with 'complex needs', Journal of Gender-Based Violence, vol 3, no 2, 167–184, DOI: 10.1332/239868019X15538587319964

4.4.3.3 It is noted that when Mairead presented as homeless, she was provided with emergency accommodation whilst her application was being assessed. Once it was deemed that the council had a duty to provide her with accommodation and she was in priority need, temporary accommodation was provided to her. The Homeless Prevention Team worked closely with Mairead's support workers. The Temporary Accommodation Team were persistent in engaging with Mairead even when this was difficult and ensured that she moved into her temporary accommodation before the baby was born. ***This is an example of good practice.***

4.4.3.4 The Housing IMR has highlighted the two issues that are critical to this review – the complexity of clients placed into temporary and emergency accommodation and the lack of support available to this cohort of extremely vulnerable people. This has been discussed in more detail earlier in the report.

4.4.3.5 It is noted that several times health services refer to Mairead as failing to attend appointments. Consideration needs to be given to the way in which we expect women with multiple and compound needs to engage with services. Is a more flexible approach required?

4.4.3.6 The review was told by delegates about a planned Homeless Health Hub which houses all the necessary services under one roof. This would bring all agencies together in one building. This was a recommendation of a Coroner's Regulation 28 Report to Prevent Future Deaths. The Feasibility Report was completed in February 2020 and, the coroner was advised, would be considered when the area entered the recovery period from the initial phase of the response to the COVID pandemic.

4.4.3.7 The review has also been made aware of the Fulfilling Lives South-East Partnership work carried out in the area, as well as the Changing Futures programme funding that has been secured over the next two years. The Fulfilling Lives stakeholder briefing (June 2021) sets out work completed so far and further work being carried out during the 2021/22 period. This work has the capacity to be hugely beneficial to the women identified through this review and should be embraced.

4.4.3.8 In addition to the above Public Health led on a joint strategic needs assessment (JSNA) with regard to complex and multiple needs. The review has been advised that a task and finish group is being established to take forward this work and there is an opportunity for the outcomes from these various processes to be shared in seeking to inform future health and social care commissioning arrangements.

Learning point

The NHS should continue to evaluate the need for a Homeless Health Hub and subject to that outcome multi-disciplinary support will be required to achieve this.

4.5 HOW EFFECTIVE IS THE APPROACH TAKEN BY AGENCIES REGARDING SAFEGUARDING AND DOMESTIC ABUSE? ARE THE TIMESCALES IN FORMAL SAFEGUARDING ENQUIRIES BEING FOLLOWED?

4.5.1 There is evidence that adult safeguarding concerns were identified by agencies working with the women. Formal safeguarding concerns were raised by the Ambulance service (SECAMB) on four separate occasions, including when Mairead was admitted to hospital in March 2019 whilst pregnant. Concerns were also raised by hospital staff and Adult Social Care (HASC) recorded that the eligibility criteria for a section 42 safeguarding enquiry under the Care Act had been met at this point; identifying domestic violence, suicidal ideation, as well as the risks to the unborn child. The records advise that safeguarding enquiries would be progressed by Mental Health services (SPFT) and Children's Services (FCL) but despite further safeguarding concerns being raised in April 2019 no section 42 enquiries were ultimately undertaken. It appears this was due to a lack of co-ordination and clarity between agencies, primarily SPFT and HASC. There was also some confusion as to the role of FCL, who had separately undertaken a strategy meeting.

4.5.2 Further safeguarding concerns were raised in respect of Mairead in April, June, and September 2019 but it appears there was initially a lack of clarity as to which agency would lead these enquiries, primarily between SPFT and HASC, and latterly missed opportunities to identify abuse and neglect was occurring. During a Police welfare visit in April 2019 Mairead denied domestic violence had occurred in the presence of her partner, with a decision made by HASC that no further safeguarding processes were required. There was concerning bruising identified in a meeting with her Lead Practitioner from SPFT in June and in a meeting in September that coercive and controlling behaviour by her partner was taking place. However, safeguarding concerns were not identified and no formal safeguarding processes followed.

4.5.3 Safeguarding concerns were first identified in respect of Amy in 2018. There were two concerns separately raised in the space of several days identifying domestic abuse. There were forwarded on by HASC to SPFT and whilst it was identified that the eligibility criteria for a section 42 enquiry was met due to staffing capacity issues the enquiry did not commence until April 2019.

4.5.4 Further safeguarding concerns were raised in January 2019 following Police and GP input when Amy had allegedly been assaulted by two men in relation to a drug debt and money then taken from her account. SPFT reported that at the time of Amy's death their section 42 safeguarding enquiry remained open and was completed posthumously.

4.5.5 Whilst there are not specific timescales the Care Act requires that local authorities must make enquiries, or cause others to do so, if it believes that an adult is experiencing, or is at risk of experiencing, abuse, or neglect. This should establish whether any action needs to be taken to prevent or stop abuse or neglect. Mairead and Amy were both identified by agencies with statutory responsibilities for adult safeguarding as having experienced abuse, but no action was taken in a timely manner to prevent or stop this.

Safeguarding enquiries, under section 42 of the Care Act, could have been undertaken in respect of Mairead, and commenced at an earlier point in respect of Amy.

It was established in both cases that the eligibility criteria for an enquiry was felt to be met, with domestic abuse considered to have occurred. Further safeguarding concerns were also subsequently identified, evidencing that these were ongoing issues.

A dedicated focus, utilising a trauma-informed approach, on the abuse Mairead and Amy were experiencing at an earlier point, working with them to identify their outcomes, may have offered increased preventative opportunities to consider alternative pathways and specialist support services.

4.5.6 At the strategic representatives' event a significant issue with safeguarding processes was identified as there once again being a lack of shared understanding across services. Examples were given of appropriate safeguarding concerns being raised that were identified as not meeting the eligibility criteria in the first instance because of the language used. Delegates described a 'translation' process needing to be undertaken for these to be progressed.

4.5.7 The review was told that whilst austerity and a lack of resources is a significant factor there needs to be a change in culture to adopt a preventative approach to safeguarding. There are examples of excellent preventative work but much of the safeguarding practice currently undertaken is crisis work, which is expensive and regarded as a false economy.

4.5.7.1 As a result of the deaths discussed in point 4.4.3.6 Housing has undertaken an audit of safeguarding training across all housing (in February/March 2021) and managers have been tasked with ensuring that all staff are up to date with mandatory safeguarding learning. This will be monitored within the department. The department are in the process of identifying specific gaps and working with the Learning and Development team to commission any bespoke training that is needed.

Learning point

In view of the feedback from the Practitioner and Strategic Representatives events there needs to be a timely response from partner agencies of the SAB regarding actions that are already in progress, or that will be undertaken in response to these recommendations. This is in line with the principle of 'no delay' in adult safeguarding and ensures the SAB has assurance that improvement actions are appropriately progressed.

4.5.8 **Sussex Police**

4.5.8.1 Amy was flagged as a 'persistent caller' but, despite this, call handlers were instructed to deal with each of her calls on its own merit and to use their professional judgement when making decisions and deploying resources. For example, on 14th May 2019 Amy inappropriately called 999 for a chat, but officers submitted a SCARF. On 13th December 2019 May called 999 to report that she had received malicious texts. Despite having 23 outstanding calls (15 requiring attendance) at the time, call handlers allocated a Grade 2 response (attendance in a maximum of one hour) due to her vulnerability. ***These are examples of good practice.***

4.5.8.2 There is evidence that, for example in June 2019, attempts to pursue an evidence-led prosecution. On this occasion, witnesses had only heard screaming and therefore could not assist with detail about what had occurred. In August 2018 where a third party found Mairead and her partner arguing the police were unable, despite repeated attempts, to contact this witness.

4.5.8.3 The NICHE record in relation to the incident of domestic abuse on 24th June 2019 shows that a request was made for the safeguarding plan in relation to Mairead and her partner to be reviewed, and that history markers were placed on all addresses and phone number. A referral to Rise was made and both adult and children's services were made aware of her current mental health issues. Whilst this is evidence of good practice, the review is not aware of the action taken by the agencies that received these referrals. This has been discussed in more detail at 4.4.2.5.

4.6 WERE THE ISSUES OF COERCION AND CONTROL BETWEEN THESE WOMEN AND THEIR PARTNERS APPROPRIATELY CONSIDERED AND RESPONDED TO?

4.6.1 The offence of controlling and coercive behaviour came into force in December 2015 through Section 76 of the Serious Crime Act 2015. One of the leading academics exploring coercive control is Evan Stark who back in 2007 described it as an 'offence to liberty that prevents women from freely developing their personhood, utilising their capacities or practising citizenship, consequences that they experience as *entrapment'*[31]. He then goes on to say that the main means used to establish control is the 'microregulation of everyday behaviours'[32].

4.6.2 The review is concerned whether when, for example, both Mairead and Amy are described as having no self-regard for her own safety and wellbeing, there was an understanding of coercion and control.

4.6.3 When Mairead attended her first meeting with Probation Services (Kent, Sussex, and Surrey CRC) in January 2019 she said that she wanted her partner to come into the appointment as she said he was her carer. This request was refused but during the session she stated that she wanted him to attend all her future sessions and that she was in the process of getting him registered as her carer. The officer agreed to this after Mairead signed a consent form. It is not clear if the possibility of coercion and control of Mairead by her partner was explored.

4.6.4 On 16th January 2019 Mairead did not attend for her termination as planned. When a telephone call was made to her partner's phone, the GP practice was advised that she did not attend as her partner did not feel that her mental health was good enough. The IMR submitted by the GP surgery provides no evidence of the potential of coercion and control having been explored.

[31] Coercive Control, Stark E, Oxford University Press, 2007
[32] Ibid

4.6.5 Mairead was described as hindering the ability to safeguard her because she refused to admit that she had been assaulted by her partner, stating twice that her injuries were self-inflicted. It is not uncommon for victims of coercion and control to deny that abuse has occurred. The review believes that this description highlights a lack of understanding about the nature of coercion and control and puts the responsibility for safeguarding totally on the victim.

Recommendation

The SAB request partner agencies review their domestic abuse training to ensure these include a specific and detailed section on coercive and controlling behaviour. Whilst accepting that it may not be feasible for all staff to receive comprehensive domestic abuse training again, it is recommended that agencies develop 'bitesize' sessions on coercive and controlling behaviour that all staff undertake.

Section Five – Learning points

5.1 In future reviews the IMR template should focus specifically on the Terms of Reference set for the review.

5.2 Language change amongst all professionals and agencies will positively alter mindsets and make a huge difference to the way engagement with and support for vulnerable women with multiple needs and compound needs is considered and delivered.

5.3 There is a need to improve the local understanding of, and response to, trauma across all services so that the system is trauma informed. It is accepted that this will take time to embed into everyday practice.

5.4 All agencies and departments need to have up-to-date policies and procedures relating to the identification of domestic abuse, processes to be followed in raising this, and actions undertaken in response.

5.5 In order to support people with multiple and compound needs all relevant roles in housing need a point of access to Adult Social Care IT systems.

5.6 The Adult Social Care IT system should be accessible to identified representatives from statutory partner agencies that are working in partnership to safeguard and support people with multiple and compound needs.

5.7 MARAC representatives and MARAC chairs would benefit from training in working with victims with multiple and compound needs.

5.8 As it has not been possible to fully reassure the SAB that from an organisational perspective professionals have the necessary skills, knowledge, and experience to meet the needs of women with multiple and compound needs this area may require further consideration.

5.9 In recognising the findings from this review agencies should consider reviewing the supervision and support being provided to professionals working directly with people across the system, ensuring improvements are made where necessary.

5.10 The way in which risk is managed both within agencies and between agencies needs to be effective and there needs to be the means to identify and to respond to escalating risk.

5.11 The NHS should continue to evaluate the need for a Homeless Health Hub and subject to that outcome multi-disciplinary support will be required to achieve this.

5.12 In view of the feedback from the Practitioner and Strategic Representatives events there needs to be a timely response from partner agencies of the SAB regarding actions that are already in progress, or that will be undertaken in response to these recommendations. This is in line with the principle of 'no delay' in adult safeguarding and ensures the SAB has assurance that improvement actions are appropriately progressed.

Section Six – Recommendations

6.1 The SAB work with pan-Sussex partners (across all three Sussex SABs) to develop an agreed definition, and accompanying terminology, in respect of multiple and compound needs on a pan-Sussex basis.

6.2 The SAB link in with work being undertaken through the Health and Wellbeing Board, Changing Futures and other workstreams, to support the development of benchmarked trauma informed approaches to enable further standardisation, commissioning arrangements and assessments of quality[33].

6.3 The MARAC operating protocol needs to be reviewed, and updated as necessary, to ensure there is clear guidance on how to manage cases that frequently cross local authority boundaries and when cases should be escalated to senior managers within the MARAC Support Team.

6.4 The SAB ask the Integrated Care System (ICS) commissioners to explore how the underlying mental health needs of people with dual diagnosis are being met, including the psychiatry element of dual diagnosis treatment.

6.5 Whilst recognising recent changes in commissioning and service provision to provide refuge to people who require detoxification support, or who have ongoing substance misuse needs, the SAB ask relevant commissioners to consider the wide variety of accommodation-based models being used elsewhere in continuing to develop refuge provision locally for those with multiple and compound needs and fleeing domestic abuse.

6.6 A clear explanation of the role of housing and the services that are provided is prepared and made available to all agencies in the Brighton and Hove area. This will enable greater shared understanding and additional support arrangements to be put in place to meet individual need as required.

6.7 Whilst accepting the inherent challenges, that the SAB ask community safety and integrated care system commissioners to explore the feasibility of providing supported accommodation specifically for women with multiple and compound needs, with consideration given to the cost benefit analysis over time of more expensive crisis driven interventions.

6.8 As part of their future audit programme the SAB consider a review of the transitional approach taken across safeguarding between Children's and Adults services, for example focusing on the identification of trauma and support offered to mothers whose children are taken into care.

6.9 The SAB to work with partner agencies to develop the framework for a multi-agency risk management (MARM) process for presentation to board members. This will enable women (as well as men) with multiple and compound needs to be referred and discussed as a key

[33] A sense of safety, Centre for Mental Health, November 2019

element in developing a preventative, multi-agency approach to adult safeguarding, in line with arrangements already in place elsewhere in Sussex.

6.10 The SAB request partner agencies review their domestic abuse training to ensure these include a specific and detailed section on coercive and controlling behaviour. Whilst accepting that it may not be feasible for all staff to receive comprehensive domestic abuse training again, it is recommended that agencies develop 'bitesize' sessions on coercive and controlling behaviour that all staff undertake.

Section Seven – Conclusions

7.1 This thematic review has identified a number of areas where a review of, or changes to, the current approach or thinking, may provide better outcomes and improve safeguarding for some of the most vulnerable women who find themselves in the Brighton and Hove, and wider Sussex, area.

7.2 Whilst the identification of those areas for learning and the resulting recommendations should be considered, it does not mean that the reviewers found widespread systematic failures or a lack of ambition amongst staff to truly make a difference. On the contrary, the reviewers found an uplifting desire to make a difference amongst the staff. This was coupled with compassion, a recognition of the 'real world' pressures upon all agencies together with inventive thoughts for improvements that would help women who find themselves with similar life challenges to those faced by these three victims.

7.3 Any review such as this will naturally take a position of thinking that will have evolved since previous reviews, process or procedures were adopted. It will also take a view at a point where social circumstances may have changed as indeed may have resources available to local areas. Some of the areas of learning recognised within this review are examples of exactly this. For instance, common language changes over time but those changes can have a significant effect upon thinking and thus the approach of staff. The term 'sex work' as a descriptor of a means of earning money to provide the basic needs for living within these cases, would be more accurately described in respect of some individuals as being 'exploited for sex'. The change of language changes the narrative immediately.

7.4 There were examples throughout this review of a variety of safeguarding and welfare support structures in place. These were all well intentioned and, in some cases, innovative. At times though local administrative structures got in the way of a consistent service across the county. For example, we recommend that the MARM process, in place in some neighbouring areas within Sussex, be considered within the Brighton area.

7.5 One of the consistent themes across each of the victim's subject of this review was that of trauma. In these cases, trauma led to substance misuse, sexual and domestic violence, mental ill-health and contact with the criminal justice system. An improved understanding of the effect of trauma across services will help tailor support for some of those women who find themselves amongst the most vulnerable within our society.

7.6 One of the specific outcomes of lifestyle affected by trauma in these cases was the women's children being taken into care. Ongoing support for women whose children are taken into care should be available and should be enduring for the reasons set out within this report.

7.7 This review recognises the work being done in Brighton and to support vulnerable women and makes ten recommendations that we believe will further enhance that work.