Brighton & Hove Safeguarding Adults Board: SAR Professionals Briefing

Thank you for taking the time to read this short briefing. It is one way by which the Brighton & Hove Safeguarding Adults Board (SAB) are supporting multi-agency professionals working with adults at risk (or families) to learn from practice.

This briefing pulls together key messages arising from a recent local Safeguarding Adults Review (SAR). We ask that you take time to reflect on these issues and consider, together with your team/s, how you can challenge your own thinking and practice in order to continuously learn and develop and work together to improve outcomes for adults. You will find, at the end of this briefing a feedback sheet to capture how you have used this learning.

The briefing has also been disseminated to the SAB Learning & Development Subgroup to ensure content is included within or informs safeguarding adults training.

What is a Safeguarding Adult Review (SAR)?

A Safeguarding Adults Review is held when an adult in the local authority area dies as a result of abuse or neglect whether known or suspected and there is a concern that partner agencies could have worked more effectively to protect the adult or when an adult in the area has not died, but the SAB knows or suspects that the adult has experienced significant abuse or neglect.

The purpose of a Safeguarding Adults Review is to learn the lessons about how professionals and organisations work together and to consider how the learning can be used to improve practice for others in the future.

How you can make a difference

Take some time to think about what these key messages mean for your practice. Ask yourself:

- Can I make changes to my own practice?
- Do I need to seek further support, supervision or training?
- Is there anything in my organisation that needs to change so that it can support best practice?

Safeguarding Adults Review: X

In December 2014 X was found dead in a caravan. There was a tube running from a gas canister outside the caravan into X's sleeping bag inside. The Coroner recorded a verdict of 'misadventure to which self-neglect contributed'. This Safeguarding Adults Review was conducted by an independent reviewer and considered multi-agency working in the 12 months leading up to X's death.

X's presenting issues and vulnerability

- had mental health problems
- at times identified as transgender – referred to as 'they' throughout this briefing
- threatened to self-harm
- had been the victim of abuse
- had a history of violent offending
- was diagnosed with a Personality Disorder and Learning Difficulty
- had a long history of self-harm

Visibly neglectful of their personal hygiene, X's overall presentation and disclosures meant that there was immediate agreement by the services involved with them that that they were vulnerable.

History

X's GP records note that they were transgender, made repeated drug overdoses in the early to mid-1990's, and had a long history of serious self-harm. In the 1990's they were flagged as being at risk of suicide.

X was known to statutory and voluntary services in Kent over many years because of their challenging personal and social circumstances. They had a well-documented history of unstable housing due to their inability to access and sustain accommodation.

X was assessed by psychiatric services in 2009 following a conviction for arson. They were diagnosed with 'Serious Paranoid Personality Disorder' and 'possible Learning Difficulties'. Their condition was said to be characterized by frequent episodes of serious self-harm and self-neglect. They could also be threatening and violent towards others and had issues with harboring food and overeating. X was vulnerable to bullying and intimidation and frequently self-reported numerous incidents in which they were a victim.

Shortly before their death X moved to Brighton, leaving behind the expected offer of accommodation in their local area and going to an area with which they had no local connection. Initially housed by the Local Authority on a temporary basis X was later given notice to quit. Investigations by the LA Housing Authority found that X had rendered themself intentionally homeless by leaving accommodation in Kent and that there was no duty on them to offer housing in Brighton. X left the accommodation in July 2014 and was rough sleeping in the Brighton area where they were supported by staff at a Day Centre, Rough Sleeper and associated Outreach Services. X remained living in the Brighton area until their death although they did return to Kent on at least two occasions and had contact with their previous outreach worker and the police.

X had difficulty in engaging with the services that they were offered and in the months leading up to their death and was particularly resistant to mental health assessments. Episodes of aggressive and threatening behaviour led to X being excluded from Day Centre services for designated periods of time. X was also the victim of bullying that was of a verbal and physical nature.

Agencies involved with X.

At the time of their death X was in contact with and/or known to a number of local services in Brighton.

These were:

- First Base Day Centre
- Pathways Plus (Brighton Housing Trust)
- Pathways to Health (MIND)
- Rough Sleeper Street Support Response Team (Crime Reductions Initiative)
- Mental Health Homeless Team (Sussex Partnership NHS Foundation Trust)
- GP Brighton Homeless Healthcare
- Brighton & Hove City Council Adult Social Care
- Brighton Housing Department

Key considerations for practice arising from the review

Key Consideration 1: Safeguarding Alerts when a client arrives from another authority.

Shortly before leaving Kent the service working most closely with X raised a Vulnerable Adult at Risk (VAAR) alert because of concerns about their vulnerability to abuse. This was not progressed by Kent Adult Social Care (ASC), seemingly because X left the county.

"There are currently no arrangements in place for the notification of a person's move where an alert remains outstanding."

When X first arrived in Brighton there appears to have been no consideration given by any of those involved with X at that stage of a notification to ASC - in the light of the Kent VAAR procedures. Given the extent of information available to all the agencies concerned it would have been clear, even at this early stage, that X was a vulnerable person with complex needs and that a planned coordinated multi-agency approach was needed.

"Had it been possible for the alert to be picked up and proceeded with when X arrived in Brighton a joined up planned multi-agency approach could have started at an earlier stage"

Learning Point

Where it is known that an individual subject to a VAAR or any equivalent from another authority is resident in Brighton & Hove, the LA should seek information about the alert from that authority and undertake their own multi-agency risk assessment to determine what action is needed by them.

Practice Reflection

In circumstances where you have decision making responsibility in the protection of adults at risk of harm, do you exercise **professional curiosity** to inform your judgement when it is known that someone subject to an alert from another authority becomes resident in the city? Is professional curiosity encouraged by your organization?

Key Consideration 2: Homelessness & Housing eligibility

"There can be no doubt that X was a difficult and potentially dangerous tenant to accommodate"

In arriving in Brighton, X had no local connection (which X never claimed or sought to establish) and so their eligibility for housing by the LA rested on whether or not they had rendered them self 'intentionally homeless', or alternatively that the LA had a duty to house them because of vulnerability.

In X's case there were then four main issues meriting further investigation:

1. mental health
2. learning disability/difficulties
3. experience of abuse and discrimination because they identified as a transgender person
4. self-neglect

The council accepted X was vulnerable for the purposes of s198 of the Housing Act 1986 on the basis that X was suffering from 'some form of mental health problems' which they were unable to verify because X refused to engage with mental health services. Their enquiries of their neighbouring housing authority focused on whether or not X was intentionally homeless. The information provided was sufficient for the Brighton Housing Department to conclude that X was intentionally homeless.

It had been recognized by Kent Housing Department that X could not live independently and there were several attempts at maintaining them in supported accommodation. These broke down as X struggled to adapt to living in a shared space. X had a criminal record involving acts of violence and threats made to burn down or bomb places where they had lived.

An analysis of all risk information available to agencies involved with X in Kent, together with current information known to services in Brighton, was necessary in order to understand the risk from and to X, and whether it had increased. From the information available to staff in Kent, and later Brighton, it was possible to extrapolate that X was vulnerable to abuse, (and in fact there were two serious abusive incidents recorded where X was the victim whilst living in Brighton), and probably experienced this on a regular basis (cumulative effect), and also that their behavior was indicative of the diagnosis of personality disorder that had been shared with them by health professionals.

Learning Point

The SAB needs to satisfy itself that all agencies represented on the Board who work with the homeless population understand the wider remit and value of Safeguarding Policies and procedures together with their individual agency responsibilities.

Practice Reflection

How confident are you to invoke the Sussex Multi-Agency Procedures to Support People who Self Neglect and Sussex Multi-Agency Policy and Procedures for Safeguarding Adults at Risk?

Key Consideration 3: Community Care Assessment

Once the decision that X was 'intentionally homeless' was made the case was referred for a Community Care Assessment (CCA) and the case closed by Housing Options.

"Although there were concerns about X's vulnerability and self-care no formal steps were taken by housing staff involved with X to seek to address these under Sussex Multi-Agency Procedures to Support People who Self Neglect' or under The Sussex Multi-Agency Policy and Procedures for Safeguarding Adults at Risk'.

These were two potential routes to address X's health and well-being.

"Whilst the referral for a CCA was the correct next step, consideration could have been given to this much earlier and a lead agency identified to co-ordinate information and determine the most appropriate actions."

Learning Point

Regular and sustained joint working between housing and ASC together with Health and Police is essential to protect people who may be at risk of abuse.

Practice Reflection

From the information provided here do you think X fell within the scope of the self–neglect procedures? What is the rationale for your decision making?

Key Consideration 4: 'Engagement'

There were statutory services in place and ready to assist X. Several appointments were offered and efforts made to meet with X at First Base and later their sleep site. These were brokered by First Base and the Rough Sleeper Team but with X's repeated difficulties in engaging with mental health services the chance of success was slim, particularly since it was made clear to X that meeting with the team would not influence a decision about their housing (this was x's primary concern).

"Had statutory professionals been able to build a trusting relationship with X it might have been possible (although not certain), by negotiation and persuasion to have assisted them to make safer choices. A record of this approach, evidenced with regular reviews and continued and creative offers of support with decisions clearly recorded and shared with all those concerned with a case, would potentially have provided X with greater continuity of care and support"

Concerns about the risk X might pose to others was shared with Sussex Police and the Mental Health Social Worker (MHSW), which prompted the MHSW to request a joint assessment with the Learning Disability Team under the Pan Sussex Self Neglect Procedures. Whilst this approach was agreed with, the Learning Disability Social Worker did not wish to conduct an assessment at X's sleep site. This response did not afford the flexibility required to engage with someone with the level of need and complexity attached to X's case.

Learning Point

It is widely accepted that it can be difficult for people with a personality disorder to engage with services, particularly treatment services. A psychologically informed approach and multi-agency management plan based on best practice can offer the best chance of success. In this way whichever agency take a lead they can set out a coordinated plan with clear aims and contingency arrangements.

Learning Point

Teams should review their service user engagement strategies, particularly as they relate to people who are diagnosed with or suspected of having a Personality Disorder or who seem unable or reluctant to engage, to ensure that this accords with best practice

Practice Reflection

How much of a block and a risk is non-engagement to the local safeguarding adults' system?

Practice Reflection

How might you have supported someone like X, who found it difficult to engage and declined and avoided support, save on their own terms, to make safer choices?

Key Consideration 5: Care Pathways for people with a Personality Disorder

A fundamental difficulty for all the agencies working with X was the absence of a fully informed and agreed assessment of their social care, mental health and learning difficulties. X's inability to engage for an assessment with a MHSW was clearly a problem for those trying to assist. Additionally no enquiries were made of Kent mental health services to establish a full forensic history.

Three months after X arrived in Brighton, Sussex Police raised a VAAR[1] alert notice (June 2014) and Hate And Risk Assessment (HARA) procedures were initiated which made reference to 'X self-harming by opening a wound on their abdomen in response to being called a 'transvestite'.

X has also told the police that they were afraid they might retaliate against the aggressors'. The HARA completed by CRI was shared with the Community Safety Team (CST) who scored the risk as standard and noted X wanted no further intervention. The CST closed their case on the basis that CRI, who were trained in identifying and working with victims of hate crime, would continue to monitor X's situation. The VAAR alert was subsequently received by ASC and forwarded without further action to the MHSW. Following conversations with staff from the Rough Sleepers Team and Housing Support, the MHSW concluded that there was sufficient support in place and were unable to identify any further role for the service. Neither the ASC assessor nor the MHSW undertook their own formal risk assessment based on the information gathered and conversations with staff from the voluntary sector.

"From the evidence available X would have met the first test in that they had an identifiable mental health issue by virtue of being diagnosed with a personality disorder."

From the information obtained from Kent it was already established that X had a personality disorder and that there were indications of a learning difficulty. This offered the prospect of two potential routes for an assessment by the mental health team and the learning disability team. This suggested that an integrated approach was appropriate. However, it was not until some months later that efforts were made to join together to undertake an integrated assessment, and at the time the Learning Disability service would offer only an office based assessment. On past performance it was inevitable that X would not be able to cooperate with this type of approach.

"Given what was known of X's forensic medical history, their presentation and behaviours a care coordinated pathway to address X's personality disorder should have been considered as a viable treatment option. At the same time when taking into account the recorded concerns about a learning difficulty and concerns expressed by some staff that X did not understand what they was being told, a plan to address this issue would similarly have been appropriate."

Personality disorders

Personality Disorders are common among people experiencing long-term homelessness. Research suggests that approximately two-thirds of street homeless people meet the diagnosable criteria for a personality disorder, although only one in ten of those will have a formal diagnosis.

Cluster A Personality Disorders:
A person with a cluster A personality disorder tends to have difficulty relating to others and usually shows patterns of behaviour most people would regard as odd and eccentric. Others may describe them as living in a fantasy world of their own.
An example is paranoid personality disorder, where the person is extremely distrustful and suspicious.

Cluster B Personality Disorders:
A person with a cluster B personality disorder struggles to regulate their feelings and often swings between positive and negative views of others. This can lead to patterns of behaviour others describe as dramatic, unpredictable and disturbing.
An example is borderline personality disorder where the person is emotionally unstable, has impulses to self-harm and has intense and unstable relationships with others.

Cluster C Personality Disorders:
A person with a cluster C personality disorder struggles with persistent and overwhelming feelings of fear and anxiety. They may show patterns of behaviour most people would regard as antisocial and withdrawn.
An example is avoidant personality disorder, where the person appears painfully shy, socially inhibited, feels inadequate and is extremely sensitive to rejection. The person may want to be close to others, but lacks confidence to form close relationships.

[1] In 2014, a VAAR was the standard way that police would alert the LA to concerns about individuals at risk of harm. This has since been replaced by a SCARF which is dealt with by the Multi-Agency Safeguarding Hub (MASH).

Learning Point

There is now a growing body of evidence to suggest that by working with people who have a Personality Disorder and by developing with them an optimistic and trusting relationship the distress they experience and outcomes can be improved.

Learning Point

Professionals assigned to work with people with a Personality Disorder need proper support, training and time.

Learning Point

Agencies should have workforce strategies (and competency structures) to support staff to have better knowledge, skills and competencies with regard to safeguarding people with a learning disability/difficulty.

Learning Point

When you work with a client from another local authority area you should seek to, as far as is practicable, establish a full forensic history

Learning Point

The Safeguarding Adult Board needs to satisfy itself that Adult Social Care, Housing and other services who work most closely with the homeless population have developed a clearly understood and coordinated assessment, referral and interventions pathway for people with a diagnosed or suspected Personality Disorders based on best practice.

Reflection Point

How much do you know about personality disorder, how this impacts on individuals and their social circumstance who may attract this diagnosis?

Reflection Point

In thinking about your own knowledge and attitudes to working with people with personality disorder, what are some helpful and unhelpful ways of responding to people with personality disorders?

Reflection Point

Do you know what services in the city that might be available, how to access help for people with personality disorders and what can be expected from these services?

Key Consideration 6: Self-Neglect

"X was clearly an extremely challenging individual and it was important for statutory services to join together with those from the voluntary sector with persistent offers of support whilst updating changes in risk factors and any deterioration in circumstances."

In the weeks leading up to X's death there was a marked deterioration in their physical condition and in the area where they were rough sleeping X was attracting the attention of local residents who wanted them removed.

The MHSW completed what is described as a 'brief and simple' assessment to ensure good engagement' (X was reluctant to engage with the process). The assessment included a mental capacity assessment; records indicated a view that if X' is found not to have capacity then a more supportive approach to dealing with the situation would be necessary'. At this point X was deemed to have mental capacity to make decisions. The Mental Capacity Act 2005 together with its code of practice says that a person should be presumed to have capacity unless it is otherwise established that they lack capacity. The decision is one of professional judgment.

The results of this assessment did not reduce the concerns raised about X and their wellbeing. There was still a role for ASC and this was recognized by the MHSW.

Before the Care Act became law the definition of a 'vulnerable' adult differed across sectors.

Self-neglect was not regarded as a 'safeguarding' issue and if someone declined to engage with services, there were strong arguments against imposing support against their will.

Clearly there is a balance to be struck based on the level of assessed risk.

The Mental Capacity Act 2005 provides a clear framework to support the assessment of capacity in relation to specific decisions. The assessment is a challenging piece of work, even more so in cases where the person's capacity presents a complex picture, where the risks are high and where significant decisions are being considered. Responding to the needs and rights of an individual who has fluctuating capacity is a complex process.

"The pattern that had developed of referring cases back and across agencies was not good practice and led to delay and a lack of leadership and co-ordination by statutory services. These issues remained unresolved at the time of X's death."

Working with Self Neglect

Social Care Institute for Excellence guidance (Braye March 2015) for professionals working with people who self-neglect recommends:

- Building a relationship of trust with the person over a period of time and at the person's own pace
- Finding the whole person and understand their life history
- Taking account of the person's mental capacity to make self-care decisions
- Being open and honest about risks and options
- Working across the safeguarding partnership in a structured approach
- Developing creative and flexible interventions

Learning Points
The procedures that were in place to protect and support X (Multi Agency Procedures for Safeguarding Adults at Risk and Sussex Multi-Agency Neglect Procedures) were for the most part not invoked and as a result an integrated and coordinated multi-agency partnership led approach was not achieved.

Learning Points
Given the complex and diverse nature of self-neglect, responses by a range of organisations are likely to be more effective than a single agency response.

Learning Points
Robust capacity assessments are critical in determining the approach to be taken by professionals, either to support the decision-making of a capacitated adult or to intervene to protect the best interests of a person who lacks capacity.

Learning Points
The Safeguarding Adult Board will need to assure itself that all agencies represented on the Board who work with people who self-neglect understand and agree the threshold, which makes this a safeguarding issue requiring action under Sussex Safeguarding procedures.

Practice reflection

How confident are you managing cases where there is fluctuating capacity? Do you feel equipped to fully explore the ethical and risk related issues in these cases and to take appropriate action?

Practice reflection

Discuss the indicators of self-neglect across the three domains – neglect of self, neglect of the environment and a refusal to accept help.

Review's conclusion

Conclusions and Recommendations

It can and has been argued by professionals involved with X that their case is typical of many that homeless services manage across the city on a daily basis. They present a challenge to services and to staff who are tasked to work with them in the most difficult of circumstances. In this case the city is one with a very large homeless population many of whom have complex needs. In the authors view X was one of the most challenging for homeless services. X's health and social care needs were complex and X was determinedly resistant to interventions connected to their mental health. The combination of vulnerability and the threat of harm they posed to others, whilst not unique, were amongst the most serious and concerning. A range of services were in place to address these needs, and they had the potential to join together in a coordinated and purposeful way. The absence of agreement about X's mental health needs and their unwillingness to engage with MH services acted as a barrier to such work. Whilst individual agency procedures were followed, these (for the most part) lack an individual 'person centred' approach. The exception to this being staff from the charitable sector who showed greater flexibility in their dealings with him. The determined focus on reconnecting X with their local area, whilst understandable as it offered X the best chance of being housed, was done in such a way that risked them feeling unheard. Of paramount concern is that the procedures that were in place to protect and support X (Multi Agency Procedures for Safeguarding Adults at Risk and Sussex Multi-Agency Neglect Procedures) were for the most part not invoked and as a result an integrated and coordinated multi-agency partnership led approach was not achieved.

Next Steps

The Quality Assurance Subgroup of the SAB will be taking forward a multi-agency case file audit of a sample of cases regarding homeless individuals who are currently in receipt of the city's services. The findings from this work will be circulated to professionals across the partnership.

Further reading

Personality Disorder

- www.nhs.uk/Conditions/personality-disorder/Pages/Definition
- symptoms of personality disorders
- treating a personality disorder.
- www.mentalhealth.org.uk/a-to-z/p/personality-disorders
- Working with offenders with a personality disorder

Learning Disability

- List of support services B&H
- A good and happy life
- Learning Disability Partnership Board

Self-Neglect

- Working with Self Neglect in Sussex

Homelessness

- List of support services in Brighton & Hove
- Brighton & Hove Rough Sleepers Strategy
- The Homeless Monitor 2016
- Facts about homelessness
- Causes and Consequences of homelessness

Engagement

- Making Safeguarding Personal
- Engaging with involuntary service users
- Helping service users engage and stay the course

Feedback

Please return completed feedback to: SAB@Brighton-hove.gov.uk

Name		**Date**	
Job Title			
Agency			
This briefing was cascaded to: **(e.g. all district nurses; duty social workers etc.)**			
This briefing was used in: **(e.g. 1:1 / group supervision with X number of staff; team meeting; development event etc.)**			
Action taken as a result of the learning:			
1-3 things you will take forward in your practice:			
1.			
2.			
3.			
Other feedback / discussion points			