REPORT OF THE SAFEGUARDING ADULTS REVIEW

REGARDING JAMES

CONTENTS

1 INTRODUCTION

1.1 Background to the SAR

1.1.1 James was a 42-year-old, white British man, who suffered an Acquired Brain Injury (ABI) in March 2010. He lived alone in a flat in Brighton, receiving care and support from a range of agencies. James passed away on 13th July 2019, the reasons for his death were listed in the post-mortem report as cardiac arrest and acute myocardial infarction, that were likely to have resulted from the use of synthetic cannabinoids.

1.1.2 The Brighton & Hove Safeguarding Adults Board received a Safeguarding Adult Review (SAR) referral in February 2020, which was triggered by the coronial processes. Due to the impact of the Coronavirus pandemic (specifically the operational pressure on agencies at that time) there was a delay in the process of obtaining further information to review and consider agencies involvement. Following receipt of that information it was agreed that the criteria for a SAR were met; namely that an adult had died because of abuse or neglect, whether known or suspected, and there was concern that partner agencies could have worked together more effectively to protect the adult.

1.2 The Terms of Reference

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

1.2.2 The time frame of the SAR was from December 2016, shortly before the first formal safeguarding enquiry was commenced by the local authority, until 13/07/2019, the date of his death at the Royal Sussex County Hospital.

1.3 SAR process

1.3.1 The report has three main sections: a) 'Summary of facts', a description of the services provided to James explaining how agencies worked together to support him; b) 'Analysis', an appraisal of the practice with, where possible, an explanation of factors that helped or hindered effective service delivery; and c) 'Lessons learned', the ways in which this specific case highlights findings about the safeguarding system. This is followed by conclusions and recommendations.

1.3.2 The following agencies made up the Review Team: -

- Brighton & Hove Health and Adult Social Care
- Brighton & Hove CCG/ Sussex NHS Commissioners
- Brighton & Hove Housing Department
- Sussex Police
- Brighton & Hove Safer Communities Team
- Money Advice Plus
- Brighton and Sussex University Hospitals Trust

1.3.3 Individual Management Reviews (IMRs) were received from the following agencies: -

- Brighton and Hove City Council Health and Adult Social Care
- Brighton and Hove Safer Communities Team
- Brighton and Hove City Council Housing Department
- Brighton & Sussex University Hospitals Trust (BSUH)
- Sussex Police
- Headway
- Southdown Housing
- Money Advice Plus

In addition, the Lead Reviewer had access to the relevant records from the following agencies: -

- GP records
- Pavilions Drug and Alcohol Services

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

1.4 Parallel Processes

1.4.1 There were no criminal processes however the coronial process was ongoing at the time this report was being prepared. The Lead Reviewer had access to documents prepared for the coronial process.

1.5 Family Input to the SAR

1.5.1 Both James' parents were dead however he had three surviving half-siblings and they were invited to contribute to the review. The Lead Reviewer spoke with two of James' half-sisters and their perspective and views are included in the report. It is intended that the full report will be shared with the family prior to publication.

2 SUMMARY OF FACTS – description of the support provided to James.

2.1 Background history

2.1.1 James grew up in north-west England and moved to Brighton as a young man. It is recorded that James had experienced a traumatic childhood, including time spent in care settings. His mother was living in Brighton and committed suicide in 2008. His father remained in the North of England and it is reported that he died in 2019.

2.1.2 Prior to the brain injury James owned a business, lived independently in a flat he had bought, and had a live-in partner, as well as family and friends. In March 2010 James

suffered an acquired brain injury (ABI) which resulted from a subarachnoid haemorrhage. James was an inpatient in hospital for many months and then spent a further nine months at a neurological centre for a period of rehabilitation. Whilst in rehabilitation he disclosed to professionals that he had used substances continuously since the age of thirteen and that he considered that his haemorrhage had been caused by a substance overdose. Records show that James was first known to the CRI (as it was known then) Drug treatment Services from 2006. His half-sister also reported to a social worker in 2013 that he had '*always been a drug user, but that he used to have much more control over his habit and that he previously used "harder drugs" than the cannabis he currently uses*'. She is also recorded as saying that James' '*main source of income was drug dealing, that he earnt "mega money" that he lived the high life and that he would spend many months of the year in Ibiza, where he did some work as a DJ'*. The sisters when speaking to the Lead Reviewer in 2021 described their brother as a recreational drug-user and that his drug-use was not problematic before his head injuries.

2.1.3 Following the brain injury James was keen to resume living independently and following a short period in a Residential Care setting he returned to his flat, which had been adapted to enable this. A social care assessment was undertaken by the Local Authority, which identified that he had significant care and support needs, and he was discharged home with care and support in place to assist with daily activities of daily living as well as day centre attendance. At the time of his discharge, in 2011, James was deemed to have capacity to manage his financial affairs although the assessment undertaken at the time said he needed help in managing his finances which was to be provided by the Money Advice Plus Service.

2.1.4 Over the following years James continued to live independently with care and support although it is evident from records that he did not feel that he required assistance from others and would frequently decline this and express verbal aggression towards staff. In 2013, following concerns being raised by his half-sister about his capacity to manage his financial affairs, a further capacity assessment was completed which determined that he lacked capacity to manage his finances. As a result, the Money Advice Plus Service became his 'appointee for benefits' which enabled them to manage and spend his benefit in his best interests. In doing this they needed to take account of his views and where he did not lack capacity, manage, and spend benefits in line with his wishes, unless the spending was not an appropriate use of the benefit.[1]

2.1.5 Between 2011 and 2015 there were numerous amendments made to the care and support provided to James and this was gradually reduced in line with his wishes. There were also periodic concerns in relation to his ongoing substance use and anti-social behaviour from others accessing his block of flats. Towards the end of 2015 the

[1] https://www.gov.uk/become-appointee-for-someone-claiming-benefits

support with daily living tasks provided by his regular care provider was stopped after a disagreement between James and a member of staff and his refusal to continue to accept their services. It is also relevant that during this period many of James' other supports ended. His girlfriend ended their relationship and other friends became less involved. Support from his family also reduced as one of his half-siblings moved abroad; the family had no direct contact with James after 2014 and assumed that they would be alerted if there was a significant change in his circumstances. They were unaware that he had ended the package of support provided by the domiciliary care agency in 2015.

2.1.6 In January 2016 an assessment was undertaken by Health and Adult Social Care (HASC) where James was deemed to have capacity to care for himself and that he was clear that he did not want assistance from any domiciliary agency. This assessment described James as needing assistance with finances which was provided by the Money Advice Plus Service. It also described James as having a history of substance misuse and that he reported using marijuana and 'spice' (synthetic cannabinoids) daily. The social worker determined James to be in regular contact with drug dealers and vulnerable if he failed to keep to payment arrangements for his drug use. Support was offered to James regarding his substance misuse, but he was adamant that it was not a problem and declined support.

2.2 James living in Brighton November 2016 – November 2017

2.2.1 In November 2016 there was an incident where James' flat was broken into by three men. It was thought that this could be related to him owing money for drugs, but it also followed from an earlier police raid on the flat where James and others were arrested for possible drug dealing and he was given bail pending inquiries. This bail was continued until 5th April 2017 when the police decided not to proceed with charges.

2.2.2 In February 2017, the Community Safety Team reported concerns raised by neighbours of a man living with James who was described as "dangerous". There were reports of lots of men going into the property and an alleged stabbing. The Money Advice Plus Service also had concerns that James was spending his money very quickly and that he did not seem well on an emotional level and was not eating properly. In February he was also seen by the Drug Treatment service when he said that he was keen to begin a detoxification process; at the time he was using cannabis but had stopped using 'spice' five days previously. In March 2017, a safeguarding alert was raised, and a safeguarding strategy meeting was held on 8th March 2017 that agreed that the social worker would liaise with the police regarding measures to enable James to be safe in his flat. Neither Community Safety nor the substance misuse service attended this meeting, Community Safety were informed of this meeting with one day's notice and were unable to attend.

2.2.3 James was seen by the drug treatment service twice during March 2017. On the second visit at the end of the month he reported using 'spice' and cannabis, and a urine test showed positive for cocaine and benzodiazepines. Following this visit

arrangements were made for James to have a residential detoxification at City Roads, a London based rehabilitation service, and this was made available for James from 11th May 2017. However, he failed to take up this service.

2.2.4 Throughout April and May 2017 there continued to be concerns about James and it was thought he was being pressurised to have inappropriate people living with him because of his dependency on drugs. There was debate about whether this constituted 'cuckooing'.[2] This led to discussion between practitioners about the best way to intervene, with consideration of whether James had capacity, and whether there needed to be a capacity assessment to inform decision making. This was requested by the Community Safety Team but was rejected by HASC staff who determined that a capacity assessment for James was '*neither achievable nor appropriate while he's being intimidated and under duress from third parties.*' They advised that under the Care Act [2014] s.42 enquiry[3] they were attempting to provide '*protective measures for James and any other adult affected meeting the s.42 criteria*'. They considered that the best way forward was to protect James by using the legislation governing the community safety team's actions and to seek a closure order.

2.2.5 At the end of April 2017 a multi-agency meeting was held that agreed to pursue a 'partial' closure order[4] which would mean that James' house was closed to all but him and named professionals who needed access. This order was granted by the court on 24th May 2017 and was immediately served on the property. James could remain on the premises but was not allowed guests unless approved by the Community Safety Team or the Police.

2.2.6 Initially the closure order was effective and there were no complaints from neighbours. James also appeared not to be abusing substances during this period. By the end of June 2017 however there was evidence that the closure order was being breached by persons entering James's property. By the end of July 2017 his neighbours were complaining again about the numbers of people visiting in defiance of the closure order. During this time there were discussions between the Community Safety Team and the Money Advice Plus Service about how to enable James to have a financial advocate to help resolve financial issues that were outside the brief of the role of appointee. These included the short time left on the lease for the flat and the need for repairs to the boiler in the flat. HASC were approached regarding these matters but

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[2] Cuckooing is a practice where people take over a person's home and use the property to facilitate exploitation. It takes the name from cuckoos who take over the nests of other birds. There are different types of cuckooing:

- Using the property to deal, store or take drugs.
- Using the property to sex work
- Taking over the property as a place for them to live
- Taking over the property to financially abuse the tenant.

The most common form of cuckooing is where drug dealers take over a person's home and use it to store or distribute drugs.

[3] An Act to make provision to reform the law relating to care and support for adults and the law relating to support for carers; to make provision about safeguarding. An enquiry is any action that is taken (or instigated) by a local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs. https://www.legislation.gov.uk/ukpga/2014/23/contents

[4] These orders allow the police and local authorities to close a premises that is persistently reported to be connected with ASB or to close a property that the police believe will be used for ASB and public order offence(s). Anti-Social Behaviour, Crime and Policing Act 2014. https://www.legislation.gov.uk/ukpga/2014/12/notes/annex/2?view=plain

indicated that they felt their role had ceased when the safeguarding issues were resolved and there were other agencies better able to resolve the outstanding issues. Following this the Community Safety Team referred James to Southdown Housing for additional support.

2.2.7 By the end of July 2017 it was clear that the closure order was being breached, so on 16th July 2017 a multidisciplinary meeting was held involving the Community Safety Team, Sussex Police, Health and Adult Social Care, Housing, Southdown Housing and Money Advise Plus. This meeting agreed that a full closure order should be explored which would mean that James would have to leave the flat.

2.2.8 In the subsequent months this decision was revisited as there were discussions about who would fund alternative accommodation for James following the implementation of the closure order. The closure order continued to be breached and there were concerns that James was being 'cuckooed' with regular complaints from neighbours that the property was being used for drug-dealing. By the end of October 2017, it was agreed by all practitioners that a full closure order was needed. This matter was precipitated on 1st November 2017 when James had to leave the flat because he was assaulted by people who had taken over the flat for drug-dealing and he was provided with emergency temporary accommodation in Eastbourne.

2.2.9 A Social Care assessment was undertaken in November 2017. Concerns were explored around cuckooing and the impact the associated anti-social behaviour was having on James and his neighbours. Concerns were also raised about his home environment.

2.3 James in temporary accommodation November 2017 – March 2018

2.3.1 A safeguarding meeting was held on 12th December 2017 chaired by HASC, with Community Safety Team, Housing, and Southdown Housing. A safeguarding plan was made that involved improving James' home environment and assisting him to attend appointments such as GP. It was also agreed that a Mental Capacity Assessment was needed around whether James could make decisions about selling his flat.

2.3.2 James remained in Eastbourne until January 2018, when at his request, he returned to temporary accommodation in Brighton while work was undertaken to make his flat more habitable. Whilst he was in emergency accommodation James engaged well with the Community Safety Team and Southdown Housing who worked with him around behavioural change, encouraging him to stop using 'spice' and finding positive and constructive things to do with his time such as work, hobbies etc. During this time Southdown Housing sourced grants to repair the boiler, windows, and shower. They also removed a hydroponics unit which was thought to be a defunct cannabis factory from the loft and worked to get James linked in with a GP and dentist.

2.3.4 On 16th February 2018 a multi-agency meeting concluded that there was no need to seek an extension of the successful closure order applied for on James' property three

months earlier. HASC agreed a package of care for James to attend Headway[5] day centre one day a week, to engage in social activities such as art and IT groups as well as working towards getting a voluntary job. Funding was also agreed for James to have 6 hours outreach work from Headway, to support him with accessing community facilities and support for him to sell his flat. The funding agreed was initially short-term but with the intention to review his long-term needs.

2.4 James moves back to his flat March 2018 - June 2018

2.4.1 In March 2018 there were immediately problems with neighbours because James allowed people to move into the flat and there were complaints about drug-use and anti-social behaviour and concerns about 'cuckooing' were again raised. At this time practitioners in Southdown Housing and the Community Safety Team discussed whether James' capacity was in question and '*whether he could be placed compulsorily in a drug rehabilitation centre because his ABI meant that he did not have practical strategies to avoid drug misuse and risky behaviours such as overdosing'*. These concerns were passed to the allocated worker in HASC by the Community Safety worker who suggested that James was '*a risk to himself and his neighbours and that this could not be managed effectively because of his drug-taking*'.

2.4.2 There is no record of how the HASC social worker responded to this request however a further multi-agency meeting was held, with James in attendance, in early April 2018. James was warned at this meeting that if there continued to be neighbour complaints the Community Safety Team would apply for a further closure order. It appeared to people at the meeting that James understood this warning and there was a reduction in neighbour complaints for the rest of the month. Following the meeting the Safeguarding Plan was updated.

2.4.3 Early in April 2018 two men moved in with James, practitioners involved did not consider them to be 'cuckooing' James however they were members of the street community and there were concerns that James could be vulnerable to exploitation from them. James continued during this time to use cannabis and 'spice' and on occasions looked dishevelled and unkempt however there was less evidence of anti-social behaviour. Throughout the review period practitioners were divided about the effect of these men; with their presence sometimes seen as a positive influence but with some evidence that they encouraged James' substance misuse and that he was exploited by them. Their presence did not provoke the same level of complaints from other residents in the flats, as previous visitors to James' flat.

2.4.4 Professional support for James, in May and June 2018, continued to be provided mainly by the Community Safety Team, Money Advice Plus and Southdown Housing. Significant work was undertaken on improving the physical conditions in the flat. There is significant evidence that during this period James was using marijuana and 'spice'

[5] *Headway* is the UK-wide charity that works to improve life after brain injury by providing vital support and information services – in this case Headway were a specialist provider service offering attendance at a day centre and outreach/community support.

and was on several occasions offered aid to cease using drugs, through a variety of substance misuse services. Although James sometimes co-operated with introductions to these services, he did not follow through, and there is little evidence of reduction in his substance misuse. There is no evidence of interventions by HASC during this period.

2.4.5 On 29th June 2018 James presented to Housing Needs as homeless, as he had been attacked in his home. Investigation by the housing needs duty team concluded that it was safe for him to return home that day with safety measures that had been put in place.

2.4.6 Throughout this period there was regular police intervention as there were repeated reports that James was allowing people into his flat to take and deal drugs. Police logs show that James' address was visited for 'cuckoo' checks on 18 occasions between 12th April 2018 and 26th February 2019 and that entry was gained and James was spoken to on 9 occasions, the other visits resulting in no reply. Overall, it appeared that whilst there was some evidence of drug use there was no clear evidence of James being a victim of 'cuckooing' during the period.

2.5 James supported by Headway June 2018 - December 2018

2.5.1 Southdown Housing Trust ceased to work with James in July 2018 as most of their goals had been achieved and their service is intended to provide targeted short-term intervention. It had been agreed in November 2017 and confirmed in February 2018 that longer term support for James would be provide by Headway who were commissioned to provide James with outreach support and attendance weekly at a day centre. There was delay in starting this service until James was settled back in the flat and the first contact was made late June 2018 with the service fully starting from 16th July 2018.

2.5.3 Initially James engaged with the Headway Service and attended the day centre on five occasions in July and early August 2018, having six meetings with the outreach service at the same time. This rapidly reduced in September and October, James did not attend the day centre and met with Outreach on four occasions out of a possible ten. In November attempts were made to reintroduce him to the day centre, and he attended on three occasions, however he only met with Outreach on one occasion. Overall engagement in activities and focussed areas was extremely sporadic, with James disengaging on many occasions. A significant problem was that he was often substance affected and/or had friends with him who were also using drugs. On those occasions, he would decline involvement with the outreach service or refuse to attend the day centre.

2.5.4 Eventually in December 2018, Headway advised HASC that due to James' sporadic engagement and his ongoing safety issues (because of his substance misuse) the service was to be halted. It was declared that Headway would not be able to reinstate support without additional separate input around substance misuse.

2.5.5 During this period the Money Advice Plus Service, Community Safety and HASC continued to be involved. On 16th July 2018, the HASC social worker met James with the Money Advise Plus worker, and his Headway support workers, to review his Mental Capacity Assessment around finances. This was because there had been numerous incidents of James' money going missing the day, he received it, his surplus income (after bills were paid by Money Advice Plus) was given to him once a week so he could purchase food and other items. A further issue was that there were changes in the way that James' mortgage was to be paid, as the Department for Work and Pensions (DWP) could only pay the interest as a loan, and if a person were not deemed to have capacity to sign the form, a deputy would need to be appointed. This assessment was not completed as although James initially engaged, he then persistently stated 'he was knackered' so it was agreed that it would be deferred. The HASC social worker made two further attempts to undertake this assessment, but both were unsuccessful. In the event the DWP continued to pay the interest despite no deputy being appointed.

2.6 Final six months of James' life December 2018 – July 2019

2.6.1 On 25th February 2019 the Safeguarding Plan was formally reviewed. It was agreed that James remained at risk of financial exploitation and cuckooing. Specifically, it was noted that he was not managing his money well and had appeared dishevelled and unkempt, which were previous indicators of 'cuckooing'. At the meeting it was agreed that the short-term aim was '*to prevent James from ongoing financial abuse as well as prevent a further incident of Cuckooing'* and that the long-term aim was '*to support James to become as independent as possible with managing his money and that he feels more confident to protect himself from abuse; this to be in accordance with James' wish to be more independent with his money*'.

2.6.2 It was reported at the meeting that a man continued to live in James' flat, but it was felt that he was supportive of James and would encourage him to engage. It was noted that James had not engaged with Headway and that they had ceased their involvement but that the Headway service could be reinstated if there was joint working with the Substance Misuse Service to improve outcomes. There was discussion regarding James' capacity to decline services and there was consensus from practitioners present that he did retain capacity. It was therefore not felt to be appropriate for HASC to undertake a mental capacity assessment regarding decisions relating to his care. It was also thought that he would have been unlikely to engage in any assessment if it had been required.

2.6.3 In May 2019 the Community Safety team visited James. The record says, "He actually looked and seemed completely fine, if not a little bit annoyed that he's recently lost his keys he came across as otherwise lucid, clean, pretty normal and relaxed". That month there was also a meeting with James, his HASC social worker and the worker from Community Safety Team. James advised them that '*his priority was around finding things to do with his time. He advised he did not find shopping support helpful but*

enjoyed going to Headway day centre and wanted to engage with this again'. James was anxious about his mortgage and they discussed the need for him to engage in the mental capacity assessment.

2.6.4 In June 2019, the Community Safety team again visited James. and his situation appeared to be improving. The flat was tidy, he had his friend staying and they had tidied the flat and there had been no reports of anti-social behaviour over a two-week period. There had been further incidents of financial abuse and James agreed that Money Advice Plus could give smaller amounts of money to him three times a week, thus reducing the impact if he were exploited again. He said that he was also keen for the Mental Capacity Assessment to go ahead.

2.6.5 On 12th July 2019 James' friend found him unwell and unresponsive and called an ambulance. He was taken to the Royal Sussex County Hospital where he received treatment and showed signs of improvement before passing away the following day from heart failure. The post-mortem report concluded that James died of a myocardial infarction brought on by using synthetic cannabis.

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

3.1 To examine whether professionals and agencies followed internal policies, procedures, and processes as well as existing multi-agency policies, procedures, and processes and whether any wider professional guidance or specialist resource was considered in seeking to support James.

3.1.1 In the main agencies broadly were acting in accordance with their internal and multi-agency policies, procedures, and processes. There was some multi-agency working and safeguarding referrals were made leading to an assessment of need and a safeguarding plan. Concerns regarding James' safety were shared amongst partner agencies and a coordinated response to risk factors was applied.

3.1.2 It is significant however that there was no consideration of wider professional guidance or specialist resource by any agency although many of James' problems stemmed from his acquired brain injury and very few of the involved practitioners had any expertise in this condition. A significant weakness of the interventions was the absence of any formal mental capacity assessments and the reasons for this are discussed later. The lack of formally documented capacity assessments meant that all practitioners were working on an understanding of 'assumed capacity' which fundamentally undermined much of their intervention. It is also evident that most of James' behaviour was attributed by practitioners to his substance misuse and that this belief directed much of the joint agency working. The relationship between ABI and substance misuse is also discussed later however it must be stated that the absence of formal capacity assessments meant there was insufficient understanding of how ABI was affecting James' substance misuse and vice versa and the implications of this for his capacity to care for himself effectively.

3.1.3 The Police have identified several occasions when information sharing between their service and other agencies was sub-optimal meaning that an opportunity to convey information to partner agencies about James' demeanour, welfare vulnerability and current domestic circumstances was therefore lost. There is, however, no evidence that if this information had been shared in a timelier manner it would have led to different interventions by practitioners. They have also identified some internal concerns about individual performance however again there is no evidence that this significantly impacted on the multi-agency working with James.

3.1.4 There is also evidence that in 2018 and 2019 James presented on several occasions at Accident & Emergency and was clearly vulnerable and showing signs of self-neglect. On these occasions James' immediate needs were addressed. There was however no attempt made to contact other agencies to check if additional supports should be provided and little evidence that his ABI was sufficiently considered. In the main this was because his attendance was out of hours and other agencies were not immediately available. It is also unclear that if the information had been shared there would have been any difference in the interventions provided, as agencies already knew that James was both abusing substances and self-neglecting.

3.1.5 Multi-agency working during the review period was largely individual practitioners pursuing their own professional responsibilities and occasionally, usually at a time of crisis, meeting to discuss the challenges presented in working with James. On occasions key agencies were not present at multi-agency meetings; an example being the meeting on 8th March 2017 which was not attended by either Community Safety or Substance Misuse Services. It also appears that James rarely attended these meetings. Generally, there was little evidence of a jointly agreed care plan with each individual agencies' actions being clearly understood and their interrelationship being co-ordinated and managed by a lead professional.

3.1.6 Much of the effective direct work, that achieved change for James, was undertaken by Money Advice Plus and Southdown Housing, co-ordinated by the Community Safety Team. This was despite there having been a HASC social worker involved for most of the period of the review. By itself this was not a problem as it reflected to some degree the challenge of working with James as he tended to co-operate only with those professionals who were directly delivering improvements to his home environment and this was rarely the role of the social worker. The difficulty however was that the social work role which should have been as lead professional and coordinator was not effective and there was no real attempt to utilise the strengths of the relationships built by the other practitioners to achieve goals such as an effective capacity assessment.

3.1.7 The Care and Support Plan produced in November 2017 (when James was in temporary accommodation) was never updated, albeit there were regular reviews of the safeguarding plan. Explanations for why the care plan was not updated are linked

to workload and the difficulties in engaging with James. The care plan was mainly a list of actions for Headway, an agency that was not yet involved, with minimal reference to the Community Safety Team and Southdown Housing who were at the time, with Money Advice Plus, providing the bulk of the support provided to James. The goals of the plan were to lower risks of abuse to James by improving his network of helpful formal and informal support, providing him with alternatives to drug taking, helping him find useful occupation through voluntary work and supporting him to protect himself from abuse and risky situations by making better choices about friendships. There is no reference in this plan to the practical difficulties James was experiencing at the time in his flat (no functioning shower and no heating) yet resolving these issues was what enabled the Southdown practitioner to engage James in a meaningful manner. The question this raises is whether the care plan was driven by the service available (as provided by Headway) rather than the expressed needs of the client. All professionals interviewed reported that James was difficult to engage and it was clear that he often would not co-operate with the services that were provided. This undoubtedly meant that working with James was time-consuming. It is clear however that some practitioners were able to work effectively with him and that a mechanism for achieving that was agreeing with James common goals which practically benefitted him.

3.2 To consider whether professionals and agencies demonstrated sufficient understanding and awareness in relation to James' acquired brain injury and what impact, if any, his brain injury, cognitive ability, mental health, and substance misuse had on interventions and decision-making? With specific consideration of whether formal mental capacity assessments were relevant and undertaken at appropriate points.

3.2.1 There were no formal capacity assessments[6] undertaken during the review period although the HASC social worker attempted an assessment in 2018. Many of the practitioners working with James told the Lead Reviewer that their organisations did not carry out capacity assessments, this included, Money Advice Plus and the Community Safety Team, Headway advised that they work in conjunction with HASC and other agencies in completing capacity assessments, where needed, but would not carry these out without HASC staff**.** Other practitioners working with James assumed that he had capacity based on their observations of how he interacted with them. For example, it is reported that the limiting factors caused by James' physical and cognitive impairment were recognised by police officers and police staff who had interactions with him. There was an assumption that he had capacity and there were no occasions when officers or staff recorded that they suspected he lacked capacity requiring a formal mental capacity assessment.

[6] How is mental **capacity assessed**? The MCA sets out a 2-stage test of **capacity**: 1) **Does** the person have an impairment of their mind or brain, whether as a result of an illness, or external factors such as alcohol or drug use? 2) **Does** the impairment mean the person is unable to make a specific decision when they need to? https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/

3.2.2 Several agencies requested that HASC undertake a capacity assessment of James. Money Advice Plus staff were persistent in this request and they report that the '*lack of an up-to-date MCA assessment was a hindrance*' as potentially if he had been assessed as not having capacity, 'best interests' decisions could have been made to support him differently. There were '*issues with his accommodation which would have needed resolving had he not died'*. They considered that James needed a 'deputy' because '*he didn't seem able to do these things for himself*'. Also, the '*presumption of capacity meant that best interests' decisions were not taken in splitting his cash over the week'* Money Advice staff encouraged *'him to have his money several times over the week instead of in one go but did not agree to this*'.

3.2.3 Initially HASC resisted undertaking a capacity assessment of James because they considered that as James was being coerced any capacity assessment would be flawed. This judgement however failed to address whether the reason he was vulnerable to coercion was because he lacked capacity. Later, however, there were attempts to undertake an assessment which the social worker explained to the Lead Reviewer proved to be difficult as ostensibly James was able to show that he had understanding and was therefore able to make decisions about how he lived his life even if some of those choices may have been risky. James was also irritated by the questions she was asking which he was easily able to understand and respond to, meaning that he was unwilling to continue participating in the process. This social worker acknowledged that she had doubts about whether James' executive functioning was fully effective but said that undertaking a more specialist assessment would have required more time with James and that she felt he would not co-operate with this. This social worker had not received any specialist training and was not aware of any way that she could access specialist support in doing such an assessment. The only service that would have that knowledge was the Community Neurological Rehabilitation Team, but James was not eligible for their service as he did not have any identified rehabilitation goals.

3.2.4 Much of the professional intervention with James was focussed on his substance misuse which was seen to be the cause of his vulnerability and self-neglect. There was little evidence however of consideration of how and whether James' ABI related to his substance misuse. When specialist substance misuse services assessed him as needing residential de-toxification because of his 'spice' use the only record of his ABI is under 'physical health' where it is noted that there are '*On-going residual effects of two subarachnoid haemorrhages*'. There was no consideration of how the ABI might interact with his substance misuse or whether he might need additional support in accessing substance misuse services. Later there was discussion within the professional network about James commitment to ending his drug use which focussed on his commitment to becoming drug-free with no consideration of how the ABI might affect his executive functioning and therefore his capacity to make such decisions, and then follow through, to act on them.

3.2.5 As there was nobody within the professional network working with James who had expert knowledge of ABI it could be concluded that there was an absence of knowledge in this area across the professional network which hindered decision making and care planning for James. The greatest omission during the review period being the absence of any formal capacity assessments that considered how his ABI was affecting his ability to live safely within the community. A significant factor in why these capacity assessments were not undertaken was that there was no obvious route for practitioners to access the expert knowledge required to undertake these assessments effectively. Another factor however would seem to be an assumption that such assessments are not required when a person apparently is able to communicate their wishes and feelings even if their executive functioning may be limited.

3.3 To consider whether the policies, processes and training that are currently in place at a systemic and organisational level to work with and support people with acquired brain injuries are sufficient in meeting holistic care and support needs and the assessment and management of risk.

3.3.1 A significant feature of James' case history is the absence of any specialist health professional working with him during the review period. There was limited input by health professionals (apart from the GP) despite James problems in day-to-day life stemming from a health difficulty. Following James' initial brain injury there was an insertion of a ventriculoperitoneal (VP) shunt to drain excess fluid from the brain. He was supposed to have this checked annually but failed to attend the appointments and there is no evidence of follow-up by the hospital to check on his welfare. Discussion with practitioners involved with James indicated that there is no provision for long-term community neurological input for people with ABI as the Community Neurological Rehabilitation Team only provides targeted interventions against specific goals focussed on rehabilitation. Given that ABI often leads to long-term difficulties and many people with ABI will require long-term support this seems to be a shortfall in the service. This means that much of the intervention to people with ABI is provided by care agencies with little expertise and apparently no access to specialist support. When there are problems other agencies become involved to work to resolve difficulties, but these interventions are often short term and focussed on resolving immediate problems not providing long term support.

3.3.2 James was mainly supported by HASC (whose focus during the review period was principally around safeguarding concerns), the Community Safety Team (whose primary focus is on reducing crime and anti-social behaviour in the community and who have an equal responsibility to victims) and Money Advice Plus (whose function was to help manage his money). None of those practitioners or services had specific policies, processes and training around ABI and there was limited access to specialist support from people who had that knowledge and understanding.

3.3.3 The Sussex Safeguarding Adults Procedures include references to ABI in Sections 2.6, 2.7 and 2.8 which are concerned with self- neglect and mental capacity. These

procedures make clear reference to the need to distinguish between '**decisional and executive capacity'** described as **'***the difference between capacity to make a decision (decisional capacity) and capacity to actually carry out the decision (executive capacity)*'. The procedure continues saying that '*Good practice includes considering whether the adult has the capacity to act on a decision they have made (executive capacity)*' and '*Where decisional capacity is not accompanied by the ability to carry out the decision, overall capacity is impaired and interventions by professionals to reduce risk and safeguard wellbeing may be legitimate'*[7]. These procedures acknowledge that such work is complex and suggest that legal advice may be required but do not provide any specific guidance as to how practitioners should undertake the assessments required to distinguish between decisional and executive capacity. There is also no suggestion that such assessments should involve the use of other professionals with specialist expertise. There is also no specific reference to the need for specialist input when working with people who have an acquired brain injury as the section is focussed on people who self-neglect and people with ABI are cited as an example of people where self-neglect may be an issue.

3.4 To consider whether cuckooing, and the wider issues in relation to exploitation that James experienced, were appropriately identified, and responded to by professionals and agencies through safeguarding procedures and processes.

3.4.1 It is only in more recent times that the term 'cuckooing' has featured within the multi-agency safeguarding vocabulary. For the purposes of clarity, cuckooing is a form of crime in which criminal gangs target vulnerable people to use their homes as a base from which to deal drugs. The vulnerable person is often coerced into allowing their property to be used for this purpose through the offer of 'free' drugs. The cuckooed person may then be forced to deal drugs to pay off the 'free' drugs they were initially given in a practice known as 'debt bondage'. The person being cuckooed will often be reluctant to raise concerns for fear of reprisals and violence. Perpetrators of cuckooing prey on the vulnerable. Drug users, and adults with other vulnerabilities such as mental health issues and learning difficulties are particularly vulnerable, but anyone can be targeted. Historically the approach taken by law enforcement agencies towards owners or occupiers of premises being used for the production or supply of controlled drugs was to prosecute them for offences of allowing the premises to be so used under Section 8 of the Misuse of drugs Act 1971, or for any one of a range of other criminal offences enshrined within that legislation. Until recently the issue of cuckooing remained largely unacknowledged, regardless of whether there were indicators to suggest that an offender might be a victim of exploitation. In the past many vulnerable individuals have been convicted of criminal offences and punished by the courts, when in truth they were victims, as opposed to perpetrators.

3.4.2 In 2016, in Brighton & Hove, recognition of cuckooing and methods to tackle this was not well established within the multi-agency safeguarding system. In October 2016,

[7] https://sussexsafeguardingadults.procedures.org.uk/pkoox/sussex-safeguarding-adults-procedures/sussex-multi-agency-procedures-to-support-adults-who-self-neglect#s2848

when James was arrested at his home (along with two others) for possession with intent to supply controlled drugs, there was no consideration as to whether he was a victim of cuckooing. When in 2017 a decision was made to take no further action against all parties, and they escaped prosecution, this was solely due to a lack of evidence linking them to drugs and money. If todays' standards were applied to the circumstances of James' 2016 arrest, there is little doubt the investigation would have established he was a victim of cuckooing and steps would have been taken to safeguard him and prosecute those who had exploited him.

3.4.3 Since early 2017 the police capability to recognise and take steps to combat cuckooing has improved exponentially and with these developments has come greater understanding across the safeguarding network. Developing an effective formula for best practice has not been achieved overnight as the problem of cuckooing is complex and change has necessitated testing new processes and modifying them accordingly. The change in culture has required practitioners to become acquainted with and proficient in adjusting to new working practices. It is evident that practitioners were sensitive to James' issues and needs but were still getting to grips with the challenges of cuckooing during 2017 and 2018 when he was being victimised. The Police had ongoing concern for James' welfare due to his numerous vulnerabilities and these formed the general theme of police reports shared with partner agencies. Similarly, the Social Workers working with James managed the cuckooing risk adequately. The Social Workers identified indicators of abuse that were exhibited by James, for example him losing money, appearing dishevelled, and his neighbours reporting noise and disturbances. These indicators led Social Workers to query whether he was using illicit substances, being cuckooed and in turn self-neglecting.

3.4.4 It must be acknowledged, however, that whilst James continued to be vulnerable to exploitation, there is less evidence in the latter years that he was being cuckooed, as there is no evidence that he was being exploited by a gang dealing drugs. Rather he was allowing friends who used drugs to live with him, and they may have exploited his vulnerability to their individual advantage. There were three police interactions with James between March 2019 and the time of his death in July of that year. Those interactions arose because of welfare concerns being raised by the Community Safety Team. At these visits, the police identified ongoing concerns regarding James' continuing drug abuse and signs of self-neglect which they rightly passed to HASC. The officers did not see any evidence suggesting that James was a victim of cuckooing.

3.4.5 Overall it would appear that in 2016 there was little understanding of cuckooing however since then considerable advances have been made by Brighton and Hove Police in tackling the issue of cuckooing. There also appears to have been sufficient understanding by other agencies of the risks of cuckooing and appropriate working by all practitioners around these issues. Work is still ongoing to improve the effectiveness of the police capability, in collaboration with partner agencies, however the efforts and

advances made in Brighton and Hove now forms the template for tackling cuckooing across the entire force areas of Sussex and Surrey Police.

3.5 To consider why this situation occurred and how learning can be taken from this situation to develop more effective and efficient practice in the future.

3.5.1 Ultimately the cause of James' death was Cardiac Arrest linked to his 'spice' intake. His drug use predated his brain injury and may have caused it. It is therefore unclear whether any intervention would have been successful at assisting him to stop using drugs. It is apparent however that the supports offered to James did not sufficiently consider the impact of his ABI and the substance misuse services offered to him made little accommodation to whether the brain injury was affecting his capacity to co-operate with the programme of care offered. James' brain injury also made him vulnerable to exploitation and the absence of effective capacity assessments meant that it was not possible to be sure that the actions taken to support him were sufficient.

3.5.2 A factor that was clearly influencing the practitioners working with James was a view that he would not wish to move to a more restrictive environment which may have been the only way that he could be protected from the harm caused by his choices concerning drug-use and friendships. Again, the absence of clearly documented capacity assessments undermines this legitimate concern. James had a right to make decisions that were risky to his health if he had both 'decisional and executive' capacity however it is not clear that this was fully assessed. It is praiseworthy that practitioners wished to achieve for James a level of independence that met with his expressed wish however this needed to be underpinned with a proper assessment of his capacity to make such decisions.

3.5.3 One reason for the absence of effective capacity assessments may lie in the absence of specialist resources to assist practitioners who are working with people who have experienced ABI. The Lead Reviewer was told that there are few specialist services available to directly work with people experiencing ABI and this means that most of the support provided to people with ABI is from generic services with minimal specialist support available to the staff working there. There is a need for more long-term specialist services for victims of ABI and for better specialist support to be available for all practitioners to enable them to operate in a way that is more accommodating of the needs of people who have experienced brain injuries.

3.6 To consider whether professionals and agencies considered whether the threshold for a Safeguarding Adult Review may have been met following James's death and whether there is sufficient clarity in relation to the Safeguarding Adult Review processes and pathways and in order to reduce the risk of significant delays or omissions occurring in future situations.

3.6.1 No professional working with James identified the need for a safeguarding adult review and this review was triggered via the coronial process. The main reason for this is that most of the practitioners directly working with James, who were alerted to his death,

had little knowledge of the Safeguarding Adult Review process. They were mainly relatively junior staff, and the process and procedures are not particularly well-known at the front line of service delivery.

3.6.2 A further relevant factor is that the death took place in hospital two days after James' admission. The police were informed by the hospital staff of James' death, three days after the event, when the consultant in charge was not prepared to issue a death certificate stating precise cause and a post-mortem examination was requested to clarify the medical cause of his death. The Police the undertook an investigation, involving a search of James' house, which revealed no trace of controlled drugs, drug paraphernalia or other forms of medication. The final cause of death was not received until two months later. Whilst the police had previous contact with James, their involvement was not such that it would obviously indicate that the death would meet the criteria for a safeguarding adult review. If James' death had occurred due to some act of violence or apparent neglect in a formal setting, for example, then it is possible that practitioners would have recognised that there would be a need for such a review and would have made a referral.

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

4.1 Services for people with Acquired Brain Injury to enable them to be safe.

4.1.1 This review has identified that the safeguarding system within Brighton & Hove is insufficiently developed to enable people with acquired brain injury to be safe. Firstly, there are few specialist multi-disciplinary services who routinely work with people who have long term problems associated with ABI; and secondly, the practitioners working within care services have insufficient knowledge and understanding of the effect of ABI and in particular the relevance of this when undertaking capacity assessments.

4.1.2 These difficulties are not unique to Brighton & Hove and national research has identified that there was:

'…a poor understanding of the problems and symptoms associated with ABI among professionals working in community services and limited knowledge about needs.' and furthermore that *'… there was often poor availability, or access, to a range of community services. This was related to a lack of tailored care for individuals with ABI, and a lack of quality interdisciplinary specialist services with expert knowledge of ABI'*[8].

There has also been discussion at a parliamentary level about the need to improve services for people with ABI. In October 2018, the All-Party Parliamentary Group for Acquired Brain Injury (APPG/ABI) published an evidence-based report 'Acquired Brain Injury and Neurorehabilitation – Time for Change' which highlighted issues surrounding the provision of neurorehabilitation services for people with brain injury in

[8] Long term care needs following Acquired Brain Injury: Final report Dr Alyson Norman1, Tolulope Odumuyiwa1, Machaela Kennedy1, Hannah Forrest1 , Freya Suffield1 , Nena Percuklievska1 ,Dr Mark Holloway2, Hilary Dicks3, & Hannah Harris1 https://www.researchgate.net/publication/323015119_Long_term_care_needs_following_Acquired_Brain_Injury_Final_report

the UK[9]. This has been followed by a further parliamentary debate on 6th February 2020. The All-Party Parliamentary Group for Acquired Brain Injury (APPG/ABI) published a briefing document for this debate that stated that '*More neurorehabilitation health professionals (physiotherapists, occupational therapists, speech and language therapists, nurses, neuropsychologists, educational psychologists) are needed to deliver services*. And that a '*national plan is needed to articulate societal benefit, raise awareness of this hidden disability, and model pathways and contracts for service planners and commissioners*'[10].

4.1.3 The Mental Capacity Act Code of Practice states that where necessary practitioners undertaking assessments should use specialist expertise to assist the assessment process. Section 4.51 states '*Anyone assessing someone's capacity may need to get a professional opinion when assessing a person's capacity to make complex or major decisions*' and furthermore…. *'If the person has a particular condition or disorder, it may be appropriate to contact a specialist (for example, consultant psychiatrist, psychologist or other professional with experience of caring for patients with that condition)*'[11]. While Section 4.53 notes '*that professional involvement might be needed if:*

> • *the decision that needs to be made is complicated or has serious consequences*
> • *a person repeatedly makes decisions that put them at risk or could result in suffering or damage'*[12].

The challenge identified by this review is how practitioners are to use specialist expertise when there is no obvious route to access such supports. Furthermore, many practitioners will not identify that there is a need for such support because their understanding of ABI and its effect on capacity is insufficient.

4.1.4 Improving services for people with ABI is not the responsibility of one agency. It requires a co-ordinated response across agencies in Health, Social Care, Criminal Justice, and the voluntary sector. Health commissioners need to ensure that there are sufficient neuro-rehabilitation specialist professionals to both support people with ABI and to support other practitioners providing services. This requires input from a skilled Consultant Clinical Neuropsychologist with experience in managing dysexecutive and behaviourally challenging brain injured people in the community.

4.1.5 Adult Social Care has a responsibility to ensure that their assessors are aware that it may be more difficult to assess capacity in people with executive dysfunction. This may require that structured assessments of capacity for individuals (for example, by way of interview) may need to be supplemented by real-world observation of the person's functioning and decision-making ability. This will need those assessors to be

[9] https://commonslibrary.parliament.uk/research-briefings/cdp-2020-0026/
[10] https://commonslibrary.parliament.uk/research-briefings/cdp-2020-0026/
[11] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921428/Mental-capacity-act-code-of-practice.pdf
[12] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921428/Mental-capacity-act-code-of-practice.pdf

provided with caseloads that allow sufficient time and access to specialist tools such as the Brain Injury Needs Indicator (produced by the Brain Injury Rehabilitation Trust) a tool that can be used as part of the assessment to help identify deficits of people with a suspected or diagnosed acquired brain injury. The NICE guideline, Decision-making and Mental Capacity (NG108) published in October 2018 provides further information with regards assessment of Mental Capacity for people with a brain injury and notes in section 1.4.3 '*Organisations should ensure that assessors can seek advice from people with specialist condition-specific knowledge to help them assess whether, on the balance of probabilities, there is evidence that the person lacks capacity…*[13]' Whilst this guidance is directed towards '*local commissioners and providers of healthcare'* it is equally relevant to any agency undertaking an assessment of capacity.

4.1.6 There is also a need for all agencies to develop a greater awareness and understanding of the effect of brain injuries on an individual. Assuming that someone has capacity is insufficient if there is also evidence of vulnerability that raises questions about someone's capacity. Whilst professionals from other agencies may not have the skills to undertake such assessments, it is their responsibility to call for the assessments to be undertaken rather than just presuming that an individual has capacity if they are able to communicate their needs. There may well also be a need for practitioners from wider agencies to contribute to the capacity assessment as their knowledge of a person's functioning is an important component in assessing whether a person has executive capacity.

4.2 Substance misuse services for people with Acquired Brain Injury.

4.2.1 Given that all professionals working with James in the latter years of his life considered that substance misuse was the primary source of his problems it is surprising that there was such limited involvement by Substance Misuse services. There were many attempts to encourage James to access such services however these were mainly unsuccessful. The assumption made by practitioners was that this reflected an ambivalence by James to addressing his drug use. It was felt that 'someone has to want change to be able to achieve that change' (the "Cycle of Change") and there were many occasions when James had stated he did not want to change his drug habit. This may be a valid perspective however another interpretation, when considering James' ABI, could be that whilst he was able to make the decision to cease his drug use, he lacked executive capacity to follow through on that decision. Certainly, James' behaviour in April 2017 would support that perspective. This requires therefore that when working with people with ABI, practitioners working within Substance Misuse services should assess capacity more fully and adapt their models of intervention to consider the specific needs of people with brain injury.

4.2.2 James drug-taking was long-standing and prior to his brain injury he had been aware of the risks of recreational drug use. James struggled to accept the limitations on his

[13] https://www.nice.org.uk/guidance/ng108/resources/decisionmaking-and-mental-capacity-pdf-66141544670917

level of independence following his acquired brain injury and wanted to live the life that he had previously lived free from support service provision. It is probable that the only way to fully reduce the risk of a drug related death for James would have been to move him into an environment where he would be monitored 24 hours per day and not permitted independent access to the community. This would have been difficult to achieve currently as there are few residential facilities available and most do not have any expertise in working with people with ABI. The challenge therefore for commissioners of substance misuse services is to consider how to enable existing services to be developed to meet the needs of people with ABI who also have substance misuse problems.

4.3 Multi-agency working – the role of the lead professional.

4.3.1 This review has highlighted some weaknesses in the implementation of the lead professional role. It is unclear whether this is unique to this case and reflects individual practice and specific workload pressures, which were eventually addressed by re-allocation, however it is apparent that in the earlier part of the review period some of the practitioners working directly with James did not feel their concerns were heard. In particular, the need for an updated capacity assessment was never addressed despite repeated requests for this work to be prioritised. There was much inter-agency communication about trying to involve additional services and asking others to act, but little evidence of a mutually agreed coherent care plan with identified tasks for all involved agencies that was reviewed and adapted over time.

4.3.2 One review cannot provide a full understanding of how services function more widely. This review has identified weaknesses in the care planning for James which may reflect wider problems in the system. James needed a long-term lead professional (his problems were not going to be quickly resolved) who was able to work effectively with a wide range of provider services (many from the voluntary sector) to assess his needs and develop an informed care plan. The extent to which the reasons for this being absent are linked to resource pressures, which may or may not have been resolved, or is indicative of wider issues, is one that is worthy of further analysis.

4.4 Understanding and use of the SAR referral process.

4.4.1 This review has shown that there is limited understanding by frontline staff of the Safeguarding Adult Review (SAR) process. This means that unless there are specific obvious concerns about the nature of a death practitioner are unlikely to make a referral for a SAR. This is particularly true where the aspects of the death that could trigger a SAR are associated with issues such as self-neglect or substance misuse.

5 CONCLUSIONS

5.1 The assessments undertaken of James' needs did not take sufficient account of his ABI and in particular the absence of capacity assessments informed by expertise in brain injury meant that the care provided to him was ineffective.

5.2 The review has identified that the reasons for the inadequate assessment and services provided are that there is a lack of specialist expertise within the multi-agency system to assist practitioners undertaking such work and the procedures and training currently provided to practitioners are insufficient.

5.3 The review has also highlighted the need for substance misuse services to be developed to provide more effective interventions for people with ABI who are also involved in substance misuse.

5.4 Finally the review has also shown that there may be potential issues regarding the functioning of the lead professional within the safeguarding system and has identified definite limitations in the knowledge and understanding of the SAR process by frontline staff across the safeguarding system.

6 SAB RECOMMENDATIONS

6.1 SAB to ask Health and Social Care commissioners to consider how to develop and improve services for people with ABI to provide better direct long-term service delivery. This work to include how to develop substance misuse services to enable them to be more accessible and effective when working with people with ABI.

6.2 SAB to ask Health and Social Care commissioners to provide a pathway to access specialist guidance for practitioners undertaking mental capacity assessments with people with ABI.

6.3 SAB to request that HASC ensure that their staff working with people with acquired brain injury receive specialist training regarding ABI and how this impacts on their mental capacity.

6.4 SAB to develop a briefing document based on the learning from this review regarding ABI and all agencies use this to develop a greater awareness of ABI and its relevance when making judgements about a person's capacity.

6.5 SAB to arrange for the Sussex Safeguarding Adults Policy and Procedures to be updated to ensure there is sufficient reference to ABI, including how and when practitioners should access specialist support when undertaking mental capacity assessments.

6.6 The future SAB audit programme to include consideration of reviewing the effectiveness of the lead professional role in engaging with other agencies to deliver care plans.

6.7 The SAB to consider how best to increase the knowledge and understanding of the SAR process across all agencies.

Fiona Johnson

8th March 2021

APPENDIX 1

Terms of Reference

Safeguarding Adult Review James

Introduction

The Brighton and Hove Safeguarding Adults Board (BHSAB) received a Safeguarding Adult Review (SAR) referral in February 2020 in respect of a gentleman we are referring to as 'James'. There was a significant delay in the referral being received, with James having passed away in July 2019, and although it was progressed immediately the impact of the Coronavirus pandemic (specifically the operational pressure on agencies at that time) delayed the process of obtaining further information in order to review and consider agencies involvement.

With further information now having been received the BHSAB has decided that the criteria for a Safeguarding Adult Review has been met. As such we are commissioning a review in order to consider whether agencies could have done more to protect James and whether there are learning opportunities for local practitioners and agencies in seeking to prevent similar situations occurring again in the future.

This review will focus on the last two years of James's life and the period immediately following this, from when the first safeguarding enquiry undertaken by the local authority commenced in February 2017 to the actions undertaken by agencies following his death.

'James'

James was a 42-year-old man who had been living alone in a flat in Brighton, receiving care and support from a range of agencies, as well as through weekly day centre attendance. He had grown up in Rochdale and moved to Brighton as a young man. He owned a business, lived independently in a flat he had bought and had a partner, as well as family and friends. However, James suffered an acquired brain injury (ABI) in March 2010, following a subarachnoid haemorrhage, which led to hospital admission in a neurological centre before a period of rehabilitation.

It appears that James had experienced a traumatic childhood, including time spent in care settings, and records state that his mother had committed suicide in 2008. He subsequently disclosed to professionals that he had used substances continuously since the age of thirteen and that he considered that his haemorrhage had been caused by a substance overdose.

Following his ABI James was keen to resume living independently and following a short period in a Residential Care setting he returned to his flat, which had been adapted to enable this. A social care assessment had been undertaken by the local authority, which identified that he had significant care and support needs, and he was discharged home with care and support in place to assist with daily activities of daily living as well as day centre attendance.

Over the following years James continued to live independently with care and support although it is evident from records that he did not feel that he required assistance from others and would frequently decline this and express verbal aggression towards staff.

There were numerous amendments made to the care and support provided and this was gradually reduced in line with James' wishes. There were also periodic concerns in relation to his ongoing substance use, anti-social behaviour from others accessing his block of flats and that he was being cuckooed.

Towards the end of 2016 the support with daily living tasks provided by his regular care provider was stopped after a disagreement between James and a member of staff and his refusal to continue. It appears that James' situation began to significantly deteriorate from the early part of 2017, with concerns raised by the police and two safeguarding enquiries undertaken by the local authority regarding his safety, anti-social behaviour, cuckooing and financial abuse. A safeguarding plan was created in December 2017, which was reviewed twice over the course of 2019 and remained open at the time of his death.

Despite efforts to increase the level of support James received, with additional input from workers from both the Community Safety Partnership and Southdown Housing as well as emergency accommodation arranged for several months, the overall situation appears to have continued to deteriorate. James continued to use substances, self-neglect and experience financial abuse and was variously described in terms such as 'dishevelled' and 'in a slightly desperate state' by professionals. He had several hospital admissions in the months leading up to his death.

James passed away on 13/07/2019 after being admitted to the Royal Sussex County Hospital. The reasons for his death were listed in the post-mortem report as cardiac arrest and acute myocardial infarction, that were likely to have resulted from the use of synthetic cannabinoids.

Purpose

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 dies as a result 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.

In this instance a Coroner's Inquest is already in the process of being undertaken and it was this process that identified that the criteria for a Safeguarding Adults Review may be met and that this

needed to be considered. A referral was subsequently made by the local authority and it is considered that the criteria for a SAR has been met in that partner agencies may have been able to work together more effectively to protect James and there may be the opportunity for multi-agency learning to take place.

Having reviewed the summaries of involvement (SOI's) agencies are required to submit concise Individual Management Reviews (IMR) that contain a timeline of key events and a comprehensive summary of the Agency's involvement. The agencies that have been identified as needing to participate in this Learning Review and complete an IMR are:

Brighton and Hove City Council Health and Adult Social Care
Community Safety Partnership
Brighton and Hove City Council Housing Department
Sussex Police
Brighton and Hove Clinical Commissioning Group
Brighton and Sussex University Hospitals Trust
Money Advice
Headway
Southdown Housing

Specific Terms of Reference of the Review

The specific terms of reference of this Safeguarding Adult Review will be:

- **To examine whether professionals and agencies followed internal policies, procedures and processes as well as existing multi-agency and policies, procedures and processes and whether any wider professional guidance or specialist resource was considered in seeking to support James.**

- **To consider whether professionals and agencies demonstrated sufficient understanding and awareness in relation to James' acquired brain injury and what impact, if any, his brain injury, cognitive ability, mental health and substance misuse had on interventions and decision-making? There should be a specific consideration of whether formal mental capacity assessments were relevant and undertaken at appropriate points.**

- **To consider whether the policies, processes and training that are currently in place at an systemic and organisational level to work with and support people with acquired brain injuries are sufficient in meeting holistic care and support needs and the assessment and management of risk.**

- **To consider whether cuckooing, and the wider issues in relation to exploitation that James experienced, were appropriately identified and responded to by professionals and agencies through safeguarding procedures and processes.**

- **To consider why this situation occurred and how learning can be taken from this situation to develop more effective and efficient practice in the future.**

- **To consider whether professionals and agencies considered whether the threshold for a Safeguarding Adult Review may have been met following James's death and whether there is sufficient clarity in relation to the Safeguarding Adult Review processes and pathways and in order to reduce the risk of significant delays or omissions occurring in future situations.**

Conducting the Review

The SAB will commission a suitably experienced and independent person or persons to undertake a hybrid Safeguarding Adults Review that will comprise:

- Reviewing and critically analysing the Independent Management Reviews completed by agencies with regard to the specific Terms of Reference for the Review;

- Co-ordinating and facilitating a Practitioner Event that seeks to understand how practitioners were making sense of the cases at the time. A key principle of this approach is to avoid the bias of hindsight; to be able to consider what would be done the same, and what would be done differently.
- Completing a report alongside a clear action plan for individual agency implementation that shares the learning from the IMRs and the Practitioner Event with regard to the Specific Terms of Reference and seeks to embed this within agency policies, procedures and practice as required.

To conduct the process in a timely period to comply with any disclosure requirements, SAB deadlines and to provide timely responses to queries.

Membership

It is critical to the effectiveness of the Safeguarding Adult Review process that the correct management representatives attend any scheduled events and meetings and complete the

Independent Management Reviews. Agency representatives must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge. They should not have had any direct involvement in the case or supervision of those professionals that were.

If there are other investigations or inquests into the death, the membership will agree to either:

a) Run the Safeguarding Adult Review in parallel to the other investigations, or
b) Conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.

Liaison with the person's family

The Reviewer, in consultation with the SAB, should consider whether it is appropriate for the families of the deceased to be involved in the Review. It should also be considered whether it is felt appropriate for any of their partners to be involved.

Media handling

Any enquiries from the media and family should be forwarded to the chair of the SAB who will liaise with the BHCC Communications Team. Members are asked not to comment if requested. The chair will make no comment apart from stating that a review is underway and will report in due course.

The SAB is responsible for the handling of the report and for all feedback to staff, family members and the media.

Confidentiality

All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this Learning Review and for the secure retention and disposal of that information in a confidential manner.

It is recommended that all members of the Review Panel set up a secure email system, e.g. Egress. Confidential information must not be sent through any other email system. Documents not on secure email must be encrypted and password protected.

Disclosure

Disclosure of facts or sensitive information may be a concern for some agencies. We manage the review safely and appropriately so that problems do not arise and by not delaying the review process we achieve outcomes in a timely fashion, which can help to safeguard others.

Appendix 2 – Glossary of Terms & Abbreviations

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

APPENDIX 3: BIBLIOGRAPHY

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