Brighton and Hove Safeguarding Adults Board

Safeguarding Adults Review in respect of Craig

Author: Clive Simmons
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1. Foreword

1.1. The Brighton and Hove Safeguarding Adults Board has today published the Safeguarding Adults Review in respect of Craig (not his real name). The Board wishes at the outset to express their deepest sympathy to the family and friends of Craig.

1.2. The purpose of a Safeguarding Adults Review is not to reinvestigate or to apportion blame but to establish where and how lessons can be learned and services improved for all those who use them and for their families and carers.

1.3. This review identifies key findings in relation to a range of areas that includes multi—agency risk assessment and management, mental health and mental capacity, safeguarding pathways and processes, and resources and environmental pressures.

1.4. Agencies do not wait for the outcome of a review to consider their own learning and an action plan will be developed to take forward the recommendations that have been made. The Board will monitor progress of this action plan to ensure that learning from the Review is widely shared and the outcomes lead to improved services in Brighton and Hove.

Annie Callanan, Independent Chair, Brighton & Hove Safeguarding Adults Board

2. Introduction

2.1. The Brighton & Hove Safeguarding Adults Board (BHSAB) received a referral from the Sussex Partnership NHS Foundation Trust (SPFT) in May 2021, requesting consideration of a Safeguarding Adults Review in respect of Craig. Following consideration of further information, the Board agreed in December 2021 to commission the review.

2.2. The Care Act 2014, Section 44, requires that Safeguarding Adults Boards must arrange a Safeguarding Adults Review when:

- An adult has died because of abuse or neglect, or has not died but experienced serious abuse or neglect, whether known or suspected, and;
- There is a concern that partner agencies could have worked more effectively to protect the adult.

2.3. Safeguarding Adults Reviews are required to reflect the Care Act safeguarding adults principles. These are empowerment, prevention, proportionality, protection, partnership and accountability.

2.4. The aims of the Safeguarding Adults Review are to improve the safety and wellbeing of adults with care and support needs and, if possible, to provide a legacy to the person and support to family and staff.

2.5. There are clear review objectives which have been addressed to achieve these aims. Through a shared commitment to openness and reflective learning, agencies involved have sought to reach an understanding of the facts (what happened), an analysis and findings (what went wrong and what went right), recommendations to improve services and to reduce the risk of repeat circumstances, and a shared action plan to implement these recommendations.

2.6. The review process to meet these aims and objectives has followed a clear learning together path. The Independent Reviewer chaired an initial panel meeting to agree the review terms of reference; conducted research by critically analysing relevant records held by agencies (including a Serious Incident report by SPFT) and by interviewing representatives of agencies; facilitating a workshop on key learning themes; and culminating in an overview report and presentation to the Brighton and Hove Safeguarding Adults Board.

2.7. A Coroner's Inquest reported on 02/11/21 that the medical cause of Craig's death is unascertained.

2.8. The Independent Reviewer has met with the following agencies' representatives in the course of the review, either face to face, online and/or at the learning workshop.

- BHSAB SAR Sub-Group Chair – Safeguarding Adults Board, Healthwatch
- Project Lead, General Managers, Community Psychiatric Nurse, Nursing Consultant, Director of Safeguarding and Principal Social Work – Sussex Partnership Foundation Trust (SPFT)
- Named GP for Safeguarding, GPs, Named Nurse for Safeguarding, Safeguarding Advisor – NHS Sussex
- Designated Nurse, Safeguarding Adults – Sussex NHS Commissioners
- General Practitioner (GP), Safeguarding Lead – Brighton Station Health Centre
- General Practitioner & Practice Manager – Wellsbourne Health Centre
- Safeguarding Lead, Senior Social Worker, Principal Social Worker, Practice Manager – Brighton & Hove City Council (BHCC), Health & Adult Social Care (HASC)
- Detective Sergeant – Sussex Police
- Lead Nurse, Safeguarding Adults – University Hospitals Sussex (UHS), Royal Sussex County Hospital

3. Overview of the case and circumstances leading to the review

3.1. Craig lived alone in Brighton and studied at a local University as a mature student. He had a history of mental health issues and substance misuse. His mental health deteriorated in 2019 and he began receiving support from mental health services. Craig was diagnosed with schizoaffective disorder, depression, and anxiety. He believed that the diagnosis should have been Attention Deficit Hyperactivity Disorder (ADHD) and was on the Neurodevelopmental ADHD assessment waiting list throughout the review period. In May 2020, his condition appeared to deteriorate significantly, accompanied by chaotic behaviour. He attended the Royal Sussex County Hospital on various occasions, due to this presentation, his mental health and substance misuse. Sussex Police visited Craig on 7 occasions and raised 8 concerns between May and December 2020. Following telephone contact in January 2021, there was no further engagement with Craig, and he was found dead in his flat by Sussex Police on 15/03/21, aged 41.

3.2. The review covers the period from May 2020 when it is considered that Craig's situation began to significantly deteriorate and concerns began to be raised, until March 2021.

4. National learning

4.1. Craig experienced a complex range of challenges. These related to his mental health, substance misuse, possible suicide ideation, self-neglect, isolation, and domestic abuse. The primary theme in exploring Craig's experience is his belief that he was living with Attention Deficit Hyperactivity Disorder (ADHD), reinforced by a private assessment and diagnosis, which underpinned his feelings of trauma and his partial disassociation with service provision.

4.2. ADHD is a debilitating neurodevelopmental mental health condition. The charity, ADHD Action, explain that "adults with ADHD have an increased risk of anxiety, depression, self-harm, suicide, alcohol and substance misuse". They point to a national waiting list crisis, with people waiting up to 7 years for an assessment and diagnosis. This has a significant potential impact on mental health and life expectancy. As concluded by the charity; "If this were any other condition it would be seen as a national emergency, given the sometimes deadly adverse impacts this has on untreated adults".

4.3. There is an urgent need for specialist neurodevelopmental services nationally to receive additional resources, alongside training to staff in primary and secondary healthcare. The impact of local provision on Craig's lived experience is explored in the course of this report.

5. Key Themes

5.1. The terms of reference for the review were agreed at an initial panel meeting in June 2022, incorporating key themes, which are summarised here.

5.2. Mental health: To consider the experience of acute mental illness and suicide ideation, and the support received in response to these concerns. It should be noted that where the term mental health assessment is used in this report it does not mean a statutory Mental Health Act Assessment.

5.3. Needs & risk assessments: To consider the effectiveness of the multi-agency response to care needs and risks.

5.4. Safeguarding adults: To consider the effectiveness of safeguarding adults responses, particularly in relation to threshold decisions.

5.5. Section 75 agreement: To review whether there was sufficient clarity in arrangements between the Sussex Partnership Foundation Trust (SPFT) and the Local Authority Health & Social Care Department (HASC) in relation to needs, risks and safeguarding responses, as part of the local Section 75 agreement for delegated services (under the NHS Service Act 2006).

5.6. Mental capacity & service user voice: To consider whether the Mental Capacity Act and personalisation were prioritised by involved agencies.

5.7. Resources & environment: To consider how resources and environmental factors impacted on care; in particular concerning austerity, workload pressures, waiting times and the Coronavirus pandemic.

5.8. Legislation & policy: To consider how compliant involved agencies were with key legislation, policy, procedures, and practice guidance.

6. Pen picture of Craig

6.1. Craig felt that his mental health concerns began at the age of 12, whilst living at his childhood home in Grimsby. From around this time he was involved in substance misuse, self-harm, and harming others. Craig was taken by his mother to see a psychologist after one incident. He was expelled from school at the age of 14 and had to leave home at the age of 15.

6.2. On moving to Brighton, he lived alone in a flat from April 2013. His mental health concerns escalated and his substance misuse continued. He also experienced isolation and self-neglect. Craig believed that he was living with Attention Deficit Hyperactivity Disorder (ADHD). He had a partner from 2017 to 2019 and experienced domestic abuse; physical, psychological, and financial. Craig studied a social science degree and felt motivated to support others with ADHD. He had

fairly frequent telephone contact with his mother in Cyprus and his sister in the north of England.

7. Engagement with Family

7.1. The Independent Reviewer and the Safeguarding Adults Board have made unsuccessful efforts to contact Craig's mother at the onset of the review, by correspondence and telephone, to discuss her wishes regarding involvement in the review. Following completion of the review, the Independent Reviewer made further efforts to contact Craig's mother via email, without response. On this basis, no further efforts have been made and family privacy has been respected.

8. Summarised Chronology

8.1. Prior to May 2020: Craig was known to mental health services in Brighton for some years and was often discharged back to the care of his GP, due to disengagement. He was previously detained under the Mental Health Act in 2010 and he also received some support from local services in relation to his substance misuse. Schizoaffective disorder was diagnosed in 2014 and Craig had taken an intentional drug overdose in the same year.

8.2. Craig attended the Royal Sussex County Hospital Emergency Department on numerous occasions from 2006, due to his mental illness, alcohol withdrawal and overdosing on legal medical stimulants, often leaving before an assessment was completed. There was a gap after 2015 until December 2018, when he attended an outpatient department, expressed suicide ideation and disclosed that he had taken an overdose. He was seen by the hospital-based Mental Health Liaison Team (MHLT) on the same day and it was recorded that; 'His partner is verbally, psychologically, and physically abusive, threatening to kill him if he continues to talk like he does (expressing paranoid delusional ideas), financially controlling and biting him, hitting him on the head'. A safeguarding adults concern was not raised at this time. Craig further attended the Hospital Emergency Department in January 2019 and was again seen by the MHLT.

8.3. He was known to Sussex Police from 2010 and was visited in July 2018, due to reports that he was distressed, shouting and had not been taking prescribed medication.

8.4. Craig was referred to the Sussex Partnership Foundation Trust (SPFT), East Brighton Assessment & Treatment Service (hereafter referred to as ATS) in February 2019 and did not attend an appointment for an assessment, to be re-referred in April 2019 when his mental health had deteriorated. A Lead Practitioner (Community Psychiatric Nurse) was assigned and completed an assessment. Craig confirmed his belief that he was living with Attention Deficit Hyperactivity Disorder (ADHD) and he was referred onto the local Neurodevelopmental Service ADHD waiting list for an assessment. The Lead

Practitioner completed a 'my care and safety plan', incorporating medical review appointments and liaison with the GP practice.

8.5. Craig received a diagnosis of ADHD from a Psychiatrist at a private clinic in January 2020, based on an online assessment, and the validity of this diagnosis was not formally accepted by the SPFT. It is understood efforts were made by the GP surgery to obtain further information in relation to this diagnosis but proved challenging. The reliability of privately obtained assessments (possibly without a full understanding of the person) and of these being undertaken virtually, alongside a potential increased risk of disengagement and harm whilst awaiting a formal assessment, are key concerns within this review.

8.6. **May 2020**: Craig's mental health had significantly deteriorated and his behaviour was becoming increasingly chaotic. The Police attended on 04/05/20, following a report of historical minor assaults by his ex-partner. The ATS completed a risk assessment and identified self-neglect and substance misuse, that suicide ideation was not presented, and he preferred home visits. A Police Single Combined Assessment of Risk Form (SCARF), the standard vulnerable adults referral form, was sent to HASC and forwarded to ATS. This did not lead to a Care Act Section 9 needs assessment or a Section 42 safeguarding adults enquiry. The ATS care plan was updated during this month. This incorporated support with abstaining from alcohol and substance misuse, attending regular Lead Practitioner appointments and medication reviews (by phone due to the Covid pandemic), maintaining contact with the GP and taking prescribed medication.

8.7. The Police visited for a second time in the review period on 08/05/20, when Craig was reported to be intoxicated and hallucinating. A further SCARF was forwarded via HASC to ATS; noting the condition of Craig's flat and his poor hygiene, that he said his ex-partner had locked him out, his deteriorating mental health, that he was identifying objects in his room as people, and that he had been drinking most of the day. The report flagged that Craig required an assessment relating to his mental health (not specifically a Mental Health Act Assessment). Feedback on the outcome of this and the other SCARFs was not provided to the Police and a risk assessment was not updated to reflect the incident. The care plan was partially updated, referring to support with abstinence and attendance at telephone appointments. A further SCARF was forwarded to ATS to consider safeguarding. The Lead Practitioner rang Craig, who declined anti-psychotic medication. He requested a new care plan, which was not completed, and the current plan was not shared with him. Towards the end of the month, the Lead Practitioner rang Craig again, who said that he was feeling stressed and isolated and wished to contact his GP regarding his physical health.

8.8. Craig was registered with the Brighton Road Health Centre from September 2019 until his death. Overlapping with these dates, he was also registered at the Wellsbourne Health Centre from November 2019 to July 2020. During May 2020, he had telephone contact with the Brighton Station Health Centre on two occasions and the Wellsbourne Health Centre on five occasions, as well as telephone contact with a mental health practitioner and a clinic visit for a blood

test at the latter practice. These contacts were mainly to request ADHD treatment, which was not agreed to, to discuss his anxiety about not receiving this treatment, and about his ex-partner and university deadlines. He was asked to provide evidence of the private diagnosis and to complete medical tests in hospital pending the ADHD assessment, which were partially completed. He was advised to speak with the ATS Lead Practitioner, who also contacted Wellsbourne Health Centre to relay the police incident.

8.9. **June 2020**: The ATS Lead Practitioner rang Craig to discuss his drug use and the risk assessment was not updated to reflect this contact. In mid-June, Craig rang the ATS to say that he was feeling increasingly depressed and having suicidal thoughts but was not planning to act on them. He felt that his relationship with the Lead Practitioner had broken down, that he was not receiving support with his depression and that he was not psychotic. The ATS Lead Practitioner returned his call and the discussion focussed on his presentation of psychosis or depression, as well as the delay in receiving an assessment for ADHD. At this time there was a two-year wait for neurodevelopmental ADHD assessments. Craig was frustrated by the delay and felt that anti-psychotic medication conflicted with his perceived ADHD condition. The risk assessment was not updated following this contact.

8.10. Craig had telephone contact with Brighton Station Health Centre on four occasions and Wellsbourne Health Centre on three occasions in June 2020, primarily concerning his request for ADHD treatment. This was not agreed and the ATS psychiatrist advised that Craig was more likely to be experiencing conduct and personality disorder than ADHD or schizoaffective disorder, whilst offering a further appointment. Diazepam and Nitrazipam (relating to anxiety) were prescribed by the surgery on agreement of the ATS psychiatrist. In late June, the ATS Lead Practitioner contacted the surgery and advised that Craig was double registered with two GP practices.

8.11. **July 2020**: The Police attended for a third time in the review period on 08/07/20, following a report that Craig was observed running around the communal area outside his flat, naked and shouting. On arrival, he was asleep in bed and wearing shorts. There were no concerns presented regarding substance misuse or intoxication. Mental health and self-neglect were identified as risk areas. A SCARF was forwarded via HSCC to ATS, requesting a health and social care assessment. There were some unanswered calls to Craig by the ATS Lead Practitioner and the risk assessment and care plan were not updated.

8.12. A Brighton Station Health Centre medication review was completed at the end of the month, and it was noted that approval for ADHD medication was awaited from the ATS Psychiatrist. He had three contacts with the practice in this month, primarily about medication.

8.13. **August 2020**: In mid-August, the ATS Lead Practitioner rang Craig, who seemed calm and reflective. He had joined an ADHD mindfulness group and had taken himself off his prescribed Mirtazapine anti-depressant medication. This information was not shared with the SPFT Multi-Disciplinary Team (MDT).

8.14. Brighton Station Health Centre completed a medication review near the end of the month and later recorded that Craig was anxious and losing sleep but was not acutely mentally unwell.

8.15. **September 2020**: There were a number of missed calls between the ATS Lead Practitioner and Craig. During the Covid pandemic, there was a tendency by agencies to complete more contacts by telephone. On 28/09/20, Craig was admitted to the Royal Sussex County Hospital Emergency Department, as he was unresponsive after apparent drug use and was experiencing suicidal thoughts. He was discharged following completion of a Mental Capacity Assessment, with an email sent to the ATS Lead Practitioner as information. The Lead Practitioner rang Craig on the following day, who expressed that anxiety at waiting for an ADHD assessment had led to his taking drugs. Craig rang the Brighton Station Health Centre on the day after to discuss medication and he seemed to be intoxicated.

8.16. Craig had two contacts with the Brighton Station Health Centre in September 2020. In one of these he relayed that he had been anxious since before the start of the COVID pandemic lockdown. Diazepam was prescribed again and further contact scheduled.

8.17. **October 2020**: A missed phone call by ATS to Craig was not followed up. The Brighton Station Health Centre responded to a medication request towards the end of the month and there were three recorded contacts with the practice before then, most significantly concerning a medication review.

8.18. **November 2020**: In early November, Craig visited the Lead Practitioner. He said that his contact with his mother had improved and he was not experiencing a mental health crisis or suicide ideation.

8.19. The Police visited Craig for a fourth time in the review period on 17/11/20. He was intoxicated, had been knocking on doors and fallen, cutting his knee. Craig was also tired, feeling in a low mood and asking to speak with someone. His flat seemed unkempt. He was accompanied to the Royal Sussex County Hospital Emergency Department for physical and mental health examinations, due to his leg pain and presentation. The Police sent a further SCARF to HASC, which was forwarded to ATS, flagging safeguarding and requesting an assessment relating to his mental health and a health and social care assessment.

8.20. Craig returned to hospital the following day for a general physical examination and again near the end of the month, when a fracture to the fibula head (below knee to ankle) was diagnosed. There is no indication of any concern in regard to the medical examinations undertaken and he was seen again in the fracture clinic in early December, before being discharged. He declined to be seen by the MHLT and returned to the fracture clinic in early December, to be discharged.

8.21. Craig had two contacts with the Brighton Road Health Centre in November 2020, mainly concerning medication, a medication review, and his frustration at waiting for an ADHD assessment and medication.

8.22. **December 2020**: The Police attended for a fifth time in the review period on the afternoon of 15/12/20. Craig had been running barefoot around a shoe shop. He told the Police that he had ADHD and was experiencing thoughts of self-harm, that he had self-harmed in the past. He was disorientated and voicing a concern that people wanted to stab him. Craig was clean and well-presented. He asked to be taken to hospital and was accompanied to the Royal Sussex Hospital Emergency Department, where he was seen by the MHLT and discharged shortly afterwards. Craig told the MHLT that his relationship with his partner could be destructive to him and triggered his paranoia. The Police sent a SCARF via HASC to the ATS, flagged as a safeguarding concern and requesting an assessment relating to his mental health.

8.23. Later in the evening, the Police visited for a sixth time in the review period, as Craig was walking outside the hospital and was naked from the waist down. They accompanied him again to the Hospital Emergency Department and he was seen by the MHLT, without immediate concerns about his condition. The team completed a ward risk assessment and, on discharging, emailed the ATS Lead Practitioner and Psychiatrist to request a review; as he was motivated to re-engage with mental health services. Craig said that he was not feeling suicidal and was planning to complete his university degree and follow a career path. He was described as fixated on ADHD treatment and frustrated when advised that he could only receive this medication by attending his GP Practice. A further SCARF was sent via HASC to the ATS.

8.24. On 16/12/20, the ATS Lead Practitioner and Craig exchanged emails, in which Craig expressed his frustration again at the ADHD assessment delay. A risk assessment was completed, noting Craig displaying chaotic behaviour, substance abuse, an absence of suicidal thoughts, and some strengths. On 17/12/20, the ATS decided that Craig was not at risk of abuse or neglect, with no further action planned in respect of safeguarding.

8.25. A final phone call between Craig and the Brighton Station Health Centre on 23/12/20 concerned a request for medication and completion of a medication review. There were no acute symptoms noted. During the review period, there had been frequent contact between Craig and the two surgeries, including one face to face contact with a nurse.

8.26. The Police attended for a seventh time in the review period on 26/12/20, when Craig was trying to find his flat door, presented as confused and was wearing only a shirt and boxer shorts in a sub-zero temperature. He was escorted to the Royal Sussex County Hospital Emergency Department, due to possible hypothermia. This was his final hospital attendance. He expressed that he was experiencing low mood and suicidal thoughts, due to the ADHD assessment delay, and that he “had had enough”. Craig was seen the next day by the MHLT and he agreed to engage with community services. He was considered to have capacity to decline medical treatment, namely an Electrocardiogram (ECG). The Police sent a further SCARF via HASC to the ATS, highlighting the increasing regularity of Police visits and an escalating pattern of behavioural concerns. This referred to safeguarding and specifically to self-neglect, requesting a health and

social care assessment. The ATS risk assessment and care plan were not updated. There were no further attendances by the Police.

8.27. **January 2021**: In telephone contact with the Lead Practitioner on 08/01/21, Craig said that he had sustained injuries in a fall in November and was now stuck inside due to 'harsh' Covid rules. The risk assessment and care plan were not reviewed and updated.

8.28. A planned ATS telephone medical review was undertaken on the same day. Craig mentioned his fall in November 2020 and said that he was experiencing general anxiety and panic attacks due to isolation in his flat. His medication was recorded and continued Lead Practitioner follow-up in the community recommended. Craig agreed to take his prescribed medication and to try and venture outdoors. There were no further successful contacts by ATS.

8.29. **March 2021**: The ATS Lead Practitioner attempted to ring Craig on 03/03/21. Craig was found dead in his flat by the Police on 13/03/21, with the cause and timing of his death unknown. An NHS letter dated mid-January had been opened. His flat was described as in a poor state.

9. Key Analysis & Findings

9.1. **General**: Craig experienced a shortened lifetime of lost potential. Whilst the review has not covered his childhood, his adult needs and risks clearly date back to this period. Historical information on any support he might have received in these formative years may have helped in understanding his story, had it been sourced by services.

As an adult, support to Craig from mental health services was primarily focused on reacting to presenting conditions, rather than endeavouring to understand and proactively respond to his wider, lived experience of trauma.

Applying the words of Desmond Tutu, there is a need for health and social care agencies nationally to adopt a more curious, preventative, and personalised approach to addressing mental illness; "We need to stop just pulling people out of the river. Some of us need to go upstream and find out why they are falling in."

A learning workshop was held in November 2022, facilitated by the Independent Reviewer, and attended by representatives of a wide range of involved agencies. Key themes were explored and have contributed significantly to the review findings and recommendations. Risk management arrangements were considered, with a focus on the meaning of high risk and the benefits of strategic and practitioner-level arrangements. The general view was that a strategic forum would be a positive initiative and is currently being considered, but that a practitioner-level arrangement may not add value to existing arrangements. There was also consideration of the Section 75 agreement, with a focus on the

Lead Practitioner role, social and medical models of care and safeguarding adults screening.

9.2. **Multi-agency needs and risk assessments (key themes 5.3, 5.5)**: It is acknowledged by agencies contributing to this review that Craig did not receive a joint, holistic, personalised needs assessment and care plan; incorporating a risk assessment and management plan. This would have focused on understanding his story, his experience of trauma due to his diagnosis, his eligible needs (mental, physical, and social) and his strengths. It is unclear whether this would have directly led to further service provision but, at the very least, he may have felt that agencies were actively listening to him and the focus would have been on his wellbeing beyond treatment. Craig did seem to have an interest in engaging with services when he felt that they were understanding and responsive to his expressed needs.

Care Act needs assessment: The Care Act, Section 9, requires that local authorities complete holistic needs assessments and care plans in response to eligible needs. The National Health Service Act 2006, Section 75, allows local authorities to delegate responsibilities to mental health services. Within the terms of the local Section 75 agreement (which is currently under review), needs assessment and safeguarding enquiry responsibilities are delegated by the Local Authority HASC to the SPFT ATS service. GPs and other agencies contact ATS duty (comprising social work, CPN and OT staff) to request assessments or enquiries. A social worker is assigned if the threshold for a safeguarding enquiry is met. If not, a lead practitioner who may be a Community Psychiatric Nurse (CPN) is assigned to complete assessments and 'my care and safety plans'. The Lead Practitioner for Craig was a CPN, as safeguarding was not identified by ATS. It is apparent that the approach of mental health services and the applied skills of CPNs are focussed on providing a specialist, medical-orientated crisis intervention response to presenting mental health concerns. In reacting to Craig's mental health needs, this tended to mean encouragement to take medication, venture outdoors and maintain contact with the Lead Practitioner to monitor his wellbeing. Care plans and risk assessments were not updated to reflect changing needs, or shared with other agencies. A more holistic, personalised, and joint care management approach to assessment and care planning is more commonly applied by social workers and, if this role is to be retained by CPNs, there should be a commitment to a clear procedure, training, and time allocation to address this role robustly.

Joint working: Craig did not receive contact from agencies in the final months of his life, in a period when his needs and risks had escalated, or active follow-up to his County Hospital Emergency Department attendance in December 2020. There was also limited contact between agencies throughout the review period to reach a common understanding and approach. However, the Police did efficiently report concerns via HASC to ATS and accompanied Craig to Hospital. The Hospital MHLT regularly referred on to the ATS Lead Practitioner, who updated the GP practices on occasions. Craig's registration with two GP practices at the same time did not seem to impact on consistency, as the messages on ADHD treatment, the primary reason for his contacts, were aligned.

Multi-agency risk assessment and management: There currently is not a multi-agency risk assessment and management structure within Brighton and Hove at either strategic or operational level. Such a structure would enable a coordinated approach and shared responsibility, as well as shared information and professional perspectives. Whilst involved agencies considered Craig's circumstances to be low risk, a holistic needs and risk assessment would potentially have identified a range of escalating concerns relating to his mental health, substance misuse, suicidal thoughts, self-care, isolation, and domestic abuse. A risk checklist and assessment tool, incorporating consideration of chronic and escalating risk, would be beneficial in triggering and supporting these decisions. In the absence of this structure, there were missed opportunities to jointly identify and address escalating risk factors, particularly in the latter months.

At a strategic level, a Multi-Agency Risk Management (MARM) forum is under consideration following a recently published review by the SAB and this would provide clinical and social care oversight of risk assessment and management plans. Such forums are very effective in coordinating a planned response to complex needs and risks, particularly when it has not been possible to effectively address these at an operational, practitioner level. Membership of the forum should include service managers with strategic decision-making accountability; incorporating HASC, SPFT, Sussex Police, University Hospital NHS Trust, ICB, named GP and Commissioning. The Ambulance Service and Fire Service may also be considerations for participation. The SPFT complex case panel might be a useful foundation for the development of a MARM.

Whilst there is not general support among local agencies for a risk management framework that is aligned to GP localities, the Independent Reviewer considers that an arrangement for convening practitioner-based risk management meetings would be beneficial as a layer beneath the MARM. This can be a simple arrangement in which any professional can convene a meeting to establish or review a risk assessment and management, including a nominated coordinator and shared responsibility. Attendance might include neighbourhood police teams. There is scope to review existing lower-level risk management processes within agencies and to further consider the potential benefits of a multi-agency practitioner-level arrangement.

9.3. **Mental health, mental capacity & service user voice (key themes 5.2, 5.6)**: There was insufficient clinical oversight of Craig's acute mental health needs, his trauma regarding diagnosis and his wider social care needs. At times, Craig mentioned suicidal thoughts and this was not recognised as a significant risk factor.

ADHD Waiting list: A primary concern was that Craig did not feel that mental health services were addressing ADHD and consequently his engagement with services could have been affected, including compliance with prescribed medication. Craig did not have an ADHD assessment. If this had been available it may have led to an ADHD diagnosis, a clearer understanding of his needs, risks, and strengths, and access to specialist support, including Cognitive Behavioural Therapy and appropriate medication. It may have led to his acceptance of the

existing mental health diagnosis and treatment plan. His engagement may have improved and the escalation in wider concerns, primarily self-neglect and behaviour seen as chaotic, may have been prevented.

During the period of the review, the SPFT Neurodevelopmental Service had a two-year waiting list for ADHD assessment and diagnosis, and this continues to increase. SPFT and the wider Sussex health system, including the Integrated Care Board (ICB) recognise the risk status of the Neurodevelopmental service, particularly in view of the higher incidence of mental health concerns in the local area. Recruitment of more clinicians is a priority, however there is a shortage of suitably qualified staff and funding implications. Some neurodevelopmental practitioners have been recruited since April 2022, but this does not impact on the length of the assessment waiting list and diagnostic capacity.

Significant system-wide work is ongoing to make improvements, including a new Neurodevelopmental Oversight Group, additional SPFT funded staff for paper triaging and RAG rating of referrals and clinical risk stratification of the waiting list. The challenges in this area of work are not unique to Sussex and there is a similar picture nationally.

<u>Mental Health Act Assessment:</u> The Lead Practitioner considers that Craig did not require a statutory Mental Health Act Assessment during the time of his involvement, as the psychotic, chaotic presentation was inconsistent and drug induced, without a clear diagnosis.

<u>Mental Capacity Assessment:</u> There was an assumption of decision-specific mental capacity by agencies involved with Craig in the review period. It is unclear whether he may have lacked capacity during periods of drug misuse and in the latter months. A risk assessment may have established a need for a Mental Capacity Assessment relating to the risk of self-neglect or have underpinned an assumption of capacity. However, he accepted Police support and hospital attendance during crises. The Hospital risk assessed in December 2020 that Craig had capacity to decline specific medical treatment.

<u>Craig's voice:</u> Whilst professionals endeavoured to be responsive to Craig's presenting needs and risks, no-one really sat down with him to try and understand his lived experience. The care plan and risk assessment were not co-produced or shared with him, although he had on one occasion requested this. There is a need for reflection on whether professionals and services, whilst caring in approach, can become to a degree desensitised to the continuous presentation of acute mental health and substance misuse concerns in the local area.

9.4. **SCARF referrals & safeguarding adults (key themes 5.4, 5.5)**: The pathway and screening involved in reporting care needs and safeguarding concerns was not sufficiently clear and robust in relation to Craig. There were grounds to suspect abuse, specifically concerning self-neglect and domestic abuse and most prominently in the latter months.

<u>SCARF pathway and screening:</u> SCARF (Single Combined Assessment of Risk Form) reports are routinely sent by Sussex Police to HASC, which are forwarded

to ATS when a service user is assigned to this service. These convey needs and risks relating to vulnerable adults and recommended actions. The reports are triaged and RAG rated by the HASC MASH (Multi-Agency Safeguarding Hub), which incorporates Police involvement, but are forwarded to the ATS without this input from MASH. The ATS duty service does involve social work screening. There is a high volume of SCARFs and the Police do not receive feedback on the outcomes.

There were 7 Police visits to Craig and 8 related SCARF reports between May and December 2020, with 4 of these between mid-November and late December, demonstrating an escalation in the level of concern. These clearly presented needs and risks as identified by the Police, most notably self-neglect (either stated or described) and also concerns relating to mental health, physical health, self-harm, substance misuse, domestic abuse and escalating chaotic behaviour. Recommended actions were included in all the reports, with safeguarding flagged in 4 reports and otherwise a request for a mental health or health and social care assessment. These reports did not trigger a safeguarding adults enquiry. In response to the SCARF on 17/12/20, the safeguarding threshold was not considered to be met. There appear to have been grounds for the ATS to have addressed repeat, escalating self-neglect concerns as a safeguarding adults enquiry and, as a proportionate response, to have undertaken this as a multi-agency needs and risk assessment. There are weekly safeguarding meetings and a safeguarding forum in the ATS, with social work input and oversight, but Craig's referrals were not considered to be safeguarding and were instead relayed to the Lead Practitioner.

This raises a concern about the clarity of the screening responsibility between the Police, HASC and ATS and, whilst there is available social work input within the receiving agencies, there was not a clear Safeguarding Adults Manager decision-making function in relation to the referrals for Craig. There is a need for greater clarity on screening responsibilities, particularly when the Section 75 agreement applies. Whilst the safeguarding adults responsibility is delegated to ATS, HASC has a Care Act Section 42 accountability and a review of the screening and decision-making process will necessitate a collaborative approach.

It is clear that the Police were responsive, listened to Craig's voice, were sensitive in their approach and managed to build some rapport and trust. However, the Police were not engaged in discussion with HASC or the ATS about his needs and risks, following submission of SCARF reports. This expectation would benefit clear communication and joint assessment and planning. An alternative consideration would be for the Police to triage reports prior to sending, with an analysis of the risk information, alongside an expectation of further discussion or feedback by HASC or the ATS. The reports were also not shared with the Hospital, which would have further enhanced joint working.

<u>Other safeguarding:</u> There were other missed opportunities to consider needs and concerns as safeguarding. The Hospital admissions in December 2018 and late December 2020 should have led to safeguarding concerns being raised regarding suspected self-neglect and domestic abuse.

9.5. **Resources & environment (key theme 5.7)**: The impact of austerity and workload capacity, alongside the COVID pandemic, are very clear factors contributing to the service and practice shortfalls recognised in this review.

Austerity and workload capacity: The ATS Lead Practitioner demonstrated professional autonomy and judgement in successfully making the case to retain casework responsibility and continuity for Craig, both when responsibility should have transferred to another geographical area and when it was felt that Craig was not engaging. However, he held an extremely large caseload of 42 service users with a range of complex mental health needs, which is understood to be standard within the service, and clearly had limited capacity to engage proactively with Craig (whose needs and risks were not seen as untypical or a high priority) and other people he was assigned to. The workload capacity within the service is also further affected by a high turnover of staff due to stress and was not at full strength throughout the review period. The resource shortfall within the SPFT Neurodevelopmental Service and the risk implications of the ADHD waiting list have been covered earlier in this report.

Trauma support to staff: It is acknowledged by SPFT managers that the Lead Practitioner did not receive sufficient support in his role and in the aftermath of the traumatic event. He had not received clinical supervision for 6 months prior to Craig's death. The Lead Practitioner did receive some support from his line manager and declined a referral to the psychology team but did not have an offer of trauma counselling support. The practice has been reviewed by a new SPFT leadership team, with the outcome that supervision is prioritised and staff in similar circumstances will be provided with a meeting to discuss individual needs and caseload demands.

Covid pandemic: Craig stated a preference for face-to-face contact, which was very limited in the review period due to Covid restrictions, as the ATS Lead Practitioner and GP surgeries mainly communicated by telephone. He also expressed concern about increasing isolation, including in his final contacts.

9.6. **Key legislation & policy (key theme 5.8)**: There were gaps in the application of the Care Act 2014, Sections 9 and 42, relating to needs assessments and safeguarding adults enquiries. Consideration of the Mental Capacity Act 2005 should have been underpinned by robust risk assessments. Reflecting a national concern, mental health is a protected characteristic within the terms of the Equality Act 2010 and the resource shortfall involved in putting an ADHD assessment out of Craig's reach was the primary factor in his trauma. Procedures relating to safeguarding adults, self-neglect and risk assessment should be reviewed, embedded and their application monitored across agencies.

10. Recommendations

10.1. **Care Act needs assessments, care plans and the Section 75 agreement**: HASC and SPFT to assure themselves that Care Act needs assessments and support plans completed under the recently reviewed Section 75 agreement meet expectations. There should be consideration of procedures, relevant skills, time allocation and training to ensure that assessments and support plans are holistic, personalised, and completed in all situations where the Care Act eligibility criteria is met.

10.2. **Risk management structure**: BHSAB and HASC to consider the development of a multi-agency risk management structure. There should be consideration of a service-level Multi-Agency Risk Management (MARM) forum with appropriate attendance and deputies, an operational-level risk management meeting arrangement, a procedure and risk levels guidance (including trauma, chronic and escalating risk), a risk checklist and assessment template, training, and alignment with or connection to West and East Sussex arrangements.

10.3. **ADHD assessment capacity and neurodevelopmental awareness**: BHSAB to ask NHS Sussex and SPFT to explore the development of a local strategy to reduce the waiting time for ADHD assessment and diagnosis. There should be continued regular risk reviews of patients on the waiting list. SPFT should review its neurological awareness training, including ADHD, to ensure it meets national requirements and best practice.

10.4. **Mental Capacity Assessments**: BHSAB to obtain assurance that Mental Capacity Act training across partner agencies is at an appropriate level and includes consideration within the training of underpinning risk assessments.

10.5. **SCARF pathway and screening**: Sussex Police, HASC, NHS Sussex and SPFT to review the SCARF pathway and screening responsibilities to ensure that decision-making is safe and proportionate.

10.6. **Safeguarding adults**: BHSAB and HASC to review (a) that safeguarding adults training across partner agencies is in line with the Sussex Safeguarding Procedures and at an appropriate level and (b) ensure partner agencies have a clear understanding of supporting safeguarding processes such as Escalation procedures and Thresholds guidance.

10.7. **SPFT Serious Incident (SI) actions**: BHSAB to seek assurance from SPFT that the Serious Incident (SI) report recommendations have been actioned, embedded, and are having a positive impact on service users and staff. These recommendations concern core standards of patient care and documentation; 3 monthly caseload reviews and support to practitioners; personalised care planning; guidance on GP contact and ongoing physical health assessments; and monthly clinical supervision of lead practitioners.