# **East Sussex Safeguarding Adults Board**

# **Response to Adult C Safeguarding Adults Review**

Section 44 of the Care Act 2014 sets out that a Safeguarding Adults Review (SAR) must be carried out for every case in which abuse or neglect is known or suspected and an adult had died (including death by suicide) or come to serious harm, and there are concerns about how organisations or professionals worked together to safeguard the adult.

The SAB commissioned this SAR to understand the circumstances leading up to the death of Adult C and to support the identification of strengths and weaknesses in how agencies worked singly and together. The purpose of a SAR as set out in the Care and Support Statutory Guidance is to “promote effective learning and improvement action to prevent future deaths or serious harm occurring again”.

Adult C experienced significant levels of domestic violence and coercive control, which were particularly severe during the last 12 months of her life, the period which this review focused on. Adult C had multiple complex needs as a result of drug and alcohol dependency, fluctuating mental health (including patterns of self-harm and periods of poor mental health) and homelessness. Her substance misuse led to involvement from Children’s Services and alternative care arrangements for her two children being sought. Adult C was involved in criminal behaviour at times to fund her substance misuse. She started a relationship with a partner in 2015, who was volatile and violent. He also had drug and alcohol problems and experienced periods of street homelessness.

Adult C was found dead by a friend on 31 December 2017. A Coroner’s inquest concluded that the medical cause of death was mixed drug toxicity.

We extend our deepest condolences to the family and friends of Adult C and thank them for their valuable contributions to the review. Adult C’s mother has contributed a written statement which is included within this response.

This SAR was conducted using a Learning Together approach, which applies systems thinking to gain a deeper understanding of what influenced professional practice. Dr Sheila Fish from the Social Care Institute for Excellence (SCIE), was appointed as the lead reviewer. She was supported by an independent consultant Alison Ridley, experienced in conducting reviews into safeguarding concerns.

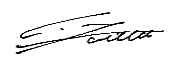
To support the process, a Review Team consisting of senior managers from the agencies involved, met with the reviewers, providing the necessary context on organisational policies and practice. Frontline staff who had worked directly with Adult C attended a workshop to talk about their experiences and safeguarding practices. Adult C’s mother and stepsister also participated in the review and shared their perspectives on Adult C’s situation. A full evaluation of the process will be undertaken to learn from the experience of all those involved in this methodology.

Specifically, this review has considered the following research questions:

* How effectively do Safeguarding and Domestic Abuse systems work together locally, for people who are victims or perpetrators, or both?
* In working with people with complex needs in relationships of domestic violence, how well do agencies understand their different roles, remits and restrictions of partners?
* What is helping and hindering us in working preventatively with women with complex multiple needs?
* How easy is it currently to respond well to women who have lost contact with their children when they are reaching out for help to re-gain contact?

The East Sussex Safeguarding Adults Board (ESSAB) has reflected on the lessons arising from this tragic case. We accept the overall findings of this SAR and are committed to taking the learning forward as far as is possible within existing statutory frameworks. The role of the ESSAB is to seek assurance from organisations in East Sussex about changes they have made since the death of Adult C. This includes around multi-agency working, the relationship and coordination between services in safeguarding women with multiple complex needs and tackling those areas where joint working could be improved.

This report sets out the formal response of the ESSAB to the findings and learning identified in the review. The actions arising from this review will be monitored by the SAR Subgroup with progress reported to the Board.



Graham Bartlett

Independent Chair, East Sussex Safeguarding Adults Board

**Finding 1:**

**There is currently no accommodation readily accessible for women with the combination of needs related to chronic trauma, drug and alcohol abuse, homelessness and domestic violence and abuse. Women wishing to remain within a couple are even less well served in terms of accommodation. This leaves practitioners having to rely on perseverance and luck to access viable accommodation.**

**Finding 2:**

**Current service set ups locally are not joined up or tailored to the needs of a small cohort of women who struggle with a combination of needs related to chronic trauma, drug and alcohol dependencies, homelessness and domestic violence and abuse. This leaves some of the most vulnerable women either excluded from services altogether based on eligibility criteria, or unable to access them because of the lack of proactive, flexible and intensive outreach support.**

**Board Response**

The Board will consider these two findings together, since access to accommodation and community support for women with multiple complex needs are inextricably linked.

These two findings highlight the current challenges faced both in accessing suitable housing options and ensuring the right specialist support is available for this cohort of women. Whilst many refuges do not accept women with complex mental health and substance misuse issues, we note that the East Sussex refuges do, and report that 80% of residents living in refuges, compared with the national average of 40%, present with complex needs. There is also a higher per capita bed count in East Sussex than many other areas in the country.

Over the past 18 months the Domestic and Sexual Violence and Abuse Services for Brighton and Hove and East Sussex has started work to develop a new joint strategy and commence the retendering of specialist domestic violence services. The significant stakeholder engagement in this process has recognised the need to review service pathways and current delivery models for adults with complex multiple needs as a priority, in the light of pressures on services and as a response to increased demand. It is our view that the learning from this SAR presents an opportunity to shape the retendering process and look to combine accommodation services with community services and to provide dedicated in-reach.

The new commission for Domestic and Sexual Violence Services presents a service specification which encourages partnership working with key agencies, including drug and alcohol and mental health services, to enable victim focused responses accommodating multiple complex needs. The tender for this service will be launched in October 2020 with the contract start date in April 2021. This new service model will also facilitate mediation and support between couples where domestic abuse is an issue, aiming to prevent both new and repeat incidences of domestic abuse.

The Board will work with partner agencies and the Commissioner of Domestic and Sexual Violence and Abuse Services across Brighton and Hove and East Sussex to ensure that the forthcoming strategy and re-tendering process embeds the centrality of partnership working and practice in improving support to victims of domestic violence and their families where complex multiple needs are identified. The Board notes the potential barriers to progress in this area, in terms of the availability of resources to facilitate more flexible and proactive ways of working, and the issue of commissioning across service areas will require further exploration.

The Board is assured that measures are already being taken to improve the offer to people with complex needs fleeing domestic abuse and requiring accommodation, through the work that East Sussex County Council (ESCC) is taking forward with partner agencies. In April 2020 ESCC commissioned two additional full-time equivalent posts into the domestic abuse refuge contract, which has reduced the client to staff ratios and enabled increased keywork time, particularly for clients with multiple complex needs. ESCC has also agreed funding for a two-year period to develop a co-located multi-agency team of specialist support staff within domestic abuse refuges and commissioned supported accommodation. The team will work with commissioned providers to upskill key workers to better support the cohort of clients who present with multiple complex needs with the aim of supporting residents in more flexible ways to manage mental health and substance misuse needs and build resilience. Work has commenced to recruit to the specialist team, and it is expected that this team will be in place in the autumn of 2020.

It is also noted that new female housing provision has opened in West Sussex in August 2020, as a joint initiative between the provider, Emerging Futures and the National Probation Service, supported by the Criminal Justice Board. This provision directly supports women who are in contact with the criminal justice system and provides 11 units of single accommodation. This service is open to referrals from East Sussex, and Emerging Futures are in the process of securing additional properties for step up provision to secure similar models of development across East Sussex, Surrey and Kent maximising opportunities for those women with multiple complex needs coming into contact with the criminal justice system. The Board will maintain links with the National Probation Service regarding the development and evaluation of this service.

When assessing application for housing assistance, Adult C was found to be ‘intentionally homeless’ (under section 191 Housing Act 1996) by one Council housing department and regarded not to be in priority need by the other (under section 189,1c Housing Act 1996). The report findings questioned whether the subsequent implementation of the Homelessness Reduction Act (HRA) 2017 would prevent the same situation from happening again. The HRA has created a new duty on local authorities to relieve homelessness regardless of priority need (and intentionality) and has enabled them to do so earlier. The process involves the production of a Personalised Housing Plan (PHP), which offers new opportunities to work with the street homeless. The Board acknowledges that the effectiveness of a PHP will in part depend on an individual’s willingness and ability to engage with it. The Board also understands that there is available guidance on how to support individuals who may experience additional barriers to engagement.

In response to the HRA the housing needs teams across East Sussex have adapted their working practices over the past two years to adhere to the requirements of the Act in ensuring timelier responses and to provide more structured provision of advice and assistance to those who present as homeless, regardless of priority need. The Board understands work has commenced within District and Borough Councils to initiate statutory reviews of homelessness with a view to agreeing new strategies which will be implemented later in 2020. These will be the first full reviews of homelessness strategies since the HRA was introduced and will examine how service provision has been affected by and responded to the Act. A consultation on this review is planned for September / October 2020 when stakeholders will have an opportunity to contribute to the development of the Homelessness and Rough Sleeping Strategy. The Board will receive updates from District and Borough Council representatives as to the process of this strategy.

The nature of multi-agency working when supporting adults with complex multiple needs requires a variety of accommodation, care and support services to manage risk effectively and ensure a Making Safeguarding Personal approach remains at the centre of risk management planning and supporting front-line practitioners to provide proactive and flexible support. This SAR has shown us that there are limited multi-agency mechanisms to bring together staff across agencies to plan and review their work involving cases which are considered to be high risk and involve individuals who may have varied and complex needs, and to engage all relevant agencies in collective working to develop a ‘team around the adult’. The findings of the review also highlight the challenges when working with adults whose needs cross statutory frameworks and who may fall just below different eligibility criteria, such that there may be a lack of a coordinated response no lead agency.

The Board will consider developing a multi-agency risk management framework to provide guidance on working with adults where there is ongoing risk, but the circumstances may sit outside the statutory safeguarding framework or service eligibility thresholds.

The review has also shown the benefit of the model of working adopted by the Fulfilling Lives service in providing proactive outreach, bringing agencies together and ensuring individuals can access the support that is available. It is noted that this service is due to end in the near future. The Board would like to consider the learning from the Fulfilling Lives programme to potentially influence future service provision and consider ways to strengthen partnership working when managing complex cases.

**Finding 3:**

**There is not currently an established multi-agency protocol or supporting tools for the proactive collection of third-party evidence of patterns of domestic violence and abuse. This leaves police responding reactively to incidents of domestic violence and abuse and trying but struggling to gather viable third-party evidence and leaves the voluntary sector frustrated at inaction against known perpetrators.**

**Board Response**

In considering this finding, the Board notes the challenges in gathering and using viable information from third-party sources. The discussions within the Board have emphasised the complexities in gathering information lawfully from sources such as medical records without consent from the victim. The discussions have also highlighted that practitioners can lack confidence to report concerns and incidents of domestic violence and abuse when an adult does not give consent. This creates an additional challenge for practitioners in that going against a person’s wishes can jeopardise working relationships. The maintenance of these trusted relationships is vital in monitoring and offering consistent support to women exposed to ongoing domestic violence and abuse, balanced against the need to protect them.

The Board accepts that current ways of working are not always well set up to support agencies to effectively and routinely record information that can then translate into evidence in Police prosecutions. Whilst the Board is in agreement with a proposal to consider the development of an overarching mechanism to support evidence-led prosecutions, and look to more creative, proactive and lawful approaches to collecting third-party information, the issue of how practitioners can respond to escalating situations and capture intelligence and frame this in a way that can support the police most effectively remains highly complex. We understand that the Crown Prosecution Service are developing a national action plan which will explore this issue further.

In 2019 the Joint Domestic, Sexual Violence and Abuse, and Violence Against Women and Girls Unit in Brighton and Hove and East Sussex reviewed the Multi-Agency Risk Assessment Conferences (MARAC) structures and referral pathways. The review highlighted the increasing numbers of referrals into MARAC as well as the challenges of safety planning for victims of complex and repeat cases. The MARAC Support Team worked with agencies to develop a ‘MARAC Hub’ model which was piloted over a period of three months from January to March 2020. Fulfilling Lives South East Partnership led on the evaluation of this pilot. The Board notes the findings from this evaluation which will inform the future development of MARAC. The recommendations from this report highlight that in order for MARAC to function effectively it is crucial to have the right representatives at the meeting to have more meaningful discussions about safety planning and to support the management of high risk domestic abuse cases often involving adults with multiple complex needs. The Board will advocate for the future development of MARAC to ensure that consideration is given to those agencies who are not routinely at MARAC but are likely to be working with adults experiencing domestic violence and abuse, and that consideration is given to ways in which they can be linked in with this forum.

The Board is of the view that improvements should be made to the way in which third-party information shared at MARAC could be used to inform protection planning and where appropriate link into Police investigations. Sussex Police have launched a Domestic Abuse Improvement Plan, which includes a review of the MARAC process to emphasise the importance of applying an investigative mindset to consider the relevance of the information shared at MARAC and how this may be converted to evidence in line with the National Crime Recording Standard.

The Board will seek assurance and updates on the outcomes of these areas of work and consider how to take forward any multi-agency recommendations. The Board will also promote the development of multi-agency guidance and supporting tools which agencies can use in supporting police with prosecutions.

The Board acknowledges that work is also required to address those cases involving domestic violence and abuse that may not meet the criteria for MARAC, for example many cases of standard or medium risk do not progress to MARAC, yet, have a large degree of agency involvement which is often not effectively coordinated.

As part of reviewing the mechanisms for effective information sharing, the Board recommends that the principles of shared data and case management systems are explored.

The SAB multi-agency training around domestic violence and abuse, and coercion and control will be reviewed in the light of any new guidance or supporting tools that are produced, and assurance sought to ensure this is accessed by the range of partner agencies working in this area.

Whilst the Board agrees with Finding 3 in principle, we do not agree with the wording set out in paragraph 2.4.10. This points to the reviewers concluding that Police did not collect all the available evidence in this case, whereas the Board is of the opinion that the information that was available from third-party sources could not be converted to evidence by the Police. The Board is disappointed that agreement could not be reached with the reviewers over more precise wording. After careful consideration of this point, our interpretation of this paragraph is that key to this finding is the potential volume of third-party information held by other agencies that could have, in theory, been drawn upon. However, any third-party information will also be subject to relevant legislation, information sharing protocols and codes of prosecuting practice.

**Finding 4:**

**A pattern of continuing to give women with complex needs short term prison sentences at a distance from their home area, disrupts any progress they may be making with the support of community teams, provides little time for specialist health care services delivered within prison to establish relationships, potentially leaving women more vulnerable on their release.**

**Board Response**

The Board notes that it is unlikely the solution to this finding sits within the realm of the SAB since it links with sentencing guidelines and is outside our direct control. However, we will use this opportunity to consider if there is a role for the Board to influence any developments in this area.

A multi-agency audit undertaken by the East Sussex SAB in 2018 in relation to complex cases, highlighted the need for more joined-up working between services supporting adults in prison. Work has been undertaken by local probation services and Change, Grow, Live (CGL) to develop a partnership protocol that supports closer collaborative working and delivery of substance misuse rehabilitation requirements and licence conditions for adults who receive short term prison sentences. This joint working arrangement includes the provision that upon sentence each adult will be allocated a community based responsible officer, who will be responsible for developing a suitable release plan. This will include communication and liaison with relevant support agencies to secure appropriate services are available upon release. This protocol is expected to be in place by early November 2020. The Board will review the impact of this partnership protocol to inform any recommendations in response to this finding and consider further opportunities to support cross-sector work in this area.

The Care Act 2014 sets out that local authorities are responsible for meeting the social care needs of prisoners residing within their areas in prisons and approved premises. Surrey has five prisons of which three are women’s prisons and accommodates the largest proportion of female prisoners in the country. Given this position, Surrey County Council operates a social care service for prisoners, which ensures that there is a lead oversight for a prisoner during their sentence. The Board will liaise with CGL and the National Probation Service to identify how this service could fit into the partnership protocol and support a more joined-up approach.

The Board is aware that the National Probation Service has recently been looking into the impact of women’s prisons being located out of their area of residence upon how agencies can work collectively to plan for release. We will seek information as to the outcome and recommendations stemming from this work as part of our response to this finding.

**Additional Board response in relation to Appraisal of Practice Synopsis**

Paragraph 3.2.4 in the Appraisal of Practice Synopsis states:

“The safeguarding enquiry process supported agencies to get in place the practical support needed to progress the plans to try to access accommodation, for example. However, the Care Act 2014 section 42 enquiry framework is not well suited to manage chronic risk of the kind Ms. C was exposed to. The safeguarding enquiry was subsequently closed on the basis that risks continued but were being managed – a view the SAR reviewers see as overoptimistic at this stage”.

Adult Social Care & Health has reflected on this practice finding and is of the view that the section 42 enquiry framework is suited to managing chronic and complex safeguarding risks. The enquiry framework outlined in the Sussex Safeguarding Adults Policy and Procedures promotes Making Safeguarding Personal (MSP), a safeguarding practice approach used in enquiries that focuses on identifying and achieving desired outcomes without any time constraints. Applying MSP in circumstances where coercion and control, chronic self-neglect, consent and difficulties with engaging requires skill and knowledge. Practitioners are required to weigh up individual rights, statutory duty, risk and benefits whilst promoting resilience, recovery and wellbeing. All of these considerations are outlined in the safeguarding procedures. Further development of the domestic abuse chapter of the procedures is currently underway with partners focusing on issues of consent where there are concerns about coercion and control. A domestic abuse toolkit has also been developed with updated training for Adult Social Care & Health practitioners.

**Statement from Adult C’s mother to accompany the Safeguarding Adults Review (SAR)**

Domestic violence is the primary cause of what went wrong for my daughter and created a barrier for her seeking help and support.

The agencies working with my daughter should have communicated and shared information about risks more effectively.  This information should reflect previous history and include detail on family background.  In my view, access to specialist family counselling, including liaison with children and other family members should be more accessible to women in such a vulnerable position experiencing escalating domestic violence and coercion and control.

As a family we have felt frustrated at the language used by many agencies to describe my daughter as ‘chaotic’ or making ‘lifestyle choices’.  Such an approach is victim blaming and does not take account how circumstances affect the decisions people have to make to keep themselves safe when experiencing such significant and terrifying abuse.

There is crucial learning in my daughter’s case about the role of the Multi-Agency Risk Assessment Conference (MARAC), and I hope that we will see direct change and improvements to ensure this process can support the victim in the true sense of the word. This would mean that it is robust and probing and that all agencies liaise to ensure that the plan is put into practice going forward. Also, that this is monitored regularly, with the allocated contact/support worker for the victim.

I would like to see the police to have more powers to support victims of domestic abuse and to arrest perpetrators.  In my daughter’s situation many agencies were involved and there was no lead professional.  Having one consistent case worker who can be the single point of contact between agencies would reduce mistakes in information sharing and ease pressure on the victim in terms of dealing with a number of different agencies.

From my perspective I want to ensure the lessons learnt from my daughter’s death will help others and effect positive change in the future.

8 October 2020