West Sussex Safeguarding Adults Board

Safeguarding Adult Review
in respect of Alan

Report Author

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1 THE REASON FOR THE SAFEGUARDING ADULT REVIEW

1.1. In July 2013 police attended a report that a 41 year old male (Alan) had fallen from a multi-storey car park. Alan was transferred to hospital but subsequently died of his injuries.

1.2. Alan had been under the care of the Sussex Partnership Community Mental Health Team (CMHT) since 1996. A few days before he died he had reported to police that a male (John), who had been involved with Alan for a number of years (and these previous involvements had led to safeguarding investigations), had stolen property from him. John was arrested and bailed with conditions not to contact Alan. John went to Alan's home and spoke to him a few hours before Alan died.

1.3. Alan was a vulnerable adult who had been in receipt of community services, and the West Sussex Safeguarding Adults Board (WSSAB) commissioned a Safeguarding Adult Review in April 2015 in line with their [1]West Sussex Adults at Risk Serious Case Review Protocol.

The Review Process

1.4. The author of this report was commissioned in April 2015 to undertake a review in line with the guidance set out in the Care Act, 2014. The independent reviewer is Brian Boxall, a retired Detective Superintendent who served with Surrey Police for thirty years. Since his retirement in 2007 he has been an independent consultant and In-Trac Associate and has undertaken a number of serious case reviews, adult reviews and domestic homicide reviews. He is currently the Independent Chair of Havering Safeguarding Children and Adult Boards.

Methodology

1.5. Terms of Reference were produced and agreed (**Appendix A**), and the following agencies were identified as having involvement with both Alan and or John.

- South East Coast Ambulance Service
- Sussex Police
- Sussex Partnership NHS Foundation Trust
- South Down Housing Association
- Western Sussex Hospitals Foundation Trust
- Worth Services
- National Probation Service
- Victoria Road Surgery
- West Sussex Drug and Alcohol Recovery Service
- West Sussex County Council Adult Social Care

Each organisation produced Individual Management Reviews [2](IMR's).

1.6. A Safeguarding Adult Review (SAR) panel were appointed to work with the reviewer, with representation from the following agencies:

- Head of Safeguarding, West Sussex County Council (WSCC)
- Principal Manager, Safeguarding Adults, WSCC

[1] *West Sussex Safeguarding Adults at Risk Serious Case Review Protocol* (2013)

[2] **Individual Management Review:** A report produced by individual agencies as part of the Serious Adult Review

- Head of Adult Social Care WSCC
- Board Manager, West Sussex Safeguarding Adults Board
- Quality Assurance Officer, West Sussex Safeguarding Adults Board
- Strategic Director Social Care and Partnerships, Sussex Partnership Foundation Trust
- Deputy Director of Social Work, Sussex Partnership Foundation Trust
- Designated Nurse: Safeguarding Adults, Coastal West Sussex Clinical Commissioning Group (CCG), Crawley CCG, Horsham & Mid Sussex CCG
- Detective Superintendent, Sussex Police
- Detective Chief Inspector, Sussex Police
- Senior Probation Officer, National Probation Services

Review Period

1.7. The review panel identified the period that should be reviewed as May 2009 to July 2013.

Parallel Process

1.8. There were a number of other review processes in respect of this case namely:

- Independent Police Complaints Commission [3](IPCC) Investigation
- Health: Serious Incident Report (SIR)
- Coroner's Inquest.

1.9. The author has had access to the final IPPC and SIR reports and attended the Inquest, which took place in July 2015. The Coroner concluded that:

> *Alan took his own life following a prolonged period of abuse and intimidation by a known individual. The statutory agencies failed through a lack of communication*.

The Coroner subsequently wrote to the author and asked for the review to examine specific areas of concern that she had identified during the Inquest. These were included in the terms of reference.

Family Involvement

1.10. Alan's parents supplied the author with a number of documents including a very detailed summary of events prepared for the Inquest. The author was able to witness Alan's father's evidence at the Inquest and has subsequently spoken to Alan's parents as part of the review.

Report Structure

1.11. This report has been written taking into account that it may become a public document. A number of specific and/or personal details relating to family members and other participants have therefore been omitted for confidentiality purposes and names have been changed. The report sets out a brief overview of the case history and then focuses on an analysis of the agency responses.

2 CASE SUMMARY

[3] **Independent Police Complaints Commission** (IPCC) is a non-departmental public body in England and Wales responsible for overseeing the system for handling complaints made against police forces in England and Wales

2.1. A detailed chronology of individual agencies' involvement with both Alan and John has been produced. The following is a summary of the most significant events taken from that comprehensive chronology. It was identified that two periods of time encapsulate issues present throughout the period under review. These were:

- May 2012 to November 2012
- April 2013 to July 2013

These periods will be set out in more detail.

2.2. From 1996 to 2006 Alan remained under the care of the Community Mental Health Team [4](CMHT) (formerly the Community Rehabilitation Team) having been diagnosed with Schizophrenia. In 2001, Alan married another service user. They lived separately in various types of supported housing. They were divorced in 2011, but remained in contact with each other.

2.3. During 2006 there were two recorded incidents of the exploitation of Alan by others. One of these was dealt with under safeguarding procedures and individuals were subsequently arrested and charged. In 2007, Alan moved to accommodation that he had identified as wanting to live in. Efforts were made to dissuade him from moving to that particular location due to his vulnerability to exploitation, but he was adamant that he wanted to move to be near his wife. He continued to receive support from the CMHT and a Floating Support Officer (FSO) from Southdown Housing.

2009-2010

2.4. In 2009, Alan moved to independent accommodation. A plan for on-going support was agreed with the FSO. He continued to be exploited by an individual (not John) who attended Alan's home and demanded money from him. The incidents were reported to police, but no further action was taken, only words of advice given. Police passed the information to his Care Coordinator. In 2010, Alan's ex wife disclosed to the FSO that Alan had been subject to a robbery. The Care Coordinator (CC1), who had a clinical background, was informed of the new information. CC1 supported Alan in making reports to the police, safeguarding alerts were not raised by any agency.

2011

2.5. Between January and July 2011, Alan started to disengage from services, failing on five occasions to attend his depot injection (deep muscle injection of anti psychotic medication). In late July 2011, Alan's father contacted the local police and raised concerns about his son being exploited by John who was living at his property. Police attended and as a result the Police Community Support Officer (PCSO) submitted a comprehensive police 'Vulnerable Adults at Risk' form (VAAR). As a result, a safeguarding alert was raised and investigated in line with the local safeguarding procedures. Sussex Partnership Foundation Trust staff worked with police, housing support workers and Alan's family. Alan moved to his parent's home whilst his property was secured and John's belongings were moved out. A respite admission was discussed with Alan but he did not wish to access this support.

2.6. In August 2011 a risk assessment was undertaken by CC1 making reference to past and current risks regarding exploitation and alcohol misuse.

[4] **Community Mental Health Teams** (CMHTs) support people living in the community who have complex or serious mental health problems. Different mental health professionals work in a CMHT.

2.7. In September 2011, there was a further complaint by Alan to police about exploitation by John. There is no record of this new information being held within CMHT so it is not known if CC1 was aware of the new reports. The safeguarding investigation that had commenced in July 2011 was closed in September 2011 with it being recorded as resolved. Alan returned to his flat but when CC1 visited Alan he reported that John had returned to his flat and was exploiting him again. Alan reported that he had a meeting with police and housing. CC1 case notes record that he considered raising a safeguarding report but there was no record of one being made. There is no record of Police raising a VAAR upon receipt of the new information or any agency raising a safeguarding alert.

2.8. An outpatient review (OAP), completed in December 2011, concluded that Alan's mental state was stable. The original Care Programme Approach[5] (CPA) care plan was continued with prescribed medicine, on going support from the Care Coordinator and a referral to vocational services regarding work.

2.9. Between October 2011 and April 2012 Alan engaged well with mental health services, missing only one depot appointment. Risk assessments were updated in April and May 2012 and discharge of Alan from care coordination was considered but not changed at that time.

2012
May 2012 to November 2013

2.10. At the end of May 2012, John was arrested at Alan's premises. This was following an assault on John's female partner. The victim confirmed to police that John had taken money from her and that he was her 'registered carer' (Department of Work and Pensions carers allowance). John was arrested, charged and attended court. He was given court bail with a condition to reside at Alan's address. It is of note that on the 31st May 2012 a history police marker was added to Alan's address at the PCSO's request:

'*Alan resides at address/vulnerable male at risk of financial abuse and manipulation from John*'

2.11. In early June 2012, the FSO attended Alan's address and was introduced by Alan to two males, one of whom was John. The FSO informed CC1 that John was possibly living with Alan again. Nobody raised a safeguarding alert and no agency response is recorded.

2.12. In July 2012 Alan contacted CC1 and informed him that John had returned to his premises and felt that he (Alan) could not live there. He was advised to contact the police and he confirmed the following day that he had contacted the police and that John had gone.

During July and August 2012 Alan failed to attend depot clinics and outpatient appointments CC1 tried to contact him by telephone and letter.

2.13. In September 2012 the situation became critical. The PCSO attended Alan's address following a report that John had taken stolen goods into the property. The PCSO later received a phone call and could hear John shouting at Alan in the background. When the local police responded John was present and Alan stated he wanted him removed. Officers removed John. Alan contacted the police again the same day stating that John was back at his flat. Police attended again but there is no record of the action they took. John was not arrested. A police VAAR was submitted, but no safeguarding alert was raised.

[5] **Care Programme Approach** The CPA is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs

2.14. Alan made further calls to police over the next four days during which he made various allegations, including burglary and fraud. Officers attended and concluded that the issues were a civil dispute and asked Alan to sign a pocket note-book entry to that effect. No formal statement of complaint was taken from him at that time; however it was arranged for Alan to attend the police station to make a statement. Officers informed him that he should bring an appropriate adult such as CC1. No VAAR was submitted.

2.15. During this period the FSO telephoned Alan The phone was answered by John who said that he was Alan's 'registered carer'. The FSO undertook a visit and Alan agreed to take out an injunction against John. FSO e-mailed CC1 and the PCSO to update them and to enquire how they could get an injunction. No individual raised a safeguarding alert.

2.16. Alan and CC1 attended the police station at the end of September 2012 to make a statement. Police officers recorded that the Neighbourhood Policing Team (NPT) was dealing with issues disclosed. CC1 recorded that Alan had made complaints about exploitation by John over a period of three years. A police VAAR was not submitted, nor a safeguarding alert raised by CC1. No formal investigation into the allegations of exploitation was undertaken.

2.17. Later on during the day that Alan had made a statement he again contacted the police. They attended his address and escorted John off the premises. John was escorted off the premises again an hour later. Southdown Housing were contacted to repair the lock that had been broken. Police returned Alan's mobile and removed alleged stolen goods. (Police records state that a VAAR was completed and submitted. This was submitted to the Community Learning Disability Team who passed it on to the CMHT) There is no record of a safeguarding alert being received within CMHT and no recorded response.

2.18. A multi-agency meeting between CC1, FSO and the PCSO took place in October 2012. There are no minutes of the meeting and no clear action plans or outcomes produced. CC1 records state that Alan was present and that he was informed to change his bank PIN and to contact the police. FSO records state that he was not present.

2.19. A few days later CC1 visited Alan and recorded that he appeared stable. A risk assessment was updated. The SIR highlighted that the same document was used as per the previous three occasions. It made no reference to past or present alcohol problems, past non-compliance, and no reference to the recent issues of exploitation. This was the last recorded risk assessment by CC1 in 2012.

2013

2.20. Between December 2012 and April 2013, Alan completely disengaged with CC1. It is recorded that CC1 made several attempts to contact him, including cold calling and sending letters. No attempts to contact him are recorded between February and April 2013. This disengagement should have indicated a risk, which was highlighted in January 2013 when Alan's father contacted Sussex police to express concern about his son's involvement with John. The PCSO made a welfare visit and Alan confirmed that John had not been at the address for some time and that he was fine.

April 2013 to July 2013

2.21. In early April 2013, Alan's father contacted Sussex Police, as he believed that John was again involved with his son. The PCSO made a welfare visit. They did not see Alan but a neighbour confirmed that John was there. A few days later the FSO met Alan at a local café, as home visits by Southdown housing staff had been suspended due to their risk assessment that John posed a risk. Alan was in a very low mood, had bruising around the

eye and grazes to his cheek and forehead. The FSO got Alan to make an appointment with CC1 and he agreed to turn John away and telephone the police if John turned up at his address. Alan expressed concern that if John got into trouble again he (John) would not be able to see his daughter who was in care. This was evidence of the emotional turmoil that Alan was facing in relation to dealing with John.

2.22. Alan disclosed that he had not taken his medication for some time. The FSO contacted the police Adult Protection Team (APT) to seek advice about Alan's situation. An officer advised that it was a neighbourhood policing problem and that he would pass the information to the Neighbourhood Police team (NPT) Sergeant and that the PCSO should lead on a multi-agency approach. Father again contacted the FSO stating that John had been around for three months and that he could not contact Alan. The FSO invited him to attend the multi-agency meeting. No police VAAR was submitted and no safeguarding alert was raised by the FSO.

2.23. The multi-agency meeting was attended by CC1, FSO and the PCSO. Alan's capacity to handle his own finances was discussed along with the possibility of a Mental Capacity Act assessment. CC1 advised that it was difficult to demonstrate that Alan lacked capacity but he would follow this possibility up. An Anti Social Behavioural Order was considered. The status of the meeting is unclear, as it was not minuted. Father was invited but declined the invitation requesting that he be updated. Alan did not attend, it is not clear if he was invited.

This meeting resulted in three actions:

- PCSO to email blank Data Protection Act Request to FSO
- All parties to continue to visit Alan
- PCSO to attend Alan's home address and remind him of his meeting with CC1.

2.24. At the end of April, John was arrested in East Sussex in relation to a domestic incident against his female partner. He provided Alan's home address as his bail address. He was already on court bail to reside at a different address, but he was not at that time arrested for any breach of bail. He still gave Alan's address when interviewed in May 2013. In May 2013, Alan's father again reported to Worthing police about his concerns that John was taking advantage of his son. He also reported his concerns to CC1. CC1 cold called on Alan's address and saw him outside with a male. CC1 informed the FSO.

2.25. In May 2013, CC1 discussed Alan at a CMHT team meeting. This resulted in a plan consisting of:

- CC1 to cold call Alan
- Refer Alan to Assertive Outreach Team (AOT)
- Liaise with Father.

2.26. There is no record of a referral to the outreach team being made. CC1 did have a conversation with Alan's father who informed him about a multi-agency meeting in May. Father believes that CC1 was not aware of the meeting, so was unable to attend. This meeting was held a few days later. The FSO and a housing manager attended, so did the PCSO, but CC1 did not attend.

2.27. CC1 did see Alan at the end of May 2013 when he declined his depot. CC1's case notes state that Alan was stable in terms of his mental health and that John was no longer at the address.

2.28. In June 2013, a Probation Officer (PO) who knew John became aware that John had registered as Alan's carer. They were very aware of the risk John posed to vulnerable people. The PO contacted the Department of Work and Pensions (DWP) to inform them,

but they stated that they were not able to disclose any information. The PO also contacted the Adult Social Care Worthing Duty Team and was advised to contact CC1. They did this by telephone backed up by e-mail.

2.29. On the 17th July 2013 CC1 was informed by the Probation Service that John was residing at Alan's flat.

2.30. The FSO met Alan on 18th July 2013 and found him to be withdrawn and he disclosed that John was causing him many problems. The FSO persuaded Alan to report the matters to the police, and on the same day Alan, accompanied by the FSO, went to make a comprehensive statement. John was arrested and bailed with conditions not to contact Alan either directly or indirectly.

2.31. A VAAR was raised by the PCSO and this led to the following actions:

- FSO provided new mobile phone to allow Alan to contact Police
- Police placed upgrade marker on system for call outs
- CC1 to see Alan for Out Patient Assessment on the 23rd July 2013.

2.32. On the 22nd July 2013 the FSO met with Alan. He was withdrawn and reluctant to talk but stated that on the evening of the 18th a friend of John's had come to his flat and had given him some money and a letter of apology from John. This information was e-mailed to CC1 and PCSO. The PCSO confirmed to the FSO John's bail conditions and the FSO updated Alan and told him to ring the police (999) if he had any contact with or from John.

2.33. In the early hours of the 23rd July Alan contacted police to state that John was outside his flat and mentioned the bail conditions. No police deployment was made to Alan's address. He was contacted by telephone and when asked, stated that John was no longer at his address. During the early afternoon of the 23rd July Alan fell from the multi storey car park.

3. ANALYSIS OF EVENTS

3.1 Introduction

3.1.1. The review author has been informed by a number of sources including the IMRs, SIR and the IPCC reports, plus evidence given by individual members of staff during the inquest, along with feedback received during the SAR panel meetings. A number of agencies such as the hospital and ambulance service only had minor involvement with Alan or John.

3.1.2. This report will examine separately actions taken on the 18th July 2013, but will not examine in detail the events that took place during the early hours of the day that Alan died. Alan's contact at that time was solely with police control staff and their actions have been examined as part of the IPCC report, which reached conclusions as to the culpability of police staff and made a number of recommendations.

This report will restrict itself to the response to Alan, which was part of a multi-agency system.

Family Concerns

3.1.3. The author has been in contact with Alan's mother and father who have also supplied him with a copy of the reports they had prepared on their behalf for use at the inquest. Many of the issues that they raised will be considered further in this report. The following provides an insight into the concerns that Alan's family had.

3.1.4. Alan was diagnosed with paranoid schizophrenia at the age of 23 years. He attended

University but was unable to complete his degree. He had a number of hobbies and friends and he stayed in contact with his family. His father believes that Alan's divorce in 2011 made him more vulnerable to John's influences and it was at this time that Alan's father first contacted police expressing his concerns about John's influence.

3.1.5. Alan's father believed John was controlling his son and isolating him from his family and friends. Father continued to raise concerns with CC1 police and the FSO but felt that his concerns were not being taken seriously, which led him to a conclusion in May 2013 that nobody was going to do anything to help his son.

In his prepared report he states:

> *Tragically, the professionals that were trying to protect Alan often went round and round in circles without a clear strategy, other than relying on Alan being able to make a statement against John and having the resilience to press charges. Insufficient consideration was given to the level of support that Alan would need to do this, given his vulnerability and the imbalance of power in his relationship with John. Also when Alan did make statements little or no action was taken.*

3.1.6. Alan's father expressed these concerns again when he gave evidence at his son's inquest.

3.2 Background Information

3.2.1. The following will provide a brief summary of Alan. It will also provide a description of the Care Programme Approach (CPA) and Safeguarding Adult Procedure processes that where in place to help support him and safeguard him. .

Alan

3.2.2. Due to his mental health diagnosis Alan had been in receipt of support for a number of years under the CPA. He became increasingly vulnerable to exploitation as evidenced in 2009 and 2010, when individuals known to him stole from him. This situation became 'critical' from 2011 onwards when John first befriended Alan.

3.2.3. Alan was considered to be a challenging individual by Southdown Housing; there were periods when he engaged well and sought support, and periods of disengagement from health services. Throughout the period he remained an open case to CMHT and was supported by the same care coordinator (CC1) from SPFT from 2009 onwards. The Southdown Housing Association IMR described Alan as:

> *Nice, quiet, gentle and unassuming man, who was very vulnerable and a potential target for bullies.*

The housing officer described Alan as:

> *…. one of the most vulnerable clients in his area of responsibility.*

The Care Programme Approach

3.2.4. Alan was being supported via the Care Programme Approach (CPA). The CPA was introduced in the 1990's to provide a framework for the care of mentally ill individuals requiring health and social care authorities.

The CPA is described in [6]*Care Co-ordination Core Functions and Competencies*

> *The CPA is a person centred approach used to inform partnership working in mental health. This partnership should always, as a minimum, include the service user, any*

[6] Karen Hardacre, *Care Co-ordination Core Functions and Competencies* **(**PSE Consulting Ltd)

carers and the CPA coordinator.

It should also include working relationships with health and/or social care professionals and other relevant organisations.

The CPA is the principal vehicle of care assessment and planning for a defined group of individuals receiving mental health care. The CPA is aimed at ensuring this group of people have access to support and services (across the provider spectrum) to meet their diverse needs, strengths, preferences and choices.

This whole systems approach to care planning and delivery promotes care activity across the individual's life domains (including housing, employment, leisure, education and other needs).

The CPA is an inclusive and dynamic process based on effective communication, appropriate information sharing and negotiation between partners. This negotiation is to draw on available resources to deliver an agreed plan of care.

All advice, care and treatment delivered in health and social care involves the making of an agreed plan. The CPA is a formalisation of existing care planning activity for those with complicated care planning needs and, when successfully delivered, will provide engagement and involvement from all participants in the partnership.

Reviewing the Care Programme Approach (2006) Department of Health, Care Services Improvement Partnership

3.2.5. The CPA was subject to review and subsequently was revised in 2008. Prior to the revision there were two levels of CPA support as described in [7]Department of Health (2008) *Refocusing the Care Programme Approach Policy and Positive Practice Guidance*

- *standard support for individuals receiving care from one agency, who are able to self-manage their mental health problems and maintain contact with services;*
- *enhanced support for individuals with multiple care needs from a range of agencies, likely to be at higher risk and to disengage from services.*

3.2.6. Alan was subject to 'Standard Care' from 2006. The CPA review in 2008 reinforced key messages about how CPA should be applied in a contemporary mental health service working within a whole health and social care system. The new SPFT [8]Care Programme Approach Policy (2010) set out the differing approaches dependent upon assessment needs. The SPFT in discussion with the author believed that Alan remained at 'Standard Care' rather than enhanced support so the expectation on the care coordinator working with other agencies was limited. The role of the care coordinator will be subject to further comment in the next section.

Safeguarding Adults Process

3.2.7. Alan was also subject to the Safeguarding Adult Boards Safeguarding Adult Policy and Procedure. At the time covered by this review this was a Pan Sussex policy adopted by all the Local Safeguarding Boards. Unlike other local health trusts, Adult Safeguarding, at the time relevant to this review, had been delegated to Sussex Partnership under Section 75

[7] Department of Health (2008) *Refocusing the Care Programme Approach Policy and Positive Practice Guidance*

[8] Sussex Partnership NHS: *Foundation Trust Care Programme Approach Policy* (2010)

agreement (under section 75 of the National Health Service Act, 2006). They had responsibility for leading SAR investigations that involved working age service users (i.e. people under the age of 65 years).

3.2.8. The operational model was in line with Association of Directors of Adult Social Services (ADASS) guidance (2005)[9]. It placed responsibility on the managers of CMHT's, both to ensure a timely, local response to safeguarding alerts, and to manage any ensuring investigations in the Investigation Manager role (IM).

3.2.9. The Care Act, 2014 has impacted upon the responsibility for safeguarding and will be discussed later in the report. It was not in place at this time. Both processes were reliant on a multi-agency response and the placement of an effective team around the adult.

3.3. Team around the adult

3.3.1. Three agencies had a prolonged involvement with Alan. They were:

- Sussex Partnership NHS Foundation Trust
- Southdown Housing Association
- Sussex Police

3.3.2. This section will examine the support being provided to Alan both by individuals and by the wider agency processes. (The interaction by agencies with John will be considered later in this report).

3.3.3. Changes in support staff can be problematic, but regular movement of staff was not a factor in Alan's case as he had contact with three professionals over a prolonged period of time.

- Care Co-ordinator A, CMHT 2009 (CC1)
- Floating Support Officer A, Southdown Housing Association 2011(FSO)
- Police Community Support Officer A, Sussex Police 2011 (PCSO)

3.3.4. This continuity in these circumstances might also have contributed to a lack of oversight review, new thought and insight. It is of note to see that in 2011 a set of new eyes led to good intervention in response to a safeguarding alert.

3.3.5. The FSO and PCSO gave evidence at the inquest and they were interviewed for their individual agency IMR's. CC1 is no longer an employee of the SPFT. He was not called to give evidence at the Inquest, or interviewed for the IMR, and has not been available for interview with the author. The only reviews to which CC1 provided information was the IPPC report and the SIR. This is unfortunate, as it has restricted the review author's ability to examine 'why' CC1 took the actions he did whilst supporting Alan. The 'why' is important to understand, so this missing information reduces some of the potential learning opportunities and will leave some questions unanswered.

3.3.6. Staff from these three agencies were involved in supporting Alan to differing levels over a sustained period of time. There was clearly confusion between the individuals as to who was the lead for the coordination of any multi-agency response. Whilst CC1 was the Care Coordinator for the CPA, and that was the perception of the FSO and the PCSO, it would appear that CC1 did not perceive their role as the multi-agency response coordinator and appeared to be only considering the clinical aspects of Alan's care. This is partially supported by the SPFT who indicate that all agencies had a responsibility to coordinate

[9] *ADASS: Safeguarding Adults: A National Framework of Standards for good practice and outcomes in adult protection work (2005)*

where appropriate.

3.3.7. What is evidenced in both the 2012 and the 2013 incidents, is that the FSO provided information to CC1 about concerns regarding John and the PCSO would also inform CC1 and the FSO, but there was a total lack of clarity and understanding as to who was going to respond. Because Alan did not always respond in the way they would have wished the FSO and PCSO described feeling helpless, fearing what would happen.

Sussex Partnership Foundation Trust: Care Coordination

3.3.8. CC1 was the Care Coordinator for Alan under the CPA, from 2009 until his death. As the co ordination of support and intervention across the agencies is central to this review CC1's role as the Care Coordinator needs to be examined further.

3.3.9. Sussex Partnership NHS Foundation Trust provides specialist mental health learning disability and substance misuse services.

West Sussex mental health services are integrated with adult social care for adults under the age of 65. Social workers are integrated into the CMHT, also known as Recovery and Wellbeing Teams. They form part of the Assessment and Treatment service (ATS).

3.3.10. CPA Care Coordination sits within the integrated CMHT and can be provided by an individual with either a clinical or social care background. The Care Coordinator in this case was a Band 6 Community Nurse. The SPFT state that it is a self-managerial role and there is an expectation that professionals at that level will be attending supervision. Care Coordinators are also trained investigating officers and *under the old Safeguarding Vulnerable Adults Policy they were responsible for undertaking investigations.*

The SPFT IMR states:

> *Clinical/Practice supervision is provided to clinical/practitioners by their own discipline under a professional lead arrangement and staff should receive monthly supervision as per Trust policy. Professionals are expected to work in accordance with values, ethics and practice standards for their profession, and are required to be registered with appropriate professional body and to meet the registration requirements.*

3.3.11. The Sussex Partnership CPA policy[10] sets out CPA principles including:

> *Assessments and care plans should address the range of service users' needs. Risk management, crisis and contingency planning are integral to the process. A number of critical issues are highlighted in the new guidance, including assessing the needs of parents; dual diagnoses; physical health; housing; employment; personality disorder; history of violence and abuse; carers; and medication.*
>
> *…For individuals requiring the support of CPA the role of the care coordinator is vital.*

3.3.12. As has been previously commented upon, the CPA programme was reviewed in 2007 and the use of the CPA for what were described previously as 'standard cases' was removed from the revised CPA, which anticipated that it would be applied to individuals with complex needs. Individuals with 'standard needs' would be allocated a Lead Practitioner. This is defined in the SPFT policy as:

The Lead Practitioner:

> *Has responsibility for facilitating the delivery of care to the service user who has been*

[10] *Care Programme Approach Policy* (Sussex Partnership NHS Foundation Trust 2010)

identified as having straightforward needs so does not require the more formal approach of CPA. They are likely to only have contact with one agency and that will be the person identified as being most appropriate from that agency.

3.3.13. The SPFT have indicated that Alan remained at 'Standard Care'. The following addendum to the SPFT IMR indicates that he remained under CPA (post the CPA review) and that CC1 was still undertaking a care coordination role. It states:

Alan was subject to Standard Care from 12/05/06-16/04/12 and his Care-Coordinator developed a care plan (CPA) for him on 16/04/12 in response to the risk of exploitation of others. The other elements of the care plan are the same as the content of the Standard care plan and focus on the administration of prescribed medication, medical reviews and consideration of transferring the care of the patient to a psychiatrist for monitoring through the Depot Clinic and Outpatient Department as the patient had no history of relapse. There were risk assessments completed on 19/08/11, 20/03/12, 15/05/12 and 10/10/12 and they acknowledged the risk of exploitation by others and tracked the alleged absence or presence of the perpetrator based on reports from the patient.

3.3.14. The SPFT IMR sets out the role of the coordinator;

To carry out or co-ordinate the assessment of the service user's needs and associated risks, including the service user as fully as possible, and taking into account the views of carers and of other agencies e.g. probation, housing, voluntary sector. Be responsible for co-ordinating the efforts of the multi-disciplinary team (including those employed in partner agencies) in delivering the care plan and following the service user through the care pathway to ensure their needs continue to be reviewed and met "(including those in partner agencies-see above)"

3.3.15. The role of the Care Coordinator is set out in the document[11] '*Care Programme Approach' Care Co-ordination Core Functions and Competencies*

Principles of practice. The Care Coordinator,

- *works in **partnership** with people who have complex mental health and social care needs, and those supporting them;*
- *strives to empower people using services to have choices and make decisions to determine their wellbeing and recovery;*
- *integrates and co-ordinates a person's journey through all parts of the health and social care system;*
- *enables each person to have a personalised care plan based on his/her needs, preferences and choices;*
- *ensures that the person receives the least restrictive care in the setting most appropriate for that person;*
- *supports the person to attain wellbeing and recovery;*
- *ensures that the needs of carers/families are addressed;*
- *brokers partnerships with health and social care agencies and networks which can respond to, and help to meet the needs of the person who is experiencing mental health problems.*

Care co-ordination is predicated on the principle that people, however vulnerable, should share in decision-making; that they are knowledgeable about themselves and the effect their conditions may have on their lives; and that they should be

[11] Karen Hardacre, *Care Co-ordination Core Functions and Competencies* **(**PSE Consulting Ltd)

empowered and enabled to inform their own recovery.

3.3.16. One of the Care Coordinators' core functions is Crisis planning and management. That functional statement, as set out in the [12]Care Programme Approach, provides a list of expected actions.

Functional statements (Crisis planning and review)

> *CPA 3.1 Assess the risk of crisis situations occurring with people, and others involved in their care.*
> *CPA 3.2 Negotiate agreement to the risk management strategies with people, their carers/families, service providers, other agencies and practitioners.*
> *CPA 3.3 Negotiate agreement on the information which will need to be shared, and with whom, in accordance with agency and legislative requirements.*
> *CPA 3.4 Ensure that the agreed actions are implemented as promptly as possible in accordance with the assessed urgency of the need.*
> *CPA 3.5 Review the outcomes of actions taken to address immediate needs.*
> *CPA 3.6 Ensure that the results of the review are communicated clearly to all those who need to receive them.*
> *CPA 3.7 Record and provide information in line with legal and organisational requirements.*

If these statements had been applied correctly then the problems of coordination of agency responses, involvement and responding to the family and the correct recording and circulation of information would have been addressed. It was not applied and that may be because CC1 did not assess that Alan was in crisis specifically in respect of his mental health. CC1's CPA risk assessments support this.

3.3.17. The Care Coordinator should have been completing the CPA care plan with input from other agencies. There is limited evidence that this was happening. The care coordinator at this time was also responsible for the coordination of safeguarding alerts. The SIR highlighted the concern about CC1's role as a coordinator. It states:

> *As per the CPA Policy it appears that Worker C was not fully established as the central care co-ordinator of the multi-agency team (mental health service, HSW and PCSO) working with Alan; he was not central in arranging multi-agency meetings which tended to rely upon the HSW and PCSO to coordinate.*

3.3.18. The response to the police safeguarding alert, resulting from the VAAR submission by the PCSO in 2011, provides evidence of how care coordinators can effectively lead a multi-agency response to a safeguarding alert. A number of multi-agency actions were identified, including liaison with police, housing worker and family. Alan was moved to a place of safety (his parents' home), his property was recovered by police and his premises secured. A respite admission was discussed but Alan, who had capacity, did not wish to access this option. These actions involved input from Alan, his father and the multi agencies and for a period of time reduced his vulnerability.

3.3.19. CC1 was the care coordinator at that time, but he was on leave when this alert was received. It was allocated to another individual who was a senior practice social worker in the integrated team , and possibly explains why the 2011 response was not replicated in 2012 and 2013 when CC1 was there.

3.3.20. It is evident that CC1 did not lead on the coordination function both around the CPA and

[12] Karen Hardacre, *Care Co-ordination Core Functions and Competencies* **(**PSE Consulting Ltd)

safeguarding. From the evidence given by the PCSO and the FSO at the inquest, it appears that that they were unaware of the specific role of the coordinator and felt frustrated by their inability to support Alan, and especially by the lack of response from CC1 when they reported issues. These concerns were also echoed by the Probation Officer and Alan's father.

3.3.21. The SIR highlights a number of issues in respect of CC1 that would explain why the PCSO and FSO felt the way they did. It concludes that CC1 was focused on the medical management of the mental health presentation with limited focus on social/lifestyle issues. The report also highlights:

> *Ineffective interface for communicating with other agencies (partnership working) CC1 did not assume the central role as Co-ordinator to establish and evidence routine and effective communication processes with other agencies. He did not formally involve other agencies/professionals in risk assessments and care plan reviews and did not share these documents/plans with other agencies/professionals involved in the support/care of Alan*

3.3.22. It is important to note that whilst the SIR was presented and referred to at the Inquest, and has been used as a source of information for this review the SPFT have highlighted that the SIR author came from a different area within SPFT (East Sussex) and did not have access to all the information held on WSCC, electronic recording system Frameworki. This resulted in the extent of CC1's involvement in the safeguarding process being potentially incorrectly analysed.

3.3.23. This is of concern to the author as the SIR, which was agreed and supplied to the Coroner, may not be factually correct. The SPFT have emphasised that they are not stating that the SIR was incorrect. The SIR report was signed off by the SPFT and submitted to the CCG the failure to include all relevant information should have been identified. The author strongly suggests that the Board needs to be assured that this situation is addressed.

3.3.24. CC1 was not undertaking effective CPA risk assessments and care planning reviews. The Trust's Clinical Risk Assessment and Management Policy and Procedures and DNA active engagement Policy was not followed.

3.3.25. CC1's shortcomings in the areas of care planning, risk assessment, record keeping and engagement was identified by the Trust in July 2011 and as a result he was subject to increased supervision for 11 months. This intervention was discontinued in June 2012 following an assessment that he had improved and was capable of carrying out duties required of the post.
However, the SPFT IMR and the SIR would indicate that CC1 continued to struggle post 2012, a situation that continued up until his time of leaving the employ of the SPFT in 2015.

3.3.26. This was not identified through supervision during 2012 and 2013. Why, is partially answered in the SPFT IMR, which stated that:

> *The Care Coordinator had regular management supervision but did not always engage in clinical supervision.*

The SIR states*:*

> *The Care Delivery Problems noted above were not clearly identified and therefore addressed during clinical supervision and existing review processes e.g. annual*

case not/clinical audits.

3.3.27. CC1 had the relevant number of cases, around 35. SPFT do not regard the size of the case load as a contributory factor in this case.

3.3.28. The only recorded evidence that Alan's specific case was considered in any detail within the CMHT, post 2012 was in May 2013, when CC1 discussed the case at the Recovery and Wellbeing Team Meeting. Part of the role of this meeting was to allow an opportunity for care coordinators to discuss a service user they had concerns about with the multidisciplinary team.

A number of actions were agreed including a referral to the Assertive Outreach Team (AOT). AOT provides services to individuals with serious mental health problems who are difficult to engage. No referral was made, and again this was not picked up or challenged. It was also suggested that the use of the Mental Health Act be considered if Alan's mental state deteriorated.

3.3.29. The SPFT IMR has stated that AOT provided services to the people with serious mental health problems who were difficult to engage with and that Alan would probably not have reached the threshold for such intervention. This may have been the case, but as CC1 did not refer the case an assessment by the AOT was not undertaken so this conclusion cannot be tested. The fact that a referral to the AOT was suggested indicates a level of concern by the individuals at the team meeting. CC1, whilst not present, updated the multi-agency meeting in May 2013 of his plans to continue to cold call and refer to the AOT.

Changes

3.3.30. As a result of this case and the CQC inspection findings (January 2015), supervision, appraisals and the safeguarding process have been reviewed by SPFT. Random spot checks are undertaken on clinical records to ensure compliance with Trust policies and as a part of the supervision process. A case load management tool has been introduced locally and the Trust is reviewing its effectiveness with a view to considering Trust wide implementation.

Sussex Police: Police Community Support Officer

3.3.31. The Neighbourhood Policing Team (NPT) had a number of core functions. The main ones were to problem solve issues within the community, engage with the public and support vulnerable people. The PCSO was a member of that team and they were designated as the 'Officer in Case' for Alan from 2011. PCSO's are not fully trained police officer's and they have no formal legal training.

3.3.32. They worked hard to support Alan and were responsible for the submission of the VAAR that led to the safeguarding alert in 2011 and again in July 2013. They also arranged the multi-agency meeting in 2012.

The IPCC report[13] highlighted the following:

> *….where a PCSO will provide valuable community welfare support, they do not have the training, experience and knowledge of wider criminal investigations of that of a uniformed police officer. A PCSO's training and experience does not provide them with the wider tactical options in dealing with such a matter as this which*

Heslop,[13] *Alan Deceased Investigation into Sussex Police Contact with (Alan) prior to his death on 23rd July 2013*. (IPCC 2015)

became complex and difficult.

It would have also been appropriate for an officer of at least PC rank to have been involved in multi-agency strategy meetings.

3.3.33. The PCSO commenced a Problem Solving File in respect of Alan. This recorded all the contact correspondence between the PCSO and other agencies. This was good practice. It is evident that most contact was taking place between the PCSO and the FSO. The PCSO also maintained contact with Alan's father.

3.3.34. The PCSO's NPT Sergeant (PS) supported them on welfare checks however; they did not receive support when they attended multi-agency meetings in April and May 2013. The police IMR concludes:

It was inappropriate that PCSO X was the only Sussex Police representative at the two strategy meetings; these should have been attended by a PS or by a member of the Adult Protection Team who would have been experienced in attending such meetings.

This conclusion assumes that these meetings were recognised to have been strategy meetings, as has been highlighted, the status of the meeting was confusing.

3.3.35. The Police IMR has identified a future risk, it states;

Currently the Neighbourhood Policing Team manages the majority of Vulnerable Adults who make repeated contact the Sussex Police. The force is reorganising a number of units and the Neighbourhood Policing Team will cease to exist in its current format towards the end of 2016. How Vulnerable Adults will be managed in the future has not yet been finalised.

Police Adult Protection Team

3.3.36. The Adult Protection Team (APT) were responsible for investigating domestic abuse assessed as being of high risk and vulnerable adults who have been offended against by professional carers and paid carers. This later category is important when considering the role of John**.**

The DS in the IPPC report also stated that the team*:*

Advise police officers who deal with vulnerable adults where criminal offences are identified.

3.3.37. The PCSO sought advice from the APT and this resulted in the PCSO arranging a multi-agency meeting. The APT team did not attend the meeting. It is of note that the APT did not raise an adult alert which would have placed the meeting on a more formal setting.

3.3.38. There is evidence that Alan had been subject to financial abuse over a period of time and he was potentially being exploited. This level of criminal investigation needed to be undertaken by an investigator with both knowledge of criminal investigations and experience dealing with vulnerable adults. At that time the APT did not have the remit to take the case, leaving the PCSO to continue to support Alan. The identification of financial abuse should have prompted a safeguarding alert being submitted leading to a coordinated response to safeguarding.

Police Response Officers

3.3.39. Whilst the PCSO responded to welfare support for Alan, it was the local response officers that responded to immediate incidents. September 2012 was a period of intense police involvement. Alan was clearly concerned about John's presence and on numerous occasions rang the police. At no time during these events in 2012 was John arrested, he was removed from the premises at Alan's request on a number of occasions, including twice within an hour but not detained. Even when they had intelligence to indicate that John had brought stolen goods into the address, they did not arrest John.

3.3.40. This is in contrast to the police action taken against John when he was abusing his partners. He was arrested and charged. (The contrast to the response to Domestic Abuse will be considered later in this report).

3.3.41. In the IPCC report the DS in charge of the APT felt that an arrest of John was justified. It did not take place, probably due to the lack of knowledge and understanding that local patrol officers had in respect of vulnerable adults in general and safeguarding of such in particular.

3.3.42. As the police IMR sets out:

> *The majority of officers that visited Alan did not submit a VAAR form, as they did not perceive that Alan was vulnerable as per the definition. (4.5.2)*

This was clarified later in the IMR:

> *Officers who attended incidents involving Alan had not read Sussex Police Policy 750 "Safeguarding Vulnerable Adults" the reason given was that their (sic) were too many policies for officers to be able to read and know especially in regards to safeguarding.*

3.3.43. This finding underpins why Alan was not considered by most officers to be vulnerable and therefore did not receive the attention that he required.

The IPCC review highlighted that;

> *Police officers and staff are not provided with formal training to aid them in identifying vulnerable adults. This is a concern because vulnerable adults that are not identified as such will not be afforded the necessary support.*

3.3.44. In 2012, when Alan attended to make a statement to the police with CC1, the officers did not take action but passed the case back to the NPT who they believed were dealing with the allegations. There is evidence of misunderstanding between the police and CC1 as CC1 recorded that Alan had reported three years of financial exploitation by John. There would have been an expectation by CC1 that this would be fully investigated and the police would lead this process.

3.3.45. There was delay and then no Achieving Best Evidence (ABE) interview, which could have fully examined the role John had played in Alan's life over a number of years. He was finally interviewed in 2013 and this led to disclosures of long term threats and financial abuse. As a result John was arrested, but this course of action could have taken place a year earlier if the financial abuse had been investigated correctly.

Southdown Housing: Floating Support Officer

3.3.46. Southdown Housing provides a range of Community Support and Supported Housing Services for vulnerable adults across West Sussex. The Independent Living Scheme is an

accommodation-based service providing single occupancy self-contained accommodation for adults who have been identified as requiring additional support due to vulnerability.

3.3.47. Floating support is tailored to the needs of the client. It averages 2 hours a week and focuses on the development of independent living skills. It is provided by a Floating Support Officer (FSO) on a one to one basis. Housing Officers also provide support.

3.3.48. FSO 1 first became involved with Alan in 2009. FSO 2 took over support in 2011. They both faced challenges in trying to maintain contact with Alan. Attempts to engage were not always recorded on the client data base.

3.3.49. FSO 2 was considered to be an exemplary support worker by their team manager. There is evidence that the FSO's worked closely with their team manager to try and problem solve the complex issues presented by Alan. This included raising safeguarding concerns with CC1 and organising a multi-agency meeting.

3.3.50. It is clear from the IMR and the direct evidence presented at the Inquest, that the FSO was frustrated by the response by CC1 to concerns raised. It is of note that the SHA Team Manager tried to escalate those concerns informally by speaking to CC1 and their line manager. There is no indication that this improved the situation. There is also no record of there being a formal escalation of concerns. It would appear that despite there being safeguarding concerns, that SHA staff did not raise a formal safeguarding alert as they felt they had informed the CC1 and the PCSO and they appear to have believed that these individuals would respond. SHA should have raised an alert not assume others would do so.

3.3.51. Why, is partially explained in the IMR comments:

> *West Sussex Safeguarding procedures in place at the time did not work effectively, with a significant numbers of alerts raised being rejected.*

This would indicate a lack of understanding of the process and a lack of an appropriate feedback being provided. This can lead to a culture of not raising alerts because they assume that they will not be accepted. The need for good escalation of concerns is required.

3.3.52. John told the FSO in September 2012 that he was Alan's 'registered carer'. The FSO tried to assist Alan in taking out an injunction against John. They were unclear how this could take place so asked advice from police, who were little help. The FSO made great efforts to obtain free legal help for Alan. The PCSO referred the FSO to the Citizens Advice Bureau (CAB) and the Vulnerable Adult Protection team who referred the FSO back to the NPT and the PCSO. This commenced in September 2012. In January, Alan stated he did not want to progress with an injunction.

3.3.53. This was an excellent attempt to support Alan and it should have been supported as part of a multi-agency plan, but it was not. The FSO had to try and gain information and support for Alan in isolation. At the inquest the FSO stated that they felt they were trying to fill gaps and felt very frustrated.

3.3.54. It was the continued support and encouragement from the FSO that led to Alan finally making a statement to police in July 2013. It is of note that in April 2013, the FSO contacted the police APT to seek advice. They were advised by the Sergeant in the APT that as the NPT was involved they suggested that they FSO held a multi-agency meeting with NPT. They stated that it fell outside the APT Terms of Reference. The APT did not submit a VAAR nor the FSO a safeguarding alert.

3.4. Adult Safeguarding Process

3.4.1. Alan was a vulnerable adult and at certain times was at risk and should have been subject to the Sussex Multi-agency Policy and Procedures for Safeguarding Adults at Risk. There was need for risks to Alan to have been identified and acted upon.

Risk Factors

3.4.2. Evidence indicates that John influenced Alan's actions, specifically his engagement with services. When John was not in contact, October 2011 to April 2012, Alan engaged reasonably well with mental health services, missing only one depot appointment. When John was present, July to October 2011, Alan disengaged. This indicates that Alan's level of risk increased when John was involved with him. His alcohol use also appears to have increased at these times.

3.4.3. By early July 2012, CC1, FSO and PCSO were all aware that John was again involved with Alan, and of the risk he posed. Whilst they spoke to each other, none of them raised a safeguarding alert. The responsibility to inform the police was left with Alan. At this point in time there should have been serious concerns about housing, possible exploitation and impact on Alan's mental health.

3.4.4. The presence of John should have been considered as an early indicator of increased risk, and a safeguarding alert considered/raised. This could have led to earlier intervention with a joint action plan. This did not occur and the risk was not clearly identified in the CPA assessments.

3.4.5. The May 2013 version of the Sussex Adult Protection Procedures[14] states:

> *If the same or a similar incident occurs that relates to the same or another person, it would suggest that the risk assessment/care plan or other elements of prevention in place are not effective. Recurring incidents may not appear to have a visible impact on the person or others; however, raising a safeguarding alert should be considered, to prevent harm being experienced in the long-term.*
>
> *Poor practice can result in harm when risks are not identified and no action is taken to prevent further incidents occurring or the concern escalating. Incident logs should always be checked for patterns by those recording incidents and those responsible for monitoring the effective implementation of that organisation's incident policy.*
>
> *Managers and staff have a duty to have systems in place that enable them to identify patterns/cumulative incidents and to raise an alert if there are a number of these, even if some are retrospective.*

John's interventions were indicators of similar incidents and repeating patterns occurring.

3.4.6. Given the history of vulnerability when John was in his life, Alan should have been considered to be vulnerable to abuse. A meeting of the multi-agency partners could then have been arranged, and a plan of action considered. This could have involved police, GP, Care Coordinator and housing and a plan of early intervention to potentially support Alan and reduce his vulnerability could have been produced and implemented with the

[14] *Sussex Multi-Agency Policy and Procedures for Safeguarding Adults at Risk* Version 3 • May 2013 (Brighton & Hove, East Sussex , West Sussex SABs 2013)

involvement of Alan. Given the risk level, a safeguarding alert could have been raised, but other than 2011 and July 2013 none were recorded.

Risk Assessments

3.4.7. The SPFT Care Programme Approach Policy, 2010[15] sets out the four essential elements:

- *A systematic **assessment** of health and social care needs*
- *An agreed **care plan***
- *The appointment of a named **care coordinator***
- *Regular **reviews** to reconsider need and/or risk and to adapt and change care plans as necessary*

3.4.8. CPA assessments should have been undertaken and reviewed. The assessment should have covered all aspects of risk both social and clinical. As identified by the SIR, effective risk assessments with input from all services did not take place. This can be evidenced in May 2013 when a Care Plan and risk assessment were completed but were completed without having contact with Alan since December 2012. The assessment failed to reference past history of exploitation, non-compliance with medication, adult at risk procedures, or alcohol misuse. This was two months before he died.

Multi-agency Meetings

3.4.9. Multi-agency meetings took place in October 2012 and in April and May 2013. They were initiated by either the PCSO (October 2012) or the FSO (April 2013). None, as far as can be seen, were initiated by CC1. No minutes for these meetings were produced so it is not clear what the remit of the meeting was, nor is there any clarity regarding decisions made. The only meeting at which Alan was in attendance was October 2012. At that meeting was the PSCO, Alan, FSO and the CC1. There were no supervisors from any agency.

3.4.10. In April 2013 a meeting called by the FSO following advice from the APT. In attendance was the FSO, CC1 and the PCSO. Three actions were agreed:

- PCSO to email blank Data Protection Act request to housing
- All parties to continue to visit Alan
- PCSO to attend Alan's address and remind him of his appointment with the CC1.

3.4.11. In May 2013 was a follow up meeting attended by the FSO and supervisors from Southdown Housing plus the PCSO, the CC1 did not attend. Five actions were agreed:

- PCSO to continue to make regular welfare visits
- CC1 to cold call the address weekly
- CC1 to refer Alan to the Assertive Outreach team
- FSO to write to Alan to arrange to meet at a café (no lone home visits)
- Housing Officer to write to Alan to state that he needed to ask John to leave as he would be in breach of his tenancy.

3.4.12. Whilst these meetings took place, like the rest of the interaction with Alan there was a lack of coordination. It was not clear who was leading or who was monitoring the actions. Other than Housing, there was a lack of managerial support especially for the PCSO. In the later meetings there was a lack of involvement of Alan or his father. However, his father was aware and invited to the May meeting. As previously stated there are no minutes and no clarity as to what these meetings set out to achieve. As a result of the concerns, the meeting did not result in any agency raising an adult alert and thereby moving into the Adult Safeguarding process.

[15] *Care Programme Approach Policy* (Sussex Partnership NHS Foundation Trust 2010)

3.4.13. Staff should be aware that multi-agency meetings that are considering an adult at risk should be regarded as formal meetings which require minutes and an action plan. Part of the meeting should consider who is in the best position to coordinate the response and ensure that actions are followed up. That can be an individual from any agency but clarity is important.

3.4.14. Other risks that could have been identified were Alan's period of disengagement and his use of alcohol and failure to take prescribed drugs.

Prescribed Medication and Failure to Attend

3.4.15. One risk that should have been assessed was Alan's failure to take his prescribed medication. His CPA plan included the use of drugs but it is evident that he was not taking the drugs prescribed. His last depot injection was December 2012 and the last time he collected his prescription from his GP was March 2012. He had not seen his GP since May 2010.

3.4.16. This failure to take his prescribed medication should have been considered a risk factor along with his continued failure to attend his psychiatric out patient assessments:

- June 2012
- July 2012
- April 2013
- June 2013

As has been previously highlighted these issues should have been set out in the CPA assessment, but the May assessment failed to highlight these issues so they were not being addressed. The CC1 did meet with Alan in May. In case notes he has stated that Alan was stable in terms of mental health and there was no suicidal risk but the risk assessment was not updated. There is no consideration of the drugs impact or effects caused by his failure to take them. If they were having no impact then a question arises as to why they were not stopped or altered.

3.4.17. Alan was listed with his GP under the Qualities and Outcome Framework (QOF). This required the surgery to complete a health check with Alan every 15 months. However, the QOF stated that a person could be exempted if they refused a health check or ignored 3 invites. He was also in receipt of repeat monthly medication. His ordering of this became erratic from 2010 with his last prescription in March 2012.

The only mental health review he received was in May 2010 as he ignored further checks in 2011 and 2012 he was exempted. His next invite being June 2013.

3.4.18. Whilst the CMHT would copy the GP into letters sent to Alan which included his non attendance, and in May 2013 CC1 sent them a letter informing them that Alan was not engaging with CMHT or taking his depot and possibly had a lodger who was detrimental to him, there appears to have been no communication from the surgery to CMHT setting out the lack of engagement and failure to collect prescriptions. There is no evidence that the CMHT and the surgery were working together. Alan had for a number of years failed to take prescribed medication.

3.4.19. There is evidence that Alan was becoming withdrawn but there is no consideration as to how his failure to take his medication may have impacted on Alan's mental health. situation.

Observations

3.4.20. The CPA if fully applied, using information from all partners, should have identified the risks posed by John to Alan both clinical and social. This should then have led to the formulation of a care plan that included crisis management. As has been identified by the SIR, CC1 struggled to apply the CPA correctly and focused on clinical interventions with limited recorded input from other agencies and Alan.

3.4.21. There were a number of occasions when a safeguarding alert should have been considered by all agencies but none were submitted other than in 2011 and 2013. Official safeguarding interventions in line with Pan Sussex policy and procedure were not undertaken, other than in 2011 when the alert was dealt with well, under the coordination of a social care practitioner (integrated into the CMHT). As CC1 has not been part of the review process, nor required to give evidence at the inquest, it has not been possible to fully understand why they took the action they did.

3.4.22. Multi-agency meetings did take place but were not within a clear structure, be it under CPA or safeguarding, which led to confusion and a lack of coordinated follow up to ensure that Alan was being supported. His involvement in the process is also unclear.

3.4.23. It is evident that the PCSO worked hard over a significant period of time to help support Alan. However, they were dealing with a very vulnerable individual with complex needs. The PCSO was neither trained in dealing with vulnerable adults such as Alan, nor in the application of the differing laws which might have been considered. They were supervised, but there is no evidence that their Problem Solving File was ever reviewed. The keeping of this file was good practice. The PCSO clearly had a good relationship with Alan's father but he got the impression that the PCSO was struggling to keep Alan safe.

3.4.24. Alan required input by a Police officer who understood vulnerable adults. This would have been the Adult Protection Team but, whilst they gave advice, they did not get directly involved as they believed that his circumstances did not meet their threshold

3.4.25. Officers who did respond failed in 2012 to arrest John. When Alan did make a complaint they failed to investigate and in fact just referred it back to the NPT and the PCSO.

3.4.26. The PCSO should not have had to deal with Alan on their own with limited support. They coped well under the circumstances, but were not in a position to fully inform a multi-agency meeting as to issues of law, or actions to which the police could commit, or to challenge the lack of response from other agencies.

3.4.27. Like the PCSO, the FSO and the housing service worked hard to support Alan. They felt isolated and unable to progress the multi-agency response at the right level. When they did attempt to seek advice or escalate they were referred back to the team they were already dealing with.

They should have made an official safeguarding alert referral and escalated when they did not get the response required. This lack of escalation within a number of agencies is apparent. The Safeguarding Board does not currently have in place an official escalation policy or procedure similar to that produced by Local Safeguarding Children Boards.

3.4.28. The failure by either CMHT or the GP surgery to assess the impact of Alan's withdrawal from taking the drugs and the depot prescribed again evidences the failure to apply the CPA assessment process and equally the failure for agencies to work together for the good of the vulnerable individual.

Safeguarding Alerts

3.4.29. As identified, safeguarding alerts for Alan should have been raised on a number of occasions when he was being exploited but this did not occur. There is evidence that when individuals did contact the Adult Social Care Team they were forwarded on. The following will examine why this might have occurred.

3.4.30. During the time covered in this review there was in place the Sussex Multi-agency Policy and Procedures for Safeguarding Adults at Risk. West Sussex mental health services were integrated with adult social care for adults under 65 years. This enabled social workers being integrated into the Community Mental Health Teams, also known as Recovery & Wellbeing Teams. They form part of the Assessment and Treatment service. Responsibility for Adult Safeguarding (under 65s) had been delegated to Sussex Partnership under Section 75 agreement (under section 75 of the National Health Service Act, 2006). Over 65 years remained with the Local Authority. This was a different structure to other Health Trusts in West Sussex.

3.4.31. The May 2013 V3[16] policy and procedure states:

> *Anybody can raise an alert for themselves or another person.*
>
> *All paid and unpaid staff and workers, and others aware of an adult who may be at risk, have the responsibility to recognise the possible signs of abuse.*
>
> *They have a responsibility to take appropriate action by reporting their concern whenever they become aware that abuse may have taken place or may occur unless someone does something to prevent it from happening.*
>
> *This is called 'alerting'.*
>
> *It is important to remember that there may be concerns that have been alerted by others of which you may not be aware. Reporting concerns can enable serious abuse or harm to be prevented from happening or from escalating.*

3.4.32. The procedure states that social care should be contacted and:

> *Upon receipt of an alert, adult social care will determine if the concern raised needs to be investigated under the adults safeguarding procedures, or if the concern might best be addressed in another way. As part of this process adults social care will gather as much relevant information as they can including, if this would not put the person at further risk, talking to the person who might be at risk as well as to the person who raised the concern.*

3.4.33. Information from West Sussex Adult Safeguarding Unit confirmed that any referrals or concerns regarding an adult come into West Sussex County Council via Carepoint (the generic access point for Adult Services). It is staffed with a mix of social care/social work and Occupational Therapy trained practitioners. If it is identified that the person being referred is already allocated to a social worker in one of the adult service team or allocated to SPFT, the referral would go directly to them. They would check the Frameworki electronic recording system and if the individual was under 65 years and hence the

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responsibility of the SPFT integrated team and was an open case, the individual making the enquiry would be referred in this case direct to CC1 as the care coordinator.

3.4.34. The review was advised that a number of individuals contacted Adult Social Care and were provided with the contact details of CC1, these include the probation officer. Not all these contacts were recorded. The only recorded contact was for September 2012 when information received from the police was forwarded to CC1, and in July 2013 when a safeguarding alert received from police was faxed to CC1 team manager. This left the care coordinator to make a decision to raise an alert and ensure that an appropriate investigation was undertaken and that an Investigation Manager within the SPFT was allocated.

3.4.35. The staff understanding of the process and their knowledge of raising alerts was lacking across all agencies. This lack of understanding is highlighted in the police submission of VAAR's.

As the police IMR sets out:

> *The majority of officers that visited Alan did not submit a VAAR form, as they did not perceive that Alan was vulnerable as per the definition. (4.5.2)*

This was clarified later in the IMR:

> *Officers who attended incidents involving Alan had not read Sussex Police Policy 750 "Safeguarding Vulnerable Adults" the reasons given were that their (sic) were too many policies for officers to be able to read and know especially in regards to safeguarding.*

3.4.36. This is a concerning comment and underpins why Alan was not considered by most officers to be vulnerable and therefore did not receive the attention that he required.

3.4.37. Whilst the Southdown Housing IMR states that all staff had received safeguarding training their ability to effectively instigate was limited. Concerns about the safeguarding system at the time are highlighted in the Southdown Housing IMR.

> *West Sussex Safeguarding Procedures in place at the time did not work effectively, with significant numbers of alerts raised being rejected and where appropriate, case referred back to CMHT.*

3.4.38. The SPFT Safeguarding Policy states:

> *In the event of an adult service user being identified at risk or the victim of abuse (physical, financial, sexual), local procedures for safeguarding adults must be followed.*

This process was reliant on CC1 raising a safeguarding alert that would then be subject to investigation and the allocation of an Investigation Manager (IM). As has been evidenced, the failure of CC1 to understand their role and responsibility led to no positive responses to the concerns raised and no coordinated response led by CC1. As no alert had been formally recorded there was then no review or oversight.

Vulnerable Adult at Risk Form; (VAAR)

3.4.39. To support the process Sussex Police introduced the VAAR.

This was described in the IPPC report by the Detective Sergeant in the Adult Protection

Team as:

> *A Vulnerable Adult at Risk (VAAR) form is used to notify Social Services that a vulnerable adult may be at risk or that the adult may require a care assessment. Any Police Officer or staff member who has contact with a vulnerable adult and there is an apparent need to inform Social Services, would be expected to complete the VAAR form"*

3.4.40. This form appears to have a dual role, the notification of an adult possibly at risk and an adult that may require care support. Officers were expected to submit these for most vulnerable adults they came in contact with. Whether it was considered a safeguarding referral and produced an alert and the appropriate response, appears to have been very hit and miss as evidenced by the differing responses in August 2011 and September 2012.

3.4.41. When the PCSO did submit a VAAR to the social care community learning disability team it was forwarded to CC1 as the coordinator. As has previously been set out Safeguarding (for under 65's) had been integrated under the lead of SPFT.

3.4.42. As is evidenced this did not always result in the instigation of a safeguarding investigation led by a multi-agency strategy and then agency meeting to consider the position and formulate a multi-agency strategy. One of the problems with the case of Alan was the lack of VAARs submitted by any officer or team other than the PCSO.

Changes

3.4.43. This section has highlighted a number of areas that impacted upon a team's ability to protect Alan. It was mainly in respect of the Safeguarding Adult Procedure it's understanding and its application, and the management of safeguarding concerns. There have been some significant changes both with regard to legislation and procedural changes that should reduce the impact in the future.

The Care Act

3.4.44. The Care Act has placed adult safeguarding on a legal footing. From April 2015 each local authority must:

Make enquiries, or ensure others do so, if it believes an adult is subject to, or at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so, by whom

3.4.45. It places the responsibility for ensuring that the investigations are effective on the Local Authority, so even though the SPFT has the responsibility for undertaking investigations for under 65 years where the, Local Authority determines this is appropriate, the Local Authority still retains overall responsibility and accountability.

3.4.46. This should significantly remove some of the difficulties that have arisen in this case. Financial abuse is specifically referenced as coming under the remit of adult safeguarding (as it had been in previous procedures), so in Alan's case safeguarding alerts would have had to be made.

3.4.47. New Pan Sussex Adult Safeguarding Policy and Procedures have been produced by the Sussex Adult Safeguarding Boards which sets out the new responsibilities under the Care Act.

3.4.48. The WSCC has introduced a Professional lead social work post in the integrated mental

Health Service. They have responsibility for safeguarding. There is also now a single point of referral and sign off all safeguarding concerns within the service. When alerts are received this should ensure that a third party, the lead professional who is a social worker, will be alerted so will add a different approach.

3.4.49. The author has been informed by SPFT that all safeguarding concerns are now logged and cannot be closed until they are resolved. New training is being rolled out and Enquiry Officer Training is taking place.

3.4.50. Whilst still investigated by the Integrated Team they will need to be reviewed and signed off by the WSCC manager as the Local Authority retains legal responsibility.

3.4.51. Sussex Police have also made changes. There were individual referral forms for Domestic Abuse, Child Protection and Vulnerable adults (VAAR). They have now been merged into one form within the crime management system. The Single Combined Assessment Risk Form (SCARF) makes the process for police officers easier and removes the need to submit two forms if a vulnerable adult also had concerns regarding children. However, the feedback from social care indicates that there are still problems in respect to the high numbers of SCARFs being submitted and their quality.

3.4.52. Sussex Police have brought together Adult Protection, Child Protection and Serious Sexual Assaults into one team to be known as the Safeguarding Investigations Unit (SIU). This unit will assist non specialist officers who are investigating safeguarding related incidents not within the remit of the SIU.

3.4.53. Sussex Police are also merging all their safeguarding policies into one policy. This will include a clear remit of the role of the Safeguarding Investigation Unit.

Mental Capacity Act

3.4.54. An issue raised by the family and the PCSO was the consideration as to the use of the Mental Capacity Act [17](MCA).

3.4.55. There are no indications that any official assessment of Alan's capacity was undertaken over the last few years. It was discussed at the April 2013 meeting but no follow up action was taken.

3.4.56. NHS Choices[18] sets out what the MCA is about:

The MCA says:

- *Everyone has the right to make his or her own decisions. Health and care professionals should always assume an individual has the capacity to make a decision themselves, unless it is proved otherwise through a capacity assessment.*
- *Individuals must be given help to make a decision themselves. This might include, for example, providing the person with information in a format that is easier for them to understand.*
- *Just because someone makes what those caring for them consider to be an "unwise" decision, they should not be treated as lacking the capacity to make that decision. Everyone has the right to make their own life choices, where they have the capacity to do so.*

[17] The **Mental Capacity Act** (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves. The MCA is designed to protect and restore power to those vulnerable people who lack **capacity**.

[18] www.nhs.uk/conditions/social-care-and-support-guide/pages/mental-capacity.aspx

- *Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.*
- *Treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms possible, while still providing the required treatment and care.*

3.4.57. Alan's mental capacity was being discussed in April/May 2013, this was more in relation to his not making some of the decisions that the team around the adult may have wished him to make. Despite being discussed, no capacity assessment was ever undertaken for Alan so there is no documented assessment of his capacity. It would appear that whilst the PCSO brought this up as an option, CC1 did not believe that he lacked capacity. Taking into account the information that has been provided here, Alan appears to have had capacity but this was never tested. It also has to be understood that capacity can change, so at one point an individual may have capacity but a short time after, due to circumstances, they may not have capacity. As no formal check was ever recorded Alan's capacity at all times was not assessed.

3.5. Agency Interaction with John

3.5.1. As identified, Alan was at increased risk when he was involved with John. John was involved with services, namely the criminal justice service, often at the same time as he was involved with Alan. So it is important to consider if there were opportunities to have identified the connection and work with agencies supporting John.

Police

3.5.2. What has been identified is that John used Alan's address as his bail address when he was arrested for offences against his partner. The court also allowed Alan's address as part of his curfew. So whilst the agencies supporting Alan were trying to find actions that would reduce the risk posed by John, the criminal justice process was allowing John to continue to use Alan's address.

3.5.3. In May 2012, Female 2 contacted Sussex Police and reported that John had assaulted her, left with all her money and gone to Alan's address. John was arrested at Alan's address. He was charged with assault and on the 1st June was bailed by the court to live at Alan's address. In July he was arrested for being drunk and disorderly. Whilst in custody he gave Alan's address, as this was a condition of his bail. In September he was arrested for not residing at Alan's address. He was re bailed to a different address but the case was dropped on the 12th October 2012. In September 2012 Alan had made a statement stating that he did not want John residing with him.

3.5.4. In May 2013, John appeared at court for assaults on female partners that had occurred in November 2012. He was bailed from court with condition of residence to stay at Alan's house. The risk to Alan as a vulnerable person should have been flagged up in the Crown Prosecution Service (CPS) file, and the CPS should have highlighted the risk to the Magistrates when John attended court. By allowing him to use Alan's address for bail purposes the court legitimised John's presence and thereby placed Alan at increased risk.

In May 2012 (a year previously) the PCSO had a marker placed on Alan's address. It highlighted John as a risk to Alan but this flag did not appear to have been communicated to, or identified by the officers who investigated the offences and prepared the court file.

3.5.5. This concern is heightened when the offences for which John was on bail are considered, theft and exploitation of a vulnerable person (his female partner) and assault. It is also of

note that John described himself as her registered carer and it is known he later described himself as Alan's registered carer.

3.5.6. If Alan's bail address had not been allowed, the risk could have been potentially reduced although not necessarily eliminated, as residence does not remove the ability to visit an address. Given the risk was increased, this should have resulted in a safeguarding alert and a multi-agency strategy which might have included appeal to magistrates court to amend John's bail conditions.

Probation Service

3.5.7. John had been known to the Probation service for a number of years. In 2009 they prepared a Pre Sentence report for an offence of Common assault and battery. These were domestic violence related offences, John having assaulted his partner at the time. It is of note that in the 2009 pre sentence report it was identified that he posed a risk of harm to the Probation Staff and others. Whilst custody was recommended he received a Suspended Sentence Order with a requirement to attend the Integrated Domestic Abuse Programme (IDAP). Later that year he was arrested for assaulting a police officer and suspended from the IDAP program.

3.5.8. He assaulted his partner again and was given a custody order thus removing him from the supervision of the Probation Service.

3.5.9. The Probation Officer (PO) at the time was concerned about John and considered that he posed a significant risk of harm. That PO monitored reports and looked out for his name in court e-mails. In May 2005, they noted that he was being sentenced for possession of an offensive weapon. It was noted that Alan's property was his court bail address. The PO was not aware of the issues in respect of Alan.

3.5.10. In June 2013, the PO noted that John was to be sentenced for domestic violence related offences and requested that they be allocated the report. They found in the bundle a statement from Alan stating that he did not want John to use his address. This was dated August 2012 and was not related to this case. The PO was concerned because this statement was at odds with John's comments when interviewed for his pre sentence report that he was in the process of becoming Alan's carer. They became aware that he had also been claiming for Carer's allowance for the partner he had assaulted.

3.5.11. The PO contacted the DWP to express their concerns about John becoming Alan's carer.

3.5.12. The PO contacted the Adult Social Care Worthing Team to establish if Alan was known to the service. They signposted her to CC1. The PO spoke with CC1 who stated he was aware of the relationship and would speak with the housing provider. The PO sent a follow up e-mail (there are concerns about the e-mail address being correct). The PO also contacted the police to advise them that John was breaching his bail by being her carer and may have committed benefit fraud, but received no reply.

3.5.13. The pre sentence report recommended a suspended sentence with supervision and prohibited John from being a carer.

MARAC

3.5.14. Worth Services are an accredited Independent Domestic Violence advisor [19](IDVA). The service supported 3 females who had been subject to both physical and financial abuse by John. Female 1 in 2009, female 2 in June 2010 and female 3 from April 2013.

3.5.15. A Multi-agency Risk Assessment Conference [20](MARAC) is a multi-agency meeting held for domestic violence victims identified as at high risk of serious harm or homicide. The MARAC was co-chaired by the MARAC coordinator and the police.

3.5.16. John was discussed at two MARAC's, July 2010 and May 2013. At a meeting held in May 2013, Alan was referred to. It was recorded as follows in minutes:

> *Victim expressed her concern that John has given police his bail address as XXXXX (a drug user called xxxx lives here) when she knows he is living with Alan (a paranoid schizophrenic) at xxxx.*

This was an update from probation.

3.5.17. There is no record of any response to this information. The Worth Service IMR highlights that:

> *If the information contained in the minutes was openly discussed at the meeting then it would be reasonable to expect the attending agencies to identify potential risk posed to Alan if John was living with him and to explore a Safeguarding Alert in relation to Alan.*

3.5.18. Whilst it is accepted that the MARAC is focused on supporting domestic abuse victims, additional information should not be ignored. In this case a check of police records would have identified the links between Alan and John and the flag on Alan's address would have confirmed the risk he posed. Additional information that is highlighted at a MARAC should be followed up by the most relevant agency, this should be highlighted as part of the MARAC action plan accepting that it was not an issue that directly involved the victim.

3.5.19. John was a serial abuser of the partners that he became involved with. The abuse was not just physical but also financial. There is evidence that his behaviour towards them was being replicated when he was involved with Alan, with Alan being the victim.

Observations

3.5.20. As well as examining agencies involvement with Alan, there was also a need for this review to consider their involvement with John in order to establish if there were any opportunities for them have intervened and thereby reduce the risk he posed to Alan. The officers working with Alan and those investigating John were working in silos. The Police IMR concludes:

> *The Police saw no joined up working between those working with Alan and those*

[19] The Independent Domestic Violence Advisors (*IDVA*) is a government initiative introduced to reduce the number of Domestic Related Homicides. *IDVAs* focus on high risk clients by supporting at a point of crisis, supporting them to plan appropriate safety management strategies.

[20] A Multi Agency Risk Assessment Conference (**MARAC**) is a local, multi agency victim-focused meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies.

with John.

The police however, were in the best position to have made these connections and join the process up. The PCSO was aware of the risk John posed. He was committing similar offences against Alan to those he was committing against his female partners. There was an opportunity to have considered investigating the two victims together but that did not happen, and the use of Alan's address as a bail address for John increased the risk to Alan.

3.5.21. The Probation Officer clearly had concerns about the risk John posed for a number of years. Fortunately the PO picked up the case in 2013 and had identified the risk to Alan posed by John becoming his carer. The PO contacted DWP and their response will be considered later.

3.5.22. The PO also contacted CC1 and the police but received limited responses. At no time did the PO raise a Safeguarding Adult Alert. They had raised the issue with the Adult Social Care, Worthing Duty Team who had signposted her to CC1. Once again like the PCSO and the FSO they believed that CC1 would respond.

3.5.23. The MARAC process could have alerted agencies to the risked posed but his risk was not considered any further than what was discussed at the meeting which focused on risk to the individual victim.

3.5.24. John was an abuser of vulnerable people but whilst the domestic violence aspect was pursued with some vigour, the risk to Alan as a vulnerable victim was not. These differing responses to domestic abuse are examined later in the report.

3.6. Response to events on the 18th July 2013

3.6.1. This was the day that the FSO persuaded Alan to attend the police station. He did and made a statement to police. As a result of this statement John was arrested. This was five days before Alan's fatal fall and is a period that requires some consideration in respect of the actions taken to protect Alan.

3.6.2. On the 19th July CC1 received a Safeguarding Alert which they forwarded to their Team Leader, who forwarded it to a service manager. This was in line with new guidance. They also received an update from the FSO who confirmed that the following had taken place:

- John was bailed with conditions not to contact Alan directly or indirectly.
- An alert was raised by the PCSO and this led to the following actions.
- FSO supplied new mobile phone to allow Alan to contact Police.
- Police placed upgrade marker on system for call outs.
- CC1 to see Alan for OPA on the 23rd July 2013.

3.6.3. On the morning of the 22nd July 2013 the FSO visited Alan; he was withdrawn and reluctant to talk. He confirmed that John had, via a third party, returned his documents, a small sum of money and a letter of apology. The FSO updated all parties and offered to go with Alan to his appointment with CC1 on the 23rd July.

3.6.4. When considering the possible threat to Alan, the actions taken soon after John's arrest would appear to have been supportive, markers on the address, supplying Alan with a mobile phone and an appointment made with CC1 plus John had clear bail conditions. These actions were as a result the actions taken by the FSO and police. CC1 did not get to see Alan on the 18th; they had a meeting booked for the 23rd July. There is no record of any

multi-agency meeting being arranged in response to the safeguarding alert but a set of actions were progressed.

3.6.5. Alan did contact the police when John arrived at his flat but there was no deployment of officers at the time. This single agency response has been fully reviewed in the IPPC report.

What is not known is why Alan decided to end his life, and specifically his action between his contact with the police in the early hours of the morning and his fall from the car park.

3.6.6. There might have been an opportunity for CC1 or the FSO or the PCSO to have tried to contact Alan in the morning of the 23rd July, but they were not aware of his contact with police the previous evening so this option was not taken.

3.6.7. There is no evidence to indicate that Alan had previously threatened to harm himself so it would have been difficult to predict his drastic course of action, but the risks to Alan had been identified and the action plan in place to try and protect him from any interference from John.

3.6.8. Alan did act as requested and contacted the police when John went to his flat however, risk posed to Alan was increased when police failed to respond to his telephone contact in the early hours of the 23rd July. The police actions have been fully examined in the IPCC enquiry report so will not be explored further in this report.

4 OTHER ISSUES

Carers Allowance

4.1. An issue that has arisen as the review progressed was John applying for a [21]carers allowance for both his female partner, and then for Alan. This was identified by the FSO who spoke to John in 2012 and he stated he was Alan's registered carer, and later by the PO when they spoke with John as part of his pre sentence report.

4.2. When the PO became aware they were concerned about the risk John posed to Alan and so contacted the Department of Work and Pensions (DWP) responsible for administering the allowance. The PO also asked that the court impose a pre sentence order, one element of which was to prohibit John to act as a registered carer.

4.3. What this case highlights is the ease with which individuals can apply for a carers allowance with no apparent checks on their suitability to care for an individual. As can be seen, John was able to claim whilst he was involved with and abused two individuals.

4.4. The Department of Work and Pensions have been contacted in order to better understand the process for application and the risks involved.

The first point that needs to be emphasised is that this is a benefit allowance. It is not, as has been referred to during the review, a registered carer allowance. It is a benefit for caring, introduced in the 1970's. In order to receive the allowance a number of conditions need to be met:

- *The customer must be engaged in caring for at least 35 hours each week.*

[21] Carer's allowance is a benefit for people who regularly spend at least 35 hours a week caring for a disabled person.

- *The person cared for must be in receipt of a qualifying benefit.*
- *The customer cannot be working and earning more than the current earnings limit.*
- *The customer cannot be in full time education.*
- *The customer must be over the age of 16 years.*

4.5. There are currently no processes in place to check who is applying, the letter received from the DWP states:

> *We do not undertake any caring assessments in relation to the carer or the person being cared for. There are no processes in place to make checks to ensure our customer does not pose a risk to individuals or that the claim is fraudulent.*

4.6. An individual can only claim one allowance at a time, they need to supply their National Insurance number when applying and this would highlight if an allowance is already being provided. This demonstrates how John stopped claiming for allowance for his female partner and then used Alan to commence receiving allowance. Both were very vulnerable individuals.

4.7. The application form requires a signature by the person being cared for but there is no ability to check that the signature is not false or whether the individual has been forced to sign.

4.8. If there is indication of a fraudulent claim then the information is passed to the DWP compliance team who would make enquiries to establish compliance. They do not as a matter of course refer them to the police.

4.9. The author has been informed that this review and other similar problems have led to the DWP reviewing their current policy.

Observations

4.10. This review has highlighted the potential weaknesses in the current administration process the DWP have in place when applying for carer's allowance. There are currently very limited checks on any applicant which, as in the case of Alan, leaves vulnerable individuals with disabilities susceptible to abuse and fraud. The findings of this review should be brought to the attention of the DWP.

Domestic Abuse

4.11. Over the past 10 years there have been extensive efforts to ensure a multi-agency approach to supporting victims of domestic abuse. This has included the introduction of multi-agency training, special court Independent Domestic Violence Advisors [22](IDVA) and the Multi-agency Risk Assessment Conference [23](MARAC) process, plus from the police, the expectation of positive action from officers attending incidents and the completion of risk assessments.

4.12. In Alan's case, he did not fit the Home Office definition of domestic violence in place at the time, as set out in Worth Services IMR:

[22] The Independent Domestic Violence Advisors (*IDVA*) is a government initiative introduced to reduce the number of Domestic Related Homicides. *IDVAs* focus on high risk clients by supporting at a point of crisis, supporting them to plan appropriate safety management strategies.
[23]

Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners of family members, regardless of gender or sexuality.

4.13. When considering Alan's situation issues confronting victims of Domestic Violence can be identified:

- Fear of offender
- Financial abuse and controlling behaviour
- Reluctant witness
- Multi contacts with police
- Other health issues, alcohol and Mental Health.

4.14. Had John been a relative living with Alan, or his partner, then he would have been considered a victim of domestic violence and could have received a different response. This might have included:

- Police taking positive action and arresting John as early as 2012.
- A risk assessment would have been undertaken to highlight the risk he faced.
- His case might have been considered for a MARAC.
- An unsupported prosecution of John could have been considered.
- An IDVA could have been allocated to Alan to help support him.
- The police Adult Safeguarding Team would have taken on any investigation.

4.15. As can be seen there would have been significantly different approach to Alan as a victim of domestic abuse.

Reluctant Victims

4.16. An issue raised by all involved with Alan was his continued reluctance to follow through with concerns about John. This was one of the reasons quoted by the police for non-action against John. This is not completely correct in this case; Alan did make complaints and included statements about what he had been subject to. As has previously been identified, positive action was not taken by police in response. Given some of Alan's comments it was the fear of what might happen that may have made him reluctant to follow up. This is a problem that regularly presents itself when trying to support DV victims. Victims are supported by an IDVA, police take positive action and arrest suspects, CPS do consider pursuing '[24]victimless prosecutions' and as has been seen the MARAC process is there to support victims.

4.17. The IDVA is an independent service to offer support; at no stage is there any indication that Alan was offered any form of advocacy. He was being supported by agency staff advising him on what to do but he may have benefitted from support from a trained independent voice helping him make decisions. That opportunity was missed.

24

CPS: ***The prosecution of domestic violence cases (2014):*** **Issued by the Director of Public Prosecutions. /www.cps.gov.uk/consultations/dv_2014_consultation.html#a12**

'using evidence other than that of the victim - prosecutors should assess as soon as possible whether there is other sufficient evidence (for example, admissions in interview, CCTV, 999 Tapes etc) to proceed. Where there is evidential sufficiency and a realistic prospect of conviction, prosecutors should consider whether a prosecution is required in the public interest in the usual manner'

4.18. John was an abuser of his female victims and Alan, using the same modus operandi, but the level of support for his female victims is significantly different and supportive.

Information Systems

4.19. There are a number of electronic recording systems in place across the various agencies. West Sussex County Council social care system is known as Frameworki (FWi). Staff in the integrated SPFT team both, clinical and social care, have access and should be inputting information on two systems. FWi for Carer's Assessments and safeguarding work and eCPA for CPA information.

4.20. As the social care staff in adult services only have access to FWi this restricts the level of information available to each of the respective teams when looking to assess safeguarding information. This is especially a problem for staff in the Local Authority's 'Carepoint' team as they will not be aware that an individual who is subject to a safeguarding alert is being supported by CMHT unless they are an active case on Fwi as they correctly do not get access to eCPA.

4.21. It has also been established that if an individual reports to the Accident and Emergency Department staff do not have access to eCPA (mental health records) and so will not be aware unless informed, that a patient has ongoing involvement with the CMHT. Staff can however refer to the Mental Health Liaison team which is an extended hours service and there is also a pathway for contacting SPFT out of hours.

4.22. Sussex Police have two systems relevant to this case. STORM which records and manages all calls into the control room and records the response by police. A history marker can be placed on the system; this is where the PCSO flag was placed in May 2012. This should ensure that officers attending an address are made aware of previous incidents or concerns. The second is the investigation and intelligence system called NICHE. This system is used by officers to research individual and addressed they are responding too. Unfortunately, STORM history markers do not show on NICHE so there is a need for officers to review both systems to ensure they have all information relevant to an address or individual.

4.23. It appears that in this case officers were not aware of the marker STORM. As a result of this case officers have been directed to check both systems and to produce intelligence reports with all information, which should ensure that STORM information is placed on NICHE.

5 CONCLUSION

5.1. Alan had been known to agencies for a number of years and was in regular contact with staff from those agencies. There were missed opportunities in 2012 to intervene in order to reduce the risk that John posed to Alan. An effective response required a well-constructed assessment of risk, informed by information from all agencies. In other words, coordinated multi-agency working to produce a clear plan, and for that plan to be actioned and reviewed. This should have taken place with the involvement of Alan, and had he wished it, with his family. In addition, this could have been organised at the centre with advocacy support if required.

5.2. As has been evidenced in this report **clear** communication and coordination between agencies did not take place. Individuals worked hard to support Alan but their actions were not coordinated, safeguarding alerts were not raised or progressed when risks were identified and supervision in all agencies failed to identify that the CPA and safeguarding was not working. Consequently there was no effective assessment of risk and escalation of

concerns did not take place.

5.3. This failure to coordinate extended to those working with John and his victims; as a result there was a failure to consider the risks he posed to Alan. In some instances, this failure effectively increased those risks, for example the bail addresses provided by John. These failures were as a result of silo working as opposed to joined up working.

5.4. This was a tragic case of an individual whose vulnerability increased when others and one person in particular (John) exploited him. Alan, with encouragement of agency staff, finally officially reports the abuse he had been suffering over a number of years to police which led to the arrest of John. A safeguarding plan was put place. Unfortunately he did not receive the appropriate response when he contacted the police in the early hours of the morning of the 23rd July 2013 and subsequently harmed himself.

5.5. It is not clear why Alan killed himself. However, it may be that timely, coordinated and joined up multi-agency intervention at an early stage would have reduced the likelihood of this outcome.

6 TERMS OF REFERENCE: FINDINGS SUMMARY

6.1. The following is a brief summary of the findings as they relate to each individual TOR set for this review, as identified in the main report.

6.2. **1) Consider what opportunities were taken, or could have been taken, by agencies to identify and address the risks to Alan.**

2) Identify whether any other interventions might have improved the outcomes for Alan.

6.3. There was clear historical evidence that, when around, John posed a risk to Alan. He financially abused him, possibly physically abused him and had a detrimental impact on Alan's behaviour, including his increased abuse of alcohol and increased disengagement with services. Effective intervention took place in 2011 but opportunities in 2012 and 2013 to commence safeguarding alerts at an early stage (had they been submitted) might have provided an opportunity to consider a coordinated multi-agency approach at an earlier stage.

6.4. It has to be taken into account that Alan was often reluctant to continue with his complaints against John, but in 2012 he did report to police that he had been financially exploited. There was no effective police investigation so no action was taken against John. It is also of note that in September 2012, police were called by Alan to remove John on several occasions, at no time was John arrested. Positive action to make Alan feel safe may have resulted in an earlier removal of John. At no time (recorded) was Alan offered any form of advocacy which may have helped Alan and the agency staff supporting him.

6.5. **3) Consider how agencies worked together and shared information? Was information shared, hindered by concerns about confidentiality?**

4) Was there joined up working between those working with Alan and those working with John? Did this generate a multi-agency risk assessment and action plan?

6.6. Whilst professionals from police, Southdown housing and CMHT worked with Alan over a number of years, and between them they contacted each other, it was not undertaken in a coordinated manner. Multi-agency meetings were held but they were ad hoc and again there was a lack of coordination, minutes or effective action plans. There is little evidence

to indicate that information was not shared due to confidentiality. Information was available and should have been sought and used by the care coordinator to inform the assessment process of the CPA, including the risk assessments, but there is limited evidence that these assessments were other than clinically based. There is no risk assessment process documented within other agencies.

6.7. **5) Did professionals working with Alan and John understand pathways into safeguarding and use the powers available to them?**

6) Consider whether single agency and multi-agency procedures were followed. Did any factor impact on the compliance with these, or the effectiveness of them?

6.8. Whilst safeguarding policies and procedures were in place it is evident that they were not clearly understood by staff for all agencies. Conclusions from the police IMR show that this was certainly true of the front line response officers. They had in place a VAAR notification form but it was not used correctly and other than the PCSO was never submitted in response to Alan's difficulties.

6.9. When the FSO and the police attempted to submit a VAAR or try to disclose their concerns via adult social care, they were referred back to the CMHT and the Care Coordinator. These potential alerts were not investigated as per policy. The process at the time failed to ensure that alerts were correctly recorded and managed, it was reliant on the care coordinator understanding their function and having the ability to co ordinate both the CPA and the safeguarding response. This did not take place so left Alan at risk. When the FSO did try and raise concerns via their team manager they received minimal response from the CMHT. Housing failed to escalate any further. There appears to be a lack of any escalation policy or procedure.

6.10. It is also evident that a number of the SPFT procedures were not complied with; including the CPA, police and the disengagement policy. The Care Coordinator did not seem to fully appreciate the requirements of the role in respect of coordinating the multi-agency approach to Alan.

6.11. **7) Was there a coordinated approach between those working with Alan and those working with John which supported effective reduction of risk?**

8) Were safeguarding concerns for Alan recognised with MARAC and MAPPA meetings and was information appropriately shared between the two processes?

6.12. There is no evidence that there was any effective coordination between those dealing with John and the team supporting Alan. The use of Alan's address as a bail address for John by both the courts and police custody officers provides evidence of this. The use of this bail address in 2012 and 2013 coincides with an increased risk to Alan, as John was being legally obliged to remain in contact with Alan. There is minimal evidence that Alan was considered a victim by those dealing with John.

6.13. John was being investigated by police and prosecuted for offences against his previous partners, themselves vulnerable individuals. When examining the offences against them there are a number of similarities with the offences against Alan; emotional and financial abuse, controlling, and John even applied for a carers allowance. There is a stark difference between the response to the victims of domestic abuse and the response to Alan. Had the teams been working together then joint responses may have been possible and the use of the bail may have been identified as a risk.

6.14. John was not considered within the MAPPA process until after the death of Alan. From the

evidence presented it seems unlikely that he would have reached the threshold required to be considered under category 3 'immediate risk'. A number of his female victims were subject to a MARAC. The only time Alan was mentioned at a MARAC (not by name) was in 2013 when the fact that John was staying with a vulnerable adult was identified. The MARAC process is there to support victims of domestic abuse but other issues identified should be taken away and actioned by the appropriate agency. Had there been a coordination between the teams working with Alan and John, then this may have occurred. There was silo working that placed Alan at risk.

6.15. **9) Following Alan's disclosure to police on 18th July 2013 was the risk assessed and action taken to promote Alan's immediate safety and welfare?**

6.16. It is evidenced that once Alan had made his statement and John was arrested, a number of actions were put in place including providing a mobile phone to contact the police, bail conditions on John and appointments made for an Outpatient Assessment. The multi-agency response was supportive but it was reliant on Alan receiving the appropriate response when he contacted the police, as instructed, if he was approached.

Unfortunately, when Alan did contact the police in the early hours of the morning, police failed to respond as they should have. The actions of the police have been fully explored in the IPPC report and a number of recommendations in respect of individuals and Sussex Police have been made.

6.17. **10) Consider whether the wishes and feelings of Alan were ascertained, recorded and taken into account when plans were made by agencies?**

6.18. It is evidenced that practitioners did communicate with Alan and tried to persuade him to undertake actions to reduce the risks he faced. However, the recording of **his** views is limited. The SIR identified that Alan's views were not always considered or recorded in the CPA assessments. He was also only present at one of the multi-agency meetings where again his views were not clearly recorded. The professionals expressed their frustration with Alan not wishing to follow their actions especially when it came to his response to John, but there are no clearly recorded discussions with Alan where his views are fully explored and understood.

6.19. The use of an advocate to help support Alan and to assist the practitioners should have been considered. There is no evidence that this took place so Alan was having to deal with well meaning individuals who were coming from three different agencies. As has been identified there was a lack of coordination so it is probable that Alan was hearing different messages and possibly be confused. An Advocate might have ben able to have sought clarity on Alan's behalf and reduced any potential confusion.

6.20. **11) The current law around vulnerable adults whether there are sufficient provisions to enable agencies to take action against perpetrators of financial abuse and thereby protect vulnerable people?**

6.21. The criminal law does have sufficient provisions to be able to take action. Financial abuse is a criminal offence so can be investigated and prosecuted.

6.22. The new Care Act, 2014 has made safeguarding adults statutory, and has specifically identified self-neglect and financial abuse as areas of concern that should be considered as requiring a safeguarding alert. The process of investigating alerts has also been strengthened with the Local Authority retaining overall responsibility for ensuring quality, regardless of who may have been allocated to investigate.

6.23. The SPFT, who have responsibility for under 65's, have also improved their responses by improving recording and supervision, including the WSCC sign off of an investigation.

6.24. These changes should improve the responses and the supervision of investigations, which should remove some of the problems identified in Alan's case.

7 REVIEW RECOMMENDATIONS

The following section sets out the recommendations arising from the findings of this review. They are split into two parts:

Part 1. Recommendations specifically for the WSSAB. These recommendations are limited in number. They are specific to either the production of a policy, raising awareness etc., or for WSSAB to be assured that agencies can evidence that they have completed a task.

Part 2. Recommendations taken from each agency IMR. These are agency specific and are based on the findings of the IMR. These are for the agency to progress and for the WSSAB to be assured that they have been completed.

The recommendations in both sections will be supported by a detailed action plan setting out how the actions will be progressed, by whom and within what timescales.

Part 1. The following are recommendations specifically for the WSSAB.

The WSSAB to:

	1. Produce a Safeguarding Adult escalation policy and to be assured that it has been adopted by all agencies.
	2. Be assured by all agencies that the Pan Sussex Safeguarding Adult policy and procedure is available to all staff and that they are aware of their responsibilities.
	3. Be assured that Safeguarding Concerns are being recorded and undertaken in line with policy and procedure.
	4. Bring this review to the attention of the DWP and to request a response to concerns identified.
	5. Ensure that learning from this review is promulgated by each agency.
	6. Be assured that actions identified by each individual agency are implemented.
	7. Bring to the attention of the CCG the identified failings that the SIR did not take into account all information available.
	8. Be assured that General Practice fully engage in the Safeguarding process and make safeguarding referrals as necessary.

Part 2. Individual Agency IMR recommendations

Worth Services MARAC process

1. *That MARAC representatives update their own agency's internal case management systems and that records are marked appropriately, in order that victims or perpetrators of domestic abuse that have been heard at MARAC can be identified.*

2. *If agencies are unable to attend in person they should read the minutes of the meeting to assist identification of other persons who may be at risk or who may be already known.*

3. *It is recommended that a robust Safeguarding pathway be created between MARAC and Adult Services. Safeguarding concerns s*hould be raised by the agency that is taking the lead on supporting the person at risk.

Sussex Partnership NHS Foundation Trust

Safeguarding Training

1. *Safeguarding training to form part of every staff member's induction.*

2. *Safeguarding to form part of supervision and the appraisal process. Safeguarding reflection and learning lessons events to be introduced to continually test understanding and competence of staff.*

3. *SPFT to be actively involved in safeguarding audits carried out by local authority safeguard leads.*

4. *SPFT to meet regularly with local authority safeguarding leads to ensure robust system is in place to provide assurance that standards are being met.*

5. *All safeguarding concerns must be reviewed by the safeguarding lead before sign-off can take place.*

   Initial action taken: This includes a single point of contact with the Social Care Professional Lead Safeguarding. SPFT safeguarding concerns (previously known as alerts) concerns cannot be formally 'closed' until they have been reviewed by the newly appointed Professional Safeguarding Lead.

   SPFT has created a new role since this incident - Deputy Director of Social Work, this role provides strategic leadership and scrutiny in relation to adult safeguarding, including implementing lessons learnt from Safeguarding Adults reviews and Multi-agency Reviews.

Supervision

6. *All staff must have supervision arrangements in place which ensure they receive annual and management supervision. Managers must have a robust system for monitoring both quality, frequency and attendance.*

7*. All supervisors must follow supervision policy guidance and ensure case management supervision includes looking at notes and discussion of safeguarding concerns.*

8. *SPFT will ensure there is an annual supervision audit and that recommendations are monitored and met****.***

Multi-agency Working

9. All staff working as care co-ordinators must ensure they are aware and fully understand the roles and responsibilities of their role in relation to the care programme approach.

10. Following the review of the current CPA policy, a comprehensive training package and clear guidance will be issued. This will focus on involvement and engagement of service users, carers and their families.

11. Develop clear guidance in regard to the relationship between CPA care co-ordination and safeguarding management, clearly defining roles, responsibilities and expectations.

Record Keeping

12.A robust process is needed to ensure that record keeping standards are reviewed and audited as part of the supervision process.

Initial Action taken: This is now part of the Trust Supervision Policy and has been reinforced by the leadership team. There is also an annual supervision audit undertaken as part of the Trust clinical audit programme.

Risk Assessment

13.Robust training needs to be in place for all clinical staff.

Initial Action taken: Online risk training forms part of the essential on line package for all clinical staff. In coastal West Sussex additional face to face risk training has been provided and is rolled out to all staff. In September and October 2015 over 50 staff received this training.

Carer and family liaison

14. Robust policies, procedures and guidance to be in place to support meaningful engagement with family and carers. CPA policy and safeguarding processes both require involvement of family and carers.

15. All families should have contact from SPFT following a serious incident. The new Duty of Candour rules have been introduced and require contact with a family in the event of a serious incident or suicide with a commitment to transparency and openness. An offer to be involved in the review process is now made in all cases and the final report shared with the Next of Kin.

General Practice

1. *Develop, in conjunction with Mental Health services, a clear communication and reporting pathway between GPs and CMHT when patients with a serious mental health condition do not attend for their annual review with the GP.*

2. *Develop guidance for GPs on safe prescribing for patients receiving regular medication for a serious mental health condition who do not attend for their annual mental health review or medication review when requested.*

Southdown Housing Association

1. *Ensure all existing SHA clients have signed information sharing agreements which give permission for SHA to share information with all agencies engaged in joint support.*

2. *Ensure recommendation to the Housing Team is taken forward and that any information received from an external source which relates to an incident affecting a SHA tenancy is investigated and followed up with the support team and any other agencies involved.*

3. *Continue to explore ways in which information relating to people who are not clients but are identified as a significant risk to vulnerable clients can be communicated across teams without breaching data protection.*

4. *SHA to ensure that assessment and support planning includes discussions on positive engagement and if disengagement occurs, FSO's work with the client to explore why this happened and identify solutions to encourage re-engagement.*

5. *SHA is currently talking to all staff about how they can improve their recording and the potential benefits this has in encouraging engagement.*

6. *SHA will continue to seek opportunities to attend meetings with statutory providers, circulating information and delivering presentations to promote an understanding of the support provided. SHA will ensure that agencies involved in joint working have a clear understanding of the service offered.*

7. *SHA will ensure Service Level Agreements and Information Sharing Agreements should be introduced as support commences or as new services are accessed by a client with all key agencies supporting an individual client.*

8. *SHA has updated all internal procedures in line with the new Sussex Safeguarding Procedures and all SHA Managers, Support Workers and Housing Officers are undertaking updated training. In addition Senior Managers in the organisation are undertaking training with WSCC to become Safeguarding Enquiry Officers.*

9. *SHA have established contact with the Safeguarding Lead Officer in West Sussex to identify escalation routes, discuss cases of concern and ensure there are improved outcomes for clients.*

10. *Regional Manager has made a recommendation to the Housing Team that any information received from an external source, which relates to an incident affecting a SHA tenancy should be investigated and followed up with the support team and any other agencies involved.*

11. *SHA has recognised there is a need to develop an internal system which ensures persons of concern and risk can be identified and are currently exploring ways in which this could be communicated across teams without breaching data protection.*

Sussex Police

1. *In the next six months Public Protection to review all Sussex Police safeguarding policies and produce a shorter overarching safeguarding policy for use by uniform officers. The remaining individual policies will provide reference points for the*

Safeguarding Investigation Unit. This would enable officers to go to one document when they seek guidance on how to deal with an incident including the remit of the SIU and how to deal with safeguarding matters which do not fall within the remit of the SIU.

2. *Sussex Police to consider if Police Pocket Note Books or Investigator Note Books, are still the most suitable place to make contemporaneous records at the scene of an incident. Until a decision has been made, within one month remind all staff of their duty to make an accurate record of the circumstances, the first complaint, any evidence and the action taken in their books. This will ensure a full and accurate record is maintained by Police and PCSO's. This will also enable officers to refresh their memories when giving evidence in court or when asked for some other reason about an incident they attended.*

3. *Consideration is given to updating the NICHE custody system to include a bail assessment that has to be completed before the system permits the bailing and release of a prisoner. The national NICHE Criminal Justice User Group are currently meeting to discuss the next amendment to the NICHE system, therefore the Sussex Police NICHE Optimisation Team within the Smarter Systems Programme should progress this as a priority to ensure any bail assessment is included in the next NICHE upgrade.*

Meeting with the relatives

1. *On 28th September 2016 the relatives of 'Alan' met with the agencies and the Independent Author, Brian Boxall, to discuss the report and had the opportunity to ask final questions. The family endorse the report, and thank all the agencies for the work they have done in preparing the report.*

Appendix A

Terms of Reference

1) Consider what opportunities were taken, or could have been taken, by agencies to identify and address the risks to Alan.

2) Identify whether any other interventions might have improved the outcomes for Alan.

3) Consider how agencies worked together and shared information? Was information shared, hindered by concerns about confidentiality?

4) Was there joined up working between those working with Alan and those working with John? Did this generate a multi-agency risk assessment and action plan?

5) Did professionals working with Alan and John understand pathways into safeguarding and use the powers available to them?

6) Consider whether single agency and multi-agency procedures were followed. Did any factor impact on the compliance with these, or the effectiveness of them?

7) Was there a coordinated approach between those working with Alan and those working with John which supported effective reduction of risk?

8) Were safeguarding concerns for Alan recognised with MARAC and MAPPA meetings and was information appropriately shared between the two processes?

9) Following Alan's disclosure to police on 18th July 2013 was the risk assessed and action taken to promote Alan's immediate safety and welfare?

10) Consider whether the wishes and feelings of Alan were ascertained, recorded and taken into account when plans were made by agencies?

11) The current law around vulnerable adults whether there are sufficient provisions to enable agencies to take action against perpetrators of financial abuse and thereby protect vulnerable people?

Appendix B

Glossary of Terms

ABE	Achieving Best Evidence
ADASS	Association of Directors of Adult Social Services
AOT	Assertive Outreach Team
APT	Adult Protection Team
ASBO	Anti-Social Behavioural Order
ASCT	Adults Social Care Team
ATS	Assessment and Treatment Service
CAB	Citizens Advice Bureau
CC	Care Coordinator
CCG	Clinical Commissioning Group
CLDT	Community Learning Disability Team
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPS	Crown Prosecution Service
DS	Detective Sergeant
DWP	Department of Work and Pensions
eCPA	Electronic Care Programme Approach
EOT	Enquiry Officer Training
FSO	Floating Support Officer
GP	General Practitioner
HSW	Healthcare Support Worker
IDAP	Integrated Domestic Abuse Programme
IDVA	Independent Domestic Violence Advisor
IM	Investigation Manager
IMR	Individual Management Review
IPCC	Independent Police Complaints Commission
LA	Local Authority
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference
MCA	Mental Capacity Act
NHS	National Health Service
NICHE	Police Custody System
NPT	Neighbourhood Policing Team
PC	Police Constable
PCSO	Police Community Support Officer
OAP	Open Access Policy
PCSO	Police Community Support Officer
PO	Probation Officer
PS	Police Sergeant
QOF	Qualities and Outcome Framework
SAR	Safeguarding Adult Review
SCARF	Single Combined Assessment Risk Form
SHA	Southdown Housing Association
SIR	Serious Incident Report
SIU	Safeguarding Investigation Unit
SPFT	Sussex Partnership Foundation Trust
STORM	System for Tasking and Operational Resource Management
TOR	Terms of Reference
VAAR	Vulnerable Adults at Risk
WSCC	West Sussex County Council
WSSAB	West Sussex Safeguarding Adults Board