| NEIGHBOURHOODS, INCLUSION COMMUNITIES & EQUALITIES COMMITTEE | Agenda Item 10<br><br>Brighton & Hove City Council |
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| **Subject:** | | **Safeguarding Adults Review: Adult X** | |
| **Date of Meeting:** | | **3 July 2017** | |
| **Report of:** | | **Executive Director (Neighbourhoods, Communities & Housing)** | |
| **Contact Officer:** | **Name:** | **Peter Castleton/Mia Brown** | **Tel: 01273 292606** |
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| **Ward(s) affected:** | | **All** | |

## 1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The purpose of this report is to enable the committee to have an overview of the circumstances of the death of adult X and the subsequent Safeguarding Adults Review (SAR) and its recommendations.

1.2 The report also outlines learning and practice changes arising out of the SAR.

## 2. RECOMMENDATIONS:

2.1 The committee is asked to note and consider the findings and recommendations from the Safeguarding Adult Review relating to adult X to ensure learning from the review is put into practice.

2.2 That the committee approves of the changes in practices that have taken place since the findings were published.

## 3. CONTEXT/ BACKGROUND INFORMATION

3.1 A Safeguarding Adults Review is held when an adult dies as a result of abuse or neglect and there is a concern that partner agencies could have worked more effectively. This review was published in March 2017.

3.2 X was a 59-year-old biological male who also sometimes presented as female and identified as transgender. In December 2014 X was found dead in a caravan. There was a tube running from a gas canister outside the caravan into X's sleeping bag inside. The Coroner recorded a verdict of 'misadventure to which self-neglect contributed'. This Safeguarding Adults Review was conducted by an independent reviewer and considered multi-agency working in the 12 months leading up to X's death.

3.3 X had a number of presenting issues and vulnerabilities including mental health problems, identifying as transgender, had been a victim of abuse, self-harmed, had a history of violent offending and had learning difficulties and a personality disorder.

3.4 X's overall presentation and disclosures meant that there was immediate agreement by the services involved with them that they were vulnerable.

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

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

## 4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 The SAR draws a set of key considerations and learning points from the review that will be monitored and progressed against a multi-agency action plan that was developed following the review.

4.2 Key highlights from those recommendations that have or will result in changes in practices include:

- SAB Chair to ensure that all the relevant antecedent information is available where a person coming to B&H from another area is identified as a vulnerable adult at risk by incorporating this requirement into social work redesign and local safeguarding procedures.
- SAB partner agencies to review their own approaches to dealing with clients that are hard to engage or persistently disengage. This will be reported back to the SAB for scrutiny.
- In May it was agreed Pan Sussex Safeguarding Procedures will be reviewed to include a section on how to manage the additional vulnerabilities of the homeless population including how to manage the complex issue of self-neglect where guidance will be reviewed and refreshed.
- The SAB Quality Assurance Sub Group will provide assurance on the efficacy of the partnership's recognition and response to self-neglect.
- SAB Chair to formerly notify the Rough Sleepers Strategy Programme Board of the review and recommendations particularly in relation to personality disorders and self-neglect.
- The SAB Quality Assurance Sub Committee have undertaken a multi-agency audit on four similar active cases with similar issues to those that relate to this case and will report back to the SAB in September.

- The report has been shared formerly with the B&HCC Communities, Equalities and Third Sector Team to review against the Trans Needs Assessment.

## 5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 The SAR has been published and is easily accessible through the Safeguarding Adults Board website. There has been no direct community engagement and consultation in relation to this case.

5.2 Actions relating to the SAR that relate to X identifying as Transgendered are linked to the Trans Needs Assessment which has been widely shared.

## 6. CONCLUSION

6.1 The review notes X's mental health problems, learning difficulty and history of violent offending, and acknowledges that X was a very difficult and potentially dangerous person for support staff to engage with.

6.2 It concludes that a range of services were in place to address X's needs, and that they had the potential to join together in a coordinated and purposeful way.

6.3 However, the absence of agreement about X's mental health needs – and X's unwillingness to engage with mental health services – acted as a barrier to such work.

6.4 While individual agency procedures were followed, these did lack an individual 'person-centred' approach. The exception to this was that staff from the community and voluntary sector showed greater flexibility in their dealings with X.

## 7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 There are no financial implications arising from this report. The cost of the Safeguarding Adults Review has been met from the current budget resources of the council and the agencies involved.

*Finance Officer Consulted: Monica Brooks Date: 08/06/17*

Legal Implications:

The statutory functions of the SAB are set out in the body of the report. It is of note that some of the recommendations are the responsibility of the Health and Well-being board.

*Lawyer Consulted: Simon Court Date: 08.06.2017*

Equalities Implications:

7.2 The Safeguarding Adults Board needs to satisfy itself that the recommendations relating to homelessness, mental health and community safety contained in the Trans Needs assessment will be fully implemented and meet current best practice standards.

## SUPPORTING DOCUMENTATION

**Appendices:**

1. SAR Adult X Full SAR