OVERVIEW REPORT

SAFEGUARDING ADULTS REVIEW

SIGNIFICANT INCIDENT LEARNING PROCESS

HASSAN

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Presented to Brighton and Hove Safeguarding Adults Board: 16 September, 2025

Final Version : December 2025

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1. INTRODUCTION

1.1 The Brighton & Hove Safeguarding Adults Board (BHSAB) received a Safeguarding Adults Review (SAR) referral in July 2023 from Mental Health services in respect of a gentleman being referred to as 'Hassan' to preserve anonymity.

1.2 This referral was discussed at the following subgroup meeting in August 2023. Significant concerns were identified in relation to the sequence of escalating events, which did not appear to have reduced through actions that were undertaken. Concerns were immediately identified in relation to multi-agency working arrangements and the effectiveness of communication and information-sharing processes between organisations, risk escalation processes, and the identification and response to discriminatory abuse. It was felt there were significant new learning opportunities and the eligibility criteria had been met for a mandatory Safeguarding Adults Review (SAR) to be commissioned.

1.3 The period for this review is from the beginning of October 2022, when it is considered the abuse and neglect Hassan experienced began to significantly increase, up until 10th October 2023, when local involvement in supporting him ceased. However, any contextual information outside of this period that is considered to be relevant will be included.

Legal Framework:

1.4 The Care Act 2014 states that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

1.5 In addition to the above SABs might select cases for either of the reasons noted in the Care & Support Statutory Guidance updated June 2020:

1. Where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults

2. To explore examples of good practice where this is likely to identify lessons that can be applied to future cases
3. In any other situation involving where a SAB chooses to where an adult with needs for care & support is involved

1.6 The purpose of the SAR is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases.

Terms of Reference:

The specific terms of reference agreed for the review were –

1. How effective were communication and information-sharing processes that took place between professionals and agencies? Evaluate their effectiveness in responding to identified risk. This should include in particular consideration of cross-border information-communication and information-sharing.
2. How well did professionals and agencies recognise and understand the discriminatory abuse Hassan experienced? How well did they recognise and understanding his background and culture, any religious needs and the impact of this in respect of his care and support needs as a person with protected characteristics?

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3. Were all opportunities were taken to support Hassan in respect of the discriminatory abuse he experienced, including the consideration and utilisation of voluntary sector organisations?
4. Were there further opportunities for professionals to respond as the situation deteriorated and concern increased in maintaining the safety of both Hassan and his partner? This should include consideration of the escalation actions undertaken, and the engagement and effectiveness of these.
5. Were the experiences, views and wishes of Hassan and his partner a key area of focus in the assessment and decision making processes?.
6. To what extent did any characteristics of the person alleged to have perpetrated the abuse to Hassan form part of your agencies assessment or decision making?
7. Please highlight examples of strong practice both within your agency, from another agency or in relation to multi agency working.

2. PROCESS

2.1 The review was carried out applying the Significant Incident Learning Process. This involves agencies producing timelines and analytical reports of their involvement and encourages learning to be identified by the staff involved in the cases and, so far as possible, aims to involve members of the families affected by the incidents.

2.2 Staff involved and the report writers were brought together at a Learning Event to discuss the reports, issues, and themes emerging, focusing on Key Episodes identified from the reports. A Recall Day followed to discuss a first draft of the Overview Report.

2.3 The Reports provided by agencies are thorough and of a high standard. The Learning and Recall Events reflected careful consideration and a determination to learn. The recommendations made in the reports for their agencies, if implemented, are calculated to bring about change. These recommendations are set out in Appendix B to this report.

2.4 The Significant Incident Learning Process was led and the report was written by Ms. Donna Ohdedar. Ms. Ohdedar has the qualifications, experience, suitability and independence to undertake reviews required by statutory guidance.

Hassan

2.5 Hassan is 48 and of Pakistani origin. Following the events that led to this review being arranged, he relocated to a different part of the country (referred to as Area B). When I called him, he told me he is committed to his partner despite his family believing that, now they are apart, he could enter into an arranged marriage. He feels he has no life where he is currently living. He sees nobody, and says he hasn't had his hair cut for a year as there is no point. His hope is to return to Brighton and Hove where he had work.

2.6 He is educated to masters level and his university years were spent in London. He still believes 'England is the best country.' He believes calling the police in his case produced 'big fat zeros' and this, alongside being let down in terms of being supported & housed post discharge from hospital, is what he feels let him down.

2.7 Hassan is thanked for his extensive cooperation with this review and his proactive commitment to enhancing learning. The views of Hassan and his partner have been woven into the text of this report.

3. THE FACTS

3.1 Hassan previously lived in a different part of the country and still has close family there. He lived with his partner in a Housing Association flat in Brighton and Hove from 2020 to 2023 and worked full-time during that period. He has a history of mental health issues (moderate to severe depression with psychotic symptoms) and his partner has physical disabilities, with both described as being carers for each other.

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3.2 Hassan began experiencing verbal racist abuse shortly after moving into the flat and, whilst it is not clear if there was a specific trigger with another individual, it was described as an 'interlinked and a complex situation'. This escalated to psychological and physical abuse with specific incidents including verbal hostility, offensive stickers being attached to the flat, and his dog potentially poisoned. These incidents were reported to the Housing Association and the Police and it is recorded that actions were taken to reduce risk.

3.3 Within months of moving in, the situation had significantly worsened. Following an initial incident when Hassan was alerted to the alarm in his vehicle going off and found it damaged with a note containing racist abuse, several days later he found the driver's seat covered in some form of chemical believed to be a flammable liquid. The Police noted that Hassan's usual routine was to smoke in the vehicle before travelling to work.

3.4 Hassan's mental health worsened in the period after this and, following an A&E attendance, he was informally admitted to an out-of-area inpatient mental health unit. This made maintaining contact with his partner more difficult and whilst he did not want to return home, he discharged himself. Community support from mental health services was arranged but Hassan reported further racist abuse several days later.

3.5 An initial Hate and Anti-Social behaviour Risk Assessment Conference (HASBRAC) took place that was attended by a range of organisations. It was noted the situation had escalated substantially and had significantly impacted Hassan and his partner, with both at that point feeling afraid to leave the flat. Actions were taken including to protect the property, gain further evidence as to what was occurring, and to explore alternative accommodation options. Hassan did not attend two subsequent meetings with mental health services, due to fears both he and his partner had for their safety. He and his partner had identified by this point that they wanted to move to a neighbouring local authority area, Lewes and Eastbourne, to be near local family members and a referral had been made to Housing services to initiate this process.

3.6 Five months later, Police raised a concern after Hassan had an unknown liquid thrown over him in a communal outside area one night. They also referenced a recent incident where metal bits or scraps had been fired at him. They identified the need to re-house Hassan and his partner as soon as possible and referenced his fears for his life in the referral. This led to a safeguarding enquiry commencing, with various actions progressed and two multi-disciplinary meetings held over the following month. Housing Services in the neighbouring local authority area advised that, despite the only action agreed likely to reduce risk was moving Hassan and his partner, there was no suitable emergency accommodation available and they were not eligible for a high-risk banding.

3.7 Four months later Hassan had a flammable liquid poured on him and was then set on fire. He experienced third degree burns to his arm requiring specialist treatment and surgery at a specialist unit within a hospital. Police identified significant planning had taken place prior to this attack, with camera wires cut at his property and batteries removed. A subsequent multi-agency risk meeting took place several days afterwards with suitable housing still not identified.

3.8 Hassan was discharged from the specialist treatment unit within the hospital and relocated to Area B where he continues to reside and he has recently moved to new accommodation.

4. KEY EPISODES

The review highlighted the following as the key episodes in the review, before & during the scoping period:

4.1.1 November 2022 response to Hassan disclosing domestic abuse

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Hassan first disclosed domestic abuse when he attended the hospital emergency department in October 2022. This disclosure was made in the context of an acute mental health presentation and was not fully explored. Further separate disclosures were made to his GP and Police in the following months, which Hassan does not recollect and feels was caused by his mental health at that time. A DASH (Domestic Abuse, Stalking and Harassment) risk assessment was completed and assessed as standard risk, i.e. the evidence did not indicate a likelihood of serious harm. The DASH risk assessment was sent to adult social care who considered the allegation and concluded that the relationship between Hassan and his partner was not abusive. This is a key episode because Hassan's disclosures of domestic abuse were considered by three agencies, but were not triangulated.

4.2 March 2023 response to flammable liquid being thrown from upper balcony

Hassan was in a communal area outside the flat one evening when the liquid was thrown over him. Police responded to the 999 call quickly and submitted a safeguarding concern, which led to a decision that a safeguarding enquiry was necessary. This was led by the social worker based in mental health services. A multi-agency safeguarding meeting took place which concluded that alternative accommodation was required. The GP was not aware of this meeting, nor notified of the outcome. It was identified wheelchair-accessible accommodation would be necessary because of Hassan's partner's physical disability. Housing services in Brighton and Hove and in Eastbourne & Lewes both advised that there was no suitable emergency accommodation available for Hassan and his partner and they were not eligible for a high-risk banding. This is a key episode because the multi-agency network formed the view that risk would be reduced by a move to alternative accommodation. However, there was complexity regarding sourcing the specific accommodation required in meeting both their needs. It also raises questions regarding how Hassan was heard and considered as an individual separate to his partner.

4.3 July 2023 Hassan sustained burns

When Hassan sustained three percent mixed depth burns (third and second degree burns) as a result of flammable liquid poured on him and set on fire, he required specialist treatment and surgery. The individual rumoured to be responsible, who was also accommodated by the housing association, provided an alibi for the time of the attack and the case did not reach the threshold that would enable it to be submitted to the Crown Prosecution Service. The police arranged a multi-agency meeting. Once again, the GP surgery was not invited. It materialized that Hassan's partner claimed the alleged perpetrator had previously abused their former next-door neighbour, resulting in the neighbour moving away. It was after this time that the abusive behaviour towards Hassan escalated. This is a key episode because agencies instantly recognized the need to relocate Hassan yet the complexity around the needs of the couple in addition to cross boundary issues frustrated the safeguarding response. This episode calls into question the potential for a short-term and long-term response to the two individuals' needs.

4.4 August 2023 hospital discharge & transition to Area A then Area B

Whilst there was communication with Adult Social Care and Housing services, no multi-agency discharge planning meeting was held as part of the process of Hassan's discharge from the specialist treatment unit within the hospital. Neither adult social care nor housing were made aware of his discharge date in advance. Upon leaving the unit, Hassan notified the police who then notified adult social care. Adult social care requested a discharge summary because they were concerned Hassan may need care due to his physical injuries. The specialist unit advised no specific care was required. However, Hassan did present to the emergency department twice not long following his discharge due to a continuing need for care of his physical injuries. This is a key episode because there was no multi-agency discharge planning meeting and there was no lead professional at this stage. This left agencies unable to adequately safeguard Hassan to relocate. Most agencies by this stage had little or no access to Hassan's voice, blocking their ability to plan or indeed to offer a person-centred approach.

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5. ANALYSIS BY THEME

5.1 Responding to Risk

5.1.1 This review has considered how agencies identified and responded to discriminatory abuse in 5.2.1 in relation to referral and multi-agency working. In 5.3 this review analyses how Hassan was seen with all of his individual characteristics. Several learning points have been identified including learning around how Hassan become isolated. Notwithstanding these factors, the review has found that there was a good understanding amongst professionals of the discriminatory abuse Hassan had suffered.

5.1.2 Hassan was allocated a specialist hate crime worker. There was no evidence that he experienced 'othering attitudes'[1] in the way professionals understood and appreciated the abuse and assessed risk in individual organisations. Considerable efforts were made to meet the couple's housing needs. Each offer, in turn, was met with a refusal, communicated by Hassan's partner. In episodes of heightened concern, the professional focus on immediate safeguarding was appropriate. Later on, it became necessary to focus on promoting Hassan's wellbeing, by prioritising his views, wishes and desired outcomes. Making Safeguarding Personal requires active listening to a person's concerns and experiences including the requirement to inform Hassan that he had the right to be supported by an advocate under Care Act Statutory Guidance section 7.2. Learning point 6 below addresses the longer-term focus that was needed in Hassan's case.

5.1.3 Hassan's disclosures of domestic abuse did not result in him accessing a service of any kind. Hassan himself feels that he was not '100% in his mind' at that time and he does not recall making them. His disclosure in the emergency department was considered quite 'wild' and was not fully explored by clinicians as it arose in the context of his acute mental health presentation where he was also making other allegations. However, he also made a later disclosure to his GP regarding coercive and controlling behaviour by his partner. It appears this information was not triangulated to form a holistic picture before choosing not to share information or make a referral

5.1.4 His third disclosure of domestic abuse within the scoping period was made to police. This was assessed appropriately using the Domestic Abuse, Stalking and Harassment (DASH) risk assessment. However, it was noted by the officer completing the assessment that they did not feel Hassan was disclosing the full nature of his relationship. When a copy of the police assessment was passed to adult social care, an assessment was undertaken. This involved contact with Hassan and his partner and speaking to other agencies. During this assessment, Hassan was clear he felt his relationship dynamic was beneficial and he did not consider it to be a problem.

5.1.5 Hassan as a male victim with protected characteristics may experience additional barriers to reporting domestic abuse over and above most victims/survivors.[2] It is common for allegations to be retracted. Hassan confirms that he has been told about words and actions of his that he can no longer recall which were made in the context of his psychotic episode. Whilst the disclosure to the police was assessed by the police and adult social care, the disclosure made in the emergency department was not assessed and it did not result in any information sharing.

5.1.6 Men may be overlooked as victims of domestic abuse because it is portrayed as a gendered crime[3]. Domestic Homicide Reviews highlight a lack of training and support in the recognition and

[1] Local Government Association Discriminatory Abuse A Briefing for Practitioners March 2024 Attitudes which seek to distance people who do not fit into assumed societal norms.

[2] 'Supporting Male Victims' The last UK government produced a policy paper in August 2022* which suggested there were 2.9 million male victims of domestic abuse in the year ending March 2020. Respect Men's Advice Line and the Mankind Initiative were reporting increasing calls from male victims.

[3] Why Are Men So Often Overlooked as Victims of Domestic Abuse? Broberg, The Centre for Social Justice June 2022

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handling of male domestic abuse.[4] Parallel strategies providing equally strong support for female and male victims are not always in place. Hassan was presenting to professionals with more than one need and professionals knew Hassan's partner was white and had a disability. Opportunities to support were lost and the response to risk may have been compromised due to lack of a shared approach across agencies to this level of complexity.

5.1.7 Police receive a call about domestic abuse every 30 seconds and the system often struggles to respond to the enormity of the challenge. However, in Hassan's case the police assessed risk and shared the results to Adult Social Care. There are four key themes which reflect the most pressing issues for any agency responding to a disclosure of domestic abuse[5] :

1. data and accountability;
2. multi-agency working;
3. resourcing;
4. and prioritisation of domestic abuse.

5.1.8 The emergency department did not prioritise domestic abuse as disclosures were viewed in the context of Hassan's "acute psychotic episode". As a result, information about this disclosure was not shared. The attendance records that were subsequently forwarded to Hassan's GP did not reference domestic abuse. It would have been good practice for a safeguarding referral to have been made at this point. This would have enabled adult social care to properly consider and explore the likelihood of domestic abuse. It would have been good practice for the police to have been notified about the disclosure. The mental health liaison team based at the acute hospital did not refer to domestic abuse in their notes, which suggests the emergency department did not notify their team of Hassan's disclosure.

5.1.9 Research[6] illustrates why domestic abuse is often not identified or responded to by health organisations. These include routine inquiry in a range of health settings being absent, limited domestic abuse risk assessments being carried out in health settings, poor communication between different clinical specialisms dealing with patients experiencing domestic abuse issues with record keeping, IT systems not 'speaking' to each other, and a lack of multi-agency working. Whilst routine enquiry is required whether a victim is male or female, in practice, the question is not always asked and there is no evidence that any health organisation asked this question of Hassan. It is encouraging to note that recent review recommendations have resulted in challenge around inbuilt bias and how male victims of domestic abuse are viewed.

5.1.10 Across Domestic Homicide Reviews, as in Hassan's case, health organisations did not share information and risk assessment did not take place. There is no evidence that Hassan was at risk of domestic abuse, but he was subject to other risks. Had risk information been well coordinated across agencies, he would have been dealt with as an individual by other services, including housing services and Victim Support. This may have impacted on the ability of the multi-agency network to reduce the risk of discriminatory abuse that Hassan was continuously exposed to.

Learning point 1: *information sharing, training, and professional curiosity all impact on how well risk is identified and understood in health contexts.*

5.1.11 Neither Brighton and Hove housing service nor Lewes and Eastbourne housing service held any information which suggested Hassan had previously disclosed domestic abuse. Had Hassan

[4] No Honour in Abuse: Harnessing the Health Service to End Domestic Abuse, Centre for Social Justice 2022
[5] Shifting the Scales; Transforming the Criminal Justice Response to Domestic Abuse, January 2025
[6] HALT Study, December 2023

continued to disclose about the experiences of domestic abuse to the housing services, this may have triggered a duty under the Domestic Abuse Act 2021 to house Hassan as an individual. His homeless application was based on discriminatory abuse and was in his partner's name, with Hassan as a member of the household. This meant that all correspondence with Hassan was with Hassan's partner first and foremost. Offers of emergency accommodation were sent to Hassan's partner alone to either accept or reject. Had Hassan spoken about domestic abuse at this stage, it is possible that an offer of accommodation may have been made to Hassan in his own right, regardless of the level of risk, if he had agreed to reside without his partner. The housing association considered Hassan to be connected to a tenant of theirs and had no direct contact with Hassan himself. Had this information been known to the housing provider, this would have allowed for that service also to have had direct contact with Hassan.

5.1.12 The second concern had been reported by the time of the 2022 Hate and Anti-Social Behaviour Risk Assessment Conference (HASBRAC) meeting. The police HASBRAC referral was clear that Hassan had thought his partner wanted to kill him, that he no longer wanted to talk to her and did not trust her. However, this meeting focused on the escalation of events around the racial abuse and there is no evidence that the issue of domestic abuse was considered in any depth. This meeting was an environment in which professionals could have become increasingly curious about Hassan and his lived experience. If the disclosures around domestic abuse had been discussed, this would have opened the door for Hassan to be treated as an individual and opportunities could have been explored to further the conversation with him around his relationship. As a Pakistani male, there should have been consideration to who might be the best person to respond. A trusted professional or a local community group may have supported the ongoing dialogue and considered with Hassan how he might have communicated about some of his difficulties with his family network.

5.2 Lead professional

5.2.1 Key opportunities for safeguarding referrals to have been made were missed, including following the Hate and Anti-Social Behaviour Risk Assessment Conference (HASBRAC) meetings. This review has reflected on why some agencies might not make referrals. Housing services and the housing provider both felt a "sense of security", or an expectation that a statutory agency with access to more information and better resources would lead the process. The mental health trust acknowledged that discriminatory abuse is not yet fully recognised as a category under the Care Act for referral. The Care and Support Statutory Guidance makes it clear that discriminatory abuse is a category of abuse that should be reported. It is common for a person to normalise the abuse they might be subject to day to day,[7] attaching stigma and shame to it and showing reluctance to share with professionals. Once professionals are aware of it, they play a vital role in referring and reporting.

Learning point 2: *Discriminatory abuse is a category for referral under the Care Act 2014.*

5.2.2 It is pleasing to note that work is being undertaken across the partnership to raise awareness of Hate and Anti-Social Behaviour Risk Assessment Conferences (HASBRACs). In Hassan's case, as in the recent case of SAR Henry, this meeting lacked the input of GP's and all relevant health services.

Learning point 3: *Health organisations should be invited to, and prioritise attendance at, Hate and Anti-Social Behaviour Risk Assessment Conferences.*

5.2.3 This review has found that prior to 2022, Hassan was able to freely circulate in the community, work, and support his partner. However, in 2022 there came a point where risks escalated and Hassan's exposure to discriminatory abuse significantly increased. Hassan's neighbour, also of Asian ethnicity and thus sharing similar characteristics, moved away. The attention of this abuser and to Hassan and

[7] Karl Mason, Research in Practice 2022

multi-agency responses were required. The housing provider did not have access to Hassan, and his partners consent was needed to speak to him. As such, the housing provider had no tangible responsibility to him and made no real efforts to engage with him. As far as housing services were concerned, Hassan's partner was the main homeless applicant. Opportunities to reverse this arose at the time of the HASBRAC and the potential to make a safeguarding referral. The HASBRAC referral form contained a paragraph outlining Hassan's partner's perspectives and what she wanted. The form also included views taken from Hassan whilst he was in hospital, in addition to the views he had previously expressed about mistrust of his partner. There was a clear role for advocacy to be arranged for Hassan to empower him to clarify his views throughout this traumatic series of events.

5.2.4 Considering the agency reports and the practitioner views, there is evidence of a multi-agency approach to Hassan. Hassan agrees overall, except for the time of his discharge from the specialist unit where he was transferred for burns treatment. This approach relied on the calling of multi-agency meetings and those meetings did not always have the right professionals around the table. The lack of a shared perspective about risk led to agencies responding in different ways and a lack of overarching coordination and planning. Review participants agree that this was the case.

5.2.5 Agencies reflected on practice to understand why this was the case, and there was a view that each agency viewed Hassan with a limited scope which did not prompt a wider viewpoint and they did not see themselves in a lead professional role. Often agencies viewed their own role in a narrow way. They were not all cited on the same information.

5.2.6 This review has considered who may have been the most appropriate person to coordinate multi agency meetings at various points in the scoping period. Whilst there was not a definitive conclusion to that, it was agreed that there was a need to do this due to the general deterioration and increasing risk factors. However, there were also several distinct issues and episodes that could have triggered a multi-agency meeting, such as a Team around the Adult process, when there was clear indication and opportunity to bring agencies together. These are:

- Hassan was a recognised carer for his partner yet he had not received a carers assessment.
- Incidents that led to Hassan's neighbour having to leave appeared to act as a trigger for escalated psychological and physical abuse
- Hassan's disclosure of domestic abuse in the emergency department, if shared, may have changed the outcome of two other risk assessments which considered domestic abuse. Or at least led to him being treated as an individual, not part of a couple, by organisations
- Hassan and his partner were afraid to leave the flat and he was missing mental health appointments from the point of the flammable liquid being found on his car seat
- Re-housing was considered the best way to safeguard Hassan, yet a combination of short-term and long-term options for the couple and Hassan as an individual were not being considered
- Key agencies were not invited to participate in discharge planning
- Hassan's voice was absent from the perspective of some agencies, and understanding how other agencies had gathered his views may have improved the collective appreciation of his perspectives

5.2.7 These arising concerns were all opportunities where agencies could have come together with Hassan, with or without his partner to understand what was happening for them both and how they could be supported with their respective needs. This would also have afforded the opportunity to discuss risk, mental capacity and safeguarding.

5.2.8 The absence of Hassan's voice in the evidence indicates a lack of person-centered planning, and challenges in communication between the services which negatively impacted on identifying the

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appropriate practitioners to include in multi-agency care planning and coordination. The six principles of Adult Safeguarding are therefore not apparently evidenced in a collective way.

5.2.9 Similarly, the findings in this review are also aligned to the thematic areas identified in the National SAR analysis:

- Information sharing and communication
- Coordination of complex, multi-agency cases
- Hospital admission and discharge arrangements
- Professional roles and responsibilities

5.2.10 Considered in the context of multi-agency coordination and identification of a lead professional, is the question of safeguarding action. Individually, practitioners did have worries and concerns about Hassan but the opportunity for collective consideration was missed.

5.2.11 A key question related to risk is whether safeguarding procedures were appropriately used. In this case the risk was around discriminatory abuse as Hassan's physical and mental health was significantly deteriorating, the home conditions had flagged concern on several occasions, and thus a safeguarding referral may have been warranted on more than one occasion.

5.2.12 It should be noted that a safeguarding referral was made when flammable liquid was thrown over Hassan from a balcony. The referral was triaged and the social worker based in Mental Health services who led the response involved Hassan fully in the enquiry and his safeguarding plan. A strength in the response was the integration between adult social care and the mental health trust. Other health organisations were less integrated into the process. The Multi Agency Safeguarding Hub (MASH) model includes police and social care but does not include health organisations. At the time there was no local form of multi-agency risk management framework (MARM) in place, which would have been triggered as the case had been escalated within adult social care. It is pleasing to note that following two recent Safeguarding Adults Reviews, a MARM[8] has now been established in Brighton and Hove.

Learning point 4: *The multi-agency safeguarding hub should include health partners.*

5.2.13 Health professionals play a crucial role in identifying risks and ensuring timely interventions. In Hassan's case he made disclosures in health settings, demonstrating this felt like a safe environment for him.

5.2.14 A second safeguarding referral was made after Hassan sustained second degree burns. Once again, this resulted in integrated working between adult social care and mental health and also many conversations made by individual services with housing. A multi-agency meeting was held on 30.03.2 that was led by the social worker and attended by the Police, Community Safety and Housing Association.

5.2.15 Many agencies expressed their frustration that a multi-agency discharge planning meeting was not convened. However, there was no evidence of escalation nor was a safeguarding concern raised at this time.

5.2.16 Therefore, the ongoing situation as well as some individual key practice episodes were simply not seen collectively through a 'safeguarding lens'.

5.2.17 There was opportunity for agencies to come together much earlier. Some of these are highlighted above. The housing association who had direct contact with only Hassan's partner was reflective at the learning event regarding perceptions across agencies regarding the idea of a lead

[8] Multi Agency Risk Management

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professional being a statutory agency with access to more information. This was a missed opportunity for many agencies to have 'taken a lead'. In particular, the housing association reflected as to whether they could have called a meeting.

5.2.18 This may have been a timely opportunity to have called a 'Team around the Adult' meeting with all agencies involved. This would have facilitated a multi-disciplinary team (MDT) risk assessment and identification of a lead professional. This is important in this case as we know that Hassan was being seen as one of a couple and this was blocking him receiving individual support.

5.2.19 In Hassan's case, more holistic multi agency collaboration and a shared appreciation of risk may have facilitated more support being available for him. However, given that services did not have that wider lens on the reality of his life, some avenues were closed which might have allowed professionals to develop curiosity and creativity.

5.2.20 Collaboration between agencies took place in pockets and approaches to risk contained in the safeguarding adult procedures were not as collaborative as the approaches which are articulated in the multi-agency risk management (MARM) protocol. The different multi-disciplinary team (MDT) opportunities described above would also have triggered the use of the MARM.

5.2.21 There is no evidence of consideration being given to Hassan's family as a potential support network for him. Similarly, other support networks were not identified for him during his increased period of isolation. The multi-agency working that took place was inadequate in terms of risk formulation and there is evidence that the protocols in place should have been facilitated. The Thematic Learning Review in Brighton and also SAR Craig required multi agency safeguarding arrangements in Brighton to develop line with other approaches already in place across Sussex. This review underscores the urgent need for this work to take effect in cases like Hassan's.

Learning point 5: *Risk formulation should take place at a multi-agency level in the established multi agency meetings under relevant protocols.*

5.3 Recognising Hassan as an Individual

5.3.1 Hassan is a 48-year-old male of Pakistani heritage who was residing in a predominantly white area in which racist abuse was a feature perpetrated against neighbours. Hassan's beliefs are that he and his family came here by choice, and he must respect the country he lives in. Hassan recalls his time at university in the UK, commenting 'England is the best country'.

5.3.2 The pressures Hassan was under in addition to the racial abuse he was suffering related to his family. He had endured a difficult divorce and was only being offered limited contact with his children. There were tensions within the community residing in the flats close by, evidenced by the fact that his neighbour was forced to move out because of abuse. He had been accused of sexual assault and had been accused of being a drug dealer. The potential for an Asian male to face discrimination when in relationship with a white female with a disability was a clear risk. There is no evidence in agency recording that Hassan's faith as a Muslim, and the importance of this to him, was considered. This may or may not have been relevant in understanding his lived experience and the sense of isolation he felt. Questions regarding whether he was a practicing Muslim or the potential for a trans racial relationship affecting whether his partner was not accepted by his family if she did not practice the Muslim faith were not considered or asked. His community links had been lost due to the racial abuse but if his prior community links had only been established through his wife these may have potentially been severed upon divorce. These were all important questions to ask to understand his lived experience.

5.3.3 Hassan explained he doesn't tell people what happened due to his own sense of shame about it. He explained 'I don't say the white man burned me. That would generate hate. 98% of the country

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are awesome.' He described his approach would be to 'give that person a chance, they may not have had the same education as me.'

5.3.4 Hassan's mental health assessments were holistic in that they recognised that the abuse he was experiencing played a part in his mental wellbeing. Therefore, treatment was not just about medication, it was about the single outcome being pursued by the entire multi-agency network i.e. sourcing safe, suitable accommodation.

5.3.5 Hassan's first disclosure of domestic abuse in the hospital Accident and Emergency department was not taken seriously. Male victims are less likely to receive follow up and support. In Hassan's case the reports the lack of coordination of risk information did not lead to him being placed at risk of abuse. Hassan was being viewed through the lens of his acute mental presentation and also his repeated retractions. Likewise, if information had been shared he may have been given individual support to pursue housing options in his own right.

5.3.6 Hassan is clear that refusals of offers of housing made were from his partner, not him. Hassan was not born in the UK; he had been given leave to remain. Thus his process of learning the culture of the UK, how police operate and other key systems and structures regarding how to protect himself and receive support would be less well developed than a person who had been born in the UK. He stated, 'My girlfriend is in a wheelchair. You don't want to take the law into your own hands.' Hassan described calling the police after the courtyard incident. He described the results of contacting police as 'big fat zeros'. On another occasion he described being in a train station experiencing being chased by people with beer bottles thrown at him. He remembers falling and then explained 'the next thing I knew I was in a mental institution. I had had a nervous breakdown.' The lived experience of a person suffering this level of abuse and with viewing him though an intersectional lens acknowledging his various identities including his gender, ethnicity and role as a carer do not appear to have provoked curiosity or shaped service design. After enduring these experiences, which were known to agencies, Hassan should have been assessed in his own right rather than being treated as one of a couple.

5.3.7 Lewes and Eastbourne housing services were challenged when it came to sourcing suitable accommodation for the couple. Hassan's partner's need was for accessible and dog-friendly accommodation, Hassan had no particular accommodation requirements. Hassan did not make an application to be housed in his own right. However, agencies who were supporting him in relation to discriminatory abuse had the opportunity to raise a safeguarding referral to encourage him to pursue such an application. Had the housing team been aware that Hassan had previously alleged domestic abuse, they may have considered making an offer of accommodation to Hassan in his own right. There are no guarantees that, had they done so, he would have agreed to reside without his partner at earlier stages of the scoping period. However, he did elect to live alone in Area B after his discharge from the specialist unit where he received treatment for his burns with the objective of being close to his children.

5.3.8 It was not only the nature of the accommodation itself that gave rise to difference between Hassan and his partner. It was the level of presenting risk. Discriminatory abuse is not widely understood.[9] This changed throughout the scoping period, but technically the couple were homeless. There was a reasonable belief of clear and present danger and on an emergency basis a commercial hotel may have been a short-term solution for Hassan. This had been offered to the couple and refused by Hassan's partner.

5.3.9 The 'section 42' enquiry, or the enquiry into the safeguarding referral correctly clarified, recorded and shared the risks Hassan faced from the alleged perpetrator. This is good practice. In assessment, Hassan's partner was considered by Adult Social Care practitioners as assertive. Hassan was

[9] Second national analysis of Safeguarding Adult Reviews: April 2019-March2023, May 2024

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responsible for physical tasks, whilst his partner is the organiser. This dynamic led to a level of co-dependency, which may not have helped Hassan to attend important appointments. Hassan crossed many intersections, including his identity as a person who had been given leave to remain in this country. This may well have led him to be less assertive if he had a lesser understanding of service design and how to access support in the UK than his partner. However, this review notes Hassan's partner interpreted the lack of a suitable housing offer as discrimination. The lack of accessible accommodation nationally amounts to institutional discrimination. [10]

5.3.10 Ethnicity, country of origin, language, religion are some of the protected characteristics that this review recognises in relation to Hassan. He was also a male and a carer in a trans racial relationship. Safeguarding Adults Reviews reveal[11] ethnicity was not recorded in 67% of cases, nationality in 76% of cases, and religion in 96% of cases. The recording of Hassan's ethnicity, religion and language was patchy across agencies. The fact of him having not always lived in the UK and been granted leave to remain here was not widely known or understood. Recording at the GP surgery, within housing and within victim support suggests the fact that Hassan was Muslim, spoke Urdu and was a British Asian were factors. Victim Support allocated a specialist Hate Crime worker to Hassan. This did not trigger referrals to carers hub or UOK, or to consider referral to organisations who support males with their mental health needs. Hassan was 'invisibilised'[12], in that his protected characteristics did not lead to greater curiosity in terms of finding creative ways to promote his wellbeing and decrease his sense of isolation.

5.3.11 Leaders do not always create the correct practice conditions for practitioners to reflect on ways of 'seeing' service users. Lack of recording of heritage, culture, ethnicity, language and belief can call into question level of curiosity services demonstrate about a person's characteristics. "Invisibilisation"[13] is linked to racism and racial bias and results in a person being rendered invisible and, consequently their vulnerability and risk relating to them not receiving the appropriate attention of services. The second national analysis of Safeguarding Adults Review's highlighted the importance of professional curiosity in ensuring circumstances of individuals are explored in detail rather than being taken at face value and encouraged Safeguarding Adults Boards to pay more attention to race and ethnicity, as well as other protected characteristics, in reviews.

5.3.12 Hassan and his partner were presenting to a number of services as a couple. Hassan was facing issues with his mental health and his gender, and race, combined with his partners disability increased his potential for exposure to abuse and to inequalities in the health and safeguarding systems. Furthermore, he was unable to reengage in work due to his sense of isolation. This reduced his ability to make relationships and improve his financial position. As a person educated to Masters level, greater curiosity could have been exercised regarding his aspirations for the future. Hassan faced inequity and barriers to support within the UK combined with isolation and very little in the way of support to improve his circumstances. Hassan spoke several languages and was not in a position to contribute his skills to society or earn a living. Recording was quite generalised by using the term 'Asian', and more specificity would have opened up more avenues to consider how better support could have been offered.

Learning Point 6: *More specific recording regarding a person's protected characteristics and aspects of their many identities would be improved where agencies view individuals through an intersectional lens.*

5.4 Opportunities to respond as the situation deteriorated

[10] House of Commons Levelling Up, Housing and Communities Committee Disabled People in the Housing Sector, 7th report session 2023 -2024

[11] Second national analysis of Safeguarding Adult Reviews: April 2019-March2023, May 2024

[12] Herzog, 2017

[13] Herzog, 2017

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5.4.1 From early on in the scoping period, both Hassan, his partner and the professional network were all agreed that the most effective way to safeguard him was to re-house him. Yet with this as an agreed priority, the system failed to protect Hassan from serious harm.

5.4.2 Legislation relating to Covid-19 significantly reduced the availability of housing options and had a significant impact on opportunities to source accommodation. Professionals stated that there was much effort given to secure accommodation for the couple. Opportunities were limited and Hassan's partner refused some options. Furthermore, the possibility of splitting them temporarily or offering short term options purely for Hassan was not explored.

5.4.3 Lack of appropriate accommodation for people with complex needs is a national concern. The NSPCC[14] reflects a range of issues including challenges around suitable stock. In Hassan's case, a further challenge was that professionals were not in contact with other agencies working with him which did not enable a full awareness on either side of strengths, vulnerabilities and risk factors. [15] This was an issue highlighted by the NSPCC. Most agencies did not have knowledge of the information about the abuse that had been suffered by the neighbour who had been 'driven out'. This was highly relevant to understanding the risk to Hassan.

5.4.4 Professionals acknowledged that it was a significant challenge to establish an effective accommodation plan and source independent accommodation given Hassan's partner's accommodation needs. It was evident from reports that the situation was becoming frustrating. GP, mental health services and adult social care wrote letters in support of the need to re house Hassan on an emergency basis. Housing encouraged the couple to accept a one-bedroom property. Whilst there were a few providers with accessible rooms, the requirement for two bedrooms reduced the pool of availability. Short term accommodation can be sourced by housing providers making spot purchases through commercial hotels. It was hard for Hassan to accept this as his partner would have to manage alone. Hassan was not a person who raised many concerns, and most agencies have reflected that any interactions he had with services were quite sporadic with contact only happening when he was asked to speak with a professional. Professionals generally accepted that within the chronology there had been a professional focus on immediate safeguarding. They reflected that nobody had stepped back and looked long term in respect of how to promote Hassan's wellbeing.

Learning point 7: Safeguarding at a multi-agency level involves not only a focus on immediate risk, but also a need to consider the long-term promotion of a person's wellbeing.

5.4.5 Whilst agencies worked together to identify appropriate housing for the couple, their experience demonstrates the ongoing challenges in relation to identifying suitable housing options for individuals with complex needs, particularly when they are considered to have capacity and are at immediate risk. This is an identified gap in services and commissioning, and sourcing appropriate housing for vulnerable groups

Learning point 8: *Regular safeguarding and housing partnership meetings improve access to information needed to safeguard vulnerable and marginalised groups.*

5.4.6 Hassan had particular needs as a carer, a potential victim and an individual with mental health needs who was isolated within the community. Support to manage the situation and fulfil his caring obligations whilst he waited and was housebound due to risk was not considered creatively.

[14] An independent review of children's social care in England - https://childrenssocialcare.independent-review.uk/

[15] Housing: learning from case reviews, April 2025

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Understanding more about his journey since being given indefinite leave to remain in 2009, having accessed a university education. Discussing whether his family based in another area could be contacted to improve his sense of isolation or whether any groups or organisations locally could offer support would all have been an important part of preventing any further relapses in Hassan's mental health requiring further periods of hospitalization

5.5 Escalation

5.5.1 Hassan was upset when recounting his experience of leaving hospital after he sustained burns to his arm. He said 'the hospital was desperate to discharge me. Lewes sorted accommodation, but I was outside the Council House with a suitcase and the person was not there. My arm was grafted and I had stitches. The lady was openly racist in front of the police officer [he named the officer], they threw me out in the rain, then put me on a train to (Area A). They said go to (Area B) and show them this email. In (Area B) they didn't know me. I was then back in hospital in so much pain when they removed the bandage. I had taken morphine which wiped out my memory.'

5.5.2 Discharge planning, upon Hassan's planned move from the specialist unit at the hospital where he received treatment for his burns was a matter of frustration for a number of agencies. The specialist unit's approach was to initiate contact with the housing team and conduct an internal multi-disciplinary team meeting, which included the discharge coordinator, therapy consultant and nursing team. The unit reflected that they did not see referrals as necessary as they felt that they were in contact with relevant agencies constantly. Housing agreed that many discussions took place. It was open to any agency to escalate the lack of discharge planning meeting under the relevant pan-Sussex protocol. Hassan was medically ready for discharge for some time before he left. This was permitted whilst accommodation options were explored and he had formulated a clear plan.

5.5.3 To summarise, the concerns expressed about the process of discharging Hassan from the specialist Unit were as follows:

Adult Social care had provided extensive information on the relevant safeguarding concerns to nurses in the specialist unit as well as to the relevant discharge coordinator. Despite this, Hassan was discharged from there without Adult Social Care being notified and Adult Social Care only discovered he was discharged because Hassan notified the police, who then notified Adult Social Care.

Adult Social Care then requested a discharge summary because they were concerned that Hassan might need care because of his physical injuries. The hospital advised no specific care was required, but it was noted by two attendees at the event that Hassan then ended up presenting to the emergency department twice not long following his discharge.

The Housing department in the neighbouring authority to area A advised they were not aware of Hassan's discharge until he presented at their offices.

5.5.4 Safeguarding Hassan required a multi-agency approach to ensure that he was discharged in a safe and supported way, and at the right time. The British medical journal[16] produced helpful guidance information about discharge planning that dates back to 2008.

It asserts that:

- Discharge planning aims to improve the coordination of services and care after a patient's discharge

[16] BMJ 2008;337:a2694 available at http://www.bmj.com/content/337/bmj.a2694 Accessed 15 December 2017

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- Good planning requires anticipation of potential problems by good information gathering, early resolution of potential barriers to discharge, and timely referral to the multidisciplinary team
- Planning involves close collaboration between the patient, the family, and the multidisciplinary team; this leads to improved patient and carer satisfaction

Due to the number of patient safety incidents, NHS England issued a patient safety alert in August 2014[17] that cited concerns as follows:

Review of these incidents identified that patients are sometimes discharged without adequate and timely communication of essential information at point of handover to all relevant staff and teams in primary and social care, including out of hours, and that information is not always acted on in a timely manner. This can result in avoidable death and serious harm to patients due to a failure in continuity of care as well as avoidable readmission to secondary care.

5.5.5 Whilst Hassan's experience did not contribute to the harm he suffered as a result of discriminatory abuse, he does want answers and the agencies themselves are frustrated at the system's inability to provide protection to him at this time. It is the coordination of the discharge process that requires further analysis. If any professional was concerned there was an opportunity to escalate concerns but this was not followed up.

5.5.6 There was a focus on hate crime, and safeguarding had become secondary to that. This review recognizes strong practice in relation to the response to hate crime and agencies' recognition of discriminatory abuse. However, there is a sense that safeguarding had become secondary to that focus. There was an opportunity to make a safeguarding referral based on discriminatory abuse and there was an opportunity to escalate at any point when professionals were frustrated by the lack of accommodation provision or the lack of a multi-agency discharge planning meeting. Cross boundary issues impacted in that it was hard to involve the correct agencies in discharge as they were out of area.

5.5.7 There was confusion as to whether Hassan's family in area B could be involved / consulted / relied upon to support discharge planning.

Learning point 9: *Complex discharge planning should always include a multi-agency meeting.*

5.5.8 It does not appear that suitability of the property that Hassan was moving to was considered between agencies who understood his injuries or the proximity of key family members or friends. There was an option for housing to discharge Hassan into accommodation locally, at least in the short time whilst he fully recovered. What happened was that he encountered a lengthy train journey to reach his destination at a time when he was still feeling unwell. A multi-agency meeting would have allowed time and space for all professionals to reflect on the best course of action. Not all professionals were sensitive to the amount of pain Hassan was suffering and this discussion would have helped.

Learning point 10: *Safeguarding training should be updated since the second analysis of safeguarding adults reviews to raise awareness of discriminatory abuse as a trigger for a safeguarding referral.*

[17] NHS England (2014) Patient Safety Alert: Risks arising from breakdown and failure to act on communication during handover at the time of discharge from secondary care available at https://www.england.nhs.uk/wp-content/uploads/2014/08/psa-imp-saf-of-discharge.pdf accessed 15 December 2017

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5.5.9 Hassan was not vociferous in raising concerns during the scoping period. His voice was not heard during discharge planning. It is a strength that adult social care used the escalation process several times regarding lack of housing provision and communication. However, the multi-agency network did not have the option to offer a joined-up response. It is pleasing to note that the specialist treatment unit has established a new complex discharge checklist which includes multi-agency discharge planning.

6. STRONG PRACTICE

6.1 The transfer of care from Hassan's GP surgery in Brighton and Hove to the Area B surgery was undertaken electronically and worked well.

6.2 There was also good transfer of care between Adult Social Care in Brighton and Hove and Area B, with the Section 42 safeguarding enquiry open until there was a formal handover meeting with the safeguarding lead in Area B. Adult Social Care also liaised with support workers based in the Area B homeless hostel that Hassan was accommodated in to provide relevant information about his circumstances and to and outline where he might particularly require support.

6.3 The GP demonstrated good practice by following up with Hassan when he did not attend appointments after what was described as his 'psychotic episode'. The practice was also diligent in ensuring they heard Hassan's voice rather than just speaking through his partner.

6.4 Hassan fed back that the support he received from Victim Support was meaningful for him. He was supported by a specialist worker by this service, who understood his cultural needs.

6.5 Mental health services visited Hassan at the specialist treatment unit after he had his surgery and supported him throughout his move to area B

7. IMPROVEMENTS ALREADY IMPLEMENTED

7.1 Moat Hosing have recruited a permanent tenancy specialist team to oversee serious and complex cases and mandatory monthly anti-social behaviour case reviews are now conducted by a manager. Their anti-social behaviour policy and procedure now has a distinct hate incident policy and procedure. A hate crime ambassador training has been delivered across customer facing departments facilitated by the police. A new role of Priority Moves Manager has been created to prioritise internal moves for service users for whom it is safe to continue to reside in their homes.

7.2 A complex discharge checklist to include multi-agency engagement is being used by the specialist treatment unit.

7.3 The GP surgery now codes and flags domestic abuse disclosures under the "safeguarding relevant" node and all safeguarding relevant information is added when received or disclosed.

7.4 The Integrated Care Board has undertaken actions to increase independent domestic abuse advocacy services within health services locally. Further consideration should be given to exploring existing resources available elsewhere that could be used to support the identification of domestic abuse more broadly, including male victims.

7.5 As a result of a recommendation from a Safeguarding Adults Review a MARM framework pilot was established in 2024. Monthly meetings now take place, chaired by Adult Social Care.

7. 6 Safeguarding Adults Reviews locally have generated recommendations about the lead professional role. The pan-Sussex Safeguarding Adult policy and procedures now include the lead professional role. Updates have been offered to highlight the importance of this.

8. LESSONS LEARNT

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8.1 ***Learning point 1:*** *information sharing, training, and professional curiosity all impact on how well risk is identified and understood in health contexts.*

8.2 ***Learning point 2:*** *Discriminatory abuse is a category for referral under the Care Act 2014.*

8.2 ***Learning point 3:*** *Health organisations should be invited to, and prioritise attendance at, Hate and Anti-Social Behaviour Risk Assessment Conferences.*

8.3 ***Learning point 4:*** *The multi-agency safeguarding hub should include health partners.*

8.4 **Learning point 5:** *Risk formulation should take place at a multi-agency level in the established multi-agency meetings under relevant protocols.*

8.5 ***Learning Point 6:*** *More specific recording regarding a person's protected characteristics and aspects of their many identities would be improved where agencies view individuals through an intersectional lens.*

8.6 **Learning point 7:** *Safeguarding at a multi-agency level involves not only a focus on immediate risk, but also a need to consider the long-term promotion of a person's wellbeing.*

8.7 ***Learning point 8:*** *Regular safeguarding and housing partnership meetings improve access to information needed to safeguard vulnerable and marginalised groups.*

8.8 ***Learning point 9:*** *Complex discharge planning should always include a multi-agency meeting.*

8.9 ***Learning point 10:*** *Safeguarding training should be updated since the second analysis of safeguarding adults reviews to raise awareness of discriminatory abuse as a trigger for a safeguarding referral.*

9. CONCLUSIONS

9.1 Hassan made separate disclosures regarding domestic abuse to the emergency department, the police, and his GP. He did not access a service of any kind as a result of his disclosures. Whilst he does not recollect these, and considers they were due to his mental health at that time, both identification of domestic abuse and links with a service are compromised for male victims, who can be overlooked. In Hassan's case risk information was not shared resulting in each disclosure being considered in isolation. Not only was a holistic approach not taken to the three disclosures but routine enquiry was not offered. Importantly, Hassan's housing need would have been considered differently with him being communicated with as an individual and under the duty to house under the Domestic Abuse Act 2021. Hate and anti-social behaviour risk assessment conferences (HASBRAC) did not invite health professionals and did not consider or discuss the disclosures around domestic abuse. Had more curiosity been exercised within the HASBRAC process regarding Hassan's protected characteristics, he may have been considered for extra support during his period of isolation, perhaps from a trusted professional, a local community group or consideration being given to communication with his family network.

9.2 Opportunities to make a safeguarding referral were missed, particularly given that discriminatory abuse placed Hassan at high risk. As his exposure to discriminatory abuse increased there was an increasing need for a multi-agency response.

9.3 When Hassan was discharged from the specialist unit where he received treatment for his burns, a multi-agency discharge planning meeting was not convened. Hassan was left to embark on a train journey to Area A in which accommodation was not in place for him whilst recovering from his injuries. Hassan, as a Pakastani male who had been given leave to remain in 2009, was in a trans racial relationship with a disabled partner. He was located some distance from his family and was

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isolated by virtue of the discriminatory abuse he had faced within his local community. Hassan had suffered with mental health conditions and had endured abuse to his dog. Recording regarding Hassan's ethnicity, religion and language was patchy which calls into question the level of curiosity services demonstrated about his characteristics. His vulnerability and risk relating to him increased as a result of not only risks within his environment escalating, but also the lack of 'voice' that was heard by agencies who had contact only with his partner.

9.4 Significant frustrations regarding Hassan's experience of discharge processes were expressed by professionals as part of this review process. There are a number of services attempting to offer a compassionate approach and largely seeing 'housing' as the problem. However, it was open to agencies to make a safeguarding referral at numerous points throughout the scoping period on the grounds of discriminatory abuse. This route seemed like the most effective one to safeguard Hassan and instigate a multi-agency approach.

10. RECOMMENDATIONS

Recommendation 1

Brighton & Hove Safeguarding Adults Board should raise awareness of discriminatory abuse as a ground for a safeguarding referral.

Recommendation 2

Brighton & Hove Safeguarding Adults Board should seek assurance that partners domestic abuse training provision supports professionals with identification of and response to domestic abuse of male victims. An example is that offered by the Violence Against Women and Girls Unit.

Recommendation 3

Brighton & Hove Safeguarding Adults Board should seek assurance regarding the process of invitations to Hate & Anti-Social Behaviour Risk Management Conferences [HASBRACs], with a view to ensuring health organisations are routinely invited. The Board should raise awareness about the importance of these conferences in identifying and responding to domestic abuse.

Recommendation 4

Brighton & Hove Safeguarding Adults Board should support professionals to assume the lead professional role with confidence and clarity, rather than assuming for example, that another service Is more likely to or better placed to undertake this.

Recommendation 5

Brighton & Hove Safeguarding Adults Board should undertake promotional activities and develop resources to improve knowledge and understanding of practicing intersectionality in adult safeguarding. This needs to reinforce the importance of thorough recording regarding protected characteristics.

Recommendation 6

The three statutory partners of the Brighton and Hove Safeguarding Adults Board should work together to continue to develop multi-agency safeguarding arrangements, focusing on the inclusion of health advice and expertise into adult Multi-Agency Safeguarding Hub (MASH) processes. This should focus on virtual communication and information-sharing arrangements, with assurance provided to the board on specific actions taken.

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