2020

Stella Maris Inquiry

Anthony Douglas CBE

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STELLA MARIS INQUIRY

TERMS OF REFERENCE AND METHODOLOGY

I was commissioned by the Chief Executive of Suffolk County Council to undertake an independent inquiry into the matters set out below.

Terms of Reference

The purpose of the inquiry is to review the events at Stella Maris over a period of some 18 months, given the level of concern being expressed by a number of individuals and agencies which makes this a matter of public interest. The priorities of the inquiry will be as follows:

1. To establish a chronology of relevant facts, incidents and processes – 'the Stella Maris chronology'

2. To understand the daily lived experience of the tenants during the period under review

3. To understand the daily lived experience of the residents during the period under review

4. To investigate the actions of all professionals from a lessons-learnt perspective

5. To make findings and recommendations covering all levels i.e., individual agency practice, multi-agency practice, national policy (where relevant)

Methodology

1. To meet with the tenants concerned (with their support worker/social worker/care manager)

2. To meet with the residents concerned

3. To meet with the lead professionals involved

4. To meet with the politicians involved

5. To examine the relevant records held by each agency involved

6. Finally, to meet with the senior managers of those agencies where there are clear lessons to be learnt

STRUCTURE OF MY REPORT

1. My report complies with my Terms of Reference. In carrying out my Inquiry, I met with all of the key individuals concerned and scrutinised a sample of relevant records, sufficient to ensure I understood what happened. This became like 'peeling an onion'. I am grateful for the co-operation I received from all agencies involved which showed open government and a determination to raise standards where this is needed. I would especially like to thank the tenants of the Stella Maris Flats and local residents who spoke candidly about distressing issues for them personally in the hope that others will not have to go through a similar set of circumstances.

THE CONTEXT IN 2020 FOR SUPPORTED LIVING SERVICES IN THE UK

2. Since the 1970's, people with mental health problems, learning disabilities and autism have been supported to live normal lives in local communities, to avoid some of the degrading outcomes they faced in some long-stay hospitals and residential 'warehouses' before then. This policy of 'care in the community' has been underpinned by a raft of legislation and government policy. It is the law, not an option. From time to time, flashpoints in the community occur, but the risks and the number of high-risk incidents are far less than they were for vulnerable people who lived inside 'total institutions'. Most of those abuses were not reported, hence the importance of shining a light on the risks to vulnerable people living in the community and 'keeping the lights on'.

3. Over the last fifty years, models of care and intervention have been transformed for the better. Person-centred care culminating in the comprehensive assessments of need required under the Care Act 2014 is the diametrical opposite of regimes before the 1970's which history has shown left many individuals with their needs unmet. All too frequently, they were abused or neglected back then. Caring for vulnerable people to a high standard is a sign of a civilised society and of a local civic society which produces community benefit by prioritising social need alongside other important objectives like education and economic regeneration.

4. A great number of individuals with complex needs are being supported in local communities throughout Suffolk. In general, the process of integration and re-integration has gone well. Vulnerable people have benefited from being able to live in the same way as everyone else without restriction. The support being given to vulnerable people in Suffolk is impressive, despite rising demand and financial constraints.

5. Supported living environments have also been transformed from the days when a single warden lived on site to where teams of care and support workers look after individual tenants and groups of tenants as a whole. As a young practitioner, I saw many wardens back in the day struggle to cope with increasing demands on them because the needs of tenants were becoming ever more complex. That tension is still with us today.

6. We face a serious shortage of suitable placements for vulnerable people with extra care needs, especially when they lead chaotic lifestyles caused by past trauma or if they have a lifetime condition which makes daily life a struggle. The tenants at Stella Maris fell into these categories. The shortage of more suitable facilities led to them being grouped together in a supported housing complex which ultimately proved unable to meet their needs. This shortage of placements needs rectifying by putting in place a separate commissioning strategy for this group. Having said that, I found no concerns about the level of funding for any of the individual tenants at Stella Maris. In fact, no expense was spared. If I have a concern it is that some of the care given to the tenants did not represent value for money for those paying for it or for those receiving it.

EXECUTIVE SUMMARY

7. The service for tenants with complex needs and chaotic lifestyles at the Stella Maris supported living scheme was set up in December 2018 without sufficient due diligence and scenario planning. The needs of some tenants far exceeded the capacity and capability of the care service that was commissioned to look after them. The housing application process was poorly administered by the spot purchasers, the care providers and by the housing association. Licence agreements would have been more appropriate for some tenants. Instead they were given assured shorthold tenancies they did not for the most part understand. Mental Capacity Assessments were not carried out and should have been. Subsequent housing management visits by the housing association were ineffective. The mix and compatibility of the tenants nominated was insufficiently considered by all concerned, partly through a lack of information sharing. Responsibility for making the placements and monitoring the outcomes rested with individual lead professionals and was not co-ordinated well in the crucial first year of the service. The level of care provided to some individuals fell short of what they needed. Skilled therapeutic support delivered through stable relationships with firm boundaries in place was needed. The environment did not allow for that. The contracts in place for care provision were too general and vague and they were not monitored well by the contracts team in Suffolk County Council.

8. In the eighteen months after the service started, none of the agencies involved communicated adequately with local residents as the situation on the ground deteriorated with noise nuisance and anti-social behaviour becoming endemic. The countless calls for help from residents and from tenants themselves and the numerous escalations from the care provider and the local environmental protection service to the statutory health and social care agencies were not responded to in a way which led to change. Shortfalls in communication and multi-agency working led to a lack of coherent planning and over-use of the emergency services. Professionals went their own way, acting independently of each other and responding to the immediate problem in front of them without seeing the bigger picture. The tenants and the residents were 'hidden in plain sight'. In the end, after months of feeling not listened to, the residents contacted a county councillor and then the local media which finally led to action being taken.

9. No joint strategy was developed between those agencies responding to the situation as a community hot spot and those agencies providing or co-ordinating care to individual tenants. The situation cried out for a senior leader to co-ordinate the response to the situation at Stella Maris but this only happened when the situation was escalated to a senior level in Suffolk County Council by a local councillor. This was in June 2020, more than a year after the significant problems began. Until then, the situation was not brought to the attention of senior leaders by front line staff in their own organisations. There was no line of sight between the top of organisations at both the political and professional levels and their front line staff. This is partly explained by not all front line staff knowing about the severity of the situation unless it applied to the individual tenant they were supporting. The care agency on the ground, Swanton Care and Community, did repeatedly escalate the bigger picture and the worsening situation to the county council as did the environmental protection service in Babergh District Council but their efforts largely fell on deaf ears. When it finally reached their attention, senior leaders took effective action, though this was still hampered by continuing difficulties in working together (see the senior manager's story in paragraph 118).

10. The prolonged lack of action has had a cumulative impact for the worse on some individual tenants, residents and care staff. Some tenants were forced to survive in a chaotic environment before finally being moved. Local residents have lost trust and confidence in the care provider and in most other agencies apart from the emergency services. Restorative measures are needed for community relations to recover.

11. A new service at Stella Maris should be commissioned as a matter of urgency so that this crucial provision for vulnerable people is not lost to Suffolk whilst ensuring those who live there are a better fit with each other and with the local community. Any existing tenant who is settled at Stella Maris should be allowed to remain there. That is a basic human right. The numerous mistakes made in setting up the current service must be learnt and applied when the next group of tenants are nominated. This process will need the oversight that was missing before.

12. I do not think the supported living scheme at Stella Maris should be closed. People with a need for supported housing and supported living have the same rights to live in a community as anyone else. There is nothing wrong with the principle behind the scheme and service at Stella Maris. It was the way it was set up, run and responded to that was

the problem. My view is that Stella Maris should remain open for a group of tenants with an enduring need for care and support but whose lifestyles are not chaotic.

13. Stella Maris was not a care home. Care homes are regulated and inspected through a legislative framework. Whilst the Regulator of Social Housing had oversight of the Housing Association involved, they had no locus with how the service operated on the ground day to day. The absence of regulatory oversight with teeth came to matter. This is an important check and balance when things start to go wrong in an establishment. None of the tenants had an independent advocate. They were wholly dependent on the mainstream agencies. I make recommendations about how the lack of external regulation and oversight can be compensated for by the mainstream agencies in Suffolk working more effectively together. If this had happened, external regulation would not have mattered so much.

14. My recommendations extend to the establishment of all new supported housing developments and supported living environments in Suffolk in the future. Such provision is hugely important for vulnerable people. Demand outstrips supply so nothing must be done to compromise the right kind of supply. However, vulnerable people and local residents need a transformed public service compared to the one they received at Stella Maris.

THE CHRONOLOGY

The developer, the landlord and the care provider

15. The Stella Maris flats are situated on the corner of Hadleigh Road and Stella Maris on the outskirts of Ipswich in the district of Babergh. Built in the 1970's as a 2 storey block of 4 flats with off street parking, the flats were extended at the turn of the century to become 9 flats. Planning Applications were made to Babergh District Council for the refurbishment of the flats: the erection of a second floor and a three storey extension to provide 5 additional flats; and the construction of 15 car parking spaces. The necessary approvals were given and the works were completed. The October 2002 application was the last planning application made in respect of the Flats. The flats were privately rented from 2002 through until October 2018 when all of the existing tenants at the time moved out and the new supported living service was developed.

16. Mention was made by the care provider at the flats, Swanton Care, that some local residents were hostile towards the tenants who moved out, who were said to be from Eastern Europe. I have found no evidence of this or of 'nimbyism'. In my dealings with them, I found the residents to be generally supportive of vulnerable people living in their midst as long as they were adequately cared for and as long as the scheme did not unduly disrupt their day to day lives or lower their property values. These are reasonable expectations.

17. In June 2018, Suffolk County Council approached Swanton Care asking them to come into the county as a new provider. They had been impressed by Swanton Care's services in Norfolk, especially Treeview Court in Norwich in which a number of Suffolk residents with complex needs had been placed successfully. Swanton Care's CQC reports are on the whole good with a regular finding about the caring attitude of staff in all of their settings. Swanton Care have a good relationship with Norfolk County Council. Suffolk wished to build more placement capacity in the county, especially for 16-35 year olds, so they asked Swanton Care if they would come into the county to develop a facility like Treeview Court but on a smaller scale. Of the development partners Swanton Care approached, only Minster Developments came up with options, two in fact, one of them being at Stella Maris. Swanton Care then brought this development opportunity to Inclusion Housing, a not-for-profit social housing landlord specialising in supported housing and living schemes. Inclusion Housing are a Registered Housing Provider as defined by s80 of the Housing and Regeneration Act 2008. Swanton Care and Minster Developments had worked with Inclusion Housing on a scheme in Telford.

18. In June 2018, Inclusion Housing's Board gave the development the go-ahead, subject to due diligence. In July, the Inclusion Housing Team inspected the property and agreed a schedule of works (18th July 2018). Their due diligence process had 3 strands: – their property team agreed the schedule of works required (18/7/18): a Housing Benefit rent test was carried out with Suffolk County Council (30/7/18); and legal due diligence took place.

19. Minster Developments acquired an interest in the property through a property lease in August 2018 into which Inclusion Housing were added. The vendor then allowed Minster Developments to start the upgrade programme. Once all the existing tenants had vacated the property, which was dealt with by the vendor's agent, the property was sold to Triple Point Real Estate Investment Trust (TP REIT PROPCO 2 Limited) on the 18th December 2018.

20. On the same day, Inclusion Housing completed a 20 year lease agreement with Triple Point and Swanton Care signed a service level agreement with Inclusion Housing. The next day, on 19 December 2018, the first 5 tenants moved in. Each tenant had an assured short-hold tenancy. The project had been due to open in September but project challenges meant this was delayed. To their credit, Inclusion Housing and Swanton Care made great efforts to ensure the new tenants could move into their new home before Christmas. This was important as they had been waiting for 3 months.

21. Triple Point Real Estate Investment Trust (TP REIT PROPCO 2 Limited) is a property company which is publicly quoted on the Stock Exchange. They bring long-term capital into the specialist social housing market where a return on investment can be delivered over a long period of time.

22. Swanton Care were awarded nomination rights to all 8 flats for 5 years without a break clause. The ninth flat was used as their base and office. Swanton Care were the point of contact for nominations to the service which they then passed on to Inclusion Housing who had the authority to grant an individual tenancy. Whilst the service was set up in the expectation Suffolk County Council would nominate tenants, it is possible for any public body to nominate an individual to such a service e.g., another local authority or another NHS Trust from out of area.

23. One of the allegations or rumours circulating in the local community is that the businesses shared Directors, so they question the separation of powers and think there might be a conflict of interest. I found no links between any of the Directors or Boards of Inclusion Housing and Swanton Care.

24. Most new supported living developments are started by social landlords who own the freehold to properties so as to be in a position to protect tenants from undue future upheaval. This is especially important for vulnerable tenants who often need a 'home for life' with long-term security. In the same way that being excluded from school and living completely outside of any formal education correlates with a far greater risk of youth offending and eventual unemployment, so the lack of secure housing equates with a much higher risk of needing care in one sort of institution or another as a vulnerable adult.

25. Inclusion Housing operate a 'lease-based model'. They signed a 20 year lease for the 9 flats at Stella Maris. Inclusion was warned by the Regulator of Social Housing (RSH) as early as 2015 that they ran the risk of insolvency, admittedly when they were a much smaller housing association with fewer than one thousand homes – they now have more than two thousand. In February 2019, the Regulator gave Inclusion Housing a G3/V3 rating, which means they were failing to meet governance and financial viability standards and were judged to be non-compliant. Inclusion Housing appealed to the High Court to overturn this rating but the High Court rejected their appeal and supported the Regulator's current assessment that a business model based on leasing properties from investment funds carries too much financial risk.

Due diligence

26. The fact that the landlord of the Stella Maris Flats is deemed by their Regulator to be non-compliant appears to have escaped any due diligence process, certainly by the contracts team at Suffolk County Council. Purchasers and commissioners should be on the look-out for issues like this when endorsing proposed new schemes and should be reviewing the situation when circumstances change materially. The key point here is that the property can be sold on by Triple Point if it ceases to provide the expected return on investment. Whilst this should not jeopardise the future stability and security of the tenants living there at the time, because they are protected by a 20 year lease even if the freeholder changes, it is an intrinsic risk. Triple Point say their objective is to keep the properties they own in the social housing sector over the long-term and that if a leaseholder like Inclusion Housing requests to extend their lease, they are given a legal option to do so. Inclusion Housing say there are no risk crystallisations for them at the moment or in the foreseeable future. They say that they continue to strengthen as a business. In their defence, the Regulator of Social Housing finds Inclusion Housing to be a lease-based provider that generally runs its business better than most, though it should be said that there are a number of such (lease-based) organisations who are still compliant with the Regulator's standards.

27. Lease-based schemes use a high-rent model. It becomes viable for the investors behind the scheme because tenants with mental health problems, learning disabilities and/or autism command a level of housing benefit that is not limited by restrictions on the benefits that can be claimed. One of the many criticisms of this business model is that because rents are high to meet the repayment requirements of the investors, this acts as a disincentive for the tenants to work because if they do, they will no longer be exempt from the benefits cap. A very high proportion of their income will then go into paying their rent, possibly triggering debt. The benefits cap may be only part of the story. Exempt specialised supported housing is not just exempt from the benefits cap, but also Local Housing Allowance (LHA) rates.

28. My view of this set up period and process is that in the second half of 2018, Suffolk County Council should have initiated their own due diligence process about the desirability and viability of the scheme and of the businesses involved. This should have led to more thought about how the service would operate rather than just to say it was needed and that it would nominate individuals to the service. Had they inquired, they would have considered whether a lease-based model of supported housing offered enough security to vulnerable tenants. They also made no attempt to run a tendering process or to ask searching questions of Swanton Care, including the strengths of their proposed staff group in relation to the likely type of nominations. Setting up a new service in a new county can be difficult as there is no ready-made workforce and no history of working within the Suffolk system and what that entails. The absence of scrutiny is regrettable as both Inclusion Housing and Swanton Care were responding to a clearly identified need.

<u>Recommendation 1</u>: That Suffolk County Council strengthens its Service Development and Contracts function, with a clear process for due diligence before a new scheme opens in the county. A more robust due diligence process would have picked up the concerns of the Regulator of Social Housing about Inclusion Housing, although Inclusion Housing should have told Suffolk County Council about their pending High Court judgment. Within the Contracts function and within Suffolk County Council as a whole, a knowledge of the needs of vulnerable children and adults and where the gaps are is essential so that contract drafting and monitoring protects the needs of vulnerable people.

Regulation and oversight

29. I have heard it said that Suffolk has over 240 supported living schemes operating in the county and that there are no problems with any of them apart from at Stella Maris. However, senior leaders were not aware of the problems at Stella Maris until June 2020 so there is no way of knowing about the safety and quality of the other 200+ schemes. Supported living schemes should not be a Cinderella service for regulation, wholly dependent on self-regulation.

30. Whilst the Regulator of Social Housing frowns upon lease-based schemes, it has limited enforcement powers when it comes to protecting tenants. It has recently used its statutory appointment powers to appoint 3 housing association Chief Executives onto the Board of Prospect Housing, a lease-based provider that was given a non-compliant rating earlier in 2020 for 'serious regulatory concerns'. Whilst legislation is expected in this Parliament to strengthen their remit, the Regulator mostly carries out paper reviews of the performance of Registered Providers (RP's) like Inclusion Housing by scrutinising their accounts and cashflow and carrying out some other checks. This lack of on-the-ground inspection and regulation extends to the care of tenants. The Care Quality Commission is the independent regulator of all health and adult social care in England. It regulates hospitals, GP's, doctors and care homes. It has no remit at Stella Maris as no tenant is receiving personal care, which is the only legal basis for their involvement. It was thought one tenant was receiving personal care when they went there in December 2018. However, the CQC now takes the view that the tenant in question is not receiving personal care as he is only being 'guided, prompted and motivated'. Legally, the CQC cannot report on anything unconnected to a regulated activity, even if they know much is wrong with a service.

31. A lack of inspection and regulation of supported living services means that some schemes and services can escape rigorous scrutiny throughout their lifetime. Some of the most vulnerable people in Suffolk are tenants or licensees in these schemes. This is a comment about the system, not any particular inspection or regulating agency. To their credit, Swanton Care registered with the CQC in July 2019 as a service team, even though their registration is now dormant as they are not providing a regulated activity - it can be activated again if in the future they provide personal care to at least one person. Directly because of this gap in oversight, I think that a greater regulatory oversight should be exercised by local commissioning agencies as part of their commissioning and contracting process. To do this properly will require new investment. Every provider should have their own contract manager.

32. Without this becoming unduly burdensome, I think that an annual multi-agency review of supported living schemes in the county should be put in place. Many schemes and services will already have a review process in place. If this is the case, the annual county-wide process should quality assure that first process, not duplicate it. At present, the biggest risk is that whilst multi-agency Panels including housing providers work on placement-finding, once someone is funded and living in a scheme they can too easily be forgotten. This happened at Stella Maris as reviews of jointly funded individuals were not completed within agreed times frames. The quality of the proformas completed was also not reviewed. Regular reviews are crucial as people's circumstances are not static and can change quickly. I am also worried that professionals who go into supported living schemes are usually going in to see one person. The risk is that they never see what is going on in the scheme or the service as a whole.

Recommendation 2: That a light-touch annual review of supported living schemes in the county takes place, properly funded and co-ordinated by Suffolk County Council (probably by the Review and Audit Team in ACS) but including housing authorities, housing and care providers and agencies such as the police so that the available information during the course of the year is collected, collated and analysed. The Service Development and Contracting Team in the County Council should co-ordinate this process, provide reviewers with a short analytical template, provide support and ensure that reviews are carried out.

Recommendation 3: Funding panels should ensure that the appropriateness of individual placements and continued funding commitments are reviewed on a regular basis.

Planning issues

33. An assumption was made by Minster Developments and Inclusion Housing as the leaseholder that no planning application was needed in respect of the Stella Maris Flats because the change of use was within a 'use class' (Category C, specifically C3b). A 'change of use' can occur within the same use class or from one use class to another. As the flats continued to be privately rented, they thought the change in the profile of tenants was not significant in planning terms. As a result, Babergh District Council, the planning authority, were not approached formally about the development through a pre-application planning request. Their current pre-application planning process was introduced in July 2017 as a chargeable service. They have no records of any request in respect of Stella Maris, hence they provided no advice.

34. It is not unusual for scheme operators to proceed either based on their own understanding of planning or with their own professional advice. However, there is a strong possibility that the development did require planning consent, either within the C3 use class or that the change of use moved the development into D1 (non-residential institutions). Babergh District Council are investigating this in order to determine if any breach of planning legislation occurred. If they find this is the case, a planning application

will be needed. Whilst it is not illegal to break planning law, a planning authority does have enforcement powers, although these can take time. Any breach and any enforcement activity arising from such a possible breach will turn on the detailed facts of this case and on professional judgment, not on a general issue about change of use. Each case has to be considered on its own facts, which can be a long and complicated process especially where there are as many issues to take into account as there are at Stella Maris. The key point for my Inquiry is that the planning authority was not approached. This is one of many examples of a lack of due diligence by all involved when setting up the Stella Maris development.

35. It would be unusual for local residents to be consulted in the absence of a planning application. It was up to either Inclusion Housing or Swanton Care to carry out some consultation if they decided it was important to do so. Inclusion Housing said this was Swanton Care's responsibility. Swanton Care decided it was inadvisable. Local residents report them as being hostile when asked about the development in November 2018. As well as this, Minster Developments could have applied for a permitted development certificate or a lawful development certificate to show planning consent was not needed. To this day, most of the residents cannot understand why the change in use did not require planning consent. The fact that such a consent may have been needed makes consultation with the residents at the time they asked even more important. This was a public relations misjudgement by Swanton Care.

36. According to local residents, the builders working on site told them the flats were being made suitable for local authority use for young people who were "too young for prison but too old for normal care" – and "a halfway house" with 'thicker doors' and a 'full-time supervisor on site'. I quote this as hearsay as neither the owners of the property (Triple Point), nor the leaseholder (Inclusion Housing), nor the care agency (Swanton Care) made contact with local residents to explain what was happening throughout 2018. Residents such as the local Neighbourhood Watch co-ordinator say that when they asked Swanton Care for a meeting, this request was refused. Residents say that when they said they would be getting together to discuss the development, the former manager of Swanton Care said to them, 'If you get together as residents, we'll sue you and we'll see it as a hate crime'.

37. Inclusion Housing and Swanton Care made the point to me that vulnerable people have as much right to live in a community as anyone else and they did not want their future tenants to be walking around with 'arrows on their head pointing out who they are'. Whilst the point about the rights of vulnerable people is well made, some attention could have been paid to reassuring local residents, most of whom were older people themselves, some living on their own, about the intended development and the safeguards being put in place. Most residents had lived in Stella Maris or Nine Acres which it leads into for decades so it is a settled, quiet and reasonably close community. It is not just with hindsight that it is obvious a positive communication and engagement process with local residents should have been initiated between August and December 2018.

38. Swanton Care's judgments about community engagement set the tone for a subsequent stand-off when the levels of noise nuisance and anti-social behaviour started up in the early summer of 2019, continuing at an unacceptable level for over a year. It was poor judgment not to seek conciliatory engagement. This had consequences in that local residents, the police and Babergh District Council gradually lost trust and confidence in Swanton Care

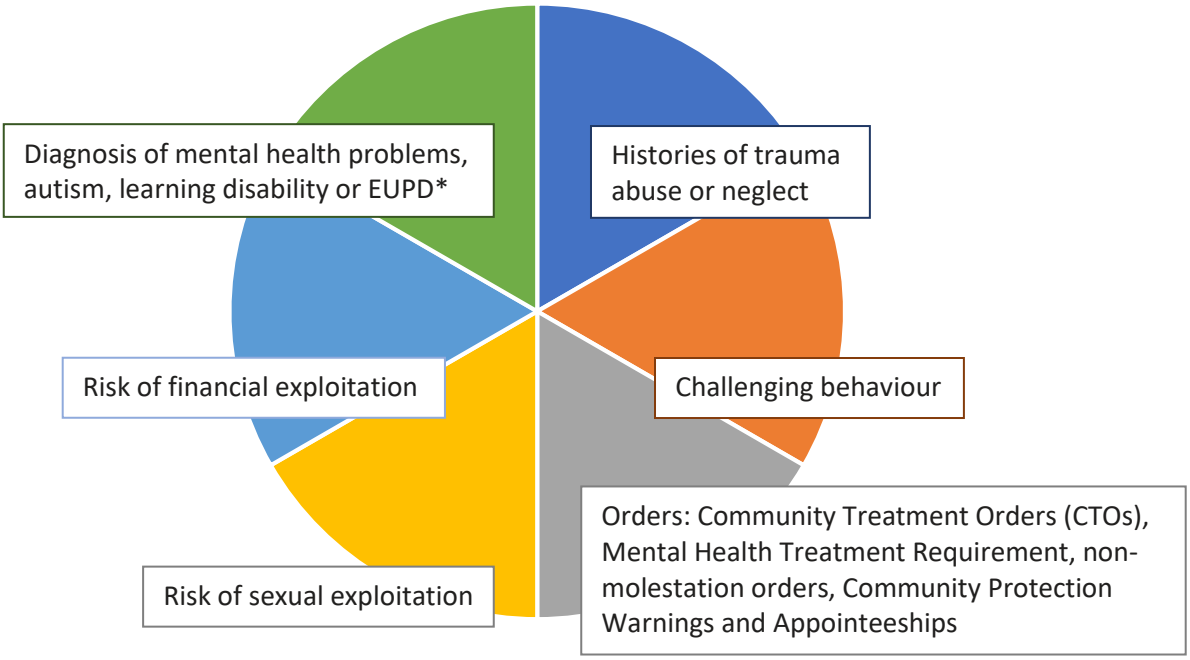
<u>Recommendation 4</u>: That as part of the set-up process for future supported living schemes, residents in the immediate vicinity of the scheme are engaged with by the future care provider and that this is also an obligation within the contract awarded to the provider by Suffolk County Council or whoever holds the contract for the scheme.

THE TENANTS

The housing application process

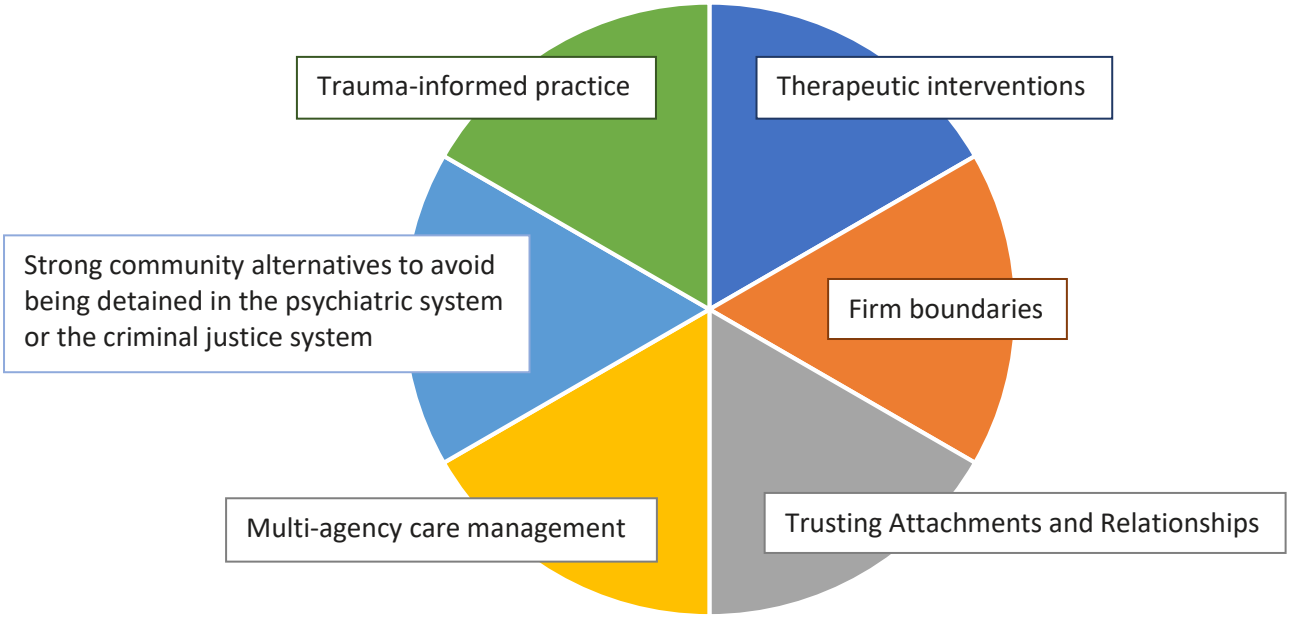
39. Each of the 5 tenants who moved into the Stella Maris Flats just before Christmas in 2018 had a degree of social, emotional or mental health difficulty. Some had been in care or had children removed from them. Most had been traumatised as children or young people by the care they received in their families whilst growing up. Other tenants joined them between January and the end of April 2019. They had similar backgrounds. With two exceptions, one 17 year old and one in their thirties, the tenants were aged between 18 and 25. They were being supported in their complex personal transitions by a number of social workers and mental health care co-ordinators (social workers or nurses). Stella Maris was set up to accommodate such individuals. Whilst the term 'chaotic lifestyles' was never used in any official documentation, it does describe with some accuracy the outward behaviour shown by some but not all tenants due to an inner turmoil.

Vulnerabilities (all tenants have a number of vulnerabilities and co-morbidities*)



**Co-morbidities – more than one diagnosis, often long-term conditions*
**Emotionally unstable personality disorder*

Needs analysis



40. Individual social workers and care co-ordinators from the Norfolk and Suffolk Mental Health Foundation Trust (NSFT) and Suffolk County Council recommended the placements for particular individuals at Stella Maris. The County Council and NSFT were in a Partnership Agreement under s75 of the 2006 NHS Act as a result of which some 65 social workers were managed by NSFT on behalf of the County Council. The local Clinical Commissioning Group contributed funding in according with their part-responsibility for aftercare under s117 of the 1983 Mental Health Act, when an individual is 's117 entitled'.

41. Authorisation of the placements was either through the Mental Health Funding Panel (MHEAT) chaired by Suffolk County Council and the CCG or through the Learning Disability and Autism Funding Panel, also chaired by Suffolk County Council and the CCG. In the early summer of 2020, 4 of the tenants had been nominated by Suffolk County Council and 4 by NSFT. Whilst extensive details of the prospective tenants are usually made available to the Panel, it is finance-focussed so does not discuss issues like compatibility with other tenants or residents in a proposal for funding. That is the responsibility of the practitioners proposing placements and those advising them.

42. Before an individual signs a tenancy agreement, the Registered Housing Provider (RP), Inclusion Housing, must satisfy themselves that she or he has the ability to hold a tenancy with all of the responsibilities that go with those rights and freedoms. Swanton Care completed the housing application forms based upon information given to them by Suffolk County Council or NSFT. When I reviewed the application forms, I concluded they understated the level of difficulty many of the individuals would inevitably face holding down a tenancy at this stage of their lives. Swanton Care told me that they had not been given the full picture about some tenants by the County Council and NSFT and that had the forms been filled in properly, they may not have accepted some of the individuals. I am not inclined to agree with this as their first manager did think she could deal with any and every problem. People described her to me as 'more of a mother than a manager'. Some tenants found her to be warm and supportive. I am sure she had a great personal commitment to supporting vulnerable people but the failure of due diligence in the housing application form process was another critical due diligence failure.

43. Little in my Inquiry was straightforward or one-dimensional. For example, some of the tenants had already been turned down by other providers. Swanton Care agreed to take people who were declined elsewhere which is fine in principle but not in practice in this case. NSFT say that for their part they made extensive details of the individuals they nominated available to Swanton Care.

44. Two tenants told me they were simply given the housing application form to sign and had no knowledge of its contents, nor were they taken through it so that they knew what they were signing. Crucially, no mental capacity assessments were made. I think it highly likely that some of the tenants lacked the mental capacity to agree to a tenancy. Mental capacity assessments are a crucial safeguard when looking after vulnerable people. Care plans depend upon them for their focus and for the type and manner of a care and support programme or intervention.

45. Two tenants had acute mental health problems. One moved to Stella Maris from a secure unit. These individuals needed wrap around care either in a specialist residential unit or in a bespoke property of their own with a team of care workers going in to support them. Mixing a group of vulnerable people together in this way with inadequate support was a

high risk strategy. In my view this is as much the responsibility of those nominating or placing the vulnerable individuals as it was of Swanton Care's inability to meet their changing needs once they were living in their new environment at Stella Maris. Some of those nominated were set up to fail by this process although the lack of suitable alternative placement options was an important factor for those who decided to submit the nominations.

46. Crucially, the mix of tenants placed did not receive a compatibility test of any description. Of course, this is hard. When you are in a hospital ward, a care home or a children's home, you do not get to choose your fellow residents. However, there is a lot of work in Children's Homes before admission on compatibility and Ofsted focus on this in their frequent inspections. As children's homes have become smaller and deal with children with more complex needs, compatibility has become an increasingly important issue.

47. The needs of some tenants placed at Stella Maris could only have been met by a care provider experienced with how to respond to challenging behaviour in a community setting. Stella Maris was set up for a much lower level of challenging behaviour and dependency but this could have been foreseen. Whilst the requirement for an assessment of compatibility between tenants in a supported housing scheme is usual in a standard housing management process, I saw no evidence this was carried out by Inclusion Housing.

48. At least two of the tenants needed firm boundaries. The absence of such boundaries at Stella Maris directly led to some of the continuous troublesome behaviour which affected other tenants and local residents profoundly. In a less-structured environment, their powerful unregulated emotions and disorganised attachments dominated their everyday behaviour and interactions. It is a tribute to Swanton Care staff that difficulties in the group of tenants did not spill over into the local community more than they did. They de-escalated situations repeatedly, as did the police when they were called out.

Recommendation 5: That consideration of the compatibility of tenants with each other is routinely made when developing new supported living schemes, so that the potential for a toxic mix is minimised. This responsibility should be shared between commissioners, care providers and landlords as consideration of this at Stella Maris was at best superficial and at worse non-existent.

49. Some tenants had formal diagnoses of learning disability or autism-related lifelong conditions. Autism is a condition for life. It never goes away, so the care needed to support an individual has to be customised and flexible over time. The care and support plans I have seen were shallow until, firstly, a new manager started work at Stella Maris in April 2020 and secondly, when the situation was escalated by a county councillor to senior management in Suffolk County Council in June 2020. Robust assessments and plans were put in place after the new Contracts Manager assigned to Stella Maris asked to see copies and found them missing or inadequate. The tenants at Stella Maris needed to be supported by an in-reaching specialist service provider skilled in supporting people with such long-term conditions, not by a care provider working within the parameters of a contract based upon domiciliary care - helping tenants to keep their flats in order, supporting them with shopping and with managing their money. The Swanton Care support workers did their best trying to reach some hard-to-reach young adults, but they were often reduced to cataloguing comings and goings and incidents reactively and ringing their mobiles when they were off site to check they were ok, as all responsible parents and carers do.

50. Some tenants were given assured short-hold tenancies prematurely. Such tenancies give statutory protection, for example against eviction without due process being followed. Whilst this is a crucial protection in housing law, most of the tenants at Stella Maris should in my view have started as licensees. A licence can be issued to individuals who are tenants but does not give the longevity of tenure that an assured shorthold tenancy gives. Licences are generally used to monitor tenants who come into a service where problems like anti-social behaviour can be anticipated.

51. Licences are generally used as a temporary measure, usually for up to 12 weeks following which an assured shorthold or assured tenancy is issued if the tenant's behaviour warrants it. The housing provider would still require a court order to terminate a licence but the notice period would be less. Moving an individual for their own safety or the safety of others would have been less complicated. Licences rather than tenancies would have been more suitable for some tenants for reasons that were well known in advance of them being placed at Stella Maris. The responsibility for this sits as much with the spot purchasers as it does with the care provider. Indeed, Swanton Care made an important point to me that they were contracted to provide a domiciliary care service, not a wrap-around care service.

Care Act assessments

52. As well as a lack of mental capacity assessments under the 2005 and 2018 Mental Capacity Acts, other key assessments such as Care Act assessments under the 2014 Care Act were missing at the point of nomination. NSFT did not provide good Care Act assessments which was part of their responsibility as they were managing the social workers transferred to them under the s75 agreement of the NHS Act 2006. The NSFT focus was on the Mental Health Act 1983 and the Mental Capacity Acts of 2005 and 2018, not the Care Act 2014. Inclusion Housing was supposed to carry out their own assessment and due diligence process before agreeing to a tenancy. I saw no sign of this being robust. Whilst Inclusion Housing's paperwork is excellent, such as its Occupancy Pack, I found no evidence they had taken into account the challenging behaviour of some of the new tenants where they lived previously and what the implications of this would be for other tenants and indeed for the care staff. These behaviours included self-harming, threats of violence and fire-setting. Inclusion Housing say their local managing agent, one of their employees, was assiduous in playing her part in the process. However, I saw no impact of this. Inclusion Housing blame Swanton Care and Swanton Care blame those who submitted nominations for being economical with the truth. The issue is that you cannot place such vulnerable people in a supported living service without far stronger assessments and care plans than were completed in advance of the move to Stella Maris.

<u>Recommendation 6</u>: That all commissioners and purchasers of specialist supported living placements build into the housing nominations process the appropriate statutory assessments under the Care Act 2014 and the 2005 and 2018 Mental Capacity Acts.

<u>Recommendation 7</u>: That this oversight and due diligence is also built into the contract development and tenancy support process for children and young people under 18, so that an all-ages approach is taken to the use of tenancies for individuals of all ages with complex needs.

53. Following the escalation to senior leaders in June 2020, the situation of individual tenants received more attention. Some were moved to placements and environments more suited to their needs. It is good that the Housing Solutions Team at Babergh District Council have been involved in supporting the next moves of 2 tenants.

54. To work with some of the young adults living at Stella Maris, the staff teams, especially the new and relatively untrained support workers needed to be trained in interventions like trauma-informed practice and setting boundaries under pressure. Some tried their best but behaviour management plans for the most challenging tenants before July 2020 lacked clear and specific advice. Whilst Swanton Care was a good employer who supported the learning and development of their staff, the training needed to provide effective care and support for people with complex needs and chaotic lifestyles was not as strong.

<u>Recommendation 8</u>: That Suffolk County Council and the Norfolk and Suffolk Foundation Trust make their training modules and materials available to care agencies to whom individuals with the most complex needs are nominated or placed. This material should include techniques to manage challenging behaviour and training in trauma-informed practice. This should be done as part of the local authority's role in managing the market and supporting smaller providers especially to raise standards and as part of NSFT's role as mental health specialists e.g., in sharing the psychological formulations for patients which give clear guidance about how to work with people and which are bespoke to that person.

55. Due diligence in relation to co-ordinating assessments, testing the compatibility of the individuals nominated and deciding on the type of housing tenure, does not sit within a defined role or a defined agency. It is a multi-agency process and responsibility and takes place on both a county-wide and locality basis. The contracts team in Suffolk County Council had an important role to play. This team experienced a repeated turnover in senior management during the period in question so that multiple contract managers had a responsibility for Stella Maris. This partly explains why the necessary level of oversight by this team was missing.

56. Since late 2019, service development and contracting for learning disability and mental health services within Suffolk County Council has been brought together in a central team within their Adult and Community Services Directorate (ACS) in order to raise standards and improve value for money. Supported housing strategy, standards, supply development and oversight of establishment of new provision now sits with this central team. However, attention needs to be paid to the workload of this team as to do this properly is resource-intensive.

57. Issues about housing tenure can also be supported by Suffolk's new Housing Co-ordinator who will give extra capacity to the Suffolk Housing Board. One of the new Co-ordinator's duties is to 'improve the support to individuals with chaotic lifestyles that reduces the pressure on housing services and reduces system costs. Shaping the market is another key function of this role. I see this as relevant. Whilst there are many housing strategies in Suffolk, they are not aligned. I recommend a Housing Needs Analysis for people with complex needs including chaotic lifestyles is developed by the Suffolk Housing Board, to then inform a Housing Strategy for this group of local citizens.

58. This analysis should be a co-production between all statutory agencies including local health commissioners. I suspect that the group living model of which Stella Maris is an example is no longer the housing model of choice. My own view is that supported living with self-contained flats in much smaller numbers (3 or 4) or bespoke accommodation for single people, including more detached single occupancy properties, is more likely to suit this group of tenants. This type of property is at a premium in Suffolk which is why a coherent property solution for a vulnerable person is often not in place even when a good care provider has been identified. Appropriate housing needs to be planned and then developed for the next generation and the generation after that. At the moment, there is not enough of this type of accommodation. This type of provision is expensive. Bespoke accommodation often needs to be adapted and customised to fit the highly individual capabilities and capacity of vulnerable people, many of whom need round-the-clock support by a team of carers exclusively working with that one person.

59. 'Chaotic' lifestyles is a simple phrase but a complex concept. As I have tried to convey, many vulnerable people behave chaotically occasionally, some of the time or all of the time. The housing needs analysis should use a working definition of 'chaotic' to avoid the term being used casually and so that the individual in question is understood rather than labelled. As much as there is any answer to this problem, it probably lies in the therapeutic input tenants receive, particularly how triggers are managed. As a minimum, a robust care plan and review structure should be in place for each vulnerable person.

<u>Recommendation 9</u>: That a housing needs analysis of people with complex needs including chaotic lifestyles is developed by the Suffolk Housing Board, leading to a housing strategy for this group covering the next 25 years given the demographic projections of a constantly increasing requirement for this group. This strategy should include a working definition of a 'chaotic lifestyle' and how those behaviours are best managed, so as to protect the interests of individuals who might otherwise be carelessly labelled and deprived of their rights.

60. The shortage of placement options is a reason why mistakes can be made. I do not want to give the impression that there were obvious immediate alternatives to Stella Maris for many of those who went to live there. The main issue is one of demand and supply and this can only be responded to with a long-term care, support and housing strategic plan for this group of vulnerable people. Back in the day, this used to be called a 'Community Care Plan'. Its contemporary equivalent now needs writing.

<u>Recommendation 10</u>: That a new care, support and housing plan for the next 5-10 years is produced, commissioned and overseen by the Suffolk Chief Officers Leadership Team.

The impact of challenging behaviour by some of the tenants both inside and outside of the flats

61. In the first 6 months of the scheme, between December 2018 and May 2019, whilst there were minor incidents of anti-social behaviour, noise disturbance and incidents between tenants inside the complex, this was manageable and to be expected from such a scheme, however undesirable this would be in a perfect world. However, the situation quickly deteriorated after the arrival of a tenant with especially complex needs in April 2019. From that time onwards, the level of anti-social behaviour, noise nuisance, more than 200 call outs to the emergency services and allegations by tenants towards each other including multiple safeguarding allegations, escalated to the point of the situation becoming out of control on several occasions. This meant that the risks could have led to extremely serious consequences. That they did not was more a matter of luck than judgment.

62. I have seen comprehensive records held by all relevant agencies concerning the hundreds of incidents at the flats which caused concern between the early summer of 2019 and mid-summer 2020. I do not propose to describe the incidents in detail as this would render the protagonists identifiable, but I will list some incidents to give an idea of the level:

    - Some tenants tying ligatures around their neck as a result of the environment becoming disturbing;
    - Regular self-harming and suicide threats;
    - Allegations of sexual assault, rape and violence against the person, including with knives (reported to the police and followed up);
    - Tenants in relationships with each other, with some concerns about consent and capacity and also making allegations against each other;
    - Racial abuse - a hate crime;
    - Fire-setting;
    - Fighting;
    - Harassment;
    - Threatening behaviour;
    - Foul language and screaming audible some distance away, going on for lengthy periods of time;

63. I should emphasise there were no allegations against staff. The allegations were about tenant on tenant, or once or twice, tenant against local resident. For example, one tenant immediately after Brexit happened in January 2019 said to a local black resident, ‘Haven’t you gone yet?’ and ‘People like you shouldn’t be here’. This was reported to Swanton Care but the resident did not wish to take it further. Some tenants reported to me being restrained by staff at times, which would have needed a separate and specific authorisation under the procedures for this.

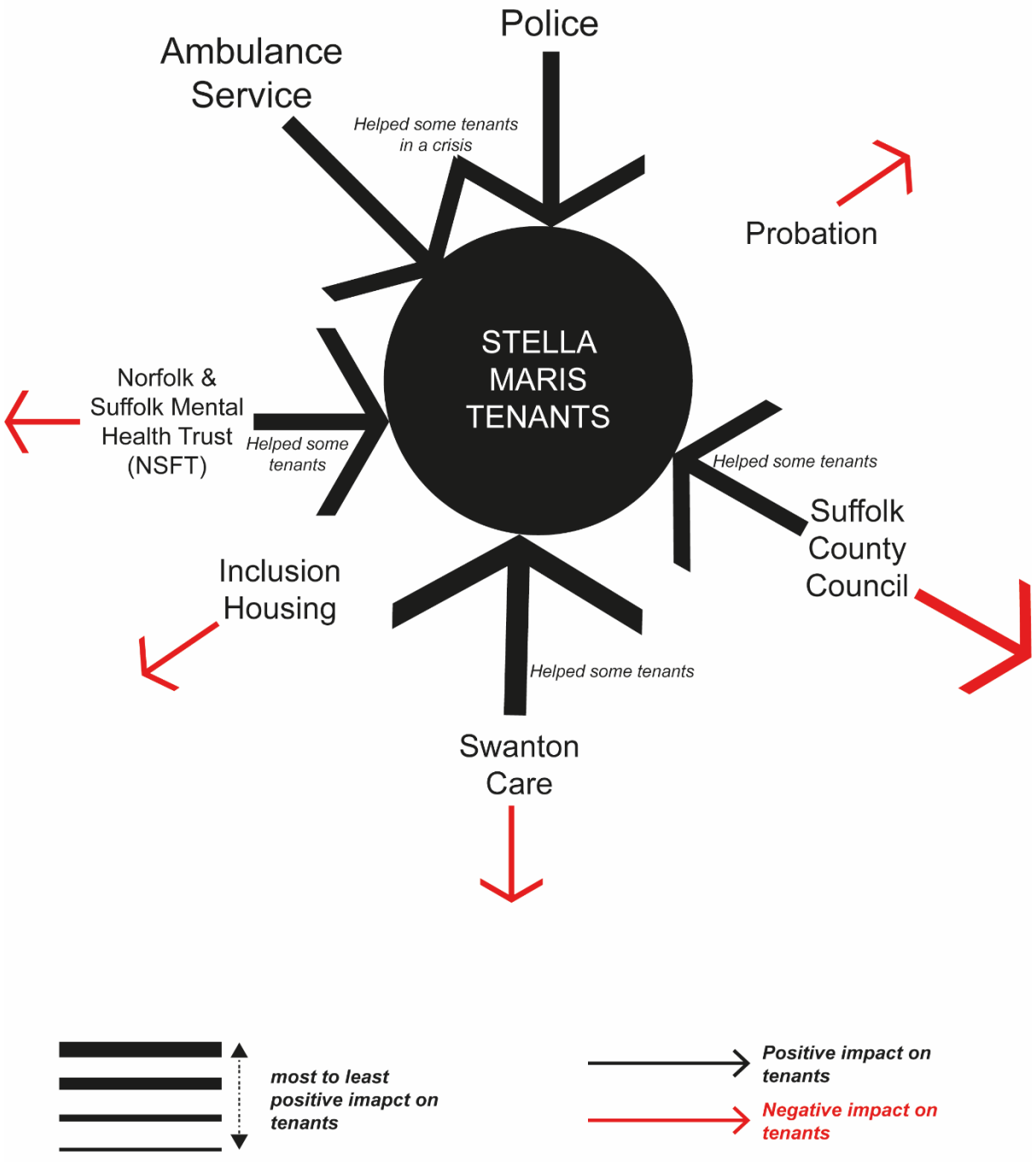
64. I would also emphasise that all serious crimes were assessed by the police who invariably concluded, rightly in my view, that both the alleged perpetrators and the alleged victims were vulnerable and that the best way forward was a multi-agency strategy for each individual concerned.

65. Many of the allegations made by tenants against each other were safeguarding allegations. Many were reported to Suffolk County Council either by the police or by Swanton Care through the multi-agency anti-social behaviour meetings convened by Babergh District Council. Some but not all of these allegations went to the multi-agency safeguarding hub (MASH). There is no evidence the MASH considered these allegations in the round. They treated each one on its own merits rather than seeing the bigger picture.

66. The impact of this highly charged environment on some of the tenants themselves, local residents and staff working at the flats was dramatic. Below are some experiences told to me by the tenants themselves. Inevitably, they are emotional statements bearing in mind the personal issues they were trying to manage and cope with. The parallel Organisational Safeguarding Enquiry noted observations by visiting professionals that tenant's distressed behaviour was not dealt with in a compassionate or dignified manner. This goes to the heart of the problem. Numerous early fault-lines in the way the service was set up led to this.

The impact of Agencies on the tenants

Most agencies were experienced by some tenants as positive and by other tenants as negative. Only the Police and Ambulance Service escaped criticism.



FIRST TENANT'S STORY

I hated the place, I didn't like it all. At the beginning, people did come in to see me but they never helped me. I wanted to join an art class but they wouldn't support me to do this, they just offered help with shopping and cleaning. I got no help to take my medication. All I wanted was someone to talk to me, someone I could tell how I feel, someone I could talk about my son with, but they kept avoiding me and sitting in the office all day. Sometimes the staff shouted and swore at me and slammed doors. Sometimes they used force with me. I had no support with anything, not with cooking. The staff were either on their phones or watching TV. I felt trapped there. I didn't like it. We hardly ever went out. I'm better where I am now. I didn't have a keyworker when I was at Stella Maris.

SECOND TENANT'S STORY

I found living at Stella Maris quite stressful. Staff didn't support me. They just reacted to me. They never ask what happened to me or why I behaved as I did. I wanted to get back in contact with my mum but they wouldn't give me her number though I knew they had it. I had to leave home but my mum is still important to me. This is what I mean by not being looked after.

We didn't do much at Stella Maris. We hardly went out though we did go to the beach at Felixstowe once as a group. I would have liked more activities and outings with us as a group. Most of the time we just sat around.

I did speak to some of the neighbours from time to time. They said they were worried we weren't being looked after properly.

I have plans and hopes. First to live on my own, then to have a family. I don't think I was helped to do this at all at Stella Maris. Where I am now, being supported in a self-contained flat, it is much better and I feel calmer.

THIRD TENANTS'S STORY

I hated it there. I hated the staff, although I get on with the new staff now, especially 2 support workers. I wanted them to help me. Staff wouldn't talk to me. I wanted someone to talk to me about what happened to me. I needed relationships, someone to talk to about how I felt. We don't do anything much here, we just sit in the communal area. We do go out with staff. Staff were verbally abusive. They screamed and shouted. I didn't get any help with cooking. Staff were always on their phones. They could not cope with us. Everything that has happened here is because of the staff. All this could have been avoided. I hoped it was going to help me. Everyone was nice for the first month then things went wrong though it's better now. I feel overwhelmed.

I'm sorry to all of the neighbours, or anyone who's been part of it. I want them to know I'm sorry for my part. It's not fair what the neighbours have been through. I know I'm part of it. I'm sorry. It's because of our problems.

FOURTH TENANTS'S STORY

I was there for 2 years. It was a very crazy place. The only good thing that happened to me was moving out. The staff weren't trained to look after people with disabilities. It was very difficult to live there. The first staff group (until April 2020) did not like the tenants and they did not look after us. They were bullies. I am quite independent so I did not really need to live there but the staff kept pestering me and irritating me. There was constant fighting outside. The staff let it happen then stood back and watched it so sometimes we were watched by the staff and filmed by the residents. When the Regional Director and the new manager took over (in April 2020), things got a lot better. They let me live my life and said if I needed help, I knew where to find them, which was true. The last staff group was so much better than the first lot. Now I have my own flat and I'm much happier.

67. The situation was made worse by the impact of Covid-19 and the national lockdown between March and July 2020. The tenant at the heart of many of the problems wanted to move away from the flats even before lockdown. It is unfortunate that the tenant's request could not be facilitated despite numerous opportunities for her to move at this earlier point in time. Indeed, at times her Probation Officer returned her to Stella Maris when the tenant had made plans to live elsewhere.

68. As well as the impact on residents and tenants alike, the care staff working at the flats, employed by Swanton Care, began to leave in significant numbers, leading to less experienced staff working shifts. Their departure was mostly with good reason as they were not meeting the Swanton Care Regional Director's requirements to better manage the care and support needed of the tenants. In addition to this, a number of staff had been recruited for a new supported living scheme that was planned for Ipswich but which did not go ahead. This meant they were placed at Stella Maris in excess of the level of

support needed there. When they saw there was no imminent prospect of further services being developed, a number left to pursue other career options.

69. Having said all this, many of the tenants enjoyed living at Stella Maris. Some made good progress in their personal development. For example, one of the original tenants who had been in multiple placements prior to moving to Stella Maris in December 2018 settled there quickly, formed a positive relationship with a support worker which lasted over a year until the support worker left, learnt to cook and budget better and started a course at a local College. This was an appropriate placement as part of a planned transition from being in care. Staff knew this tenant very well and responded to their emotional needs. Unsurprisingly, this was partly because this tenant was much easier to engage with than many of the other tenants. Swanton Care make the point that tenants were free to leave their flats and could not be worked with in a way that would be possible in a more structured setting.

70. Swanton Care also helped another tenant who could not walk when he arrived due to physical health issues, including not being able to walk to Ipswich town centre alone. He can now do many of these things including managing personal care when prompted, shopping and enjoying life more. This shows that there was no single experience of living at Stella Maris. Perspectives and lived experiences were very different.

The safeguarding allegations

71. Vulnerable children, young people and adults are at a permanently higher level of risk for various reasons. They are more vulnerable to every possible adverse experience in life. This is why those responsible for their care and support need to be on permanent alert. It is also why family and professional carers need the support, tolerance and understanding of the wider community. The level of support for vulnerable people in Suffolk during the March-July Covid-19 lockdown was excellent. The challenge now is to extend these collaborative working practices into the times yet to come.

<u>Recommendation 11</u>: To build the multi-agency working practices displayed during the Lockdown into future multi-agency working practices, initially through writing a Lessons Learnt paper for the Suffolk Chief Officers Leadership Team (SCOLT).

72. The risks to vulnerable people remain with us today. They are not just episodes from history. The abuse of vulnerable adults living at Whorlton Hall Hospital in Durham was only exposed by BBC undercover filming in May 2019. Before then, large numbers of visitors, inspectors and others had been in and out of the hospital without noticing anything untoward. Closer to Suffolk and in September 2020, ten workers at Yew Trees Hospital mental health unit in Essex were suspended amid claims patients were "dragged, slapped and kicked". Physical and emotional abuse were rife. Managers had seen the abuse on CCTV and alerted the Care Quality Commission (CQC). Abuse and neglect can happen even in regulated services. Professional, political and community curiosity is needed to prevent doors abuse and neglect behind closed doors.

73. There were 4 sets of safeguarding allegations and concerns at Stella Maris during the period in question, as set out below:
    - Allegations by tenants about one another;
    - Risks to tenants outside of the building, such as exploitation;
    - Threats to Swanton Care staff on site;
    - Public protection issues for local residents who were affected emotionally and psychologically by what happened.

74. As well as the 40 notifications to the Care Quality Commission – for which they had no role or responsibility - 34 referrals were made by various agencies to the Multi-Agency Safeguarding Hub (MASH). This is the front-line point of contact for new safeguarding referrals in which Children and Young Peoples Services (CYPS), Adult and Community Services (ACS), the police, health and education work together so that a multi-agency response to safeguarding concerns is made from the outset. The reason the MASH did not appreciate the service-wide problem is partly explained by the fact that 27 of the 34 referrals related to 2 tenants, both of whom had a care co-ordinator and a social worker respectively. The MASH adjudged each referral on thresholds and then passed the referral to the allocated practitioners.

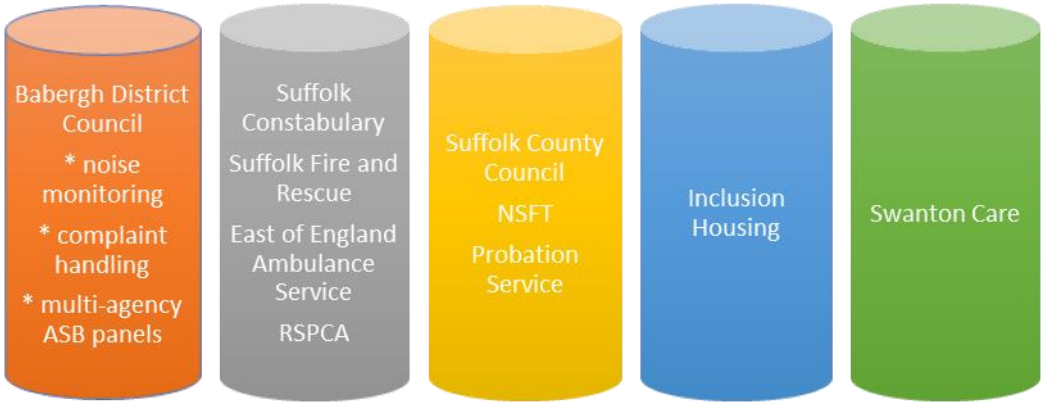
75. It is important to recognise that many of the risks posed to and by some individual tenants would have happened wherever they were living at this point in time. Those worrying behaviours were mainly due to the separate traumatic and abusive backgrounds they experienced. These tenants were neither mad nor bad. They were distressed and in constant emotional and psychological pain in varying degrees. This level of distress meant that every day this manifested itself in a degree of conflict, threats and explosive moments. However, it is astonishing that so few risk assessments were carried out, either of the risks posed by tenants to each other or the risks to individual tenants through being in that environment. Teaching individuals how to keep themselves as safe as possible in adverse circumstances was also missing, at least from the paperwork. This gap continued into the Covid-19 period with at least one tenant not socially distancing and with no effective action taken by any of the agencies as a result.

76. Some of the allegations were dealt with appropriately at the time. Others were dealt with on site by Swanton Care as best as they could. It would have been better if each allegation had been referred on to safeguarding services in the multi-agency safeguarding hub (MASH) as soon as they occurred. This would have increased the chance of a more effective and co-ordinated response. It was only when the current on site manager took up her role in April 2020 that Swanton Care referred a safeguarding allegation every time. Of course, how and when to make a referral is not straightforward in an environment where threats and allegations are being made all the time. Distinguishing a real concern from a fabricated concern is not easy but the lack of referrals prior to March 2020 constituted a fundamental breach of safeguarding protocols and was potentially unsafe.

77. A failure to take into account safeguarding concerns was apparent at many stages of the set-up and operation of the Stella Maris service. For example, the care plan for one tenant stipulated that they should not live anywhere near their family who had subjected the tenant to various types of abuse over many years. Yet this tenant was nominated to Stella Maris despite it being within a few hundred yards of their home address. This disconnect between assessed need and actions taken was often stark. Knowledge of the Suffolk Safeguarding Adults framework was sketchy, hence my next recommendation is that the Suffolk Safeguarding Partnership, the owner of the Framework, takes steps to make housing providers and care agencies in Suffolk more aware of Care Act principles and practice.

<u>Recommendation 12</u>: That the Suffolk Safeguarding Partnership offers a training and support package – the materials only - to housing providers and care agencies aimed at embedding the Suffolk Safeguarding Adults Framework.

78. Most significantly, the teams focussing on anti-social behaviour including noise nuisance and the teams dealing with safeguarding concerns and allegations never worked together properly, despite numerous meetings convened with that intention. Various individual officers tried to involve one another but they never became a team. This is an issue for the Suffolk Safeguarding Partnership to follow up as it should with any referral about poor multi-agency practice. They should do this in conjunction with the Community Safety Partnerships operating across Suffolk.



<u>Recommendation 13</u>: That the Suffolk Safeguarding Partnership takes further steps to promote more effective links between safeguarding agencies and agencies whose primary reporting line is into Community Safety Partnerships.

THE WORK AND IMPACT OF PROFESSIONALS

Care management and care co-ordination

79. All of the tenants at Stella Maris had adult care social workers, leaving care practitioners or care-co-ordinators (known as carecos) with responsibility for their case. These professionals had been allocated each case (tenant) for a specific purpose within a statutory requirement. In addition, some tenants were also allocated to probation officers as well as Swanton Care keyworkers – who were support workers. In the background but still members of the teams involved were psychiatrists, psychologists and managers. The 8 tenants were therefore being supported by many professionals. My scrutiny of records and interviews with staff and managers show that beyond a shadow of a doubt, all were committed to the health, well-being and safety of the tenants. The case records written by Suffolk County Council, NSFT and Swanton Care were copious and detailed. The perspectives below from one of the social workers involved shows both the amount of work done and the frustrations.

A SOCIAL WORKER'S STORY

I was the social worker for 2 of the tenants at Stella Maris, both of whom I supported to move on during the last 3 months. Both tenants were unhappy at Stella Maris. For 1 of the tenants, I was supported by my manager to move him out of Stella Maris and into an emergency placement because of the concerns about the level of care and support received there. I reviewed him in March this year but was not given key information about the extent to which he was struggling. When I visited him more recently, I found him and his flat to be in a state of neglect and this led to the submission of an organisational safeguarding referral. Both of the tenants said to me repeatedly that they felt that the support workers at Stella didn't care. I found the provider to be unprofessional at times. They wouldn't agree to reducing the care and support when this was requested and also employed people who did not declare that they had bullied one of my tenants at school. They said they were providing care when the tenants said they weren't. When I visited, there was no COVID social distancing in place and no PPE being used by the staff.

Since moving to their new accommodation and support, both tenants are thriving in their new environments. One of them looks cleaner and healthier, has put on weight and is attending his hospital appointments. I have been surprised because I thought that Stella Maris was a specialist resource and they are now both in mainstream services

As I have said throughout my Inquiry, accounts of the same situation differ between those involved. When partnership working is outstanding, all participants share a common narrative. Here is the story of a particular tenant through the eyes of Swanton Care.

THE CARE PROVIDER'S PERSPECTIVE (SWANTON CARE)

One of our tenants has a mental health diagnosis after a significant trauma occurred in her life some years previously. She has a history of self-neglect and historically has refused medication and support. At times she can present with a risk of assaulting others with both physical and verbal aggression, when unwell and not taking medication.

The staff story is that supporting this tenant was a difficult process. Somedays we just ensured her safety and personal hygiene when she was bed bound with her mental health. On other days we were assaulted by her when she wanted coffee and when asking her if she wished for support. It must have been difficult for the neighbours as she was loud and swore a lot and sometimes she would be naked, all linked to her declining mental health. We did everything we could, often getting hit, spat at, all whilst trying to cover her dignity whilst spending hours and hours and sometimes days on the phone to the crisis team – they didn't seem interested and several AMHP's (approved mental health professionals) wouldn't attend if on duty as she had previously assaulted them and they'd just say call the police if you're concerned.

Whilst she lived at Stella Maris, she had several short stays in hospital and one depot injection but no trauma treatment and then was discharged often without us being informed. She would arrive home in a taxi and within three weeks we were fighting for her with the same teams and same calls to get help again. She had six assessments before she went into hospital this time all within days of each other.

It must have been as hard for the neighbours to have seen and heard her language as it was for us. They used to call her the "voice "when they called the office to complain and this used to upset me. We could not tell people what and how hard we were fighting for her to get the help. It was very hard. I am glad she is now going to get the help, and this is what she needs.

80. Their job was not easy. Some tenants were hard to reach and either wanted to be left alone or they engaged aggressively. It was not surprising that the staff group and some of the professionals in the background spent most of their time reacting to worrying incidents. Despite this, scrutiny of the Swanton Care logs and the record held by Suffolk County Council and NSFT show that a significant amount of time and effort went into motivating individual tenants to stop risky behaviours and to promote safer strategies in their daily lives. This included advice about safe drinking, use of illicit drugs, attitudes to relationships and improving personal hygiene, to name just a few. Considerable benefit would have accrued from this work but this is not reflected in the files or the interviews I carried out. That is typical of front-line work as the orientation in case records is to problems and consequent action, not to everyday improvements. In particular, the importance of support in times of trouble was chronically under-recorded.

81. One reason professionals did not get together across the various silos and divides about the situation at Stella Maris is that many did not know about it. Whilst this may seem odd, the fact is that many professionals went in to meet or talk about their client and were not able to even know who the other tenants were, let alone talk about issues in common. Silo working between agencies was matched by silo working between individuals. The need for confidentiality and protection of personal information was a frequently given reason. This was true even when some tenants started up relationships or at least sexual contact with each other. Few involved understood that information can and should be shared in good faith where a safeguarding concern arises. I recommend a way forward about this, involving Caldicott Guardians who are the owners of safe information sharing in the main agencies involved.

Recommendation 14: That the Suffolk Safeguarding Partnership convenes a meeting of Caldicott Guardians for each statutory agency involved with a view to clarifying when it is right and proper to share safeguarding concerns and with whom.

82. I was concerned about the level of conflict between the main agencies involved during the most difficult part of this timescale under scrutiny – May 2019 until May 2020. A lot of time and hundreds of e mails were sent by individual professionals trying to engage with other individual professionals. The scale of activity was grand, but activity does not in itself bring about a high impact and positive outcomes. There was far less sense of organisations engaging with other organisations, which is usually a sign of a system leadership problem. Some practitioners spent months trying to get an issue sorted out. There were too many unanswered e mails, meetings not attended, visits not made when they had been arranged and many complaints either about conduct or performance of one or more professionals by others. A conversation-based culture was needed, not a tetchy e mailing culture. No whistleblower or 'freedom to speak up guardian' came forward, which suggests the culture may have been either closed or complacent. Poor multi-agency working compounded the day to day problems at Stella Maris. I have concluded it would not be right to single any agency out for blame. The failures were systemic. I would hope my Inquiry report can be read as a case study to inform better partnership working. Whilst there was good partnership working in respect of some individual tenants, the overall situation lacked solution-focussed system leadership until June 2020 when senior managers started to get a grip of it.

83. I am encouraged by the steps being taken by the Learning Disability and Autism service within the Adult and Community Services Directorate (ACS) in Suffolk County Council, about their allocation policy and practice in respect of vulnerable people. From the end of the year, all cases will be allocated to individual practitioners, divided into active cases and cases where a watching brief is sufficient. Whilst caseloads will be larger, there should be no extra pressure on practitioners because the division between active and a watching brief is the regulator. Importantly, waiting lists will go. Even more importantly, every vulnerable person with a learning disability and/or autism will have a named practitioner to contact.

Best interest meetings

84. Formal best interest meetings are meetings convened in order to make important decisions on behalf of an individual who lacks the capacity to make that decision on their own. This should involve the person themselves, those close to them and the professionals around them. A Best Interests Assessor normally carries out an assessment to inform decision-making. Capacity for the tenants at Stella Maris fluctuated, so that any best interest meeting would need to be decision-specific where the decision in question must be the right one if the individual concerned is to be protected from abuse or exploitation for example.

85. Many of the professionals meetings held about Stella Maris lacked a structure and clear outcomes. A best interest meeting would have had a clear agenda leading to binding decisions. It can be informed by a Best Interests Assessor and chaired or reviewed independently if this will help. If decisions cannot be reached through a consensus taking account of the individual tenant's views and that of those close to them, an application could be made to the Court of Protection to waive the individual's rights. In the Stella Maris context, this would be the wrong route as fluctuating capacity is legally complex to prove, unlike more obvious and straightforward applications to the Court of Protection where it is evident an individual lacks capacity.

86. I recommend Best Interest meetings are used on a regular basis when decision making about a vulnerable adult whose capacity fluctuates is at risk of being delayed or risks a lack of clarity. This should be to make context-specific decisions only.

87. Such a structure could have enabled earlier and sharper decision making for at least two tenants who were either subject to repeated Mental Health Assessments or decisions about future living arrangements. One tenant had seven Mental Health Act assessments within 4 months, some leading to detention, some not. Mental Health Act assessments are made by psychiatrists and Approved Mental Health Practitioners (AMHP's) and professional judgment is used as much as hard evidence. My view is that where an individual is involved with several agencies simultaneously, that a Best Interest meeting is the best way to find an overall way forward including the relevance of a Mental Health Act admission. Of course, such an admission can only made by a responsible clinician (RC), not by a case review or a conference. However, I suspect better and earlier decisions would have been made on behalf of at least 3 tenants if a more formal multi-agency structure including the vulnerable person themselves and their representatives or advocates had been in place. In the latter regard, the use of independent advocates was insufficiently considered.

<u>Recommendation 15</u>: That Best Interest meetings are used to structure decision making about vulnerable people who lack capacity and where a vulnerable person, their family or carers and professionals are in disagreement about the right way forward for them. I particularly have in mind when decisions are needed urgently.

The intersection with children's services

88. Many young adults at Stella Maris had either been in the care system in Suffolk or one or more of their children had been removed from them by a family court in care proceedings as they were unable to look after them. After leaving care, if their needs continued after the transition to young adulthood, their cases were transferred from children's services (CYPS) to adult care services (ACS) within the County Council. They were seen as vulnerable adults, not mothers and fathers. Those tenants at Stella Maris were mourning the loss of their children. The child taken from them will have a care plan of their own. I also recommend that the adult whose child is removed has their own care plan which supports them to become stronger and more capable as a potential parent in the future. Suffolk refers parents in this situation to one of its own county-wide services, Positive Choices, but understandably some parents do not engage at the time. Such a service can stop some children being born automatically into care if their parent has not changed their lifestyle or behaviour or if they remain lacking in the capacity and capability to look after a child. I recommend that parents who lose their child or children are formally advised they will be offered help should they choose to take this offer up, including a referral to Positive Choices.

<u>Recommendation 16</u>: That Children and Young Peoples Services (CYPS) in the County Council ensure that parents whose children are removed from them because of risk, abuse or neglect, are advised they will be helped and supported to keep their next child should they wish to take up this offer of help and support.

Medication management

89. Several concerns were expressed to me about medicine management. Most of the tenants were taking powerful medication for their various difficulties, including anti-psychotic medication which if not taken in the right way can prove fatal. Some tenants mixed their prescription drugs with alcohol and illicit drugs like marijuana and cocaine. I heard stories which were denied by caregivers that medication was left outside tenant's flats for them to take in and self-medicate. On another occasion, a tenant missed vital medication. A rumour circulated amongst local residents that some tenants had swapped their medication for fun or kicks. This information came from one of the tenants because some residents were speaking to individual tenants in the street which is how they knew a lot of what was going on. Whilst the agencies involved were maintaining strict codes of confidentiality about personal information being breached, information was free-flowing outside of the Flats, including on social media. Those in authority need to recognise these back doors to information and work with them, not pretend they are not there.

90. Swanton Care dispute some of these incidents and say they have MAR charts (a document to record the administration of medicines) and follow BNF (the British National Formulary for Drug Groups) protocols. As with much of what happened at Stella Maris, there are different versions of the same event. The rumours about the use and misuse of medication may be true, fabricated or exaggerated but I think it prudent for the local Clinical Commissioning Group (the CCG) to review its guidance to providers about medication management.

Recommendation 17: That the local Clinical Commissioning Group (the CCG) for North East Essex, Ipswich and West Suffolk, reviews its guidance to providers about medication management.

Anti-social behaviour

91. Local residents were subjected to noise nuisance and anti-social behaviour for well over a year. However, despite a lot of activity in response, little reduction in the level and type of noise or of anti-social behaviour was achieved. Inclusion Housing did move the smoking and bin store areas so they were not so close to a resident's house and garden, having been required to do so by Babergh District Council. They also considered putting up shrubbery at the perimeter of the Flats aimed at deadening the noise but decided this would not achieve a worthwhile noise reduction.

92. As with the impact of the flawed housing application process, agencies blamed each other for not taking action or not supporting each other in the efforts to deal with anti-social behaviour. Each agency felt unsupported by the others. This was another example of poor partnership working as good to outstanding partnership working requires partner agencies to help each other to meet their core objectives. In addition, the effort/efficiency ratio – which measures the amount of effort needed to become efficient and effective – was low. Below are some examples.

93. Babergh District Council installed noise monitoring meters twice in the property of the resident nearest to Stella Maris but this did not lead to a reduction in noise nuisance because the maximum level reached was only 58 decibels, below the World Health Organisation (WHO) recommended level and well below the Statutory Nuisance level. For the residents it was the type of noise as much as its volume. Some tenants were described as wailing and screaming in a distressed way. This is confirmed by the audio recordings.

94. Babergh District Council also encouraged the resident in question to maintain a written diary of events which he duly did over a long period of time. His diary entries were read and noted, including by myself. They show the high degree of distress he experienced.

95. Babergh District Council received 40 complaints from residents but because they were from 3 residents they grouped the complaints together into 3 separate responses instead of understanding the rising tide of emotion locally. Only one Environmental Protection Officer understood the extent of the problem. Even though he was unable to take enforcement action because no single example of noise nuisance met the statutory threshold, he continued to visit the local resident and show great care and humanity for him. Others who might have been there to give the residents some comfort and to try to take action were conspicuous by their absence.

96. Babergh District Council convened a number of multi-agency anti-social behaviour panels but if action was taken, it was not known about on the ground, nor was it escalated to a senior officer in any partner agency, nor did it have an impact. The minutes of six meetings held between July 2019 and July 2020 are rightly not available on the council's website as they contain personal information about individual perpetrators and victims. However, a communications protocol should be developed and agreed between agencies as some communication about what was happening and what was being done would have helped. Babergh District Council and Swanton Care did try to engage the wider multi-agency group without much luck and were not helped by the departure of a mental health caseworker from NSFT with whom they were liaising up until the spring of 2020.

97. It is possible Babergh District Council's response to the local residents was influenced by their housing tenure. Council tenants fund an ASB service from the rent they pay. If a victim or complainant is an owner-occupier or privately renting and the source of the ASB problems is also an owner occupier or a private renter, complainants may receive a more limited service unless the complaint can be considered a 'statutory nuisance'. Babergh have decided to appoint an individual officer to respond to complex cases of anti-social behaviour in the future. This is a welcome development. I include their response below.

98. Babergh District Council do place a lot of emphasis on local residents accessing information via their website. Their website is well organised and clear but it is asking a lot of local residents to understand what can and can't be done and what they can or can't do simply by studying a website. An example of this was the expectation on residents to find out about the 'community trigger' mechanism contained in the Anti-Social Behaviour, Crime and Policing Act 2014. This allows residents to demand a case review in the face of persistent anti-social behaviour, However, residents did not know about this, nor were they informed it was an option open to them. More face to face contact with them giving high quality and accurate information was needed. This is also an example of the limits of remote working. Front line staff need to be working inside local communities to know what is going on, not just offering meetings via remote video platforms, Covid-19 notwithstanding. Remote working offers great opportunities to get business done more efficiently, but it has its downsides too, especially in work with vulnerable people. Remote working can be done about them but not with them.

REFLECTIONS FROM THE ENVIRONMENTAL PROTECTION TEAM

The work on the Stella Maris case was very resource intensive for us in the Environmental Protection Team. Officers were involved in the case for 14 months from summer 2019 and at its peak, we were spending about a day a week on this.

Early on, it became clear that the noise issues were only one part of a wider anti-social behaviour problem and that other agencies were and should be involved. The Police were already aware and there was good co-operation between them and Babergh. Efforts were made to engage with both the care providers and the facility's owner, although they were slow to engage until a formal notice was served.

The delay in the providers engaging was frustrating. It was only after speaking to them that the perceived issue with SCC's placement of residents in the service was identified. It was difficult to find the correct liaison officer at SCC and this prolonged the case. Once identified, the officer knew nothing of the issues, which was frustrating as their predecessors had been advised and we also had SCC representation at the Anti-Social Behaviour multi-agency meetings. The Police had put in a number of referrals to the MASH, but it wasn't clear how these were acted upon. However, once the Head of Operations and Partnerships (Mental Health and Learning Disabilities/Autism) became involved in June 2020, SCC was swift to engage and take control of the issue.

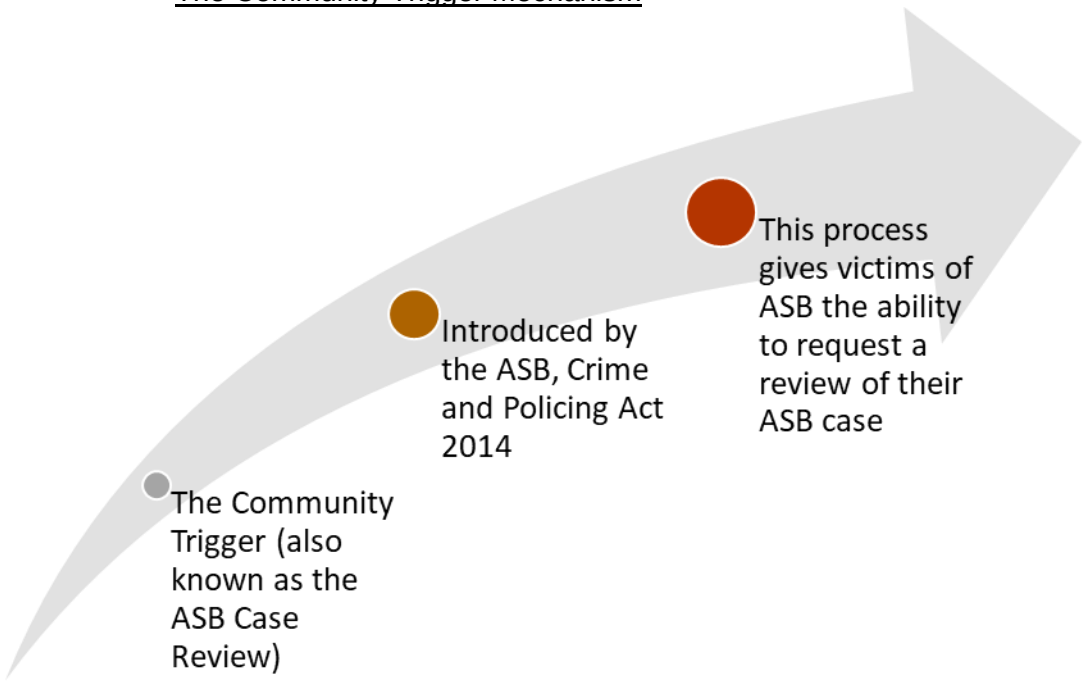
Between July 2019 and July 2020, the case was raised on 6 occasions at the Babergh Anti-Social Behaviour multi-agency meeting, where there were representatives from both the Police and SCC. This well-established group has been useful to us as officers in the past and has facilitated good communication with partner organisations and promoted joint-working. However, we realise that these meetings could have even more impact if the progress of cases was more rigorously reviewed not only from meeting to meeting, but over time. Actions assigned need to be followed up at each meeting, but it would be even better if there could be more updates in between meetings so that we could move things forward more quickly.

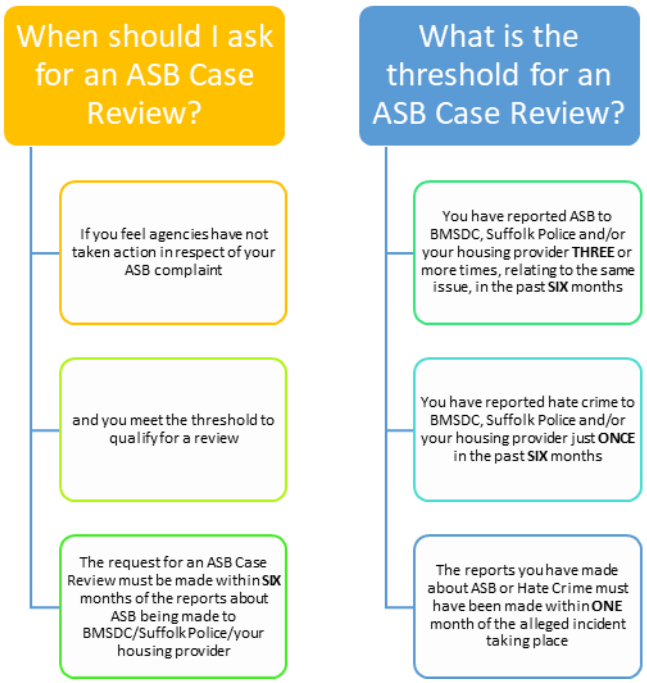
Affected residents have been at the forefront of our work and the Environmental Protection Team was in regular communication with them. Throughout, the Team endeavoured to support residents in seeking a resolution, even once it became clear that environmental legislation would not be the appropriate route to secure this. We are really pleased that things are now improving for them.

We always want to do the best we can for our residents and our organisation has used the reflections and learning from this case to review our internal structures for dealing with anti-social behaviour, to appoint an additional caseworker to lead on complex cases of anti-social behaviour, to introduce E-Cins, a case management system for Anti-Social Behaviour cases and to review our internal procedures. This also includes a greater focus on escalation within our own and partner agencies and on clarification of contacts with other partners. This, together with a review of the multi-agency anti-social behaviour meeting procedures by the partners will be incorporated into future interventions and will result in more effective and efficient partnership working in future.

<u>Recommendation 18</u>: That Babergh District Council reviews its working practices to ensure that community hot-spots featuring persistent anti-social behaviour are escalated to a senior officer and reviewed formally to ensure the right type and level of multi-agency working and action is in place.

<u>The Community Trigger Mechanism</u>





99. A Community Protection Warning Letter (CPW) was sent by the police to a frequent visitor to the Flats. This was an important step because it started to set boundaries and signified an escalation of concern. The CPW contained various requirements but the recipient along with the tenant being visited boasted of how they could circumvent the requirements whilst still technically complying with the CPW. This shows the difficulty the police and other agencies face when dealing with persistent anti-social behaviour. The police or local council have powers to upgrade a CPW to a Community Protection Notice (CPN) and if a CPN is not complied with, to go to Court. However, this action was too little, too late. Previous to the CPW being issued, Inclusion Housing had issued a warning letter and an Acceptable Behaviour Contract to a tenant but these did not produce any change.

100. Each tenant had Positive Behaviour Support Plans (PBS), which were reviewed and refreshed. There were two plans. The first was detailed, the second was a quick reference chart for staff.

Personality disorder

101. Some tenants had a diagnosis of personality disorder, either as their primary or secondary difficulty. Agencies sometimes clashed about whether the actions of a tenant with a personality disorder was evidence of challenging behaviour or a mental health problem. For example the police were pushed by NSFT and Probation to take some individuals through the criminal justice process whereas the police took the view that the issues were about the individual's mental health problems and that it was mental health services that were needed, not the arresting and further criminalising of vulnerable people, some of whom were already subject to court orders that were not being adhered to. Such disagreements were intense and powerful enough to cause deep rifts between organisations. It was rare for agencies to twin track action through the mental health and criminal justice routes simultaneously and to make context-specific decisions about which route to follow each time. Agencies were polarised and people with a personality disorder were not offered stable and clear care management until weekly multi-agency meetings were started in June 2020.

102. Those individual tenants diagnosed with an emotionally unstable personality disorder (EUPD) were more likely to be discharged from hospital or from an NSFT service if they were deemed untreatable or unworkable with. Whilst the approach taken by NSFT is in line with the National Institute of Clinical Excellence (NICE) guidance on personality disorders and ICD10 (the World Health Organisation's Medical Classification List) about which interventions work best, they could in my view have offered psychological supervision and support to the Swanton Care staff team to help them care more effectively for some of the tenants with a personality disorder.

103. I think the rigid distinction between someone who is treatable and someone who behaves in the same way but does not have a formal mental health diagnosis is unhelpful, especially as the underlying challenging behaviour and the interventions needed can be similar. My main concern is that local mental health services operate a traditional medical model which does not take sufficient account of the social determinants of mental health problems. The consequence is that some individuals and their carers experiencing profound and continuous emotional distress feel abandoned by statutory services. NSFT attempted to close the case of one tenant with these difficulties despite there being a court-imposed Mental Health Treatment Requirement within a Probation Order which

meant their case could not be closed. NSFT feel that they are being asked to treat individuals who are untreatable and that this is an improper use of their scarce resources. Whilst I understand this position, it is another example of weak system leadership between all agencies by leaving this issue unresolved and being acted out in new case after new case.

104. NSFT is developing a Personality Disorder Strategy with the idea being to extend the new pathway being trialled in Norfolk into Suffolk when funding is available. The pathway is likely to be called 'The Personality Disordered Complex Needs Pathway'. The main interventions are dialectical behaviour therapy (DBT): mentalisation-based treatments (MBT); and use of structured case plans (SCP). Whilst I am sure the strategy being developed in Norfolk will be helpful, I think Suffolk should develop, own and implement a Personality Disorder Strategy of its own, and do this at pace. Such a development can still link closely with the work being done in NSFT. I recommend this is funded by health and social care in Suffolk working together to bring change about.

<u>Recommendation 19</u>: That Suffolk develop its own Personality Disorder Strategy, jointly developed and funded by the CCG's covering Suffolk jointly with Suffolk County Council.

The current s75 agreement

105. One of my key findings is that the current s75 agreement under the NHS Act 2006 by which around 65 Suffolk County Council social workers are managed by NSFT did not work for the tenants at Stella Maris. It became clear to me that Suffolk does not have its own coherent plan about how mental health services are delivered. I found it especially striking that some of the tenants' wider social, family and environmental needs and also the needs of carers were not reflected in NSFT case plans. I found an absence of person-centred whole life planning even for one tenant who had been known to services for nearly all of her life and who desperately needed a lifetime plan. The shift from a health focus to whole life planning is such a basic aspect of good community care that I think a significant culture change is needed as a matter of urgency. The absence of Care Act assessments being produced routinely by the social workers in NSFT in the cases I saw is another indicator of concern.

106. The requirements on mental health social workers set out in the Care Act are not being met, judged by what happened at Stella Maris. This includes a greater visibility of their family members, carers, friends and more thought about their environment. This is a vulnerability not just for Suffolk County Council and for NSFT but for vulnerable people whose needs are not being assessed in the round.

107. This is not just an NSFT problem. Suffolk County Council has allowed the social workers to become embedded in NSFT within a health framework, rather than the County Council working with NSFT to drive a new standard and spread for community mental health provision. This could only have been led by the County Council as the role of the CCG is to fund health services and the major deficit is in the application of the Care Act.

108. I recommend that the social workers are no longer managed by NSFT and transition back to Suffolk County Council within their Adult and Community Services Directorate. Further work is needed to decide how a future locality-based structure would operate so that the specialist services providing mental health, learning disability and autism services are integrated but not diluted. Planners need to take into account the development by the Suffolk CCG of new pathways for learning disability and autism, so that related developments are synchronised. A significant change being scoped is to offer a service, not a threshold. I am convinced that to transition the social workers back into Suffolk would be in the best interests of people needing services, their families and their carers. Suffolk County Council and NSFT would remain important operational partners but I think this change would lead to a more holistic service to people with complex needs. Many of the tenants at Stella Maris would have benefited from less rigid pathways being applied to their care and this change should lead to fewer turf wars about eligibility for specific services.

109. Such a change would need a well-managed transition, so as to achieve a harmonious separation from NSFT rather than to replicate the acrimonious divorce that took place between NSFT and Norfolk County Council a few years ago about the same issue. For example, care needs to be taken to ensure there are sufficient Approved Mental Health Act practitioners (AMHP's) in place to carry out the volume of Mental Health Act assessments needed. Now, Norfolk's mental health social work service is embedded in the County Council's community teams structure which I would like to see replicated in Suffolk.

<u>Recommendation 20:</u> That the s75 agreement between Suffolk County Council and the Norfolk and Suffolk Foundation Trust is ended and that the social workers transition into the community-based structure of Adult and Community Services (ACS) in Suffolk County Council.

Call outs to emergency services

110. Emergency services were called out to the Flats on over 300 occasions between December 2018 and August 2020. 163 calls were to the police, 108 to the ambulance service resulting in 39 visits, with the remainder being to the Suffolk Fire and Rescue Service and the RSPCA in relation to the treatment of pets. It would have been impossible for the police or the ambulance service to say no to any of these call outs as each had a prima facie concern about risk or harm which meant they were duty bound to respond. The police went out every time. The ambulance service triaged and graded every call. These calls were handled in their call centre with the support of a clinician. 69 of these calls were referred to other agencies and health pathways. The local ambulance crews also got to know the property, the tenants and the issues.

111. Most calls were made by tenants expressing concern about other tenants. Some were made by Swanton Care and a small number by local residents. It is indicative of the tensions within Stella Maris that half of the calls were made by one tenant about other tenants. A factor in his frequent calls was his infatuation with the police. He liked to see police officers and talk to them. In fairness to Swanton Care, they were often unaware these calls were being made. The police feel Swanton Care could have done a lot more

on many occasions and that they, the police, ended up acting as good care staff would and should have done.

112. Neither the police nor the ambulance service placed risk markers on the Flats or flagged the multiple call outs after a certain period of time as warranting further investigation. The high number of call outs to emergency services were neither cross-referenced within organisations or with each other This was in part due to the respective incident logging systems of the police and ambulance service being unable to aggregate data automatically. Ambulance service data was logged for each flat within Stella Maris, not for the complex as a whole. Police data was collected by types of shift, not by location. So, day shift, evening shift, night shift and weekend shift calls were neither aggregated nor were they joined up.

113. As a result, senior police officers and ambulance service managers were unaware of the situation at Stella Maris until July 2020, despite the impact on their front line staff (see below). A technical upgrade is needed in the police's incident logging system, Webstorm, to avoid a risk of the same situation recurring. If the situation had been flagged within the police, it is likely their Strategic Intelligence Unit would have analysed the data for a senior officer to then be tasked with mapping a way forward within their problem-oriented policing framework.

FRONT LINE POLICE OFFICERS TELL THEIR STORY

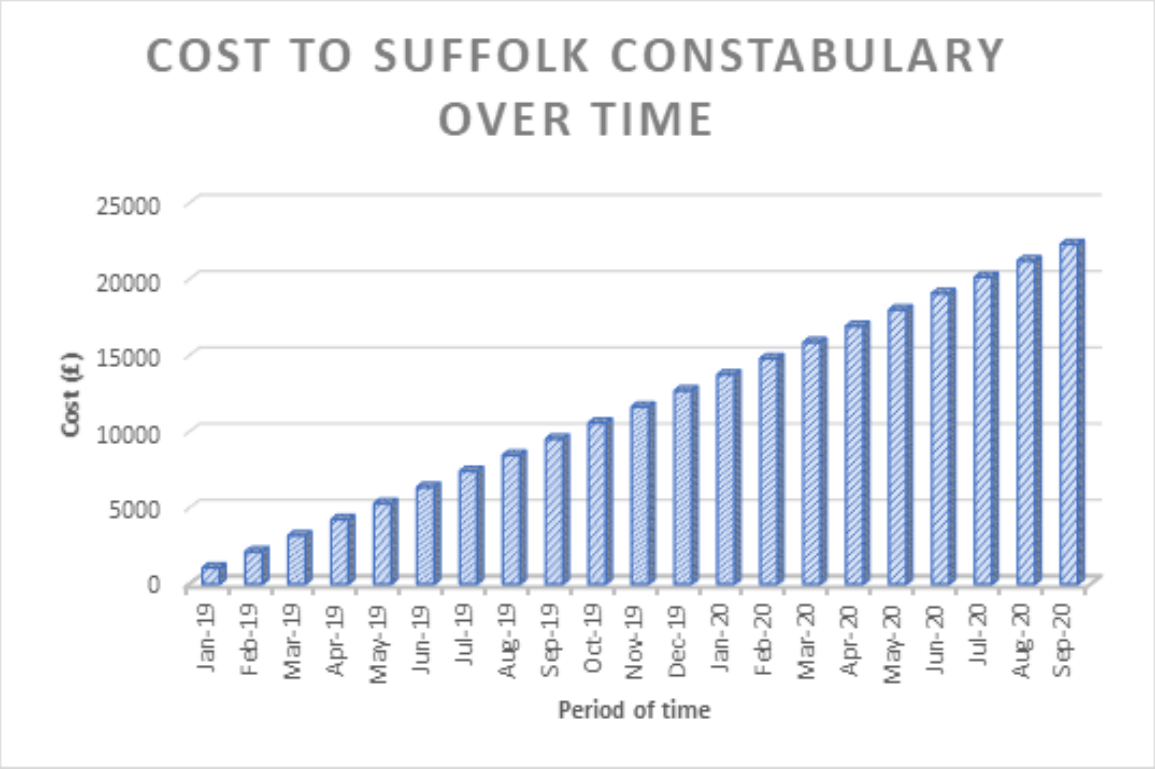
The impact on us has been phenomenal, starting in November 2019. We feel let down by Swanton Care and Babergh Council. The Council had an equal responsibility to consider action following anti-social behaviour but we feel they left it to us. Swanton Care just sat back and waited for us to arrive. At one point, all of the agencies suggested they step away and leave the most difficult tenant to us. We nearly imploded at that point as we kept saying the tenants presenting most problems had such obvious emotional and mental health problems, they had to be classified as extremely vulnerable, not as criminals. We felt for the residents as well. What happened to them was unfair.

Recommendation 21. That the police put in place a technical upgrade to their incident logging system, Webstorm, to allow for an easier read across when they are called out on multiple occasions to the same address or situation.

114. I also recommend that after a set number of call outs to emergency services, an escalation to a senior officer is triggered. It is for each agency to work out the best way of triggering escalation operationally and I make this recommendation specifically to the police and ambulance services. For now, escalation needs to be made by managers on the ground who know the situation in advance of upgraded call logging systems doing this automatically.

<u>Recommendation 22</u>: That the police and ambulance services put in place a trigger mechanism for escalation after a set number of call outs.

115. The local police Safer Neighbourhood Team (SNT) covers a large geographical area, including Ipswich West, Babergh and the surrounding area. The situation at Stella Maris became their single biggest concern during the period in question, despite them dealing with many high profile crimes and criminals. This meant they had fewer resources to use for other work, which led the Police and Crime Commissioner to express concern publicly about the cost of call outs and value for money. He was right to do so as a lack of join up by other agencies often leads to more emergency calls outs to the police. The police were outraged at one point in a professionals meeting when other agencies suggested they all walk away and leave the police to deal with the situation. This shows how partnership working in Suffolk, usually so effective, became extremely frayed to the point of splitting in this situation. Steps need to be taken to avoid this situation limiting the effectiveness of joint working. The graph below shows the estimated rising cost of call outs to Suffolk Constabulary amounting to over £20,000 and I also make a recommendation to the Suffolk Chief Officers Leadership Team about future joint working, not just between the police and mental health services, but across all public sector agencies in Suffolk. Partnership working has to be worked at constantly. It does not happen on its own. Many agencies work well together in a crisis. It is in the less high-profile situations that partnership working needs attention.



<u>Recommendation 23</u>: That the Suffolk Chief Officers Leadership Team put in place a programme to develop and maintain effective partnership working at all times, not just during a crisis.

Escalation

116. The situation at Stella Maris was not escalated to senior levels in any single statutory organisation involved until June 2020. It was escalated within Swanton Care and Inclusion Housing to their respective senior leaders. Escalation within the main statutory agencies was lacking despite one of the tenants being the top local priority for local police and despite the situation at Stella Maris being the most complex anti-social behaviour case in the local area in recent years. The lack of a clear line of sight between senior and junior staff within organisations is worrying. Of course, senior managers are dependent on their front-line staff realising they are dealing with a situation they should escalate. However, each agency should satisfy itself there are no internal barriers to escalation.

<u>Recommendation 24:</u> That statutory agencies review and update their internal escalation process so that a community hot spot which is more than immediate and temporary is escalated to senior officers so that a service-wide and multi-agency response is put in place.

117. There are a number of reasons for the lack of escalation, apart from the technical difficulties facing the police and ambulance service I have highlighted. Here are some:

- Whilst they were numerous, the incidents at Stella Maris when viewed singly and separately were judged as low-level to professionals accustomed to prioritising high-impact single incidents;
- There was a disconnect between the management system dealing with noise disturbance and anti-social behaviour and the health and social care system co-ordinating the care and support needs of individual tenants;
- No single individual or agency realised that if the concerns of each agency were aggregated, the situation would have been given a much higher overall priority. This also shows how rigid eligibility criteria used by agencies to define access to services and systems used for demand management and reduction can miss situations which are not high priority if looked at in isolation but which would command a much higher priority rating if considered together.
- Some officers did not sufficiently appreciate the level of risk to tenants or to residents. Those officers from various agencies would benefit from training in carrying out risk assessments and victim impact assessments. and how to take effective action. Responses do usually improve after effective training.

118. I recommend that a senior officer takes a lead role in co-ordinating the response to such a community hot spot as Stella Maris in the future. That officer can belong to any organisation as long as she or he is tasked to problem-solve across the multi-agency system.

The story below is told by the senior manager who responded to the issues when they were finally escalated to the most senior level.

A MANAGER'S STORY (SUFFOLK COUNTY COUNCIL)

I first became aware of the issues at Stella Maris on the 8th June 2020, when I received an email from the outgoing Head of Service Development & Contracts in Suffolk County Council, who had had recent contact from Babergh District Council to escalate the deteriorating situation at Stella. This initial email was then immediately followed by urgent contact from a raft of people and organisations, including a member of the Suffolk County Council Corporate Leadership Team who was approached by the local county councillor wanting to escalate the situation urgently. I was able to allocate a new contract manager to get a grip of the issues.

It soon became clear that there were multiple agencies involved and that each organisation was viewing the issues through their own lens and criteria. There was no single accountable lead for the system and there were varying levels of escalation to and from each agency. There were 8 tenants living at Stella Maris at the time. Some were clearly very unwell, living chaotic lives and challenging services and professionals, impacting on residents' quality of life. I quickly discovered that all tenants were on assured shorthold tenancies which made moving people on much more difficult and there were clear compatibility issues and safeguarding concerns. Meanwhile, agencies differed in their approach and interpretation of events- some feeling that the tenants were too vulnerable to take action against them; others feeling that the level of risk was much lower and that they should be held to account for what was perceived to be poor behaviour. The situation was made more difficult by the COVID restrictions which were in place due to the global pandemic and the fact that anxieties were heightened all round.

I was able to set up a multi-agency update meeting which provided a forum for all the organisations to come together properly, share information and agree to a plan of action. Through the support of my Director I secured a more appropriate level of input for those most at risk. Within 6 weeks, 4 of the tenants were supported to move on. This took a considerable amount of time and urgent input from a number of people and was entirely reactive as the opportunity to be proactive had been lost. The forum provided an opportunity for improved communication and a chance to understand each other's perspectives and roles. Although it was often challenging, the agencies started to work together.

Looking back over the last 3 months, I can see that Stella Maris was a perfect storm. I really hope that we can learn from the situation because it had such an impact on everyone involved- the tenants, the local residents and the professionals involved who all worked flat out to try to remedy a difficult situation at pace and under pressure.

<u>Recommendation 25:</u> That a multi-agency escalation policy is put in place, including the appointment of a senior manager to take a leadership role across agencies in relation to any future community hot spot where many agencies are involved and the issues are complex.

The role of local politicians

119. Elected representatives pride themselves on being active in their local communities in order to highlight and take up issues for local residents which need action and resolution. Concerns about Stella Maris were first raised with a Parish Councillor for Sproughton Parish Council on the doorstep very early on. This was neither recorded in the Parish Council minutes nor escalated. The Chair of the Parish Council was then contacted by one of the residents in October 2019, asking for help. She forwarded his e mail to one of the new District Councillors but it was not until this councillor was contacted by a second resident in May 2020 that he contacted the local county councillor who then became instrumental in getting the issues into the public domain.

120. The Chair of the Parish Council intends to note such incidents in future, so that they can be referenced or cross-referenced in case of a situation continuing or worsening as this one did. Another local politician worried he had not heard about the situation earlier.

121. I would have expected the political system to be more aware and active about such a community hot-spot as it was happening and to advocate on behalf of local residents. From my own experience, elected members usually know about local issues throughout Suffolk much quicker than happened at Stella Maris. This was partly because the ward councillors were only elected in May 2019 so they were still making links. A better information flow based on briefings and alerts between the different tiers of government in Suffolk would be beneficial, as would a guide for new members on how to navigate the Suffolk public sector bureaucracy, which like any bureaucracy is hard if you don't know where to go to and who to go to.

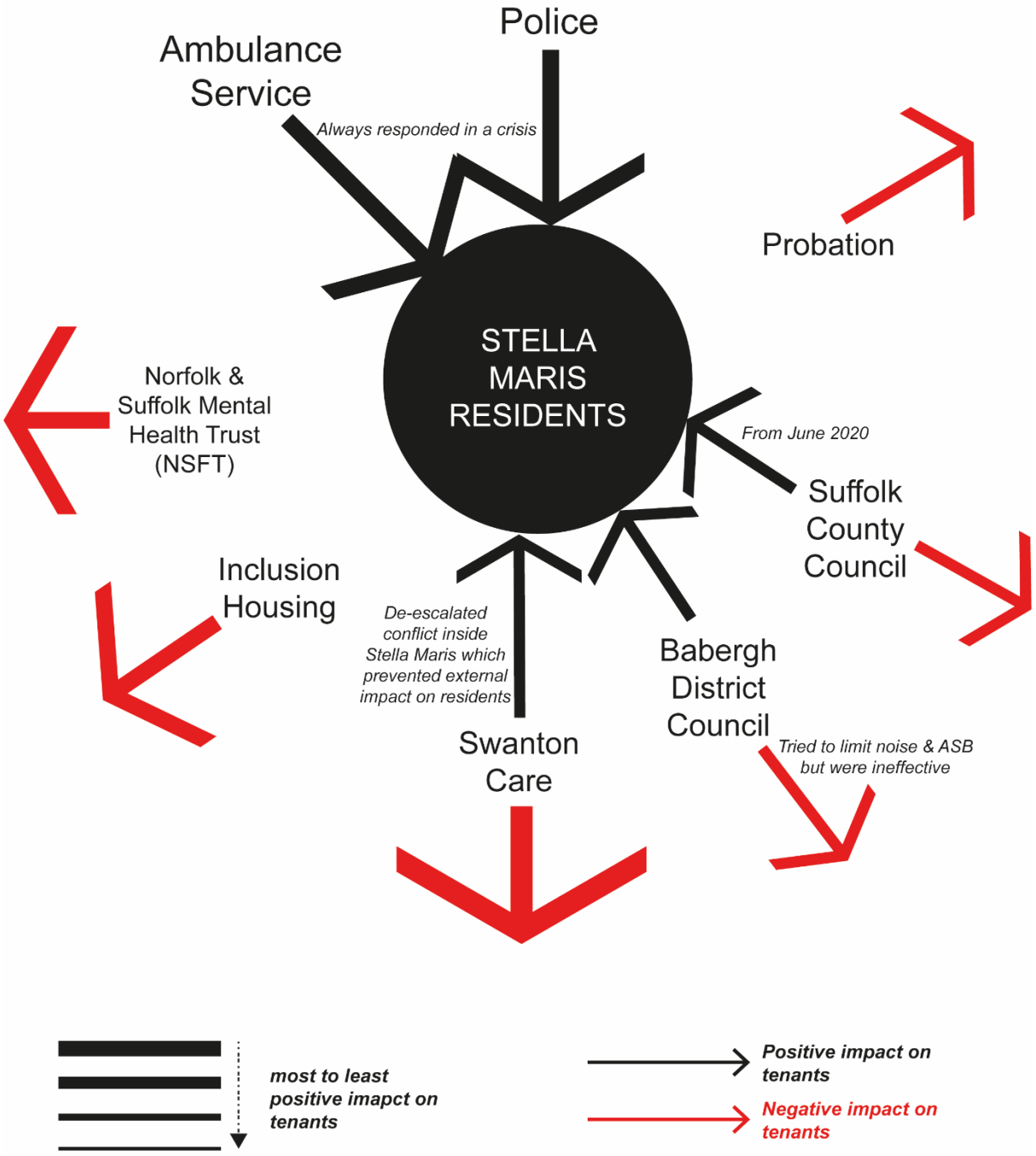
<u>Recommendation 26</u>: That the tiers of government in Suffolk explore how a more structured system of alerts and briefings could raise awareness of important issues before they become a crisis. Briefings for new members about how the Suffolk public sector works could be part of this framework

THE LOCAL RESIDENTS

122. The experiences of residents at Stella Maris were largely ignored apart from one Environmental Protection Officer who was worried about the well-being of one resident in particular. Residents were innocent victims of the noise nuisance and anti-social behaviour over a period of eighteen months. They were never thought of as victims. The emotional well-being of some residents suffered considerably. They tell their own stories directly below my commentary. The fact that their well-being was ignored does in my view mean that both the District Council and the County Council failed in their duty as 'leaders of place' to fulfil a duty of care to these local residents within the framework of the Localism Act 2011 and the Health and Social Care Act 2012 clauses about community well-being.

The impact of Agencies on the residents

Most agencies were experienced by some residents as positive and by other residents as negative. Only the Police and Ambulance Service escaped criticism.



123. About 1 in 5 people living in Suffolk are aged 65 or over. Over the next 20 years this is forecast to rise to 1 in 3, compared to 1 in 4 in England. Population growth since 2011 has been exclusively in older age groups and this is expected to continue. The majority of residents affected by events at Stella Maris were older people (over 65). A key objective of the Joint Health and Wellbeing Board for Suffolk is that 'older people have a good quality of life' (the Board's Strategy Refresh, 2019-2022). An impact assessment about the impact on the local community when the Stella Maris Flats were being developed in 2018 could have led to a deeper understanding about this.

124. The most extensive engagement with the residents was not carried by the agencies you might expect, but by the police, albeit not until early July 2020. The police carried out a StreetMeet survey of 15 households. 13 responded, making an 86% response rate, the highest they have ever received. Most residents said they did not feel safe or happy living in their street and that they used to enjoy the area more than they did at the time of the survey. They blamed Swanton Care who they felt were 'not managing the property as well as they should be'.

125. Customer care for the residents was also poor. They were not advised of steps they could take to remedy their situation, such as the Community Trigger for Anti-Social Behaviour. Mediation was contemplated by the District Council but not progressed, eventually due to Covid-19, though it had been first suggested several months before the lockdown. Swanton Care are now keen to do this. Whilst Swanton Care escalated their concerns to the relevant authorities, they did not keep in touch with the residents either to reassure them or to explain the reasons for the constant disturbance.

<u>Recommendation 27</u>: That District Councils and the County Council encourage the use of victim impact statements where a local situation is impacting on the emotional well-being of a resident or a group of residents. Whilst many individuals shy away from a suggestion they are victims, a stronger culture of victim support will promote greater community well-being.

126. One resident who worked night shifts and needed to sleep during the day did not sleep for 2 weeks as a result of the constant noise and disturbance. Another resident who was working from home during the March to July Covid-19 lockdown, could not make or receive calls on many occasions. The fact that more people are likely to be working from home in the future, means that noise control is even more important, especially noise during conventional working hours. This also affects students at school and university who are needing to study at home more. I recommend that District Councils review their noise nuisance policy and procedures with a view to providing greater protection from local noise nuisance for those working and studying in their homes.

<u>Recommendation 28</u>: That District Councils review their policy and procedures with a view to offering greater protection to local citizens from noise nuisance, especially with more people working and studying at home.

127. Local residents have lost trust and confidence in all agencies, specially the care provider Swanton Care. Only the emergency services emerge exempt from criticism. The main issue is the lack of trust and confidence the residents now feel. Restorative practice will be needed to re-build trust and confidence. I recommend that a senior manager from one of the main agencies involved becomes the point of contact for the residents of Stella Maris for the next twelve months, to build trust and ensure a return to normality in the local area.

<u>Recommendation 29</u>: That a senior manager from one of the main agencies involved acts as the point of contact and liaison for the residents of Stella Maris for the next twelve months, with the task of working with local residents to restore their trust and confidence in local agencies. A multi-agency co-ordinating group should come together if needed.

128. The residents were not saints. Inclusion Housing's managing agent reported one resident being verbally abusive to her. Some in Swanton Care found them to be aggressive, negative or hostile. At some point, one resident took video footage of what was happening, which was unwise even if understandable. Covert filming can become an issue in itself regardless of the content if a complaint is made. It is unfortunate that because the situation was left unmanaged for so long, all of those involved eventually turned upon each other.

129. There are regrets. The tenant at the centre of much of the concern, especially about anti-social behaviour, said to me they wanted to apologise for the upset they had caused to local residents. This was a heartfelt apology.

The resident's stories

FIRST RESIDENT'S STORY

When Swanton Care opened for business circa Dec 2018, we were not consulted by the District Council that the home would be used to house tenants with mental health issues for 5 years. And indeed that Inclusion homes had been given a 20 year deal.

Over the past 18 months, we have had virtually daily incidents with three main tenants. We haven't been able to simply go out into our gardens and relax without swearing and shouting, we even had to shut our windows just to prevent noise spillage.

We have tried to engage with Swanton Care but communications broke down after they essentially sent emails saying that they were changing things for the better, but would only email the Environmental Officer and subsequently stopped speaking to him.

Things actually got worse from Feb/Mar 2020 and prompted us to push back, as things were getting to boiling point. Staff were encouraged to be rude to residents by management.

Our firm belief is that Swanton have demonstrated a complete dereliction of duty to their clients. The county council need to consider a change of use to assisted living rather than supported living. Also we question if the District Council actually followed correct procedure before granting a licence for Stella Maris after no consultation with the residents.

Our biggest fear is the next group of tenants or clients could be much more threatening. This small community is a mix of people working from home and retired people who are not able to challenge or willing to confront the tenants of Stella Maris.

SECOND RESIDENT'S STORY

No one is taking responsibility for the people living in the flats. They seem to have been abandoned to fend for themselves even though they do so obviously need help. They roam around with seemingly no boundaries on their behaviour. I have no knowledge of the wardens because I have never seen them outside the flats no matter what was going on outside. I have been told by my neighbours that the wardens have hung up the phone when they have been called. This despite residents of the flats sleeping in a tent on the pavement or in the nearby park or screaming and shouting in the road. I have worried that someone inside the flats was being abused on a regular basis because of the episodes of screaming (not shouting) from inside the flats that can go on for some time.

On a personal level, I have lived here for 27 years. I am retired and widowed. Since my family left home, I have lived alone. In the last 20 months I have experienced increasing levels of fear, anxiety and anger about this situation whilst feeling powerless to change anything. I cannot have my two young grandchildren, who are an important part of my life, around to visit as the screaming which can be heard from the Stella Maris Flats is just too distressing for them to hear. This same screaming has meant that my windows have had to be closed at night, even during the tropical nights that we have experienced over the summer.

I've lived here for 27 years but I wonder if I can carry on. I live on my own and my friends are here so I don't want to move but I am scared sometimes even though I am a retired nurse and I have seen pretty much everything in my working life. I now park my car in the garage every night rather than feeling it is safe to leave it on the drive. I get a sinking feeling when I turn into our road after seeing the litter strewn everywhere and people sitting on the edge of the pavement.

All care provided should have some positive outcomes somewhere. I am at a loss to see any positive outcomes for anyone involved in this sorry mess and that includes these obviously distressed young people. I presume the funding for this enterprise is coming from the health care budget in some form. I consider that this is a misuse of public funds. There must be a better way to tackle this. If a member of my family were being lodged in this facility, I would be distraught.

One of the tenants is again sleeping in the park with her boyfriend who is banned from entering the flats. How can this be right in a civilised, caring society? I fear something catastrophic happening at some point. I worry for the future. Will we see any real change on a permanent basis?

THIRD RESIDENT'S STORY

I'm a broken man. It's a living hell. My health has worsened and my doctor has increased my medication for high blood pressure. My tremor has worsened. I cannot sleep properly because of the noise. I cannot go out and enjoy my garden. I don't like living in my house anymore. My grand-daughters aged 8 and 3 don't visit me any more.

Lockdown has made it worse. I am a busy professional person now working from home more. I have to apologise to customers on the telephone because they can hear screaming and foul language in the background.

All that has happened has got to me. The screaming, the fighting, starting fires in the street, threats shouted at me from tenants that they are going to kill themselves, screaming from a tenant that they have been raped in their room and the frequent use of a leaf-blower by one of the tenants to calm themselves. One incident that disturbed me greatly was when a tenant wandered into the street semi-naked. When staff asked the tenant to stop, the tenant shouted that she "wanted her mum". Perhaps the most disturbing moment was when tablets were thrown into my garden, that and when one of the tenants lay down in Hadleigh Road 'wanting to die. On the night of the riot, the same tenant stood in front of a delivery van.

All of this has meant that my grandchildren cannot visit me at home. Instead I meet them in the park across the road. The long term effects of all of this on my physical and mental health are a constant worry. A doctor's letter went into the council about my health.

I would like to see the tenants receive better care and an improvement in the current situation for all of the local residents.

FOURTH RESIDENT'S STORY

Most of us living close to the Stella Maris Flats have been affected in some way or another by the behaviour of residents there. This has been on-going for approximately the past eighteen months. It has progressively worsened in latter months, until the county councillor and the media stepped in.

We were not able to freely invite friends/family over as were embarrassed by what we may have heard or witnessed. Fighting/ verbal abuse/ foul language/ litter/fires/ taking up camp on the footpath at all times of the day and night.

There have been too many incidents to mention.

Our liberty of enjoying our sanctuary has been diminished and there seemed to be little or no recourse that we could see from Swanton or the council however much we tried. This must be rectified.

The waste of resource, time and money on the emergency services has been incredulous. It is unacceptable but if they didn't attend to de-escalate a situation what would be the alternative? I dread to think

Swanton care, the council and any other agency involved were simply not capable of looking after the complex residents in this supported dwelling. They were too much to handle, out of control and did not have any respect for where they lived or the people that surrounded them. We had been told that the support workers were told not to engage with certain difficult individuals, how is this support/care? This is not the right place, nor does it have the specialist staff needed for these complex individuals. The root of the problem is in the running of this business. There seems to be a visible lack of consequence or code of conduct in there. Not fit for purpose and a complete waste of money.

It has been extremely frustrating having to live in such unpredictable surroundings.
We are a neighbourhood that respects and looks out for one another. A fair few are elderly and vulnerable.

We do not deserve or shouldn't be put in such a position as we have been for the past eighteen months. We too need protection and help.

If this establishment is to stay, we would all like to be assured that we do not have to go through what was literally a harrowing time again in the future. As importantly the clients themselves should be placed and given the correct care and accommodation that suits their needs and not just passed on for it to happen somewhere else.

FIFTH RESIDENT'S STORY

I met one of the tenants when he wanted to help my friend who was cutting my hedge. He picked up the bits to put in the bin. On another occasion I found someone had tidied up the bricks that had been broken off my wall. That was him too. After that he always waved or spoke to me as did some of the other tenants. They also asked about my husband who had a few visits to hospital and wished him well. I am telling you this because there is a good side to these young people but if things don't suit, they get extremely angry and that is when they need expert help.

On one occasion when I went to bed at 10.45pm I saw the tenant who speaks to me lying on the pavement along with two dark shapes that looked like a TV and a suitcase. I could not sleep and got up again at 11.30pm to find him still there. This worried me so I rang the office and asked if they were supposed to be looking after the young people there. Someone came out and they both went in.

Many times the three of them have sat on the pavement, blocking the way so anyone walking would have to go into the road to get round them. They would eat and drink and leave litter around. Again I rang one day because it was very windy and litter was blowing around. I did not want it in my garden as I try hard to keep it tidy. It was cleared up.

Another day I looked through my bedroom window and saw the tenant I know light something in the gutter. It burned more so he used a t-shirt to try to put it out. Unfortunately it fluttered across to my side and as I have trees I was worried about it. Once it was out he found a piece of wood about 15 or 16ins long, it looked like a piece of the fence, and tried to light that. When it did not light he got a second piece with paper between and lit it that way. This time it was very near their laurel hedge so again I rang the office. A while later he knocked on my door and asked if I had seen a fire, when I said I had he said "That was me ". Then he asked why I had rung "them". I told him that fire was dangerous and I didn't like it. He then said that he did but walked away.

Then there was the time when they set up a tent on the grass verge and ran an electric cable from a first floor window across the pavement. The police came but it still stayed there.

If I was outside I very often heard shouting and screaming. I could not hear the words but it was enough to stop me going out in my garden. It made you wonder what was happening to them. It was quite distressing.

The police have called to ask questions about some incidents. It is a worry when you see the police at the door. You immediately think something has happened to a loved one.

Those young people in there are in need of professional help but seem to get no help at all. They deserve better.

THE FUTURE

130. I have made 30 recommendations for improvement which are set out in full at the end of my report. I have been heartened by discussions with all of the agencies involved about how the lessons to be learnt can be implemented. Some have started this process already. For example, Swanton Care have pledged to work more collaboratively, including with local communities where they manage supported living services and to exercise due diligence over assessments and plans for those vulnerable people referred to them. The police have also started to revise their internal procedures. These improvements are welcome and can be grouped with the more cohesive approach to contracting by Suffolk County Council and by Babergh District Council's strengthening of their anti-social behaviour team. This is the start of a multi-agency improvement programme.

131. I have tried to be fair, evidence-based and focussed on what can go right in the future, not on what went wrong in the past. If my report is uncomfortable reading for some and where I have made a professional judgment based upon an interpretation of conflicting evidence or what I have been told, I take full responsibility for what I have concluded and what I have written.

132. I plan to meet with the residents again in November this year and to take with me the senior manager who has been appointed as their future point of contact. I am also offering to meet with each senior leadership team in the agencies involved to talk my recommendations through, in order to inform action plans.

133. Finally, and to re-cap, I do not think that the Stella Maris flats should be closed. At least two tenants wish to remain and they should be allowed to. I recommend that the remaining flats are let to individuals with a clear need for specialist supported housing but whose lifestyles are not chaotic. Whilst a new care provider at the scheme may be able to get off to a fresh start, trust and confidence has diminished between all parties involved and will take time and effort to rebuild. Swanton Care may still have a future role to play in Suffolk should they wish and they could discuss their ideas such as a 'Keyring Support Model' with the Contracts and Commissioning teams at Suffolk County Council and with the landlord of Stella Maris, Inclusion Housing.

134. To risk what has happened over the last year repeating itself would be irresponsible. To let the Flats to people who need them but who will blend easily into the local neighbourhood would be responsible and would have the support of local residents if their trust and confidence can be restored as a matter of urgency through vastly improved communication.

135. If I am allowed one aspiration as a result of my Inquiry, it would be that it makes a positive difference for all tenants in supported living environments in Suffolk.

<u>Recommendation 30</u>: That Swanton Care and Inclusion Housing discuss the future use of the Stella Maris Flats with Suffolk County Council as a matter of urgency within the framework set out above.

THE RECOMMENDATIONS

Recommendation 1

That Suffolk County Council strengthen its Service Development and Contracts function, with a clear process for due diligence before a new scheme opens in the county. A more robust due diligence process would have picked up the concerns of the Regulator of Social Housing about Inclusion Housing, although Inclusion Housing should have told Suffolk County Council about their pending High Court judgment. Within the Contracts function, a knowledge of the needs of vulnerable children and adults is essential so that contract drafting and monitoring protects the needs of vulnerable people.

Recommendation 2

That a light-touch annual review of supported living schemes in the county takes place, co-ordinated by Suffolk County Council (probably by the Review and Audit Team in ACS) but including housing authorities, housing and care providers and agencies such as the police so that the available information during the course of the year is collected, collated and analysed. The Service Development and Contracting Team in the County Council should co-ordinate this process, provide reviewers with a short analytical template, provide support and ensure that reviews are carried out.

Recommendation 3

Funding panels should ensure that the appropriateness of individual placements and continued funding commitments are reviewed on a regular basis.

Recommendation 4

That as part of the set-up process for future supported living schemes, residents in the immediate vicinity of the scheme are engaged with by the future care provider and that this is also an obligation within the contract awarded to the provider by Suffolk County Council or whoever holds the contract for the scheme.

Recommendation 5

That consideration of the compatibility of tenants with each other is routinely made when developing new supported living schemes, so that the potential for a toxic mix is minimised. This responsibility should be shared between commissioners, care providers and landlords as consideration of this at Stella Maris was at best superficial and at worse non-existent.

Recommendation 6

That all commissioners and purchasers of specialist supported living placements build into the housing nominations process the appropriate statutory assessments under the Care Act 2014 and the 2005 and 2018 Mental Capacity Acts.

Recommendation 7

That this oversight and due diligence is also built into the contract development and tenancy support process for children and young people under 18, so that an all-ages approach is taken to the use of tenancies for individuals of all ages with complex needs.

Recommendation 8

That Suffolk County Council and the Norfolk and Suffolk Foundation Trust make their training modules and materials available to care agencies to whom individuals with the most complex needs are nominated or placed. This material should include techniques to manage challenging behaviour and training in trauma-informed practice. This should be done as part of the local authority's role in managing the market and supporting smaller providers especially to raise standards and as part of NSFT's role as mental health specialists e.g., in sharing the psychological formulations for patients which give clear guidance about how to work with people and which are bespoke to that person.

Recommendation 9

That a housing needs analysis of people with complex needs including chaotic lifestyles is developed by the Suffolk Housing Board, leading to a housing strategy for this group covering the next 25 years given the demographic projections of a constantly increasing requirement. This strategy should include a working definition of a 'chaotic lifestyle' and how those behaviours are best managed, so as to protect the interests of individuals who otherwise might be carelessly labelled and deprived of their rights.

Recommendation 10

That a new care, support and housing plan for the next 5-10 years is produced, commissioned and overseen by the Suffolk Chief Officers Leadership Team.

Recommendation 11

To build the multi-agency working practices displayed during the Lockdown into future multi-agency working practices, initially through writing a Lessons Learnt paper for the Suffolk Chief Officers Leadership Team (SCOLT).

Recommendation 12

That the Suffolk Safeguarding Partnership offers a training and support package - the materials only - to housing providers and care agencies aimed at embedding the Suffolk Safeguarding Adults Framework.

Recommendation 13

That the Suffolk Safeguarding Partnership takes further steps to promote more effective links between safeguarding agencies and agencies whose primary reporting line is into Community Safety Partnerships**.**

Recommendation 14

That the Suffolk Safeguarding Partnership convenes a meeting of Caldicott Guardians for each statutory agency involved with a view to clarifying when it is right and proper to share safeguarding concerns and with whom.

Recommendation 15

That Best Interest meetings are used to structure decision making about vulnerable people who lack capacity and where a vulnerable person, their family or carers and professionals are in disagreement about the right way forward for them. I particularly have in mind when decisions are needed urgently.

Recommendation 16

That Children and Young Peoples Services (CYPS) in the County Council ensure that parents whose children are removed from them because of risk, abuse or neglect are advised they will be helped and supported to keep their next child should they wish to take up this offer of help and support.

Recommendation 17

That the local Clinical Commissioning Group (the CCG) for North East Essex, Ipswich and West Suffolk, reviews its guidance to providers about medication management.

Recommendation 18

That Babergh District Council review its working practices to ensure that community hot-spots featuring persistent anti-social behaviour are escalated to a senior officer and reviewed formally to ensure the right type and level of multi-agency working and action is in place.

Recommendation 19

That Suffolk develop its own Personality Disorder Strategy, jointly developed and funded by the CCG's covering Suffolk jointly with Suffolk County Council.

Recommendation 20

That the s75 agreement between Suffolk County Council and the Norfolk and Suffolk Foundation Trust is ended and that that the social workers transition into the community-based structure of Adult and Community Services (ACS) in Suffolk County Council.

Recommendation 21

That the police put in place a technical upgrade to their incident logging system, Webstorm, to allow for an easier read across when they are called out on multiple occasions to the same address or situation.

Recommendation 22

That the police and ambulance services put in place a trigger mechanism for escalation after a set number of call outs.

Recommendation 23

That the Suffolk Chief Officers Leadership Team put in place a programme to develop and maintain effective partnership working at all times, not just during a crisis.

Recommendation 24

That statutory agencies review and update their internal escalation process so that a community hot spot which is more than immediate and temporary is escalated to senior officers so that a service-wide and multi-agency response is put in place.

Recommendation 25

That a multi-agency escalation policy is put in place, including the appointment of a senior manager to take a leadership role across agencies in relation to any future community hot spot where many agencies are involved and the issues are complex.

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Anthony Douglas CBE

Written between late August and early October 2020. Published on 15 October 2020.