Bristol Safeguarding Adults Board Briefing

Information about Briefings

This is produced by BSAB to help practitioners reflect and continuously improve their practice.

Thank you for taking the time to read this Information.

There are three areas of learning:

- What you must know
- What you should know
- What is good to know

At the end is a feedback form to help us assess how you and your organisation has implemented the changes

SAR Briefing: BSAB Lessons Learnt

What Is A SCR/SAR?

A Serious Case Review (SCR) is the old name for a Safeguarding Adult Review. The Care Act 2014 states that Bristol Safeguarding Adults Board (BSAB) must commission a review when:

- an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more or effectively to protect the adult
- an adult in its area has not died, but the Board knows or suspects that the adult has experienced significant abuse or neglect.

BSABs can arrange for a SAR in any other situations involving an adult in its area with needs for care and support but will only do so when learning can be gained which can be used to prevent future harm or death to others within the city and / or wider.

The purpose of a SAR is to determine what relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death so that lessons can be learned.

About the individuals

Robert was 24 years old when he was murdered by another resident (B) at a supported accommodation provision in 2013. Robert was the father of two children. He was described as ‘‘an exceptionally nice man, who was warm and friendly…supportive and compassionate to others’ experiences’. Robert had experienced psychosis for which he was detained in hospital under the Mental Health Act (1983) in June 2011. He moved into the supported accommodation provision as the next stage in his rehabilitation. Robert had experienced bullying and harassment in his previous accommodation.

B was 41 years old when he killed Robert. He is described by those who knew him as a frightened and anxious man, and someone who was vulnerable to bullying and needed support. Prior to Robert’s death, B had complained to both X House and the police over a period of months that 4 residents, including Robert, were sexually harassing him. At times B would leave the accommodation to sleep rough in order to escape from perceived sexual harassment. No evidence of sexual harassment could be found. Similar behaviour and allegations were reported at B’s previous accommodation too.

What can you do?

Read the full report on the BSAB website

Ensure your organisations policies and procedures are up to date

What must you know:

- This case underlines the importance of collecting all possible information from a range of agencies on the previous history of new residents in supported accommodation, in order to have as full as possible an understanding both of their vulnerability and also any risks they might pose both to themselves and to others. It is vital that professionals **complete HSR applications accurately and do not minimise risk** to support a client to access accommodation. It is good practice for accommodation providers to speak to previous providers when the adult moves in to fully prepare for their needs and ensure information is not lost.

- Accommodation providers' risk assessment process should **holistically** consider an individual's needs and strategies for managing these, not just at the risk to tenancy.

- Escalation of concerns or challenging of other organisation's decisions is essential to keeping adults' safe. Professionals should follow the BSAB Escalation Procedure if they are in disagreement with the decisions of another agency. This includes the decision not to offer support if your professional assessment is that that service is required

What should you know:

- **Liaising and communicating with GPs** as part of a multi-agency response to adults with complex needs is particularly important when they are not engaging with secondary mental health services. Communication with B's GP was not sustained after he moved accommodation. The GP was not approached for advice or support when his mental health deteriorated.

- B never engaged with secondary mental health service prior to Robert's death. Many adults struggle with **engagement.** Bristol has The Assertive Contact and Engagement (ACE) Service which reaches out to people and groups who face complex barriers to services, including barriers due to cultural background or chaotic lifestyle. Anyone can refer an adult to this service.

What can you do?

Take some time to think about what these key messages mean for your practice.

Ask yourself:

- Can I make changes to my own practice?
- Do I need to seek further support, supervision or training?

What would be good to know:

- **Indirect violence should be seen as a potential risk factor** for actual violence. B had taken indirect action against neighbours in previous accommodation – e.g. hitting a wall with a hammer, and trying to kick a door down – which did show he could take violent action when in fear for his own safety. His behaviour could be difficult and challenging when he was distressed, and there are records of him getting into verbal arguments and of complaints being made about him to the police in the past by other tenants and family members.
- Housing support providers may need to seek advice and support on mental health issues, including autism and Asperger's syndrome. **Bristol Mental Health** offer services in Bristol for adults with mental health needs. Details of services and contact details can be found here
- Out of hours staff need to be fully briefed on **de-escalation strategies** and current risk assessments in order to respond effectively to crisis and assess risk appropriately.

Please complete any reflections that you have had from reading this briefing and any practice changes you are going to make:

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