Bristol Safeguarding Adults Board

Serious Case Review of a Male Adult RC

Date of birth 05.12.1988 Date of Death 9.08.2013

Executive Summary

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1. Introduction

This Serious Case Review was commissioned by Bristol Safeguarding Adults Board (BSAB) following the death of Robert on the 9th August 2013. Although B was charged with the murder of Robert he was eventually found guilty of manslaughter due to diminished responsibility. Robert and B were both living in supported accommodation at "X House", a service for people who have a mental health issue, are homeless or vulnerable. Both men had accessed the accommodation via the Housing Support Register, a Bristol City Council single point of access for referral to housing agencies and support services. Robert was fully engaged with secondary mental health services and had been for several years prior to the incident. Whilst B had demonstrated indications of mental distress over several years, he had never engaged with secondary mental health services, he appears to have avoided any voluntary contact and never reached any threshold for use of the Mental Health Act to compel engagement.

At the time of the incident Robert was 24 years old and B was 41 years old.

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 X House to sleep rough in order to escape from perceived sexual harassment. No evidence of sexual harassment could be found. B had demonstrated this pattern of behaviour in previous accommodation but detailed information about this, and ways of mitigating his distress, had not been recorded and passed onto X House. Ways of ensuring that B engaged with services had also not been passed on from his previous accommodation.

On the evening of Friday 9TH August, after staff had left the premises, B telephoned the police to complain that he was again being sexually harassed by Robert. The police attended but left as they did not find any evidence for B's claims and thought that Robert was not on the premises. After making two further calls to the police B said that he would "deal with the matter himself". Five minutes afterward B fatally stabbed Robert.

At the time of his death both Robert and B were considered as vulnerable men under the Bristol City Council's 'No Secrets in Bristol' policy. A vulnerable adult is defined under the policy as:-
A person over the age of 18 years who has, or may need, help with their everyday living because they are a disabled person experiencing physical or sensory impairment, learning difficulties, mental distress or are frail, older people AND are unable to care for themselves or protect themselves from significant harm or exploitation.'

Both were living in the same supported accommodation for people with mental health needs.
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On the 23rd October 2013 the BSAB determined that that Robert's death met the criteria to undertake what was then referred to as a Serious Case Review (and would now be a SAR) having regard to the criteria at the time and commissioned an independent review::

- *The BSAB should conduct a Serious Case Review when abuse or neglect is known or suspected to be a factor in the following circumstances involving a vulnerable adult(s):*
- *A vulnerable adult dies (including death by suicide)*
- *Where there has been a suspected act of omission by an agency which contributed to abuse or suspected abuse or neglect of a vulnerable adult. Where during a case there has been a serious breach of the safeguarding adults' policy "No Secrets in Bristol".*

2. Terms of Reference

An independent chair and author were appointed and a review team comprised of senior managers, who had no direct involvement with the case, from all agencies and organisations who had involvement with Robert and B.

Agencies represented on the SCR Panel:

- Bristol Clinical Commissioning Group
- Bristol City Council
- S Housing Association
- Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
- Avon and Somerset Constabulary
- NHS England

In order to learn from the events surrounding the death of Robert the Serious Case Review adopted the following terms of reference agreed by BSAB. :

We will examine the following aspects for both. RC, victim, and B, the perpetrator of the crime against RC:

- *The risk assessment and risk management practices of all agencies involved.*
- *Multi agency information sharing and support to manage risk in the supported living environment.*
- *The range of services that both individuals had access to or could have had access to, including supported living, in order to inform the future commissioning of supported living.*

The timeframe for the review to look at was **1st January 2010 to 10th August 2013**

3. Family Involvement

Robert's family met with the Chair of the SCR and a Panel member on 10 February 2014. They reviewed the proposed terms of the SCR and also added some questions of their own. Some of these questions were outside of the scope of the SCR, i.e post the incident. The family's areas of concern can be summarised as follows:

- whether the right type of service for vulnerable people with mental health issues is being commissioned,

- what type of assessments were carried out regarding the suitability of both men for the service,
- was information shared
- if staff had been available, could the fatal incident have been prevented?
- Did the provider follow health and safety policies and procedures,
- do the police have policies and procedures in place which give guidance on working with vulnerable people,
- what follow up was done to ensure B kept appointments.

These questions were integrated into the questions asked of interviewees and the analysis undertaken of chronologies and internal management reviews.

Robert's family moved out of the UK during the Serious Case Review and although there has been ongoing contact with them no further face to face meetings with the family were held. The family expressed a preference for email contact and did not accept offers of telephone or Skype contact. The family responded to the draft report as it was developed and this helped to shape the final version. Robert's family have asked that he is referred to as "Robert" throughout this summary. The family commented on the final draft version of the review on the 25th October 2015 as follows:

Robert was a much loved son, brother and father of two. As a family we have been attempting to deal with his sudden and unprovoked death since August 2013. Our family have suffered a loss that cannot be understood by those not impacted by it.

Part of the issues with Robert's death is that it appears to be so senseless. We read this Report and see that Robert had been singled out by another resident. A resident who has shown similar behaviours at previous residentials yet this was not recognised. We also fail to see how Robert was properly safeguarded from a threat other than to tell B his continuous claims of sexual harassment were unsubstantiated.

Part of the pain is having to deal with various reviews that have resulted from the loss of Robert whilst he was in the care system, for example this Serious Case Review.

As a family we are expected to trust that the Recommendations are based on more substantial evidence than we have been provided with and that the Report will help prevent such a senseless death occurring in the future. We find this questionable.

4. Methodology

The Review adopted a ‘mixed methodology’ using a lessons learned approach as developed by the Social Care Institute of Excellence (SCIE) alongside Independent Management Reviews (IMRs) and a combined chronology of events. The SCIE approach was used to look at the whole system around both men, looking at what policies and processes were in place at the time rather than with hindsight, and the sense that professionals were making of issues at the time, the thinking that lead to their actions or lack of action. Interviews were held with key individuals involved with both or either men. Independent Management Reviews and chronologies regarding both parties were also commissioned from the agencies who had regular contact with Robert and B during the agreed timeframe. Agencies involved were :

- S Housing Association
- Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
- Bristol City Council Neighbourhoods and City Development Services
- Avon and Somerset Constabulary
- GP for B
- The Bristol Autism Spectrum Service (BASS)
- X Hostel

These reports, together with feedback from the individual interviews, form the basis of the Serious Case Review. The independent author then created a combined chronology and wrote the Overview Report. This executive summary is based on the overview report

5. Factual/Contextual Summary

Robert was described by his mental health worker as ‘an exceptionally nice man, who was warm and friendly. As a member of an AWP Recovery Group, he was described as supportive and compassionate to others experiences. He listened well and was emotionally intelligent and mature.

His support worker described him as “good fun to work with, cheeky and characterful, with good motivation, and some chaotic behaviour. He needed support and had been a victim of bullying in other settings”.

Robert moved to the X House accommodation in on 20 November 2012. He had a difficult time prior to his move to X House where he had begun a new stage in rehabilitation from serious mental health issues. At the point of referral Robert was living in a private hostel. Robert had been bullied and his mental health was thought to be deteriorating as a result. Robert had experienced psychosis for which he was detained in hospital under the Mental Health Act (1983) in June 2011. The HSR recorded that Robert had no known history of violence, or harm to self or others.

B was described by those who knew him as a frightened and anxious man, a ‘victim’, and someone who was vulnerable to bullying and needed support. Staff from the hostel where B lived previously described him as “someone who lived very quietly, and kept his room neat and tidy but did not have friendships with other men in the house. He valued support from the church. He was a troubled man who needed support.”

B was assessed on the Housing Support Register (HSR) as being at minor risk of self-harm. There was no known history of violence or risk to others recorded on the HSR. B was assessed as at medium risk of damaging property as he had damaged CCTV cameras in 2011. B reported that he felt anxious amongst people he didn’t know and preferred to be alone. It was noted on the HSR risk assessment that B had made allegations of sexual harassment at the hostel he lived at, but this was seen as an indicator that he should live in a smaller unit as he was “vulnerable”. B was accepted by the provider and moved into X House on 8 April 2013.

B made complaints about Robert and other residents within a month of moving into X House, and continued to feel discomfort in their presence. He complained of sexual harassment and bullying and he felt particularly vulnerable at night and at weekends when no staff were present. He contacted the police and made formal complaints to the housing provider. These complaints were investigated and followed up but were

found to not be substantiated. There was no evidence that B was being sexually harassed by Robert or any other resident. At times B dealt with his feelings of insecurity by leaving the house and going away to stay in his tent for few days or sleeping rough. However he continued to feel these concerns and to make complaints up the point of Robert's death.

B was initially described by staff as being peaceful and unlikely to be aggressive or violent. However over time they became concerned that he was at high risk of loss of tenancy and had increasing concerns about his mental health. They were also concerned about his vulnerability when he left X House following perceived harassment and slept out.

6. Analysis of themes

Inter-Agency Communication and Information Sharing

Both Robert and B had contact with range of agencies prior to moving to X House and continued to do so whilst living there. Information regarding Robert was known through his use of secondary mental health services and the information sharing relationships between mental health staff, X House staff and the HSR .

B and his history were not so well known, he moved frequently and for periods had been homeless and sleeping rough. No single agency was in possession of all the facts that have been gathered for this report.

However key pieces of information regarding the degree and intensity of B's obsessions were not passed on through the HSR or by the hostel B had previously resided in to X House.

B's previous provider had ensured that he visited his GP by accompanying him, and had a strategy for calming him when distressed, but these details were not passed on to X House. B was felt by his previous provider to need access to 24 hour staff and self contained accommodation. X house offered the best fit in having a self contained flat on the premises, but did not offer 24 hour staff availability, it did however have staff during weekdays and two evenings per week and was as such

the most adequately staffed premises. However no contingency plans were made for B outside of staffed hours, his intense need for immediate access to reassurance was not recognised by the provider.

B did not see his GP again after being admitted to X House. The need for staff to take him to the GP was not known. B's GP had recognised his mental distress and intended to refer him onto appropriate services once he was securely housed. X House were supporting B to make connections at the local homelessness support centre, including access to counselling and psychological support, but did not liaise with his GP.

B had regular contact with the police, (including significant out of hours contact) both prior to moving to X House and whilst living there. He had been known to the police when he was sleeping rough and when his attempts to live with his family broke down. The contacts he made with the police whilst living at X House were mainly to do with concerns he had about sexual harassment from other residents. This pattern of complaints had occurred in B's previous placements. The police did not identify any pattern or escalation to B's behaviour, they did not make referrals to the police safeguarding adults team or to the local authority team, or to mental health teams. They assumed his supported housing workers would manage the situation.

5.1 Risk Assessment and Risk Management

The HSR did not contain sufficient information to formulate an accurate risk assessment or management plan about B's obsessions with being sexually harassed. Information from B's GP or from his previous hostel accommodation could have enabled X House to formulate a risk management plan around de escalating B's distress. This information was neither sought, or provided.

The chronology compiled for the Serious Case Review illustrated that B's history of frequent moves and reluctance to engage with services, as well as his need to keep himself separate from others, made it difficult to fully assess any risks he might pose. He was himself vulnerable to bullying and harassment and seems to have often acted out of fear and concerns for his own mental or physical safety. In addition his

frequent moves and relatively short stays in different settings made it difficult to see any established patterns or to accurately predict his behaviour.

Could the risk of B taking such extreme physical violence against Robert have been predicted by those who worked with him? 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. However there is no record of him having taken direct action against a person or recorded evidence that he would use a weapon to attack someone. As a person both self identifying and being identified as a “victim” of harassment B was not subject to any increased scrutiny regarding possession of weapons within the premises. B’s feelings of persecution had become intense over the weeks before he killed Robert. X House strategies of supporting him to report to the police in order to value his perceptions, of confronting and counselling him, were clearly not working. However it is hard to find indicators that he would have taken the violent action that he ultimately did.

X House did begin to revise their risk assessment of B after observing his behaviour on a CCTV camera in a communal area on the 14 June 2013. B appeared to be having a verbal argument with two residents including Robert, he suddenly ran at the two others, diverting and rushing past them at the last minute. X House became more concerned about the degree of his mental health issues and for the first time saw that he could be a perpetrator of abuse. They found it difficult to persuade B to get help for his intense feelings of persecution, ultimately they were able to get his agreement to start some counselling and support at the C centre. B felt the answer to his distress was to retreat to a spiritual community. There is no evidence that X House approached B’s GP for further advice and they did not feel supported by secondary mental health services with regard to B or others with potential mental health issues.

When interviewed for the SCR an X House staff member said that

It is difficult within the house to manage risk and demand and respond to these given the limited staff cover (ie not weekends or evenings). There was a risk assessment in place and B was initially considered a low risk. It is hard to engage with mental health services 'who do not value the perceptions and concerns of supported living providers"

5.2 Suitability of Supported Accommodation for Robert and B

Prior to placement at X House both B and Robert had been judged as needing 24 hour staffed accommodation. This was not available in the Bristol area. X House was judged suitable for both men as it had good daytime cover until 7pm each night and on-call cover at nights and weekends. Robert had a good level of support as in addition to the support provided by X House staff he had regular support from external mental health services.

B was in the right type of accommodation, i.e. one of the self-contained studio flats, but he lacked any additional support, in particular the access to quickly available reassurance when distressed. He had 2 attended sessions at the Bristol Autism Support Service, but this was focused on providing information about Asperger's Syndrome and Autism and helping people to understand their condition rather than any therapeutic input.

There is no accommodation for people with mental health issues needing both a supported living environment and 24 hour support in Bristol.

5.3 Access to Mental Health Services: Diagnosis and Treatment

Although both men had mental health needs, their engagement with, and access to, mental health services was very different. Robert had been diagnosed with a serious mental illness and was receiving regular treatment and support. B was recognised as having mental health needs but was not deemed to be suffering from a serious mental illness. He had been diagnosed as having childhood autism and Asperger's Syndrome and was not receiving direct support from mainstream mental health services as he did not appear to meet the criteria for services, and was also not willing to engage with them for further assessments. A number of opportunities to

engage B in a mental health assessment arose. B was assessed by mental health services in another local authority area in 2011, but the service had judged that he did not need a service from them and that he had a mild Learning Difficulty and Personality Difficulties of an anxious/avoidant and paranoid type.

A further mental health assessment would have needed B's consent, as he was not considered as being in need of an assessment under the provisions of the mental health act 1983.

In 2012 B was seen by a doctor at Southmead Police station after being detained by the police. The doctor recorded that his presentation at the time did not indicate he needed to be assessed under the mental health act for potential sectioning. This appears the only recent occasion when a mental health assessment could have been compelled.

Information from his GP prior to March 2013 recorded that B was viewed as suffering from a mental illness and that he believed that he could feel other peoples' thoughts about him. He was also described as having a high level of anxiety around other men. The GP did not feel the previous diagnosis of mild Learning Difficulty was accurate, and thought that his mental health difficulties were chronic and of long standing. The GP had planned to refer him to mental health services once he was in stable accommodation but lost touch with B after he moved to X House.

There was frustration expressed by agencies about the difficulty of getting mental health services to advise and support staff working with people who were unknown to local services but who were still appearing to experience mental distress. The Police were also concerned about out of hours access to support from mental health services, often being left with crises which needed a professional other than the police to respond to. It was felt by these agencies that opportunities to access mental health services were not easily available. Agencies within the scope of the SCR have described the need for a consultancy service from mental health to support agencies (including the police) in the community who are dealing with vulnerable people. Housing support agencies found that the entry criteria for mental health services was high which made it difficult to access general advice and support.

Decision Making and Actions Taken

The agencies involved with both B and Robert appear to have made their decisions based on the best information available to them at the time; however none of them had access to all the information.

On the evening of the 9th August the X House staff were not on the premises and were not fully aware of the stress B was experiencing immediately prior to the incident. Out of hours support from the housing provider was limited and the person on duty at the time did not know B or his background and only had telephone contact with him. The out of hours worker was assured by B's calm discussion, reporting that he said he was fine and was polite and calm and thanked him for his call. At this point, it is highly likely that B had already determined to take the action he subsequently did to "deal with it himself". He had no knowledge of B or the historical situation.

If B had responded as he had in previous instances of distress and agitation it is possible that if a member of staff he knew had been present they may have been able to support him, or he may have chosen to leave the premises for a short time as he had done in the past. The out of hours worker did not know of these options.

The police who responded that evening had mental health training, one officer had also had training in working with people with Autism. However they had no information regarding B's background, and took the approach of dealing with each individual according to their immediate circumstances, forming quick judgements on the basis of what they saw. Officers were not trained sufficiently to identify that B may have autism, and indeed this identification can be hard for a well trained professional to make quickly. Having found no evidence of harassment they contacted the X House out of hours on call staff, passing the responsibility back to the housing staff. They believed that they had left B calm but unhappy with their response.

B called the police again at 21.28 to say that Robert was resisting police which was a criminal offence and he was being harassed and sexually harassed by him. He told the police he would be making a complaint as he was not being kept safe. He subsequently phoned them again at 21.48 asking them to arrest Robert but that as

they would not do anything he would deal with it himself. The last police call handler B spoke with demonstrated impatience with him, and did not provide any reassurance or calm listening which may have helped in the situation

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Conclusion

This case has led to the tragic death of one man and has significantly affected the future life of another and the families of both. Could Robert's death have been predicted or prevented? Reliably shared information between agencies, agreed and understood risk assessment and management in supported housing services, underpinned by ready access to mental health advice, would have provided a framework for working with B effectively and would have reduced B's distress and provided more insight into what his behaviour was indicating and what the real risks were. Accommodation with 24 hour support may have also reduced the liklihood of the extreme escalation in B's behaviour. However no agency involved was able to predict that B would kill Robert or that he was capable of such an act.

Lessons to be learned and Recommendations to Bristol Safeguarding Adults Board

Lesson 1: 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. In order to achieve this, agencies need to work together closely and to ensure all relevant information is shared.

Information is personal to the person it relates to. However there are circumstances in which it is essential to share personal information in order to prevent very significant risks to the person or the people they are living with. Information about the background, needs, vulnerabilities, and risks posed by individuals on the Housing Support Register is crucial in enabling housing support providers to fulfil their responsibility to assess the suitability of the person thoroughly, to consider all

aspects of vulnerability and risk and to consider the impact of accommodating or supporting that person on others living at the same address. Information enabling risk assessment on **all** potential risks must be included.

Information sharing becomes particularly important when individuals frequently move between providers, or spend periods sleeping rough.

In this case the provider had no information on the perpetrators specific support needs, e.g. support needed to access health services, strategies for reducing risk or about themes of concern regarding enduring mental health issues. The provider had a risk assessment process, but was only given information about risk to tenancy and not the historical concerns about B.

The Housing Support Register in Bristol enables referrals to be made to appropriate services for people with high, medium and low support needs. Information from a range of sources must be used to determine the level of support needed, factoring in all information known about the individual's needs.

Recommendation 1: Improved information sharing across all agencies working with people who are on the Housing Support Register **.**

A protocol and process must be devised for accessing, sharing and updating information held on individuals on the Housing Support Register. This will include protocols regarding consent and ownership of information, triggers for information sharing, a mechanism for sharing. GPs must be included in this process and their role considered. Information should be multi agency where possible.

Information about specific support needs and information enabling risk assessment on all potential risk must be included.

There must also be clear recording of the expected outcomes of accommodating a person with housing related support needs. These should be reviewed; particularly when people cannot be placed in appropriate accommodation, their progress and the suitability of the accommodation must be considered in a partnership between the resident, the provider and other involved agencies.

Agencies need to ensure that out of hours staff have access to information on individuals and are able to share this information on the basis of a need to know with

police officers who are attending un staffed premises in order to address concerns expressed by residents. This should include any risk assessments and management plans which need to be shared in order to de escalate crisis situations.

Lesson 2: Risk assessment and management tools are under developed and inconsistent amongst supported housing providers. Assessment and management focus on the risk of loss of tenancy but not around other risk assessments. A common process and tool could have been used as a vehicle for communicating risk regarding individuals across the agencies who worked with them. Risks to the service user and others, including others at the address, need to be covered, together with risk caused through non engagement of the individual with services. This is also related to the finding of lesson 3, in order to identify and manage risk well, providers need ready access to advice and support from services who understand the type of risk posed and how best to manage this.

Recommendation 2: Housing Support Register referrers and providers to use an agreed risk assessment and risk management protocol and process across Bristol

The first step will be to scope existing providers and agree risk domains. The next step is to identify an approved model of risk assessment and risk management which can interface with existing statutory risk assessments. The protocol and process will be launched with stakeholders via targeted events. The model will be reviewed after 3 months of operation.

Both recommendation1 and 2 need to be aligned with work currently being developed as part of the Bristol Fulfilling Lives programme.

Lesson 3: Housing support providers need to be competent to consistently undertake risk assessments and generate risk management plans in partnership with people being supported by them. Housing providers can use risk assessments to inform support arrangements, for example what type of out of hours arrangements are required, what contingency plans need to be in place for each individual, and for the overall setting in which they are accommodated. Risk assessments and management plans need to be dynamic and responsive to new information and observations.

Recommendation 3: Housing support providers must ensure their staff are competent to use the agreed risk assessment and management protocol and process is available and mandatory, and that support, advice and mentoring is identified and accessed. A training programme, based on agreed competences, must be developed as part of the risk assessment and management protocol above.

Lesson 4: Supported housing providers are faced with an increasingly complex group of people needing services over and above those offered by the housing support provider. Risk assessment and management in such settings is not just about the risk of losing tenancy. People living in supported accommodation may have disengaged or not wish to use services. Services may not become involved with them until after a crisis has occurred. The staff who are engaged with people do need ready access to support and advice about how to meet needs and manage very difficult and risky situations on a daily basis. This must include support and consultation from specialist services with regard to service users who are on the autism spectrum as well as mental health concerns. There is currently no agreed escalation route for providers when situations reach crisis point. Providers can be left feeling that their concerns and experiences are being dismissed by statutory and specialist services and may in turn hesitate to be assertive if referrals are rejected. Providers may not be aware of the range of services offered and be isolated in their attempts to deal with concerns. People who statutory services find hard to engage can be worked with via their existing relationships with providers and relationships built via this route.

Recommendation 4: Housing support providers must have ready access to consultation, advice and support on mental health issues, including autism and Asperger's syndrome. There must be an escalation route should grave concerns or a crisis develop. Providers must know when and how to access multi agency forums.

A model for accessing advice and support for providers and the people living in supported accommodation must be agreed. In reach or liaison models should also be considered, together with consideration of how existing services can be more accessible. Access to information for providers and others out of hours must also be considered.

Lesson 5: Both of the men who are the subject of this SCR were said to need a service which offered 24 hour support, this level of support was not readily available at the time they were in need of supported accommodation.

Many of the agencies involved in the SCR have expressed the concern that the range of supported accommodation available for people who have complex needs, including enduring mental health issues, is not comprehensive enough and does not include options for people who need 24 hour support as part of their rehabilitation into the Bristol community. This assertion should be explored by the relevant commissioners and the range of housing options reviewed.

Recommendation 5: The range of available accommodation for people with mental health issues needing housing related support must be urgently reviewed. Commissioners must review accommodation options for people with severe and enduring mental health issues. This will link to accommodation as well as mental health strategies. The nature of provision needs to be captured and analysed, the gaps and changes needed analysed and a mental health accommodation strategy confirmed.

Glossary of Terms

A/E Accident and Emergency Unit

AWP Avon and Wiltshire Mental health Partnership Trust

BASS Bristol Autism Spectrum Service

BCC Bristol City Council

BSAB Bristol Safeguarding Adults Board

CCTV Closed Circuit TV system

CPA Care Programme Approach (multi-agency support plan)

DAIT Domestic Abuse Intervention Team (no longer in use)

DASH Domestic Abuse, Stalking and Honour-based crimes (multi – agency system)

HSR Housing Support Register

IMR Independent Management Review

SCR Serious Case Review