Bristol Safeguarding Adults Board

Response to the Serious Case Review into the Death of Mr C

The Board would like to express our condolences to the family and friends of Mr C and thank them for their contributions to this report and working with us at this difficult time. All the organisations which make up Bristol Adult Safeguarding Board including Avon and Somerset Constabulary, Bristol Clinical Commissioning Group and Bristol City Council regret the death of Mr C.

The Board welcomes the findings of this serious case review which provides important learning for all agencies on how we can improve our support to people who are reluctant to accept help. Bristol Safeguarding Adults Board accepted the findings and recommendations of the Serious Case Review into the death of Mr C at an extraordinary Board meeting held on the 11 August 2016.

The Board is confident that the recommendations in this report will further develop and improve the way agencies work with people in similar circumstances and ensure that agencies continue to work together to minimise the likelihood of events such as these happening in the future.

The Board has asked one of its sub groups, the Safeguarding Adults Review (SAR) sub group, to monitor the multi-agency actions taken to implement the recommendations of the review. The SAR subgroup will provide a quarterly progress report to the Safeguarding Adults Board, enabling the Board to challenge and support agencies in enacting the recommendations.

Recommendations

Recommendation 1

That BSAB should develop a joint protocol to be followed when working with individuals who self-neglect.

A joint protocol to address the needs of people who self-neglect will be developed by BSAB.

Recommendation 2

That BSAB should assure itself that partner agencies have adequate policies and training plans in place to ensure improved practice in matters relating to Mental Capacity Assessments and that these

plans will enable staff both to become more confident and competent in carrying out such assessments, and also to understand and respond appropriately to the findings of the assessment.

A training self-assessment has been requested of partners by BSAB and this has included questions in relation to Mental Capacity assessments. The outcome of this will be incorporated into a review of overall training provision within and across agencies. The Board will also be seeking assurance from agencies that regarding their policies in relation to Mental Capacity Assessments and how they ensure these are being adhered to.

Recommendation 3

There is no local inter-agency understanding or agreement about how concerns can be escalated in any cases requiring multi-agency input, including self-neglect, so the Bristol SAB should draw up a local agreement identifying how agencies can flag concerns about escalating problems, and what responses are required.

BSAB has developed an escalation protocol and this will be implemented and its use monitored by the board. Agencies are encouraged to effectively challenge colleagues in other agencies regarding managing concerns relating to self-neglect and safeguarding matters.

Recommendation 4

The Bristol SAB should seek assurances from AWP that policies and practice guidelines in relation to engaging with individuals with co-morbid mental health and drug misuse issues have been reviewed in the light of learning from this case.

The BSAB has written to the Chief Executive of AWP to seek these assurances.

Recommendation 5

Bristol SAB should assure itself that the relevant agencies are robustly recording and tracking any individuals who are subject to S117MHA.

Assurances will be sought from the relevant agencies that individuals subject to s.117 are effectively tracked and that this information is kept up to date and available to those who would need to be aware of it.

Recommendation 6

Given that there are lessons to be learnt from this case for all agencies involved in Mr C's life, Bristol SAB should accept this report; disseminate its findings to all SAB partner agencies and assure itself that individual action plans are being implemented

The report was accepted in August 2016 and as stated the SAR sub group will be overseeing individual agency action plans and seeking to disseminate the findings of the review across partners.