Bristol Safeguarding Adults Board publishes Serious Case Review into death of Mr C

Today, 3 October 2016, the Bristol Safeguarding Adults Board (BSAB) has published the executive summary of the independently commissioned Serious Case Review (SCR) into the death of Mr C, together with the board's response to the report.

Mr C died in Bristol on 6 September 2014 in a house fire. A coroner's inquest into the cause of Mr C's death is also due to start on 3 October.

The BSAB's role is to lead on adult safeguarding in the local area and ensure the right procedures are in place across its partner agencies to help and protect vulnerable people. The function of an SCR is to identify strengths and gaps in safeguarding processes so that lessons can be learnt and improvements can be made.

The purpose of this SCR is to look at the circumstances surrounding Mr C's death and whether agencies involved with Mr C could have worked together more effectively. The review has been written by an independent author who was commissioned for her expertise and previous experience.

Louise Lawton, independent chair of the BSAB, said: "On behalf of the board and its partner agencies I would like to express our very deepest condolences to Mr C's family for their loss. I would also like to sincerely thank Mr C's family for being involved in the SCR process; particularly Mr C's son whose input helped the author develop a rounded picture of his father.

"The findings of this review highlight a number of key things, particularly around how agencies recognise and deal with the complex issues of self-neglect and mental capacity. It also looks at how risks are identified and managed, how concerns are shared and escalated within and across organisations, and the importance of context on how decisions are made. The impact of restructures on agencies' responses is highlighted as an underlying factor.

"The author has made a number of recommendations for improvements to be made, which the board fully accepts. In response, the board has begun developing an action plan, which outlines how each suggested change will be implemented.

"Work has already started in a number of areas. For example, an escalation process is now in place so that concerns can be more easily flagged and shared across agencies, and the board is developing multi-agency guidance about cases of self-neglect. The board is also working with partner agencies to review the training they have in place, including around the Mental Capacity Act, which is a law designed to protect people, and is seeking assurances about how policies are adhered to.

“There are lessons for all agencies involved with Mr C and this review has generated important learning which will be disseminated accordingly. The board will be overseeing implementation of the recommendations across agencies and scrutinising changes to ensure they are long-lasting and put in place quickly.

“Protecting vulnerable adults is an absolute priority for the board and its partners. It is impossible to remove all risk from life, but I hope that this SCR will help agencies to better identify and support people who are reluctant to accept help from agencies.”

Full details of the recommendations set out in the SCR and the BSAB response can be found here: https://www.bristol.gov.uk/policies-plans-strategies/bristol-safeguarding-adults-board

ENDS

Notes to editors:

The BSAB has published its Executive Summary to coincide with Coroner’s inquest because the Executive Summary will be referred to during these proceedings.

This review started before the board was established on a statutory basis in April 2015. It has been completed with oversight from the board to ensure that any recommendations made are clear and will be audited for progress made. Reviews started after April 2015 are known as Safeguarding Adult Reviews.

Throughout the SCR and other documents, Robert Crane is referred to as Mr C.