Response to MM Serious Case Review by Bristol Safeguarding Adults Board

Introduction

As Independent Chair of the Bristol Safeguarding Adults Board (BSAB) I am responding on behalf of the Board to the publication of a Serious Case Review (SCR) into the tragic death of Melissa, a 18 year old female killed by a 19 year old male (YA2). Both young adults had additional care and support needs and were placed in the same supported accommodation provision by local authorities outside of Bristol.

The BSAB would like to express our condolences to the family and friends of Melissa. Melissa's family have engaged with the BSAB throughout the process of undertaking this review. They have made recommendations to the Independent reviewer and the BSAB as part of this process that have been crucial to the development and understanding of this review. I would like to thank them for their engagement with us in this regard. Melissa's father has also produced his own public statement which is posted on our website alongside this Board Response.

Due to the circumstances surrounding Melissa's death, the BSAB commissioned a Serious Case Review (SCR) in November 2014 in order to establish what could be learnt from this tragedy. The review was commissioned in advance of the implementation of the Care Act 2014 and was therefore conducted as a SCR rather than under the new Safeguarding Adults Review (SAR) framework.

The purpose of a serious case review is to identify lessons learnt from the case under review with respect to multi-agency practice. Serious Case Reviews should be open and transparent and present the learning identified in an effective and accessible way.

Through undertaking this process the BSAB has accepted learning that has emerged and has acted accordingly. As part of the publication the BSAB has taken steps to ensure that the Safeguarding Boards or equivalent structures in the home local authorities of both young adults have been provided with learning from this review in order to inform their scrutiny of necessary changes to practice identified. In response to this incident, the report's findings will be shared with relevant regulatory bodies today in order to inform their learning and oversight of the response to Melissa's death. Many of the findings from this review have national implications and as such have been shared with the relevant national organisations to contribute to wider debates and policies.

The SCR could not begin until the completion of the criminal proceedings which has been one factor contributing to the significant delay in completing and publishing the review. In addition organisational restructures and changes to personnel in contributing agencies have also presented challenges to completing this review in a timely and effective way, not least because of the wide geographical spread of organisations involved. We are acutely aware of the impact that delays in publishing this review have had on the family and we are thankful

to them for their ongoing commitment to producing a robust review that can promote change.

In an Extraordinary Board meeting on the 6th June 2017 the BSAB made the decision to accept a restructured report based on the one written by the Independent Reviewer. Following the completion of a draft of the report it became clear that through no fault of the author, the methodology adopted did not enable the report to be written in a way that could easily and clearly capture the learning required from the case. It was not possible for the Safeguarding Adults Review sub group and the author to agree the best way to achieve this and it was therefore decided that the Board would receive the draft report and that the Joint Business Unit Manager of the Board would produce a final report using the very valuable information, findings and recommendations of the draft report. No new findings or recommendations have been made.

This Serious Case Review was commissioned in response to a serious and tragic incident in the city despite it not being a statutory duty to do so at the time. We have published the report in full including the Independent Reviewers' findings and recommendations which are unchanged. This is the first Serious Case Review that the Board has published in full instead of providing an Executive Summary. This is due to a change in approach and structure that will be adopted by the Board for this and all future Safeguarding Adult Reviews. The Board accepts these findings but has taken steps to enhance the learning for local agencies through the development of this local Board response. Despite publication not being a requirement of an SCR commissioned at this time the BSAB is committed to transparency and dissemination of learning.

The report makes clear that there is much to be learnt from why and how Melissa died and from how organisations worked with and responded to YA2. Some of the practice reviewed in the report was poor and opportunities to prevent YA2 having the opportunity to harm Melissa were missed by a range of professionals in the months leading up to Melissa's death. Melissa's concerns were not heard or responded to strongly enough when she raised concerns about YA2's behaviour and we seek to remind all agencies of the need to ensure that the voice of vulnerable adults is not just central to our safeguarding response, but within all our practice. This case also highlights the need to address the apparent failures in transitional planning, case management, risk assessment and risk management between the placing local authority, independent sector and the NHS.

One of the key messages from this review is that placement of vulnerable adults in accommodation where other adults with complex needs are placed, requires significant consideration of not just the needs of the adult being placed but the risk posed to and by other adults in that accommodation. Whilst the authorities that placed Melissa and YA2 were outside of Bristol, this learning can be applied across the whole area: compatibility risk assessments should be completed by the housing provider to assess whether the combination of adults placed together is safe and appropriate. Furthermore information sharing at points of transition between provisions is essential to effective risk assessment and risk management t. The report has identified the need for more robust notification structures to be in place when adults with complex needs are housed with private providers

outside their home local authority and the Board will be escalating this with the relevant National agencies.

Recent meetings with the GP practice for Melissa and YA2 while they were in Bristol have identified specific learning that the BSAB intends to take forward in addition to the main recommendations. GPs are not routinely provided with the information necessary to assess risk to their staff or to allow them to robustly advocate for appropriate placement options when new patients from out-of-area move into local Care Homes. The Board is committed to working with commissioners and private providers in Bristol in response to this review to improve collaborative working in this area.

The death of Melissa in a Care Home in our city was truly tragic and shocking. The BSAB has sought to coordinate agencies from across a wide area to review and learn from this. While this has proved challenging at times, we believe this report provides some significant findings for all the agencies and local areas involved to take steps to safeguard other young adults from harm. You will find their statements and responses published alongside this report.

We have been informed of significant learning and changes already implemented by many of the stakeholders involved in Melissa and YA2's care. Some of these are set out in the Board response below. The BSAB had agreed to not only act upon the findings of the Independent Reviewer but also learn from the wider lessons that this case has highlighted as I have set out in the Board response. We will be holding a learning event in November to support practitioners in Bristol to implement the findings of this review.

It is my hope that this review and its findings will support organisations to improve practice and reduce the opportunity for such a tragedy to happen again.

Louise Lawton

Independent Chair
Bristol Safeguarding Adults Board

Findings and Recommendations

Finding

The Forensic Assessment report was a crucial document in order to appreciate the risks that YA2 presented. Acting as they did without reference to this document was a serious omission. Care Home 1's IMR stated "*that receipt of that report would not have changed its assessment of YA2's suitability for placement at [Care Home 1] or the care arrangements that it put in place*". There is therefore a clear dissonance between the risk outlined in the forensic assessment and the stated position of Care Home 1. Had YA2 been provided with support which addressed the risks as outlined within the forensic assessment report the placement at Care Home 1 could have been suitable. However, it is clear that the support provided by Care Home 1 did not meet his needs as far as the risks he posed.

Recommendation 1

That Bristol Safeguarding Adults Board should share the concerns expressed in this SCR about the processes and practices adopted by of Care Home 1 with the Care Quality Commission.

BSAB Response

Concerns about Care Home 1 were shared with the Care Quality Commission through the Safeguarding Adults process. We will be sending a copy of this review to the Care Quality Commission today. The Care Home was inspected in May 2016 and received a rating of 'Good'.

Recommendation 2

That Bristol Safeguarding Adults Board seeks assurance that Care Home 1 has fully addressed the deficiencies identified by this SCR. Additionally; this SCR should be shared with all authorities which have service users currently placed in Care Home 1.

BSAB Response

The BSAB has been assured that Care Home 1 have addressed the concerns identified through regulatory and multi-agency safeguarding meetings. Care Home 1 received a 'Good' rating from the CQC in May 2016.

Finding

There are substantial challenges for YA2's Home Authority in placing and subsequently supporting children and adults they, out of necessity, place on the UK mainland. Because of these substantial challenges and the issues identified in this case it is recommended that the authorities in YA2's Home Authority make use of this SCR report to reflect on

their arrangements for placing children and adult's off-island, taking into consideration the separate jurisdiction and legal framework.

Recommendation 3

That Bristol Safeguarding Adult Board writes to YA2's Home Authority to request that it takes the necessary actions to ensure that it is able to independently and effectively manage the process of placing children and adult's off-island.

BSAB Response

The BSAB have involved YA2's home authority throughout the SCR process including having a representative on the SCR Review Panel. The BSAB and the Independent Reviewer ensured that the findings of this review, including Recommendation 3, have been shared with them.

Finding

The possibility of placement breakdown would require a "*material relationship*" with the host authority to be established rapidly. The placing authority seems to have not considered the risk that the Forensic Assessment report on YA2 stated he presented to the wider community. This risk included locations such as swimming pools, changing rooms, hotels described as "*high risk*". There were "*material*" issues to discuss with the host local authority.

Recommendation 4

That Bristol Safeguarding Adults Board writes to the Department of Health to advise them of the absence of notification of out of area placements by the placing to the host authority so that the Department can consider what action is necessary.

BSAB Response

A letter and a copy of the SCR report have been sent to the Department of Health today, now that that the SCR has been published. The BSAB recognises that many placements are commissioned by Local Authorities rather than Clinical Commissioning Groups, including the two placements of YA2 and Melissa in this case. There is current no formal national expectation for the placing local authority to inform the hosting local authority when a vulnerable adult is placed in their area. For this reason these concerns and copy of this report will also be shared with ADASS (Association of the Directors of Adult Social Services).

The BSAB recognises that private providers offering accommodation to adults with significant care and support needs can put a burden on the resources of the host local authority. It is therefore vitally important that Bristol continues to maintain excellent links to providers of care services in the area. To this end the Board will be working with local commissioning teams and BSAB Provider Representatives to strengthen the BSAB's contact with and dissemination of information to providers.

Finding

This SCR has identified that the YA2's Home Authority and Care Home 1 had a differing understanding of what the phrase "*1:1 staff support*" actually means. It would be helpful to all concerned – service users and their families, providers, placing authorities and regulators - for individual staff support levels to be expressed unambiguously within placement agreements.

Recommendation 5

That Bristol Safeguarding Adults Board brings the importance of expressing individual staff support levels unambiguously to the attention of NHS England and suggest that they write to all potential placing authorities to advise them of this. Given the potential for individuals to be placed in England from elsewhere in the UK, and in this case YA2's Home Authority, NHS England should also communicate this to other relevant jurisdictions.

BSAB Response

A letter and a copy of the SCR report have been sent to NHS England today, now that that the SCR has been published. We will also provide this to ADASS as both Melissa and YA2's placements were commissioned by Local Authority Social Care teams. In addition the BSAB have requested that Bristol City Council provide assurance to the Board that staffing support levels are unambiguous in their commissioning arrangements for adults with care and support needs.

Commissioners and providers have a reciprocal duty of care to ensure that commissioned packages of care are based on appropriate risk assessments which may necessitate accessing local specialist services. The BSAB accepts the report's finding but will be expanding it to develop practice for providers undertaking robust risk and needs assessments when an adult is placed in a care home. The Board will particularly focus on the area of risk assessment and risk management in respect of the compatibility of adults living together. We recognise there is a gap in the national evidence base in this area and will be building on the research available and offering Bristol providers training in this regard

Finding

Care Home 1 has introduced a "*compatibility assessment*" in order to address this omission. It would be prudent for BSAB to seek assurance that it is operating effectively.

Recommendation 6

That Bristol Safeguarding Adults Board seeks assurance that the arrangements they have put in place to ensure that the risks posed by and to, other service users resident in Care Home 1 are working effectively.

BSAB Response

Compatibility assessments have been introduced by Care Home 1 and are reviewed through safeguarding and regulatory frameworks.

The BSAB will also be addressing this issue across the city by delivering learning event on undertaking risk assessments and getting assurance that commissioners consider these as part of their review of commissioning standards.

Finding

The reticence of Residential School 4 in reporting incidents involving YA2 to the police had a number of negative consequences;

- managing incidents 'in-house' sent the wrong message to YA2;
- YA2 might be managed on the basis of allegations presumed to be true but untested by investigation;
- any record of incidents could not be assumed to be completely objective and accurate; and
- failure to report matters to the police prevented referral to MAPPA or the securing of relevant criminal justice disposals.

Recommendation 7

When disseminating the learning from this SCR, Bristol Safeguarding Adults Board, and all the bodies which have contributed to the SCR, should take the opportunity to reinforce the importance of full and accurate recording of safeguarding concerns.

BSAB Response

The BSAB's published Information Sharing Guidance in 2016 which included information for all professionals on the importance of accurate recording of safeguarding concerns. The

BSAB will share this finding with the Bristol Safeguarding Children Board (BSCB) and the Bristol Safeguarding Education Team to reinforce within their training of school safeguarding leads. We would expect that similar work is undertaken in Melissa and YA2's home authorities.

Recommendation 8

That Bristol Safeguarding Adults Board writes to the Department for Education to advise them of the practice of some independent Schools not to report serious crimes allegedly committed by pupils with challenging behaviours, so that the Department can consider whether any action is necessary.

BSAB Response

A letter and a copy of the Serious Case Review have been sent to Department for Education today, now that that the SCR has been published. In addition the BSAB will share this SCR with the Bristol Safeguarding Children Board and request that they take action to ensure themselves and the BSAB that the safeguarding of children in independent schools is suitably robust.

Finding

The reluctance to involve the police in the strangulation incident in March 2013 was explained by Residential School 4 as an action which would have been inconsistent with the therapeutic approach of seeking to avoid punitive consequences for undesirable behaviour. The tension between arriving at the most appropriate therapeutic approaches to meet an individual's needs whilst affording others an appropriate measure of protection from the risks they presented is a theme in this SCR. There is a balance to be struck between the desire not to criminalise some behaviour and to manage this within the therapeutic setting against the need to protect others who may be at risk from this behaviour. Incidents should always be reported to the police. This does not automatically mean that a criminal investigation will occur. It would however assist in the development of a better understanding of risks and enable the effective management of these within a multi-agency framework. Those responsible for YA2's care prioritised his therapeutic needs. This inadvertently resulted in the safety of those caring for him being compromised. There may be much for practitioners and managers to reflect on by exploring the decision making in this case.

Recommendation 9

That Bristol Safeguarding Adult Board shares this SCR Report with the authorities in YA2's Home Authority, and the relevant Safeguarding Adult and Children Boards in Melissa's Home Authority, together with NHS Trust 1 so that the SCR can inform training and development.

BSAB Response

The BSAB will share the SCR with the named agencies and Boards identified in this recommendation in order that it can inform their training and development strategy.

Finding

Placing authorities and providers need to ensure that there is a robust placement failure contingency plan when placements are made.

Recommendation 10

Bristol Safeguarding Adults Board considers how best to disseminate the message that placement breakdown contingency plans for out of area placements are essential.

BSAB Response

The findings of this review will be presented in briefings to all the Adult Social Care Team Managers in Bristol focusing on the requirement and implementation of robust contingency plans. It is the responsibility of Melissa and YA2's home authorities to also disseminate this finding effectively amongst their teams. The BSAB expects the Safeguarding Adults Board, or equivalent group, to seek assurance of the effectiveness of this finding being disseminated.

Recommendation 11

Bristol Safeguarding Adults Board write to YA2's home authority to request that they submit their transition services for independent inspection.

BSAB Response

This recommendation from the Independent Reviewer has been shared with the YA2's home authority both in the drafting of this report and in advance of publication. It is noted that YA2's home authority have:

- commissioned an external review of all off island placements, and

- re-written their off island procedures and transition processes which are now overseen and reviewed by the new post of Director of Communities and the Medical Director.

In Bristol, the BSAB are working with the BSCB to develop new practice guidance for professionals working with older adolescents and young adults. The two Boards are also currently updating our Safeguarding Children, Adolescents and Young Adults with Disabilities guidance.

Finding

Adverse outcomes arising from deficiencies in managing transition from children's services to adult services have been a feature of many SCRs in respect of adults. However, there is, as yet, no central repository for SCRs (and now Safeguarding Adult Reviews) to enable the widest dissemination of learning and to allow issues which feature prominently or repeatedly in SCRs, such as transition, to be considered as part of the national policy agenda.

Recommendation 12

That Bristol Safeguarding Adults Board writes to the Department of Health to propose that a central repository of safeguarding adults review reports is established in order to ensure that learning from such reviews is shared more widely and that arrangements are made to periodically analyse safeguarding adults review reports in order to identify significant issues which could require a national policy response.

BSAB Response

The Department of Health has already commissioned Social Care Institute of Excellence (SCIE) and Research in Practice for Adults (RiPFA) to improve the quality and use of safeguarding adults reviews (SARs) through a national repository. This action is therefore complete.

Finding

The extent to which Care Home 1 was not a suitable placement for both Melissa and YA2 raises the question of whether there is sufficient provision for adults with Autism Spectrum Condition and Asperger Syndrome. It also raises the question of whether there is sufficient knowledge and expertise within placing authorities and the bodies which advise them on these matters, concerning the range of placements qualified to meet the needs of the service user they wish to place, and whether enough priority is being afforded to the

development of local services for adults with Autism Spectrum Conditions and Asperger Syndrome.

Recommendation 13

That Bristol Safeguarding Adults Board write to NHS England to advise them of this SCR and the messages which emerge from the SCR which indicate there is a lack of suitable provision for adults with ASC and Asperger Syndrome, insufficient expertise in placing authorities to identify the most suitable placements and a need to develop more local ASC and Asperger Syndrome services.

BSAB Response

A letter and a copy of the SCR report have been sent to NHS England today, now that that the SCR has been published.

NHS England has set out a clear programme of work with other national partners, in transforming care for people with learning disabilities – next steps, to improve services for people with learning disabilities and/or autism, who display behavior that challenges, including those with a mental health condition. This will drive system-wide change and enable more people to live in the community, with the right support, and closer to home.

Led jointly by NHS England, the Association of Adult Social Services (ADASS), the Care Quality Commission (CQC), Local Government Association (LGA), Health Education England (HEE) and the Department of Health (DH), the Transforming Care programme focuses on the five key areas of:

1. Empowering individuals
2. Right care, right place
3. Workforce
4. Regulation
5. Data

This work is driven forward by the Transforming Care Delivery Board (TCDB).