Response to Kamil Ahmad and Mr X Safeguarding Adult Review
Bristol Safeguarding Adults Board

Introduction

In July 2016, Kamil Ahmad was murdered in his home, a supported living provision for adults with mental health needs, by Mr X who was a fellow resident. Mr X was convicted of Kamil's murder in October 2017 and received a life sentence with a minimum tariff of 23 years. As Independent Chair of the Bristol Safeguarding Adults Board (BSAB), I commissioned independent reviewers Donna Ohdedar and Mark Dalton to undertake a Safeguarding Adults Review which examined the involvement of organisations working with both men in the period leading up to Kamil's death. The BSAB has accepted the report's conclusions and its findings in full.

I would like to extend my thanks and condolences to Kamil's family who met with the Independent Reviewer to discuss the review and share their views and memories of Kamil. The BSAB and I recognise that this has been a deeply traumatic and distressing time for all those who knew Kamil and we are grateful to them for their time and considered contributions to the review.

The independent report authors concluded that Kamil's death could have been avoided and identified opportunities that could have been taken to separate Kamil and Mr X at an earlier time. This included the process by which Mr X was discharged from a secure hospital the day of Kamil's murder, multi-agency coordination of care and assessment of risk, and the opportunities to pursue termination of Mr X's tenancy at the housing provision.
A wide range of providers who were working with the two men have engaged with this review. The review has highlighted the importance Kamil placed in his support from the voluntary and charity sector, particularly agencies specialising in support for refugees and asylum seekers. The BSAB will reinforce the importance of statutory services engaging effectively with these specialist community services to ensure the needs of refugees and asylum seekers are appropriately assessed and met.

The report acknowledges that Mr X posed a risk to others, but that this was intensified by racial and personal dislike focused excessively on Kamil. Whilst Mr X has contended that he does not hold racist views, the review found a significant history and pattern of racially motivated hate crimes against Kamil that culminated in Kamil's tragic death.

It is of the utmost importance that the organisations in Bristol use the findings of this report to progress practice in safeguarding adults at risk from hate crime, and develop professionals' understanding of the risks associated with hate crime in the context of multiple and complex support needs. It will be the responsibility of the BSAB to ensure that robust actions are taken by organisations across the partnership to drive these changes.

As well as sharing the findings of this review widely, the BSAB are commissioning the development of an inter-personal risk assessment tool for use by housing providers. Currently there are no evidence-based tools available for providers to use to consider the compatibility of adults in their provision. Whilst a number of models have already been adopted by providers locally, the BSAB's project will fund the development of an evaluated tool to support developments in this area of work.

The Board Response below sets out the actions the partnership will be taking as a result of this review however the organisations involved will also be taking forward individual action plans. In addition, organisations have already made changes as a result of Kamil's murder which are set out below.

Louise Lawton
Independent Chair
Bristol Safeguarding Adults Board

Recommendations and Board Response

1. The Bristol Safeguarding Adult Board (BSAB) should refresh and re-launch its Adult Safeguarding escalation policy for all partner agencies.

The BSAB ratified an updated Escalation Policy in March 2018. This has been widely distributed through Board partners and organisations across the city. It can be found on the BSAB website and the use of it is monitored through audits.

2. The BSAB should arrange an audit of safeguarding alerts, referrals and responses to understand how the vulnerabilities of asylum seekers are explored and assessed.

The BSAB will be undertaking this audit as part of the 2018-2019 Business Plan. Specialist refugee and asylum seeking agencies will be invited to contribute to this process.

3. The BSAB should work with voluntary agencies and charities who support refugees to ensure pathways are in place to support individuals who do not meet the thresholds of the Care Act.

As agencies involved in the SAR, Bristol Refugee Rights and SARI have produced a learning document with the key relevant findings from their involvement supporting Kamil before his death which has been shared and discussed with all organisations working across Bristol with asylum seekers and refugees. The learning from the review is also being shared regionally as part of the South West Migration Partnership.

Since Kamil's death, SARI have established a regular attendance at Bristol Refugee Right's drop in and are now part of the Refugee Forum in recognition of the need to improve the coordination and expertise of hate crime services working with refugee and asylum seekers.

The BSAB Business Manager attended the Bristol Hate Crime and Discrimination Services quarterly meeting and presented findings and key learning from the work of the BSAB including the importance of the escalation policy and means by which voluntary sector services can challenge statutory partners.

BSAB members have been invited to attend an event on the 29th June 2018 run by a group of asylum seekers, disabled people and allies which is open to professionals across the city. this partnership. Supported by voluntary agencies in the city, the Disability and Migration Event will be an important opportunity for sharing learning and dissemination best practice about supporting refugees and asylum seekers with care and support needs.

Building on learning from this case the Refugee Forum will be developing support for interpreters about reporting safeguarding concerns for adults at risk. Furthermore Bristol Refugee Rights will be developing training sessions for refugee and asylum seekers on hate crime and safeguarding to deliver to refugees and asylum seekers in the city. The BSAB will work with refugee and asylum agencies as they implement these changes going forward.

4. The BSAB should implement multi-agency training to raise the awareness of hate crime in all its forms (disability, race, religion, sexual orientation and gender identity), including support for victims when reporting hate crime and in identifying appropriate social and therapeutic support.

The Bristol Hate Crime and Discrimination Services (https://www.bhcds.org.uk/) was established in July 2017, commissioned by Bristol City Council. Together the services offer a

wide range of specialist training for organisations across the city. This training has been publicised through the BSAB. The BSAB is commissioning a new programme of inter-agency safeguarding training as part of the 2018-19 training plan which will include responding to Hate Crime.

5. The BSAB should produce multiagency guidance for the management of two or more service users who are not related, or members of the same family group but living in shared accommodation.

The BSAB is commissioning the development and evaluation of a new interpersonal risk assessment tool for use by shared accommodation providers. This tool and the findings of the evaluation will be shared with providers across the city. Further to this, in November 2017 the BSAB held a practitioner learning event on the issue of managing interpersonal risk in group accommodation setting where existing research was shared to a large multi-agency audience by Research in Practice, and good practice from organisations across the city was shared. The findings of this event have informed the commissioning of the tool.

As the city's lead commissioned service supporting victims of hate crime, SARI have updated their risk assessment tool to reflect that victims of hate crime living in shared accommodation with the perpetrator are at high risk and should be responded to, and advocated for as such.

Further to this both BCC and the CCG, as key commissioners in the city, have introduced a requirement for all providers to carry out compatibility risk assessments of the introduction of new people to accommodation when they are considering new referrals.

6. The BSAB should produce guidance for practitioners on the assessment of need and risk assessment of vulnerable adults (including asylum seekers). This guidance should explicitly address the issue of unconscious bias and how this can affect professional judgements and practice.

In the 2018-19 business year, the BSAB will undertake a review and update of the existing safeguarding guidance in relation to unconscious bias and develop a standalone practitioner learning resource. The BSAB will seek to do this in collaboration with other key partnerships in the city, particularly the Safer Bristol partnership.

Bristol voluntary and charity services have developed a leaflet outlining resources and services for refugees and asylum seekers which can be found in a range of languages at https://www.bristolrefugeerights.org/how-we-help/i-need-help-i-start/ and will be disseminated through the BSAB services.

7. The BSAB should ensure that assessment guidance recognises the valuable contribution charities and voluntary organisations can make to the assessment process. Protocols for effective information sharing should be devised to overcome difficulties of sharing information where this is in the best interest of the service user.

The BSAB have two new Board members who represent VOSCUR, the city's voluntary and community sector's support and development partnership. These members have increased the voice, influence and reach of the voluntary sector within the BSAB strategic partnership and are vital in ensuring that protocols and decisions taken at the Board consider and involve the role of the voluntary sector appropriately.

In addition, BCC is working alongside the BSAB to support partners to undertake a review of the role of the lead professional in complex cases involving physical and mental health needs. This review is considering whether current structures are robust enough in identifying the complex cases that need a clear co-ordination role between agencies. This will include the development of guidance on how information is shared across all organisations.

8. The BSAB should review practice and ensure staff are adequately trained in making interventions and referrals to substance misuse services.

The BSAB will work with ROADS (Recovery Orientated Alcohol and Drugs Service) to evaluate referral routes for adults with care and support needs into their service and highlight any gaps in referring agencies. The BSAB will also seek assurance from the key agencies working with Mr X in this review as to how they ensure staff are equipped to provide appropriate interventions and referrals in this area of work where an adult has co-presenting alcohol misuse and mental health needs.

9. Avon and Somerset Constabulary Lighthouse Victim and Witness Support should review how their delivery model of hate crime services could be made more accessible through models such as assertive outreach and improved joint working.

The BSAB will monitor the work by Avon and Somerset Constabulary and Bristol Hate Crime and Discrimination Services to develop their practice in this area, and ensure that adults at risk with care and support needs receive as responsive a victim care service as possible.

10. AWP should review the procedures for information sharing and decision making when patients are transferred in either direction with all commissioned independent health care providers. The information provided for this review suggests that these crucial elements are

dependent on individual practitioners who have knowledge of the requisite systems. However, it fails to consider the possibility of individual error and the need for contingency plans when a key professional is absent from work.

AWP have now put in place a protocol setting out clear standards for discharge planning meetings and arrangements under the Care Programme Approach (CPA) in the event of planned discharges, discharges by appeal and unplanned discharges is in place. Facilitated discharge staff are embedded within the crisis teams and link in with wards including private providers and AWP have developed their bed management team's role so they link with private providers to provide clinical updates. There is also a local bed management team to review all cases.

The BSAB will request assurance of the effectiveness of these changes after implementation.

SINGLE AGENCY RECOMMENDATIONS

The implementation and effectiveness of single agency recommendations made by the independent reviewers will be monitored by the BSAB.

1. Discharge planning is a joint responsibility between the hospital and community mental health team. A protocol should be put in place, setting clear standards for discharge planning meetings and arrangements under the Care Programme Approach in the event of a planned discharges, discharges by appeals, and unplanned discharges. This should include clear guidance on the requirements (AWP).

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2. Arrangements should be made to ensure that Care Coordinators/case managers receive information about a service users progress when they are in hospital and are aware of impending discharge and other developments. (AWP).

AWP have informed the Board that arrangements have been updated for care co-ordinators/case managers to receive information about a service user's progress when in hospital and to ensure they are aware of impending discharge and other developments. This

is now via a non-clinical bed manager who ensures information regarding referrals for beds, admissions, discharges and out of area placements is up-to-date.

3. Safeguarding Section 42 enquiries should not be closed down prematurely before there has been a risk analysis based on the available information and key professionals have been consulted, a rationale for the decision made should be evidenced, recorded and communicated to the referrer and individual. If a section 42 enquiry is not undertaken, signposting to other agencies giving advice or information should be considered. (BCC).

As a result of the review BCC safeguarding procedures have been reviewed and staff working with adults at risk of harm will be receiving new training which incorporates learning from all recent SARs. In 2017 the BSAB implemented a programme of multi-agency audits, including auditing safeguarding section 42 threshold decisions and enquiries. The findings of these audits are reported to the BSAB. In addition last year BCC implemented the Quality Assurance and Learning Framework. This sets practice standards, which are informed by statutory guidance. All staff employed in BCC's Adult Social Care services are expected to meet these standards and are reviewed against them.

In addition, BCC's Asylum Team will be holding a development session for Adult Care Managers and staff, focussing on how they work with refugees and asylum seekers to ensure professionals across the service are clear on what services and support are available and how it can be accessed.

4. The AWP bed availability policy should be revised to avoid mentally ill people in crisis remaining in the community where they are a risk to themselves and others. (AWP).

AWP have revised the Bed Management Standard Operating Procedure (SOP) and the Bed Management Team now includes a senior clinician who has experience in crisis and inpatient care. The Bed Management Team meet daily to discuss discharges, bed availability, need from the inpatient wards and need for the day. Throughout the day the bed coordinator manages the need, in conjunction with the clinical need, and will escalate as appropriate. If admission is required and a bed is not available within the Trust, external providers will be sought.

5. Cygnet Health Care should ensure that its discharge procedures require active engagement with referring organisations to ensure the safe handover of responsibility between the Hospital and community services. (Cygnet Health Care).

Cygnet Health Care have informed the Board that since Kamil's murder they have taken steps to improve discharge planning and information sharing, including the formation of the Cygnet central referral line, improved standardisation of admission information

requirements, and implementation of mental health act administrators coordination support of s117 aftercare planning meetings.

6. AWP should provide guidance and training for all staff to assist them in deciding when to use the Police 101 (non-emergency service) and when a 999 call is appropriate. (AWP Crisis Service)

Guidance has been provided for all staff to assist them when deciding whether to use the police non-emergency service (101) or if 999 may be more appropriate. The Police Escalation Booklet produced by Avon and Somerset Police has been circulated to community teams.