Safeguarding Adult Review
Overview Report

Review into the death of Daniel, who died in 2021 in Bristol

Review Panel Chair and Report Author:
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Contents

1.0 Introduction

1.1 For the purposes of this report and in order to protect the identities of those involved the subject will be known as Daniel.

1.2 It is easy for Safeguarding Adults Reviews (SARs) and Overview Reports to focus on events and the involvement and actions of a number of agencies; it is important that this SAR and this report recognise that, at their centre, is a human being, who should be treated with respect, and likewise their family members.

1.3 Daniel was born in 1957 and was 63 years old and living in a multi-occupancy mental health hostel run by a charity, Second Step, at the time of his admission to hospital on the 14 June 2021.

1.4 Little is known of Daniel's life before he moved from Manchester to Bristol in 2007. He refused to provide details of his Next of Kin or Nearest Relative as defined in the Mental Health Act 1983 (MHA) to any agency other than the University Hospitals Bristol and Weston NHSF Trust. However, it is known that he had been married, that there was a daughter, [redacted] that his wife had died, and he also had a sister. Daniel had refused to provide details of his daughter, who would have been his Nearest Relative under the Mental Health Act 1983. After his death, his daughter was identified by the Police, and she visited Bristol to sort out Daniel's possessions. She was contacted to ascertain whether she would like to contribute to this SAR, however this was declined.

1.5. Daniel was first known to Adult Social Care (ASC) in Bristol in 2007, when he was planning to move from Manchester; he was assessed as not having eligible care and support needs at that time and he moved without ASC involvement.

1.6 Daniel's health and social care needs were assessed and supported under the Care Programme Approach following his admission to psychiatric hospital under Sections 2 and 3 of the MHA prior to the review period.

1.7 Daniel had a number of significant health diagnoses, including Chronic Obstructive Pulmonary Disease (COPD), Hypothyroidism, Transient Ischaemic Attacks, had had a subdural haemorrhage in 2010, Delusional Disorder, Paranoid Schizophrenia and HIV. The latter was contracted through infected blood products.

1.8 Daniel appears to have made a homeless application to Bristol City Council (BCC), but this would have been prior to the introduction of the Homelessness Reduction Act 2017 and the introduction of BCC's current IT system. The details of the application are not accessible and are not therefore available to the SAR.

1.9 Daniel was referred by a Homelessness Housing Advisor to [redacted] high support male only accommodation, run by the Salvation Army (SA) on the 1 March 2018 and subsequently interviewed and moved in on the 15 March 2018. He was still living there at the beginning of the SAR's review period.

1.10 On the 14 June 2021, Police on a routine patrol were flagged down by one of Daniel's fellow residents concerned about Daniel. They found Daniel on his bedroom floor, looking extremely emaciated and malnourished with burns or blisters over the front of his body. They called an ambulance and Daniel was taken to and admitted to the Emergency Department at Southmead Hospital, where he alleged that the resident who flagged down the Police had intentionally thrown boiling water from a kettle over him.

1.11 Daniel was moved to the Intensive Care Unit when his condition deteriorated where he died in June 2021.

1.12 A Coroner's Inquest was held and completed on the 13 October 2021; this found the causes of Daniel's death to be Bronchopneumonia and Chronic Obstructive Pulmonary Disease and that the superficial scalding was not a direct factor in his death. However, it is likely to have caused him to fall to the floor where he is suspected of having lain for a period of time, resulting in hypothermia and a further deterioration in his already fragile physical condition.

1.13 The case was referred to the Keeping Bristol Safe Partnership (KBSP) Safeguarding Adults Executive (the Executive) for consideration for a Safeguarding Adults Review (SAR) on the 18 June 2021 by Avon and Somerset Constabulary - see Appendix B. The referral was passed to the Serious Case Review Subgroup (the Subgroup) on the 9 July 2021, when the referral was considered and the Subgroup agreed the criteria for a Safeguarding Adults Review (SAR) had been met and therefore recommended to the Executive that a SAR be undertaken.

1.14 On the 18 August 2021, the Executive confirmed that an SAR should be undertaken in accordance with the multi-agency Safeguarding Adults Review Procedure.

1.15 This report was authored on behalf of the Executive by Mr Pete Morgan, an Independent Consultant.

1.16 The administration and management of the Safeguarding Adults Review Procedure has been carried out by the KBSP's Business Unit.

1.17 This review was commissioned under s44 of the Care Act 2014; its commissioning will be reported in the Executive's Annual Report for 2024/5 and its findings and their implementation will be reported in the Annual Report for 2024/5 as required by the Act.

1.18 The report was ratified by the Keeping Adults Safe delivery group at a specially convened meeting held on 22 July 2024.

2.0 The Safeguarding Adults Review Terms of Reference

2.1 The Terms of Reference for the review were agreed on the 30 March 2023 and were regularly reviewed as the review progressed to ensure they remained fit for purpose.

2.2 The finalised Terms of Reference are to be found in Appendix A.

3.0 Family liaison and involvement

3.1 Contact was made with Daniel's sister by letter to offer her the opportunity to meet or speak to the Independent Author and to do so accompanied by a supporter if they so wished. She was also provided with information on Safeguarding Adult Reviews produced by the KBSP.

3.2 She was advised she could change their mind about meeting either of the above at any time and that she would be given the opportunity to see and comment upon the findings and recommendations contained in the final draft of the report before it was presented to the Executive.

4.0 Independent Overview Report

4.1 The Board sought expressions of interest in the role of Independent Chair for the review through the National Local Safeguarding Adult Board Chairs' Network and appointed Mr Pete Morgan as the Independent Author.

4.2 Mr Pete Morgan was the Head of Service – Safeguarding Adults with Birmingham City Council and subsequently the Independent Chair of two Safeguarding Adults Boards. He has chaired and co-authored over 20 Safeguarding Adults Reviews for a number of Safeguarding Adults Boards and is the Independent Scrutineer of the Safeguarding Panel for Advance Support and Housing, that provides accommodation and support for adults with care and support needs.

4.3 He had no involvement, directly or indirectly, with any member of the families concerned in this review or the commissioning, delivery or management of any of the services that they either received or were eligible for prior to being commissioned to write this report.

4.4 He had no involvement, directly or indirectly, with any of the agencies contributing to this review prior to being commissioned to write this report.

5.0 Agency Involvement prior to the Review Period

5.1 As has been mentioned previously, agencies providing IMRs were able to include brief details of any particularly relevant involvement they had had with Daniel prior to the review period.

5.2 Daniel had been admitted to psychiatric hospital in Bristol under Section 2 of the MHA in 2009 and in December 2017. The latter was rescinded in January 2018 though he remained an informal patient for a period of time. He was admitted under Section 3 of the MHA in June 2013, making him eligible for Section 117 Aftercare. He was also admitted under Section 3 of the MHA in Manchester in 2014, though details of this admission were not available to the SAR.

5.3 Daniel was intermittently open to BCC Adult Social Care (ASC) from 2007, initially when he was planning to move to Bristol from Manchester. He was assessed then to not have eligible care needs, a situation that didn't change when he was subsequently admitted to hospital due to complications with his physical health, particularly his COPD.

5.4 Daniel was advised as to his housing options at each contact with ASC and referrals were made for reablement support to build on his strength on his discharge from hospital. Daniel continued to express a wish to live in the supported accommodation rather than move to more independent living.

5.5 Daniel is recorded to have expressed a mistrust/dislike of social workers due to his past experiences, but this was not expanded upon nor explored further with him.

5.6 There is no record of any concerns about Daniel's mental capacity other than at times of crisis in his mental health; no formal Mental Capacity Act assessment was therefore carried out either prior to or during the review period.

5.7 On the 7 February 2018, ASC record a completed assessment under section 9 of the Care Act 2014 which identified that Daniel had eligible care and support needs and conformed a weekly Personal Budget of £135.40 but there is no record of any services being provided, terminated, or reviewed prior to the commencement of the review period.

5.8 On the 12 June 2019, contact was made by Daniel's Care Coordinator (CC1) with ASC; there is some confusion as to whether this was a request for an assessment under the Care Act 2014 or raising a safeguarding concern – reference is made to financial abuse. There is no recorded response until the 5 August 2019 – see 6.2 below.

6.0 Key Events and Findings

6.1 At the start of the review period, Daniel was living at [redacted] run by the Salvation Army (SA).

6.2 On the 5 August 2019, ASC Access and Response Team (ART) - now the Swift Response Team - record a phone call from Daniel's Care Coordinator (CC1), a Recovery Navigator in the Avon and Wiltshire Mental Health NHS Partnership (AWP) Recovery Team to Care Direct advising that the referral made on the 16 June 2019 was urgent. It was acknowledged by a Senior Practitioner (SP1) that the referral was reassigned by ART to the Duty Desk of the Maximising Independence Team South D as this team were already involved with Daniel. The referral had referenced possible financial abuse.

6.3 On the 5 August 2019, AWP record an email exchange between CC1 and his support worker (SUW1) at the Salvation Army (SA) in which SUW1 advised that Daniel has now been with the SA for 16 months and needs to consider moving to a "level 2 hostel and potentially move to a level 3 or 4". Daniel had told SUW1 that he hoped to move to Preston in a year or so, but that he had reservations about moving as he felt he benefitted from "being close to Southmead Hospital and various shops".

SUW1 also suggested Daniel would benefit from a Care Needs Assessment under section 9 assessment of the Care Act 2014 to help identify the most appropriate accommodation and support for Daniel and asked if, given Daniel's variable mobility issues, a referral could be made for physiotherapy input and possible walking aids. SUW1 advised that Daniel's benefits are changing from Disability Living Allowance to a Personal Independence Payment (PIP), but that there had been no problems with financial abuse – see 6.2 above.

6.4 CC1 advised SUW1 that she had contacted Care Direct and the Duty Manager at [redacted] and will do so again regarding his accommodation but asked that SUW1 do so as well to explain that, whilst Daniel is settled at [redacted] it is not a long-term solution to his accommodation needs. She also advised that, given a family connection, a transfer to Preston should be relatively easy.

Finding 1:
Daniel should have had a s9 assessment under the Care Act 2014 when his support in the community came to be managed under the Care Programme Approach, which should coordinate his health and social care needs.

Finding 2:
Daniel's situation should have been reviewed at least annually under the CPA, including a review of his s9 assessment and therefore any mobility issues, and the appropriateness of his accommodation.

6.5 On the 7 August 2019, SA record a Service Review was completed with Peer-to-Peer Evaluation with Second Step (SS) and BCC; no evidence was recorded regarding Daniel.

Finding 3:
Given the contact that had been made by CC1 with ASC, it is surprising that a Service Review did not identify that Daniel was inappropriately placed at [redacted]

6.6 On the 21 and 27 August 2019, AWP record that CC1 tried to contact SUW1 and left a message for him to contact back. On the 27 August 2019, ASC record that Daniel's allocated Social Worker (SW1) also tried to contact SUW1 and left a similar message.

6.7 On the 27 August 2019, AWP record that CC1 contacted ASC and was advised who Daniel's allocated Social Worker was, though she was unavailable.

6.8 On the 29 August 2019, ASC record that SW1 rang CC1 but she wasn't in and SW1 was unable to leave a message.

Finding 4:
It is of concern that SW1 could speak to CC1's office but not leave a message for her.

6.9 On the 29 August 2019 ASC record that SW1 also rang SUW1 and arranged a review for Daniel on the 5 September 2019 at [redacted]

Finding 5:
It is of concern that SUW1 did not respond to the messages left for them – see 6.6 above.

6.10 On the 29 August 2019, ASC record SW1 being advised of Safeguarding Concerns and a Safeguarding Enquiry under s42 of the Care Act 2014 commencing. but the Safeguarding Forms were initiated on the 3 September 2019. The closure date for the Safeguarding Enquiry is recorded as the 7 October 2019.

Finding 6:
The s42 Enquiry related to possible financial abuse; the recording of the Closure of the Enquiry, dated the 7 October 2019, refers to the perpetrator having moved to another property and that the Police investigation was still in progress.

Finding 7:
The Closure report also contains Daniel's date of death, which raises questions as to when the Closure report was completed.

Finding 8:
There is no reference to the process by which the s42 Enquiry was completed in the chronology provided for the SAR.

6.11 On the 3 September 2019, ASC and AWP record a phone conversation between SW1 and CC1. CC1 advised SW1 their concerns about Daniel's health, his desire to move on from [redacted] and his need for support. They arranged to meet on the 5 September 2019 at the review when SW1 would assess his needs – see 6.9 above –and for an update on the safeguarding referral that CC1 had raised.

6.12 On the 3 September 2019, SW1 recorded a referral to the OT service for an assessment of Daniel's mobility issues at [redacted] and his difficulties in transferring from his bed to a chair. This referral was cancelled on the 12 September 2019 after SW1 saw that Daniel was able to transfer safely. SW1 was to contact Daniel's GP to ask for a physiotherapy referral to assess his need for a mobility aid.

Finding 9:
It is not clear on what basis SW1 made the referral to the OT Service as, at this time, Daniel's social care and support needs had not been assessed.

6.13 On the 5 September 2019, ASC and AWP record a review being completed, attended by CC1, SUW1 and SW1. It is implicit but not explicit that Daniel was also in attendance. The following housing options were identified:

1. Continue on the homeless pathway and go to medium support housing.
2. Go through Home Choice (with an increase in banding supported by (SW1) and have a package of care in place.
3. Use his s117 aftercare to secure appropriate accommodation with support.
4. Move back to Manchester to be with friends. It is felt by (SUW1) that Daniel would benefit from supported accommodation – an individual flat with wardens.

6.14 It was recorded that Daniel "appears to wish to remain living at [redacted] and wanted to arrange his accommodation with SUW1 without any ASC involvement.

Finding 10:
It is not clear under which procedure this review was held; if it were under the CPA, then a broader range of agencies would be expected to be invited.

Finding 11:
It is of concern that the review makes no reference to the s42 Enquiry that had commenced on the 29 August 2019.

6.15 On the 10 September 2019, AWP record CC1 meeting Daniel to begin developing a Wellness Recovery Action Plan (WRAP); Daniel found it difficult to reflect on his mental health issues, both historical and current, but did accept SUW1's "account of his deterioration and illness". Daniel spoke of challenges between his mental health and his HIV, including the complication of separate medication dosette boxes. CC1 recorded Daniel's daily routine and noted that Daniel was well orientated when well, had a good memory and was looking forward to activities organised by [redacted]

Finding 12:
While it is good practice to develop a WRAP with Daniel's active participation, it is of concern that this is only happening now; the SAR is not aware of the date Daniel entered the CPA procedures, but his entitlement to s117 Aftercare under the Mental Health Act 1983 is recorded as the 4 June 2013.

6.16 On the 18 September 2019, Health Centre 1 record receipt of a letter from the Brecon Unit at Southmead Hospital requesting a review of his medication and for details of all prescribed medications for their information as Daniel couldn't remember them. This request only occurred because "Connecting Care", the system that allows health professionals access to details of a patient's prescribed medication, was temporarily not working.

6.17 On the 24 September 2019, ASC and AWP record an email from SW1, copied to CC1, to SUW1 asking if they had gone through his housing options with Daniel as agreed at the review – see 6.13 above -, advising of the need for Daniel's GP to make a physiotherapy referral for a walking aid and asking that they let them know if Daniel doesn't want to pursue this.

6.18 On the 2 October 2019, SW1 rang SUW1 but they were away on training; SW1 asked to speak to Daniel but he wasn't available.

6.19 On the 3 October 2019, ASC record the saving of a consent form signed on the 5 September 2019.

6.20 On the 3 October 2019, Health Centre 1 record that the South West Ambulance Service NHS Foundation Trust (SWAST) contacted them as they were present with Daniel, who had had a dry cough for ten days and his breathing has worsened. He was seen that day by his GP to review his COPD; an antibiotic was prescribed.

6.21 On the 8 October 2019, ASC record an email from SUW1 advising that they had discussed housing options with Daniel: his options, in order of preference were:

1. to return to Manchester to live with his family, though SUW1 was not sure how realistic that was,
2. to return to Manchester to live in supported housing such as warden-controlled complex,
3. to move to a warden-controlled complex in Bristol,
4. look further into Veteran's provision and
5. to move through the Pathway as a stepping stone to suitable housing locally.

6.22 SUW1 also raised a query about Daniel's finances – whether he had been paying for services that should have been covered by his Section 117 Aftercare eligibility. Clarification was being sought.

Finding 13:
While it was good practice for SUW1 to have gone through housing options with Daniel, it is of concern that this appears to have taken over a month to complete and SUW1 hadn't responded to the email or message left for them – see 6.17 and 18 above. It was also good practice that SUW1 identified the possibility of Daniel being charged incorrectly for services.

6.23 On the 9 October 2019, AWP record that CC1 visited Daniel and updated him about the latest enquiry into the contaminated blood which had caused him being infected with HIV in 1989 and of which he was unaware for 10 years. Daniel considered that he had no mental health issues before his HIV diagnosis and did not agree with the symptoms of psychosis - hallucinations and hearing voices - that had led to him being referred to AWP. CC1 advised that he was likely to be discharged by AWP Bristol Mental Health Services as the primary aim of their involvement had been allocated to a social worker which had been achieved and his mental health was stable.

Finding 14:
It is of concern that an agency was going to withdraw its support from Daniel without convening a review under the CPA, which coordinated the assessment and meeting of his health and social care needs.

6.24 On the 26 October 2019, Health Centre 1 record receipt of a 111 NHS report but not what it referred to.

Finding 15:
While it may be of little significance, it is of concern that the Health Centre didn't record the details of the 111 NHS report and that no other agency was aware of it.

6.25 On the 30 October 2019, ASC record that it was confirmed that Daniel's Section 117 Aftercare entitlement doesn't cover the services referred to in 6.22 above. It is not recorded whether Daniel was advised of this.

6.26 On the 8 November 2019, SS record receipt of the nomination by SA for Daniel to move from [redacted], submitted via the Operational Managers Group for the Housing Pathway (OMG).

6.27 On the 9 November 2019, Health Centre 1 record a review of Daniel's medication and mild COPD. It was recorded that he smoked 60 cigarettes a day and was given cessation advice. A red flag was raised on his records regarding possible Sepsis; further evaluation was needed, and a Treatment Escalation Plan developed.

Finding 16:
It was good practice to review Daniel's medication and his COPD and to identify the possibility of sepsis and the need for a Treatment Escalation Plan but of concern that there is no record of either being followed through.

6.28 On the 15 November 2019, ASC record the authorisation of the Support Plan Review held on the 3 October 2019 after a number of amendments suggested by the authorising Senior Practitioner (SP2).

6.29 On the 15 November 2019, ASC record that Daniel's case was closed due to active involvement and moved to the "Await Review" tray; this was standard practice for a case that has no allocated social worker but has an active support plan to ensure a review is held at least annually.

See Finding 14 above.

6.30 On the 15 November 2019, Health Centre 1 record a review under the Care Programme Approach (CPA) was held but no details of who attended or its outcomes. ASC record SW1 attending a review of Daniel's situation but there was no Review Form completed as would have been the case if SW1 chaired the review, so it likely that SW1 attended the CPA review. SW1 recorded that "Professionals feel [redacted] is not a suitable placement for Daniel" but that he wished to stay there and "within the Homeless pathway". Daniel "appears to have capacity around this decision – Case to be closed and re-opened when Daniel expresses his interest to move on".

6.31 On the 18 November 2019, AWP record a phone call from CC1 to SW1: "following the review" (see 6.30 above) Daniel stated he was happy to stay at [redacted]. While SW1 had "assessed him as having care needs, as Daniel had wanted to stay and as he has capacity, (SW1) will not be taking any further action." ASC could support Daniel to look at housing options in Bristol, but as he stated he wanted to move to Manchester and as BCC do not place outside their area, he might apply to Home Choice in Manchester. Daniel did not meet the criteria for an Occupational Therapy (OT) assessment and declined a physiotherapy referral from his GP as he considered "walking aids may make him more vulnerable at the hostel."

6.32 SW1 advised CC1 that they would be closing Daniel's case with a contingency plan should he change his mind regarding accepting support with his housing needs or his situation deteriorates. CC1 agreed they would make an appointment to meet Daniel.

Finding 17:
It is of concern that SW1 did not advise the CPA review of ASC's intention to close their active involvement with Daniel.

6.33 On the 18 November 2019, CC1 rang to speak to SUW1 but they were not available, so a message was left asking them to ring back.

6.34 On the 19 November 2019, SA record that Daniel, in the long term, wishes to move to Manchester but that this is currently not possible, that he has health issues including restricted mobility, is noted that he has no rent arrears, "engages well with Support," is switching from DLA to a PIP and is bidding for properties on Home Choice. A placement at Hopetoun House, a supported living service is considered but deemed not suitable by Daniel as not being wheelchair accessible.

Finding 18:
This is the first time that it has been suggested that Daniel was a wheelchair user and raises questions about the quality of the s9 assessment of his social care and support needs and the appropriateness of the referral to the OT Service

6.35 On the 26 November 2019 SA and SS record that a referral for a placement for Daniel at Wood Street, a Level 2 shared house with a ground floor vacancy had been submitted. Level 2 housing has a higher level of support than Level 3, which Daniel was originally referred to.

Finding 19:
It is of concern that Daniel was referred for a placement that was acknowledged as inappropriate as it had a higher level of support than he had been assessed as needing.

6.36 On the 27 November 2019, SS record an email between Senior Project Worker 1 (SPW1) and their Team Manager (SSTM1) to advise that they have described the layout of the property with SUW1, who will discuss this with Daniel.

6.37 On the 29 November 2019, SS record an email to SA Pathway Lead for Pathway 1 (PLP1) advising that Daniel will be viewing the property at Wood Street to see if it is suitable for him.

6.38 On the 3 December 2019, AWP record an email from SUW1 to SW1 copied to CC1 in which they advise that Daniel may be moving to a ground floor room in a Level 3 shared house, 1 Wood Street. It meets most of Daniel's needs – ground floor level access, close to relevant facilities and a bus route to Southmead Hospital. The issues are that the bathroom is on the first floor and there is less support than at [redacted], not being directly staffed. Daniel is going to view the property and could move in next week. Daniel had spoken about the possibility of moving to accommodation for the over 60s and SUW1 described his mood as fluctuating more than usual.

Finding 20:

It is not clear why SUW1 was contacting SW1 when their involvement with Daniel had ceased.

6.39 On the 3 and 10 December 2019, SA record OMG meetings noting that Daniel had visited Hopetoun House several weeks before and rejected it as a possible placement as it wasn't wheelchair accessible – see 6.33 above. SA was not aware Daniel used a wheelchair and clarification was sought.

See Finding 18 above.

6.40 On the 13 December 2019, AWP record a phone call from CC1 to Daniel; he advised them that he is moving to Shaftesbury Avenue and suggested they contact SUW1 to arrange a visit.

6.41 On the 16 December 2019, SS record that Daniel had signed an Assured Shorthold Tenancy Agreement for a room at 62 Shaftesbury Avenue and had moved in. The property is a Level 3 supported shared house for up to four males managed by SS but owned by LiveWest. This move is recorded on the Housing Support Register.

6.42 On the 17 December 2019, AWP record receipt by CC1 of an email from SUW1, copied to SW1 advising them of Daniel's move to a property that is a step-down from [redacted] in terms of the level of support provided. Daniel will be allocated a support worker from SS. CC1 replied by email, due to difficulties in contacting SUW1 by phone, asking to arrange a visit to Daniel or to be present at the handover to the new support worker to ensure all mental health support is in place. Daniel was then to be discharged from the Assessment and Recovery Team as he had moved to Level 3 supported accommodation with a support worker from SS.

See Findings 14 and 20 above.

6.43 On the 18 December 2019, SS record that SUW2 completed a Staff Risk Management Plan (SRMP) without any reference to Daniel being involved. This is not standard practice within SS. The SRMP was reviewed and revised with Daniel once a relationship had developed with his support worker.

Finding 21:
It is of concern that Daniel's SRMP was completed as part of the admission procedures without his active participation.

6.44 On the 23 December 2019, AWP record receipt of an email from SUW1 to CC1 and SW1 confirming that SUW2 was now Daniel's support worker.

6.45 On the 24 December 2019, ASC record that the closure of Daniel's case and its movement to the 'Await Review' tray was confirmed see 6.29 above**.** It is also recorded that a letter was sent to Daniel advising him of the above and including a copy of his review and support plan and advice about how to request a review should his circumstances change. This letter and its attachments were not available to the SAR as there is no copy on ASC's records system.

6.46 On the 27 December 2019, AWP record an email from CC1 to SUW2 advising that they are Daniel's Care Coordinator but that he is due to be discharged from the service and asking that they visit to complete the discharge "if all is well".

See Finding 14 above.

6.47 On the 2 January 2020, SS record that Daniel's SRMP was reviewed and revised. It would appear the record was amended when Daniel later said that he had reported being assaulted by a fellow tenant at 62 Shaftesbury Avenue; after the assault he went to Manchester where he had family and friends and presented at A&E for medical treatment. He also reported the assault to LGBT services in Manchester who said they would contact the Police – see 6.50 below.

6.48 On the 7 January 2020, AWP record receipt of a phone call by a Community Nurse (CPN2) in the Bristol Mental Health Single Point of Access from the North Manchester Psychiatric Liaison Service (NMPLS) to inform them that they had seen Daniel and asking for information on their involvement with him. As Daniel was open to the Recovery Team, the call was transferred to their Duty Desk and CPN2 advised CC1 of the contact by email.

6.49 On the 7 January 2020, AWP record that CPN2 contacted NMPLS and advised that Daniel had been stable for some time and was due to be discharged from their service; they provided details of his prescribed psychiatric and HIV medication. Manchester advised that Daniel had presented to them alleging that he had been assaulted in Bristol and wished, in the long term, to move to Manchester. They had no concerns for his mental state or capacity, and he was seeking new accommodation in Manchester. Given the time of the phone calls – 6pm -, it was agreed to advise Daniel to stay with the friends he had been staying with and return to Bristol in the morning. CC1 was advised of the above by email.

6.50 On the 8 January 2020, BCC Safeguarding Adult Team (SAT) record receipt of a safeguarding referral from the LGBT Foundation in Manchester following Daniel attending a drop-in session and disclosing that a fellow tenant had broken into his room and assaulted him at 62 Shaftesbury Avenue and that Daniel had fled to Manchester as he felt unsafe. The Foundation had contacted Daniel's GP and organised his prescribed medication and contacted SA who in turn were contacting SS. Daniel had been provided with a food voucher.

6.51 On the 8 January 2020, AWP record receipt of the email and assessment from NMPLS – see 6.48 above – and CC1 checked if Manchester had Daniel's mobile number but they didn't. CC1 then contacted SUW2 who told them that Daniel had complained of someone shouting at him and had been advised to stay away from him while it was decided what to do. CC1 advised SUW2 that Daniel was currently in Manchester but would be returning to Bristol and asked if they had a mobile number for him.

Finding 22:
It was good practice for services in Bristol and Manchester to liaise and share information to ensure support to Daniel was co-ordinated.

6.52 On the 8 January 2020, AWP record that CC1 contacted Supporting Independence who had been delivering Daniel's medication as SA do not do so. This service will now stop as Daniel is being supported by SS who will take this role on. SS do not normally provide this service but did so during the period of the Lockdown. CC1 added Daniel and SUW2's mobile numbers to their system. CC1 then spoke to an un-named Senior Practitioner, and agreed that, as Daniel had no identified mental health needs, his case should be closed.

See Finding 14 above.

Finding 23:
It is of concern that Daniel's case could be closed a matter of days after he left Bristol due to an alleged assault by a fellow tenant.

6.53 On the 8 January 2020, ASC record that Senior Care Direct Advisor (SCDA1) was advised that Daniel's support from Supported Independence would be ending as he had moved to accommodation that can provide the support he needs. There is no record of any discussion of Daniel's mental health needs. Supported Independence were asked to complete an online contact referral so that Daniel's support plan could be ended, which was done.

Finding 24:
While it was good practice to close Daniel's support package from Supported Independence, it is of concern that this didn't result in a review of his support package at his new tenancy to ensure continuity of support to him.

6.54 On the 8 January 2020, Daniel's GP record contact from the LGBT Foundation in Manchester and agreed to send a script for non-HIV medications.

See Finding 22 above.

6.55 On the 8 January 2020, SS record a letter being sent to Daniel as the First Stage of their Abandonment Procedure advising that, as he was not living at 62 Shaftesbury Avenue, he should contact them to advise whether or not he intended returning to the property by the 15 January 2020. There is no recorded response to this letter. At this stage, SS were not aware of the alleged assault on Daniel or his response to it.

Finding 25:
Given the events of the previous week, it is of concern that standard procedure was followed in contacting Daniel about his accommodation.

6.56 On the 1 January 2020, SAT record allocating the safeguarding referral – see 6.50 above – to a Senior Social Worker (SSW1). SSW1 contacts CC1, SUW2 and SW1 and is advised of Daniel's current situation, his likely return to Bristol and upcoming discharge from mental health services as he is stable. SUW2 advised that they were unaware of the alleged assault until informed by the LGBT Foundation - see 6.50 above.

6.57 On the 10 January 2020, AWP record a phone call to SSW1 by CC1; SSW1 didn't consider that "Daniel meets the threshold for safeguarding at present" but did have concerns that he could be homeless if he attempted to obtain social housing in Manchester. CC1 confirmed that, as Daniel's mental health is currently stable, the intention is still to discharge him from their service.

Finding 26:
It is not clear on what basis SSW1 assessed Daniel's situation as not meeting the "threshold for safeguarding" without having direct contact with him.

6.58 On the 13 January 2020, SAT record that SSW1 has tried to contact Daniel and left a message asking him to contact them. SSW1 also spoke to SUW2 and was advised that Daniel has returned to Bristol and gone to the SA. He was advised to return to SS.

6.59 On the 14 January 2020, SAT record a phone conversation between SSW1 and SUW2 in which SUW2 confirms that Daniel has returned to 62 Shaftesbury Avenue but isn't interacting with staff. SSW1 records that Daniel "does not appear to have care and support needs which are preventing him from protecting himself", based on him going to Manchester. SSW1 therefore "makes a triage decision that BCC has no duty to make s42 enquiries" and the safeguarding referral was closed but ASC would accept a referral should there be further safeguarding concerns.

Finding 27:
The basis for SSW1 closing the safeguarding referral appears to have been reached without any direct contact with Daniel, and despite his means of safeguarding himself, there was a risk of homelessness by going to Manchester.

6.60 On the 14 January 2020, SS record that SUW2 received a phone call from SA on the 13 January 2020 to advise that Daniel had returned from Manchester and presented at their hostel. He had been advised to go to SS but didn't do so that day.

6.61 On the 15 January 2020, AWP record a CPA review attended by Daniel and CC1 that was also a discharge meeting. Daniel asked for more domiciliary support to be provided to help with cooking and keeping him safe. They "discussed that his mental health remains stable despite a difficult move" and that he had been in close contact with his family. Daniel was discharged from the Recovery Team.

Finding 28:
It is of concern that the CPA review was attended by only CC1 and Daniel and that he was discharged from the Recovery Team without discussion with the other agencies involved in supporting him in the community.

Finding 29:
It is not clear what impact Daniel's discharge from the Recovery Team would have on his supported package being managed under the CPA.

6.62 On the 16 January 2020, SS record that SUW2 reviewed Daniel's SRMP which stated that "Daniel had reported that he was attacked and physically assaulted by

another resident in his room on the 2 January 2020" and that he was "waiting to be moved to another property for his own safety". On the same date, SS record that Daniel viewed and moved into a room at [redacted], another Level 3 shared supported house in the Homelessness Pathway.

6.63 On the 17 January 2020, AWP record an email from CC1 to SUW2, copied to SW1, advising that Daniel had been discharged from the Recovery Team and that they and Daniel felt he would benefit from Level 2 support – 24-hour presence of a support worker - as he struggles with his mobility, dietary needs, cooking, and cleaning. CC1 also advised that they were leaving the Recovery Team.

Finding 30:
It is of concern that CC1 considered that Daniel would benefit from a higher level of support than he was currently receiving but had discharged him from the Recovery Team without ensuring he had an appropriate support package in place.

6.64 On the 17 January 2020, SS record that the Housing Support Register was updated to show Daniel's move from 62 Shaftesbury Avenue.

6.65 On the 22 January 2020, AWP record a message received by the Duty Desk from Daniel asking for a call back as CC1 had left and that he had been discharged from the Recovery Team. The Duty Officer, a Health Care Assistant, (HCA1), rang Daniel back and left a message to call back if he wanted to speak to someone.

6.66 On the 27 January 2020, AWP record a phone call from Daniel to the Duty Officer (HCA2) asking to speak to CC1. The phone line was poor, and Daniel got frustrated and ended the call before he could be told that CC1 had left the Team. HCA2 rang him back to advise him of the above. Daniel told HCA2 that CC1 had contacted SS to say Daniel needed a social care referral and HCA2 advised that he should speak to his support worker at SS.

Finding 31:
At this stage, Daniel's support appears to still be under the management of the CPA process, but no contact is made by AWP staff with other members of the CPA review group to advise them of Daniel's situation.

6.67 On the 29 January 2020, Health Centre 1 record receipt of a letter from AWP advising of Daniel's discharge from the Recovery Team, that his mental health is stable and that he is receiving support from SS and accessing Social Care.

Finding 32:
While it is good practice for the Health Centre to be advised that Daniel has been discharged from the Recovery Team, this is two weeks after the discharge and makes no reference to the status of Daniel's situation under the CPA.

6.68 On the 10 February 2020, Health Centre 1 record texting Daniel advising him that he will have to register with a new Practice as he has moved out of their catchment area.

See Finding 14 above.
6.69 On the 13 February 2020, SA record a Service Review was completed with Peer-to-Peer Evaluation; no evidence was recorded regarding Daniel.

Finding 33:
Given the events of the previous seven weeks, it is of concern that a Service Review, which would normally be expected to review any customer at immediate high risk, made no mention of Daniel.

6.70 On the 14 February 2020, Health Centre 1 record that Daniel was phoned to arrange a COPD review; he advised he had registered with another Practice – see 6.67 above – so no appointment was made.

6.71 On the 17 February 2020, the Health Centre 2 record that Daniel registered with them.

Finding 34:
It is of concern that, assuming the Daniel was still open to the CPA procedures, his new GP was not informed of this.

6.72 On the 26 February 2020, SS record that a Personal Recovery and Development Plan (PRDP) was completed – the only action was to buy Daniel a new mobile phone. On the same date, Daniel's SRMP was reviewed along with his risk assessment. Both were unchanged.

Finding 35:
It was good practice to agree a PRDP for Daniel and to review his SRMP and risk assessments though the latter could have been reviewed sooner after his move to [redacted].

6.73 On the 11 March 2020, the Health Centre 2 record writing to Daniel asking him to contact the surgery to book an appointment for blood tests due to his prescribed medication. This was the first of six such letters sent before the 15 June 2020.

Finding 36:
It is of concern that the Health Centre's Did Not Attend procedures were not initiated by the lack of response from Daniel to the letters.

6.74 On the 24 March 2020, SS record a phone call from a Support Assistant (SA1) to Daniel to check how he was doing; he said he was fine. SA1 encouraged him not to go out and, if he does, to wash his hands on his return. SA1 advised Daniel that, due to Covid-19, most contact would be by phone and gave him their mobile number should he need to contact them.

Finding 37:
It was good practice to advise Daniel of the impact of the Pandemic on his support services and to ensure he had the means to contact SS if necessary.

6.75 On the 30 March 2020, SS record a phone call from SA1 to Daniel to check how he was; he said all was fine apart from the hot water in the house being “down”, but he had already informed the Housing Worker responsible for the property.

6.76 On the 31 March 2020, Health Centre 2 record receipt but not the contents of a letter from the Brecon Unit at Southmead Hospital. The Brecon Unit record this as advising the Practice of a phone contact with Daniel due to Covid-19; he had advised them he was fine.

6.77 On the 31 March 2020, SS record a call from Daniel to SA1: he thought he’d missed a call from them. He was fine but coughing a lot and spoke of wanting to cut down how much he smoked; they agreed it was something to look at in his next PRDP review.

6.78 On the 31 March 2020, SS record a phone conversation between SUW5 and Daniel regarding a possible move to Clouds Hill due to his physical health. This would have provided the same level of support but in a self-contained flat. The following day, Daniel declined the move as he was settled where he was and didn’t see the point of a move to another temporary tenancy.

Finding 38:
It was good practice to keep Daniel’s accommodation needs under review with regard to his physical health needs.

6.79 On the 2 April 2020, SS record that Daniel rang SUW5 to report that the hot water in the house was still not up to temperature though the heating was working. He had had a “fainting fit” earlier but felt OK after sitting down; otherwise, he was fine.

6.80 On the 3 April 2020, SA1 rang Daniel having missed a call from him the day before. He repeated what he had told SUW5 the day before.

Finding 39:
It was good practice for SA1 to respond to missing a call from Daniel.

6.81 On the 7 April 2020, SS record a phone call from Daniel to SA1; he had aches in his legs and dizziness which meant he was having difficulty getting out of bed. When asked, he said he had no other symptoms and thought it might be linked to his other health conditions. SA1 suggested he contact NHS 111 to check. As it stopped him going out to the shops, SA1 agreed to discuss with SUW5 and their Senior Project Worker (SPW2) how they could support him. Daniel later rang back to say he thought his fainting etc was linked to the stroke he’d had two years before.

6.82 On the 8 April 2020, the Brecon Unit record that Daniel didn’t attend an appointment. There was no evidence presented to the SAR that any action was taken under the Brecon Unit’s Did Not Attend Procedures.

Finding 40:

It is of concern that whilst the Brecon Unit initiated its then Did Not Attend procedures, it would appear that they were unaware that his support was being coordinated under the CPA process.

6.83 On the 8 April 2020, SS record a phone call to SUW5, advising that he'd received his new microwave but wasn't strong enough to get it out its box. The same date, Daniel phoned SA1 and advised them of the above but said he'd ask another tenant to help him.

6.84 On the 9 April 2020, SS record a conversation between Daniel and SUW5 in which they discussed food deliveries and SUW5 agreed to get Daniel a brochure from Wiltshire Farm Foods of pre-cooked meals.

Finding 41:
It was good practice to review how Daniel could get a balanced diet but of concern that SUW5 didn't check that Daniel's microwave was now operative.

6.85 On the 19 April 2020, SS record that SA1 saw Daniel; he was still having difficulty finding a take-away that will deliver to him, so he is eating mainly sandwiches – his microwave was still in its box.

6.86 On the 22 April 2020, SS record that SUW5 noted that Daniel has had food delivered by a volunteer and was feeling well.

6.87 On the 4 May 2020, SS record that Daniel's SRMP was reviewed and remained unchanged.

6.88 On the 5 May 2020, SS record that Daniel's PDRP was reviewed but limited to Daniel to start bidding for properties on Home Choice when it reopens after Covid-19.

Finding 42:
It was good practice to review Daniel's SRMP and PDRP and, by implication, his risk assessment.

6.89 On the 26 May 2020, SS record a phone call from Daniel to SA1 the only issue was the rubbish in the house and the garden. SA1 agreed to see if there was anything they could do about the situation.

6.90 On the 2 June 2020, SS record a phone call from SA1 to Daniel; he said he was well but raised concerns about is food being stolen from the kitchen and two other tenants knocking on his window to let them in at night when they had been locked out. SA1 agreed to raise these issues with the Housing Team.

6.91 On the 8 June 2020, SS record Daniel ringing SA1 to advise that he had lost some staff contact numbers – SUW5 and Housing Worker 1 (HW1) – when transferring contacts to his new phone. SA1 texted the numbers to him.

6.92 On the 16 June 2020, SS record a phone call from Daniel to SA1 to advise that his fridge and freezer have arrived but that his food is still being stolen. SA1 agreed

to chase up the fitting of locks in the kitchen. Daniel also said he had nearly fainted when out shopping and had had to get a taxi home but felt better now.

Finding 43:
The above are examples of Daniel feeling able to contact staff about concerns and their responding appropriately and promptly.

[redacted]

6.94 On the 23 June 2020, Daniel's SRMP was reviewed by SUW5 but no changes required.

See Findings 35 and 42 above.

6.95 On the 16 July 2020, the Health Centre 2 record texting Daniel about his blood tests; he responded the same day to advise that "he has bloods done regularly outside of Bristol" though there is no EMIS (the Information and Management System used by Health) record of this. He thought they were last taken in January 2020. Daniel was persuaded to have bloods done locally plus ECGs and agreed an appointment could be made for them.

6.96 On the 22 July 2020, SS record a phone call from SA1 to Daniel: locks in kitchen now fitted but milk still being stolen from the fridge. SA1 agreed to talk to SUW5 about getting Daniel a small fridge for his room, funded by Sylvia's Fund, a source of funding for SS service users.

6.97 On the 24 and 27 July 2020, SS record contact between SA1 and Daniel; Daniel reported he was fine. He'd contacted SUW5 with a problem with his door but HW1 would be dealing with it.

6.98 On the 28 July 2020, the Health Centre 2 record that Daniel's blood test results were all in the normal range as was his weight – see 6.95 above.

6.99 On the 6 August 2020, SS record that SA1 met Daniel and he signed an application to Sylvia's Fund – see 6.96 above – but said he'd missed an appointment with the Brecon Unit as the transport hadn't turned up. SA1 agreed to let SUW5 know. The details of the missed appointment are not known.

See Finding 40 above.

6.100 On the 9 August 2020, the Brecon Unit record writing to the Health Centre 2 and the pharmacy advising them that Daniel had missed an appointment and they had been unable to contact him.

Finding 44:
It is of concern that the Brecon Unit's Did Not Attend procedures were insufficiently robust to require contact to be made with him or, if this was unsuccessful, one of the support services directly involved with him.

6.101 On the 18 August 2020, SS record that SA1 visited Daniel at his tenancy; he asked to see her in private and disclosed that on the 14 August 2020 tenant A had become aggressive with him because he wouldn't give him a cigarette, he'd made racist remarks and threatened "to get a knife and stab him before he leaves". This had happened in tenant B's room and witnessed by tenant B as well as a cousin of tenant A. Daniel said he didn't feel safe in the house and wouldn't use the upstairs toilet as it is next to tenant A's room and he keeps his door open. SA1 discussed Daniel calling the Police but he wanted to avoid doing so and for SS to speak to tenant A; Daniel is keeping out of his way as he fears tenant A will be verbally abusive to him. He suspects that tenant A is angry with him for mess he left in the bathroom a few weeks ago.

Finding 45:
It is of concern that SA1 didn't raise a safeguarding concern with ASC and that their manager didn't recognise the need to do so.

Finding 46:
It was good practice to not contact the Police as Daniel requested, but of concern that no reference is made to Daniel's capacity to make this decision given his history of having had strokes.

6.102 On the 2 September 2020, SS record that SUW5 reviewed Daniel's SRMP; a further review was set up for the 2 December 2020.

Finding 47:
It is of concern that there is no record of any follow up with Daniel on the issue of his relationship with tenant A and that it wasn't referenced in the review of his SRMP.

6.103 On the 11 September 2020, the Health Centre 2 record a series of phone calls with Daniel and SUW5; Daniel rang the Health Centre at 11:13 saying he needed help and sounding very distressed. He passed the phone to SUW5 who said they'd made a routine call on Daniel and found him unable to walk having been very unwell for 3-4 days. A phone appointment with a GP was arranged for later that day. A GP rang at 12:47 and spoke to SUW5, who is the contact given in Daniel's records. They hadn't seen Daniel but had been contacted by a colleague to say Daniel was unwell and they were going to see him. GP agreed to ring again later when SUW5 would be with Daniel. At 15:07, the GP spoke to SUW5 again: SS staff were concerned for Daniel who had taken to his bed and weren't clear if he was taking his medication. A home visit was agreed that evening. At 19:00, the GP visited but got no reply; they couldn't see the key safe that they were advised was there and contacted the Police but agreed the threshold for forcing entry wasn't reached so a message was left for the support worker, most probably on their work mobile, advising them of the above.

6.104 On the 12 September 2020, the Health Centre 2 record a home visit when the GP sees Daniel due to his arriving back from shopping at the same time as the GP arrived. The GP described "fairly squalid living conditions – bedsit very hot, thick with cigarette and cannabis smoke, bed very dirty, soft drinks everywhere, Daniel thin, shuffling gait, unkempt, coughing, no sign of serious new problem warranting call

out, evidently able to mobilise as walked to Tesco and back several 100s of metres". The GP fed back to the support worker regarding the need to "clarify the key safe issue, get Daniel's number etc".

Finding 48:
It was good practice for the GP to call again to see Daniel and feedback to SUW5 but of concern that they didn't raise a safeguarding concern as a result of the GP seeing Daniel's living conditions.

6.105 On the 16 September 2020, the Brecon Unit record receipt of a letter from the Health Centre 2, copied to SS, asking for an update, though for what is not made explicit.

6.106 On the 17 September 2020, SA record a Service Review, but no evidence recorded regarding Daniel.

See Findings 3 and 33 above.

6.107 On the 29 September 2020, the Brecon Unit record writing to the Health Centre 2 advising that Daniel missed an appointment on the 8 September 2020. The letter referred to weight loss from a year ago but "recent correspondence implied his weight loss had stabilised". It is not clear what correspondence this refers to or who weighed Daniel.

See Finding 45 above.

6.108 On the 23 October 2020, SS record an Incident Form completed by SUW5 having been phoned by Daniel to report that tenant A had been bullying him. He described tenant A as "out of his head", keeping shouting at him, banging his door and generally intimidating him and committing antisocial behaviour. SUW3 went to see Daniel in his room and discussed calling the Police but Daniel wanted to avoid this. He is staying out of tenant A's way and feels the cause of tenant A's behaviour is the mess he, Daniel, left in the bathroom a few weeks ago – see 6.101 above.

See Findings 45 and 46 above.

6.109 On the 26 October 2020, SS record SUW3 and SA2 visited Daniel to check he was OK. He said he'd had no trouble with tenant A over the weekend and even had "half an apology". He said he was feeling dizzy and was encouraged to drink some water. They discussed getting a lanyard for his key to prevent him losing it and the need to reorganise his room if he gets a fridge - see 6.96 and 6.99 above.

6.110 On the 2 November 2020, SA record a Service Review, Peer to Peer Evaluation but no evidence recorded regarding Daniel.

6.111 On the 3 November 2020, SS record that SUW3 met Daniel in his room and supported him to ring Southmead Hospital about his medication. Daniel complained of feeling dizzy and tingling in his hands and feet; he was advised to drink water for the dizziness and contact his GP for the tingling.

6.112 On the 5 November 2020, SS record that SA1 visited Daniel to check how he was; he was unhappy with the situation with tenant A in the house and he was advised to speak to SUW5 who was calling at the house that afternoon. He also complained about his health but didn't want the GP contacted. He asked about the £50 he has in the house safe which he wants to use to buy a new phone.

6.113 On the 11 November 2020, SS record a phone call from Daniel to SUW5 advising that his mobility was worse, and he was finding it difficult to get around but didn't want any help contacting his GP. He did ask for help contacting Southmead Hospital about his virology medication.

6.114 On the 17 November 2020, SS record that SUW5 and Daniel bought and set up a new phone. SS's records were amended to show the new mobile number.

6.115 On the 18 November 2020, the Health Centre 2 record contact with Daniel but not the form it took: "Difficulty using legs. No circulation. Struggling to walk. Sometimes better sometimes worse. Difficult to understand patient. I believe this is due to a stroke. 1 month+ Tel appt made Tel number checked".

6.116 On the 25 November 2020, SS record a phone call from Daniel to SA1 asking for help getting some shopping, which they gave him. He told them he had a phone appointment with his GP that afternoon.

6.117 On the 25 November 2020, the Health Centre 2 record a "Vulnerable Adult Review"; GP spoke to Daniel who advised that he had got worried waiting for his phone appointment and had tried to ring the Centre but couldn't get through and had called 999 instead. Daniel handed the phone to a paramedic who considered Daniel needing an assessment at the hospital due to abdominal pain, possible low level of consciousness and significant postural hypotension, to which Daniel agreed.

Finding 49:
It is not clear what the status is of a "Vulnerable Adult Review" and of concern that the terminology is likely to cause confusion.

6.118 On the 25 November 2020, University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) record that Daniel was taken to the Emergency Department by the SWAST, arriving at 17:17. Daniel advised that he had been feeling dizzy/faint for 8 months, had a chronic cough, produced sputum, had reduced mobility, intermittent pain in his chest and pain in his abdomen. Bloods were taken but nothing of note recorded; his abdomen was examined but nothing of note recorded. Chest-ray was normal. His mobility was assessed as satisfactory. Possible further inquiry for malignancy and review of his care package was noted. He was assessed as fully alert on the Glasgow Coma Scale. Daniel was discharged at 22:14 and advised to get up slowly, stay hydrated and contact his GP if further advice needed. He was also advised to self-isolate as he had been in the same bay as a Covid positive patient. A discharge letter was sent to the Health Centre 2.

Finding 50:

It was good practice to take Daniel to hospital where he was appropriately assessed and discharged; it is of concern that the Health Centre had no record of this hospital attendance.

6.119 On the 1 December 2020, the Health Centre 2 record texting Daniel advising him that his COPD review was due and asking him to contact Reception to arrange an appointment.

Finding 51:
While it was good practice to contact Daniel to advise him to arrange an appointment to review his COPD, it is of concern that the lack of any response didn't initiate the Health Centre's Did Not Attend procedures and that no contact was made with Daniel until after the New Year.

6.120 On the 7 December 2020, SS record a phone call from Daniel to an unknown member of staff saying he was being threatened by tenant A; the member of staff was enroute to the house and spoke to him when they arrived. Daniel said he didn't feel safe in the house, as tenant A is being aggressive with all the tenants and banging his door and shouting at him. He was advised to call the Police if tenant A "puts his hands on him". The member of staff then went to speak to tenant A.

See Finding 45 above.

6.121 On the 14 December 2020, SS record that Housing Worker 2 (HW2) and an unnamed member of staff saw Daniel. He said that things had calmed down at the house, but he didn't think it would last. He was advised to contact staff if anything happened.

Finding 52:
It is of concern that no contact was made with Daniel for a week to check how things were in the house.

6.122 On the16 December 2020, SA recorded a discussion with SS, Elim Housing, Live West and BCC Homelessness Commissioning Team regarding Contract Management and Quality Delivery but no evidence recorded regarding Daniel.

6.123 On the 18 December 2020, SS record that Daniel rang SUW5 to complain of tenant A's aggressive and threatening behaviour and that SUW5 completed an Incident Form and submitted a referral for an Adult Social Care Assessment on the 21 December 2020 due to his concern about Daniel's ability to manage at [redacted]

See Finding 45 above.

6.124 On the 22 December 2020, the Brecon Unit record that Daniel didn't attend his appointment that day, that he wasn't answering his phone, and they hadn't "seen him for a while." However, it is also recorded that he "has been in contact with the pharmacy team and is engaging with his treatment." The review was advised that this would have been based on blood tests demonstrating that the anti-viral

medication was being taken and was being effective, but no evidence was provided of blood tests being completed.

See Finding 44 above.

Finding 53:
It is not clear how it can be stated that Daniel "is engaging with his treatment" given how long it was since he was last seen by the Brecon Unit.

6.125 On the 23 December 2020, ASC Swift Response Team (SRT) record receipt of the referral from SS – see 6.123 above.

6.126 On the 25 December 2020, the Police record receiving a call from a resident at [redacted] not Daniel, alleging that tenant A was shouting at him and had gone back into his own room with a knife. The Police attended and arrested tenant A on suspicion of threats to kill. The complainant didn't want to pursue charges, just wanted tenant A to leave him alone. Daniel was spoken to as a witness but didn't want to get involved. The Police recorded no concerns for Daniel. They attempted to contact the SS Support Worker unsuccessfully and left a message asking them to contact the tenants to "resolve any issues."

6.127 On the 26 December 2020, the Police record a call from a tenant at [redacted] again not Daniel, alleging that tenant A had "returned from custody and was outside threatening to kill him." Daniel was identified as a witness but said he had only heard an argument and a scuffle on the stairs, he hadn't seen anything. The complainant again declined to press charges. No concerns were recorded about Daniel and a "Treat as Urgent" marker was placed against his fellow tenant's address and the Neighbourhood Beat Team advised.

6.128 On the 27 December 2020, the Police record a call from tenant A reporting a theft of £600 from Daniel's flat; the Police attended and found Daniel's wallet, containing at least £620 in his flat. The Police record finding Daniel lying on his bed, which was "extremely dirty with stains and liquid marks on it"; they also described the room as being very dirty. The Officer recorded he was unable to assess properly Daniel's mental state but he was concerned about his confusion. As a result, the Police referred Daniel to the Lighthouse Safeguarding Unit, a support service for victims and witnesses of crime, and a Blue, Red, Amber and Green (BRAG) risk assessment tool was completed, rated "green", due to his disclosed health concerns and had appeared confused. A BRAG risk assessment was also completed for tenant A due to concerns for his mental health. It should be acknowledged that the "Treat as Urgent" marker had not been placed on Daniel's address, but that of a fellow tenant.

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Finding 54:
Although it was good practice to refer Daniel to the Lighthouse Safeguarding Unit and to complete a BRAG risk assessment, it is of concern that none of the above three incidents generated a safeguarding referral from the Police to the local authority, despite there being concerns for his mental health.

6.129 On the 6 January 2021, the Health Centre 2 record noting that Daniel wasn't on Statins which has been suggested on a recent "HIV letter" from an undisclosed source and that he is due a COPD review and that he will be written to about both issues.

Finding 55:
It is of concern that Daniel's history of not responding to letters didn't lead to the Health Centre using a different communication medium to contact him or contact another agency involved in supporting him.

6.130 On the 11 January 2021, SS record a phone call from Daniel to SUW5 to advise that he had been contacted by "someone" about the care assessment referral – see 6.123 and 125 above. SUW5 rang Care Direct Advisor (CDA1) who had emailed him; they advised that the referral had been forwarded to First North Team (FNT) and that after speaking to SUW5 wasn't convinced he needed a care assessment, and they would have to speak to their manager.

Finding 56:
Although it is a matter of semantics, the issue was whether Daniel was "eligible" for an assessment under the Care Act 2014, not whether he "needed" one. It is also of concern that nobody communicated the manager's decision to Daniel or SUW5.

6.131 On the 12 January 2021, SS record that SUW5 visited Daniel; he was in bed but said the house was "peaceful" and there had been no trouble.

6.132 On the 15 January 2021, SWR record sending a "delay letter" to Daniel, advising that he was on a waiting list for a Care Act Assessment.

6.133 On the 20 January 2021, SS record a Health and Safety Check (HSC) being completed by HW3, who noted that "Room needs a clean." HSCs are completed monthly, but this is the first to be included in the chronology from SS.

6.134 On the 25 January 2021, SS record a phone call from Daniel to SUW5 asking him to book transport to a hospital appointment on the 26 January 2021, which he did.

6.135 On the 26 January 2021, the Brecon Unit record that Daniel attended his appointment. It was noted that Daniel had been discharged from mental health services in December, had changed GP, and had support twice a week.

6.136 On the 27 January 2021, the Health Centre 2 record sending Daniel a text message asking him contact to Reception to arrange a medication review.

See Finding 55 above.

6.137 On the 4 February 2021, SAT record receipt of a safeguarding referral from SS; the same day, the Senior Practitioner, SAT (SP 4) identified this as a request for a service rather than a safeguarding concern and therefore not appropriate for SAT.

It was therefore linked to the existing referral on FNT's waiting list – see 6.132 above.

6.138 On the 8 February 2021, the Health Centre 2 record leaving a message on Daniel's mobile regarding the need for a medication review.

See Finding 55 above.

6.139 On the 12 February 2021, the Health Centre 2 record texting Daniel asking him to contact the surgery as his unspecified "specialist" has informed them that his iron levels are low, and he should see his GP to discuss this.

See Finding 55 above.

6.140 On the 17 February 2021, SS record that an unnamed member of staff and SUW4 visited Daniel; he was in a good mood but advised them of a problem with the washing machine which they passed on to Housing.

6.141 On the 22 February 2021, SS record a visit by SUW3 to see Daniel; he was well but there was a broken window in the house.

6.142 On the 25 February 2021, SS recorded that HSC and HW4 noted "Overall cleanliness: OK; Overall tidiness: Good; New bedding ordered."

6.143 On the 26 February 2021, UHBW record Daniel being taken to the ED by SWAST ambulance at 23:47, having called 999. He was experiencing dizziness, nausea, abdominal pain, and rectal bleeding. His abdomen was noted to be tender but no concerns regarding alertness, mobility, capacity, malnutrition, pressure sores, bloods, ECG, or chest x-ray. Discharged at 4:30 on the 27 February 2021 with safety advice and advised to contact his GP for follow up.

6.144 On the 26 February 2021, the Health Centre 2 record the above attendance at the ED.

Finding 57:
Although there is no record of why or how the SWAST was called to see Daniel, it was good practice to take him to hospital and for the Health Centre to be advised of his attendance at the ED.

6.145 On the 1 March 2021, the Police record a 999 call by a tenant at [redacted] not Daniel, reporting he had been assaulted by tenant A. The Police attended and the complainant was taken to hospital as "he had significant injuries". CCTV footage showed that the complainant was the aggressor and that tenant A had acted in self-defence. Daniel advised the Police he had heard shouting but hadn't left his room and therefore saw nothing. The Police didn't note any concerns regarding Daniel's health or living conditions. As the "Treat as Urgent" marker – see 6.127 – was not against Daniel's address within [redacted] it didn't trigger any response to this incident.

6.146 On the 3 March 2021, the Health Centre 2 record sending Daniel a text message advising him that if the symptoms that caused his attendance at the ED are ongoing, he should contact them.

See Finding 55 above.

6.147 On the 9 March 2021, SS record an unnamed member of staff were phoned by Daniel about a problem with his phone; the member of staff visited and sorted the problem out and noted Daniel was booking an appointment for his Covid-19 vaccine.

6.148 On the 17 March 2021, SS record that Daniel contacted an unnamed member of staff as he wasn't feeling well and wanted to contact SUW5; the member of staff visited and recorded that Daniel was "feeling a little better … (*and*) just needed a bit of company."

6.149 On the 29 March 2021, SS record that an HSC was completed by HW4, who noted "Overall cleanliness: OK; Overall Tidiness: OK; needs new bedding; discussed painting (walls) – tenant says he doesn't want".

6.150 On the 30 March 2021, the Brecon Unit record Daniel attended an appointment; he was weighed – 57.4kg, down from 58.3 on the 26 January 2021 – and had said he was eating 1 meal a day. Other writing unintelligible.

6.151 On the 7 April 2021, the Health Centre 2 record "Fast track referral for suspected lower gastrointestinal cancer".

Finding 58:
It is not clear what prompted the "Fast track referral", but this may be due to the "unintelligible" recording – see 6.150 above – but the Health Centre don't record any communication from the Brecon Unit.

6.152 On the 7 April 2021, UHBW record receipt of a referral from Health Centre 2 – see 6.151 above.

6.153 On the 9 April 2021, SS record HW3 visited Daniel; discussed opening a bank account.

6.154 On the 12 April 2021, SS record Daniel advising SUW5 that he has had testosterone and iron injections at Southmead Hospital.

6.155 On the 14 April 2021, UHBW record an internal notification of the need for urgent investigations and sets deadlines for further investigation.

6.156 On the 19 April 2021, the Health Centre 2 record sending Daniel a text message advising they have issued the medication he had requested and asking him to book a telephone review with a GP.

See Finding 55 above.

6.157 On the 20 April 2021, UHBW record that Daniel didn't attend his appointment with the colorectal surgeon; he will be offered a further appointment.

Finding 59:
It is of concern that UHBW weren't advised of Daniel's history of not responding to written communications – including texts.

6.158 On the 20 April 2021, the Health Centre 2 record that Daniel didn't attend the appointment above – 6.156.

6.159 On the 22 April 2021, the Health Centre 2 record sending Daniel a text advising they had been trying to contact him and that they try again the next week.

See Finding 55 above.

6.160 On the 27 April 2021, SS record that an HSC was completed by HW4 who noted: "Overall Cleanliness: Poor; Needs new bedding and a clean".

6.161 On the 28 April 2021, the Health Centre 2 record that SUW3 called on Daniel's behalf: he was "incredibly unwell, unable to get out of bed, dizzy spells, wants nutritional supplement drinks".

6.162 On the 28 April 2021, SS record an unnamed member of staff, in SA2's absence on sick leave, visited Daniel, noting he was unwell, weaker than usual, dizzy and unable to get out of bed. He had an appointment with the colorectal specialist but was unable to go. He also has another on the 13 May 2021 to do with a bone scan.

6.163 On the 28 April 2021, UHBW record that Daniel failed to attend his appointment with the colorectal specialist; it was noted that a letter was sent to his GP advising that he would be offered a final appointment.

See Finding 59 above.

6.164 On the 29 April 2021, the Health Centre 2 record a phone call to Daniel to follow up on previous contacts; he initially picked up, but it is not clear if Daniel was feeling too unwell to speak or just hung up. The GP tried to ring him back but left a Voice Mail message and a text message was sent advising to call back if he needs to speak to a doctor as they understood from his support worker that he was unwell and wanted some specialist drinks.

6.165 On the 30 April 2021, the Health Centre 2 record a further attempt to speak to Daniel and a message was left advising to call back and speak to the duty doctor if he has an urgent issue.

See Finding 55 above.

6.166 On the 4 May 2021, SS record that an unnamed member of staff visited Daniel; he was in bed, but said he felt a little better. They agreed to meet the next morning to go to the post office and do some shopping.

6.167 On the 5 May 2021, the Health Centre 2 record that Daniel did not attend his appointment with the colorectal specialist – see 6.157, 158, 162 and 163 above.

6.168 On the 5 May 2021, SS record that an unnamed member of staff visited Daniel as arranged – see 6.166 above; Daniel was up and dressed and they went to the post office to withdraw some money and did some shopping; Daniel was described as "in a better place" and they agreed to meet the next week.

6.169 On the 5 May 2021, UHBW record writing to Daniel's GP to advise that he had been discharged from the colorectal outpatient clinic as he had not attended his appointments. In addition, his notes had been reviewed by the colorectal consultant and a referral was no longer required.

Finding 60:
It is not clear on what basis it was decided that a referral to the colorectal clinic "was no longer required" as Daniel hadn't been seen or examined.

6.170 On the 10 May 2021, the Health Centre 2 record "chronic kidney disease stage 3".

Finding 61:
It is not clear on what basis it was diagnosed that Daniel had chronic kidney disease stage 3.

6.171 On the 20 May 2021, the Health Centre 2 record sending Daniel a text to advise that they have been told he didn't attend his hospital appointment and that a GP would visit him on the 4 June to discuss this and what happens next.

See Finding 55 above.

6.172 On the 25 May 2021, SS record that SUW5 visited Daniel; he was described as not looking well but said that he was OK. Another referral was submitted for a care assessment.

Finding 62:
It is of concern that there is no record of ASC receiving this referral.

6.173 On the 28 May 2021, SS record that HW4 was denied access to Daniel's flat to complete an HSC.

Finding 63:
While Daniel had the right to refuse entry to an unannounced visit, the lack of a follow up visit to complete the HSC is of concern.

6.174 On the 1 June 2021, SS record that a new Team Manager for Supported Housing started in post (SSTM2).

6.175 On the 4 June 2021, the Health Centre 2 record that a GP tried to phone Daniel but got no answer and left a voice message asking him to contact the surgery to arrange a further discussion if required.

See Finding 55 above.

6.176 On the 8 June 2021, SRT record that Daniel was allocated to a SW (SW2) in FNT.

6.177 On the 11 June 2021, SS record that an unnamed member of staff called to see Daniel but "he was not at home".

6.178 On the 14 June 2021, UHBW record a letter from the Endoscopy Admissions Team to Daniel's GP advising Daniel had been discharged as they were unable to contact him.

Finding 64:
It is of concern that Daniel hadn't been seen for over two weeks as he was meant to have weekly visits as part of his support package.

Finding 65:
It isn't clear what the basis of Daniel's referral to the Endoscopy Clinic was.

Finding 66:
It is of concern that the Endoscopy Clinic weren't made aware of Daniel's history of not responding to written communications and an alternative medium of contacting him wasn't used.

6.179 On the 14 June 2021, the Police record that an officer on routine patrol was flagged down by tenant A asking for assistance as he believed "one of his house mates was dying." The Officer found Daniel in his bedroom and described him as appearing "extremely emaciated and malnourished and appeared to have burns or blistering over the front of his body." An ambulance was called, and Daniel was taken to the ED at Southmead Hospital. At the hospital, Daniel told staff that tenant A had "purposefully thrown boiling water from a kettle over him" the previous evening. Tenant A was arrested and interviewed over the allegation. The Police record that Daniel's "sister raised concerns with police, regarding potential neglect from those caring for Daniel. Please 1.4 above for details of the issues relating to identifying Daniel's family structure. During a conversation with SS, an officer was advised that Daniel's support worker was in the process of raising a concern about Daniel, prior to this event and tenant A had also raised concerns about Daniel's welfare to the support worker two weeks prior to this incident. There is no record of tenant A ever raising concerns about Daniel's welfare.

Finding 67:
There is a lack of clarity as to the details of Daniel's family structure and therefore who was his Nearest Relative as defined by the Mental Health Act 1983; this is despite the AMPH following the correct procedure at the time of his admission to hospital under s3 of the Mental Health Act 1983.

6.180 On the 14 June 2021, SS record an Incident Form was completed and a Police Incident Form was received. SS record a phone call from the Police referring to the incident that took place "the previous evening", the 13 June 2021 and advising that Daniel is likely to be in hospital some time and that tenant A had been taken into custody that evening. The Police later stated that they did not complete a BRAG risk assessment as Daniel died before the Police could speak to him.

6.181 On the 15 June 2021, North Bristol NHS Trust (NBT) record an Emergency Department Discharge Summary was sent to Daniel's GP, that Daniel was admitted to Gate 33a Southmead Hospital and that "information was shared within NBT" around Daniel's skin and general condition on admission to the hospital and to advise the Ward Manager of safeguarding concerns.

6.182 On the 16 June 2021, NBT record trying to contact SS support worker to request information on Daniel but got no reply.

6.183 In June 2021, NBT record making a "referral to Bristol safeguarding for severe neglect and physical abuse." The SAR has been advised that this was in accordance with NBT standard practice and procedure.

Finding 68:
It is of concern that no safeguarding concern was raised by the Police or SS and not by NBT until three days after Daniel's admission to hospital, but this does not detract from the high quality of medical care provided to Daniel in hospital.

6.184 In June 2021, SAT record receipt of a safeguarding referral from the Specialist Safeguarding Practitioner (SSP) at Southmead Hospital. The referral details concerns about Daniel who had been admitted with burns having had hot water thrown over him by his neighbour. Daniel "was found bedbound, very malnourished and with pressure sores. He was moved from burns to ICU following a deterioration in his condition."

6.185 In June 2021, the Health Centre 2 record a phone call from Southmead Hospital to advise them that Daniel died at 14:05 in the Intensive Care Unit.

6.186 In June 2021, SS record a phone call from the Police to advise them of Daniel's death.

[redacted]

7.0 Analysis and Issues to be Addressed

7.1 The SAR needs to recognise that some of the events that impacted on Daniel pre-date the review period. While the SAR neither saw nor requested information relating to these events, they are relevant and learning needs to be taken from them.

7.2 The SAR also needs to recognise that the impact of the Covid-19 Pandemic and the resulting Lockdowns will have had both directly on Daniel and on the staff

working with him. This is not to excuse any short-comings in the quality of that care and support but to seek to understand how it occurred and the pressures that may have affected the behaviour and performance of agencies and staff involved.

7.3 This analysis, the issues to be addressed and recommendations that result from it will assume that learning relevant to one agency will be transferable to partner agencies and across local authority boundaries.

7.4 The findings identified in the key events above can be grouped under nine themes, some of which are linked to specific agencies and some to generic areas of practice that apply across agencies.

7.5 Many of the findings apply to more than one theme, and it would be possible to group them under different themes. The findings of good practice will be addressed as a whole; they will not be identified against each theme.

7.6 These themes are:

- Care Programme Approach
- Adult Social Care
- AWP
- Salvation Army
- Second Step
- Health
- Adult Safeguarding
- Police
- Good Practice

7.7 The themes are not in an order of importance, but in an order that appears to the author to facilitate an understanding of the issues identified in their context in some form of chronological order. The theme of Health covers several agencies who can be linked in their contact with Daniel.

7.8 Within each theme, this analysis will identify Issues to be addressed; these will be brought together into recommendations in the conclusion.

7.9 Care Programme Approach
Findings: 1, 2, 10, 11, 14, 17, 28, 29, 31, 35, 40 and 67

7.9.1 The Care Programme Approach (CPA) was introduced in England in 1991 to coordinate the assessment and management in the community of adults' mental and physical health needs and their social care and support needs. It is now being succeeded by the Community Mental Health Framework. Since its enactment in April 2015, it should therefore include an assessment under s9 of the Care Act 2014 of the adult's social care and support needs, to identify whether there are any eligible such needs, with a subsequent review at least annually to ensure the assessment is up-to-date and accurate. An assessment under s10 of the Care Act 2014 should also be included if the adult had a relevant carer, which Daniel didn't.

7.9.2 There is no record of Daniel having had such an assessment – or an assessment under the NHS and Community Care Act 1990, the relevant legislation

prior to the Care Act 2014 – that informed or was considered within the CPA process at any stage during the review period. How the management of Daniel's health and social care needs was coordinated is therefore unclear.

7.9.3 The CPA process requires at least annual reviews to ensure that the adult's health and social care needs are being met appropriately and that agencies are working together to do so. This review is only aware of two reviews held under the CPA process, on the 15 November 2019 and the 15 January 2020; the former is only recorded as being held under the CPA by the Health Centre 1 with no record who attended and the latter only by AWP who record that it was attended by only Daniel and his Care Coordinator.

7.9.4 The very limited attendance at the two reviews that were held raises questions about agencies' commitment to the CPA process, questions that are compounded by decisions being made about the support provided to Daniel, including the closure of several agencies' involvement not being discussed with or communicated to the other agencies one would expect to be part of the CPA Review Group. Equally, information on major changes in Daniel's situation were not shared appropriately – the Health Centre 2 were not informed he was under the CPA process, the s42 Enquiry that was initiated in August 2019 was not discussed in or lead to a CPA Review being convened, nor did Daniel's various changes of address during the review period.

7.9.5 There was at least one other review, held on the 5 September 2019, which might have been held under the CPA process. This lack of appropriate recording of the CPA process extends to the recording of appropriate information by the agencies supporting Daniel; as someone who had been admitted to hospital under s3 of the Mental Health Act 1983, there should have been a record of who his Nearest Relative, as defined by that Act, was. There is a legal requirement for the Nearest Relative to be involved in the assessment leading to the admission and to be advised of their rights once the admission has taken place. While this only became an issue at the time of Daniel's death, no such record appears to have been made.

7.9.6 The review was not informed of the date that Daniel first came under the CPA process or if/when he was discharged from it, despite this information being requested.

7.9.7 While there is no direct causal link between Daniel's death and the apparent failure to implement the CPA process properly, it remains the case that the multi-agency process in place to coordinate the assessment and management of Daniel's health and social care needs was either not followed or was not fit for purpose.

Issues to be Addressed.

- **The multi-agency CPA process should have been informed by the appropriate assessments of Daniel's social care needs.**
- **Each agency involved with Daniel should have been aware of when he first came under the CPA and if/when he was discharged from it.**
- **There should have been at least an annual review held under the CPA process while Daniel's support needs were being managed under it.**

- **All agencies providing support to Daniel should have been invited to attend any review held under the CPA process.**
- **All reviews held under the CPA should have been recorded in a standard format, with minutes circulated to Daniel and all relevant agencies.**
- **Agencies should have informed each other of changes in Daniel's situation and discussed their potential withdrawal of support to him to ensure the consistent assessing and meeting of his health and social care needs.**
- **When new agencies began supporting Daniel, they should've been informed that he was under the CPA process and invited to join the Review Group.**
- **The CPA process should have ensured that all relevant information was recorded and available to all agencies.**
- **Management oversight of practitioners should have identified that either the CPA process was not being implemented properly or that it was not fit for purpose.**

7.10 Adult Social Care
Findings: 1, 2, 9, 10, 11, 17, 18, 20, 24, 56, 62 and 67

7.10.1 As stated above, as someone whose health and social care needs were meant to be being assessed and managed under the CPA process, Daniel should have had a formal assessment of his social care needs under the legislation that pertained at the time he entered the process. There is no record that this took place other than a Care Act Assessment dated February 2018 with a weekly budget agreed of £135.40.

7.10.2 The above assessment should have been reviewed at least annually, and there is no evidence that any such reviews were held.

7.10.3 On the 3 September 2019, Daniel was referred to the OT Service for a mobility assessment before any assessment of his care and support needs had been completed; this referral was cancelled some days later. This raises questions about the process by which the OT referral was raised.

7.10.4 On the 18 November 2019, AWP record that Daniel had been assessed as having "care needs" but not eligible for an OT assessment but a day later a possible tenancy for him was dismissed because it was not wheelchair accessible. This suggests that either the assessment that decided Daniel had care needs was inaccurate or had been poorly communicated to partner agencies.

7.10.5 While it may be a matter of semantics, there is a clear difference between someone "needing" or "being eligible for" an assessment under the Care Act 2014. The fact that his care and support needs were being managed under the CPA process, should've demonstrated that he was eligible for an assessment under s9 of the Care Act 2014.

7.10.6 ASC's recording of when they closed Daniel's case raises questions about its quality; this is recorded as taking place on both the 15 November 2019 and the 24 December 2019; the lack of clarity as to the status of Daniel's case may explain why SS continued to contact his allocated social worker after they had closed the case.

7.10.7 The quality of ASC's recording is also called into question by the lack of any recorded formal assessment to establish Daniel's social care needs before a Support Plan was in place on the 3 October 2019 and by the lack of any record of a referral from SS on the 25 May 2021.

7.10.8 ASC are one of the agencies identified as having issues to be addressed specific to the CPA process above, so these issues will not be identified here too.

Issues to be Addressed

- **There were several opportunities for Daniel's social care and support needs to be assessed and his eligibility for services established – for example when he was discharged from hospital after his admission under s3 of the Mental Health Act 1983 and after his strokes – which were missed.**
- **While Daniel would appear to have been in receipt of a support plan of some sort, there is no evidence that this was regularly reviewed.**
- **The robustness of an assessment process that allowed a referral to be made to the OT service without Daniel being seen, a referral that was withdrawn once he had been seen.**
- **The robustness of an assessment process that identified no need to refer Daniel to the OT Service when, a day later, a tenancy was deemed inappropriate for him as it was not wheelchair accessible.**
- **The robustness of a resource allocation process that enabled a support package to be agreed without a clear recent assessment of care and support needs.**
- **The inappropriate language and therefore potential practice that doesn't distinguish between "needing" and "being eligible" for an assessment under the Care Act 2014.**
- **The quality of case work recording that caused confusion as to when Daniel's case was closed to active involvement and transferred to the status of "Await Review".**
- **The apparent lack of cross-agency liaison when major decisions were being made about Daniel's case, not just by those staff in direct contact with him, but also their managers.**

7.11 Avon and Wiltshire Mental Health NHS Partnership
Findings: 4, 12, 14, 23, 28, 29, 30, 31, 32 and 67

7.11.1 As someone who was open to several agencies, the need for clear and regular communication between these agencies is paramount. It is therefore puzzling that on at least one occasion it was not possible, in the unavailability of Daniel's allocated worker, to leave a message for them with their office.

7.11.2 Within a matter of days of Daniel leaving his tenancy as a result of an assault by a fellow-tenant, the decision was confirmed to close the active involvement of the Recovery Team with him. At the time of the confirmation, it was known that the assault had taken place, that Daniel had gone to but was returning from Manchester and that ASC had closed their active involvement with Daniel.

7.11.3 The above was compounded by a delay of two weeks in other agencies being advised of Daniel's case being closed to the Recovery Team.

7.11.4 There was an inconsistency in the assessment of Daniel's level of need and the support he actually received, compounded at the time of his discharge by not ensuring he had an appropriate support package in place.

7.11.5 AWP are one of the agencies identified as having issues to be addressed specific to the CPA process above, so these issues will not be identified here too.

Issues to be Addressed:

- **The robustness of the "back-office" services to support operational staff when they are out of the office.**
- **The apparent lack of cross-agency liaison when major decisions were being made about Daniel's case, not just by those staff in direct contact with him, but also their managers.**
- **The lack of consistency between assessed levels of need and the level of support offered to service users.**

7.12 Second Step
Findings: 3, 5, 13, 19, 20, 21, 25, 33, 35, 41, 45, 47, 52, 63 and 64

7.12.1 During the review period, there were at least four Service Reviews carried out by Second Step in conjunction with the Salvation Army and Bristol City Council; at none of these Service Reviews was Daniel's case discussed. Prior to all four reviews, there had been incidents or causes for concern about Daniel that Second Step staff would've been aware of and which should have led to discussion as part of the review.

7.12.2 There was an inconsistency between Second Step's assessment of Daniel's level of need and the services he was referred to. This may be indicative of a disconnect between those staff who were in contact with Daniel and therefore had direct knowledge of him and the managers involved in deciding on potential referrals.

7.12.3 There were several concerns around the performance of members of staff, in particular, around their support of Daniel; in the case of one, these related to them not responding to messages left by other agencies related to a delay in completing a task agreed in a review and contacting a colleague in another agency after they had closed their involvement with Daniel. All may be explained by poor internal processes for passing on information and/or poor management overview of staff performance.

7.12.4 The other concerns related to a lack of follow-up on issues; for example, reviewing with Daniel his options for having a balanced diet but not checking that he had an operative microwave to prepare meals with, not calling back to complete a Home Safety Check and not following up with Daniel the issues around his relationship with tenant A.

7.12.5 When Daniel fled Bristol after the assault in January 2020, within a week Second Step had initiated their formal Abandonment Procedure. While it is accepted

that such procedures need to be in place and implemented, given the nature of their tenants and their health and social care needs, there needs to be a degree of flexibility built into them to allow managers to respond appropriately to the tenant's circumstances.

7.12.6 Second Step have to complete a Staff Risk Management Plan for each tenant, but there was some inconsistency in when these were completed and the involvement of Daniel in completing his. The latter may be indicative of poor recording on the part of individual members of staff, but if it is, this should have been identified by their managers. Poor recording practice may also account for the lack of any record of tenant A raising concerns about Daniel's welfare, as he claimed to the Police.

7.12.7 There were several occasions when Second Step could have raised a safeguarding concern about Daniel, either because of the behaviour of other tenants towards him or because of the state of his tenancy. While it is difficult to be definitive at this degree as to whether doing so would have resulted in a response from ASC, it remains the case that no consideration is recorded either by operational staff or with their managers as to whether or not to do so.

7.12.8 There was also one occasion in February 2021, where ASC record receipt of a safeguarding referral from Second Step which Second Step do not record submitting.

Issues to be Addressed:

- **Are staff who participate in Service Reviews with the Salvation Army and Bristol City Council appropriately aware of issues within the individual services.**
- **Are staff who decide on which services to refer tenants to fully aware of their relative strengths and weaknesses and the level of support they require.**
- **The robustness of the "back-office" services to support operational staff.**
- **The robustness of management overview and supervision of operational staff.**
- **Are Second Step's internal procedures sufficiently flexible to facilitate managers recognising the circumstances of individual tenants.**
- **Are Second Step's Recording Policies and procedures fit for purpose and their implementation appropriately monitored by managers.**
- **Is Second Step's internal Safeguarding Adults Policy and Procedure fit for purpose and appropriately embedded in practice.**

7.13 Salvation Army
Findings: 3, 19 and 33

7.13.1 The Salvation Army did not have direct contact with Daniel once he left [redacted] in December 2019; however, they were part of the Service Review process with Second Step and Bristol City Council. The concerns identified above therefore apply to them as well as Second Step, albeit with a slightly different focus as the expectation would be that the provider would bring full and accurate information to any Service Review.

Issue to be Addressed:

- **The robustness of the monitoring processes put in place by the Salvation Army to ensure Service Reviews and referrals for service are provided with up-to-date and accurate information.**

7.14 Health

7.14.1 Health Centre 1
Findings: 15 and 16

7.14.2 While it is not specific just to the Health Centre 1, a common thread through the SAR is the lack of routine information sharing between health agencies about the medication prescribed to Daniel. However, it does not appear to have caused any issues for Daniel by any interaction between the different medications prescribed for him.

7.14.3 There were two examples of gaps in the Health Centre 1's recording as presented to this SAR. The first applied to the lack of detail of the nature and outcome of a referral to 111, the second to a lack of any recorded response to the identified need for a Treatment Escalation Plan for Daniel and the possibility of him having sepsis.

Issues to be Addressed:

- **The robustness of information-sharing processes within health agencies as to prescribed medication.**
- **The robustness of the Health Centre 1's internal recording Policy and Procedure.**

7.14.4 Health Centre 2
Findings: 36, 48, 49, 51, 55, 58, 59, 61, 65 and 66

7.14.5 A feature of Daniel's time registered with the Health Centre 2 was his failure to respond to letters and texts. This is not to suggest that this behaviour was limited just to this Health Centre but it was not apparent elsewhere from the information available to this SAR.

7.14.6 Despite the above and Daniel's history of mental and physical issues, the Health Centre didn't attempt any other means of contacting Daniel, such as contacting his support worker or ASC. Nor did they initiate their Did Not Attend Policy and procedure despite knowing Daniel was open to other agencies such as the Brecon Unit and ASC.

7.14.7 In addition, the Health Centre didn't advise services they referred Daniel to of the difficulties of engaging with him. As a result, they also communicated with him by letter and text with the predictable result that he did not engage with them.

7.14.8 As has been stated above, there are concerns about the implementation of the CPA process around Daniel, exacerbated by a lack of clarity as to when Daniel entered the process and when/if he was discharged from it. It may therefore be that

that the Health Centre was unaware that Daniel's health and social care needs were/had been managed under the CPA and of the need to liaise with other agencies about his care. Some of the issues to be addressed specific to the CPA process may therefore apply to the Health Centre.

7.14.9 It is not clear what the term "Vulnerable Adult Review" means and what its status is relative to the local multi-agency Safeguarding Adults Policy and Procedure. It is also likely to cause confusion as the term "vulnerable adult" is not used in the Care Act 2014 deliberately to avoid any suggestion that there is anything inherent in an adult that causes them to be abused or neglected.

7.14.10 In September 2020, Daniel was seen at home by his GP who described his accommodation as being "fairly squalid" but did not raise a safeguarding concern on the basis of self-neglect with ASC.

7.14.11 The information available to this Review was unclear as to the reasons for Daniel's "Fast track" referral to the colorectal consultant or his referral to the Endoscopy Clinic. It is also unclear what the basis was of the diagnosis that he had stage 3 chronic kidney disease.

Issues to be Addressed:

- **The robustness of the Health Centre's Did Not Attend Policy and Procedure and their implementation.**
- **The robustness of information-sharing between health agencies regarding difficult to engage patients.**
- **The robustness of the Health Centre's Safeguarding Adults Policy and Procedure and their implementation and their interface with other similar internal policies and procedures.**
- **The compatibility of the Health Centre's Safeguarding Adults Policy and Procedure with the local multi-agency equivalents.**
- **The robustness of the Health Centre's recording of referrals on to specialist services, their basis, and outcomes.**

7.15 Brecon Unit
Findings: 40, 44 and 53

7.15.1 It should be acknowledged that there is an issue about the depth of information requested from and provided by the Brecon Unit to this review; no information further to their chronology was requested as there was no obvious discrepancies with the information provided by other agencies – hence the use below of terms such as "recorded response" and "it would appear."

7.15.2 There were several instances of Daniel not keeping appointments with the Brecon Unit, but these did not always prompt a recorded response under the Unit's Did Not Attend Policy and Procedure nor any contact with any of the other agencies supporting Daniel. It would appear that the Unit's Did Not Attend Policy and Procedure requires only that the Primary Health provider be advised of a patient's non-attendance, it doesn't require any attempted direct contact with the patient, though some unsuccessful attempts are recorded, or their carers/support agencies.

7.15.3 As has been stated above, there is a lack of clarity as to when Daniel first came under the CPA process, when/if he was discharged from it and the robustness of its implementation. It may therefore be that the Unit was unaware that Daniel's health and social care needs were/had been managed under the CPA and of the need to liaise with other agencies about his care. Some of the issues to be addressed specific to the CPA process may therefore apply to the Unit.

7.15.4 In December 2020, the unit record that Daniel "is engaging with his treatment" despite the only recorded contact with him since the review period commenced in August 2019 was in January and March 2021. Either this statement, or the information available to this SAR, is incomplete or inaccurate – see 7.6.3.1 above.

Issues to be Addressed:

- **The robustness of the Brecon Unit's Did Not Attend Policy and Procedures and their implementation.**
- **The robustness of the Brecon Unit's Recording Policy and Procedures and their implementation.**

7.16 South West Ambulance Service NHS Foundation Trust (SWAST) Findings: 50 and 57

7.16.1 On two occasions, Daniel was taken to hospital by ambulance; on one occasion, his GP was advised by the hospital of his attendance at the Emergency Department by a discharge letter; on the second occasion, his GP was advised but it is not known by who.

7.16.2 On one occasion, an ambulance attended Daniel at his home address when the crew spoke to his GP but there was no confirmation of the attendance and its outcome recorded by the Health Centre.

7.16.3 There would appear to be a lack of clarity as to the correct protocol by which GPs are advised of the SWAST attending their patients.

Issues to be Addressed:

- **The robustness of the protocol by which GPs are advised of contact between their patients and the South West Ambulance Service NHS Foundation Trust.**

7.17 University Hospital Bristol and Weston NHS Foundation Trust (UHBW) Findings: 50 and 60

7.17.1 Daniel twice attended the Emergency Department at the Hospital; on one occasion his GP was informed of the attendance by a discharge letter, though it is not clear by who. On the other occasion, the GP was not informed.

Issue to be Addressed:

- **The robustness of the protocol by which GPs are advised of contact between their patients and the University Hospital Bristol and Weston NHS Foundation Trust's Emergency Department.**

7.18 Adult Safeguarding
Findings: 6, 7, 8, 26, 27, 45, 48, 54, and 68

7.18.1 There was a s42 Enquiry into possible financial abuse completed in October 2019; the Enquiry was closed while a Police investigation was still in progress, which raises questions as to the appropriateness of the closure as not all relevant information could have been available to inform that decision. The records also show that the alleged perpetrator of the abuse had moved to another property but without stating what action was taken with regards to them or to safeguard Daniel of other adults at risk he was placed/accommodated with. The records give no detail of the process by which the s42 Enquiry was completed, such as Daniel's involvement.

7.18.2 Perhaps of greater concern is the fact that the Closure Report contains the date of Daniel's death, almost two years later. This calls into question the date when the Closure Report was actually completed and therefore the integrity of ASC's recording processes.

7.18.3 A safeguarding concern was raised after Daniel alleged that he had been assaulted by another tenant in January 2020; this concern was triaged with the outcome that it was closed as not meeting the "threshold for safeguarding" without any direct contact with Daniel and, despite his means of safeguarding himself, was to put himself at risk of homelessness and taking himself to Manchester.

7.18.4 In August 2020, Daniel reported to a member of staff that he'd been threatened by a fellow tenant and didn't feel safe in the house to the point where he would not use the upstairs toilet. This should have been raised as a safeguarding concern with ASC, an opportunity missed by both the member of staff and their manager.

7.18.5 A month later, a further missed opportunity to raise a safeguarding concern occurred when Daniel's GP visited him and described the state of his flat as "fairly squalid." It does not appear that the GP shared his concerns with SS staff, but this does raise questions about the level of sensitivity of SS staff to possible self-neglect.

7.18.6 In late December 2020, the Police were called three times to Daniel's shared address – only one pertained directly to Daniel – which resulted in the completion of a BRAG risk assessment and him being referred to the Lighthouse Safeguarding Unit within the Police, partially due to concerns for his mental health. While this was the appropriate action for the officers who attended, it is of concern that the Lighthouse Safeguarding Unit didn't refer these concerns on to ASC as a safeguarding concern.

7.18.7 ASC record receipt of a safeguarding referral from Second Step – Second Step have no record of submitting this referral – which appears to have been triaged and re-categorised as a request for a service without checking back with the referrer.

7.18.8 When Daniel was admitted to hospital in June 2021, a safeguarding concern wasn't raised by the Hospital until three days after his admission because of his general condition of self-neglect and pressure sores. These had not been picked up

and raised as a safeguarding concern by the Police or Second Step or on his initial admission to the Hospital.

Issues to be Addressed:

- **The robustness of the process by which s42 Enquiries are carried out, closed, and recorded.**
- **The integrity of ASC's Recording Policy, Procedures and Systems.**
- **The degree to which the Principles of Making Safeguarding Personal have been embedded in safeguarding adults practice across Bristol.**
- **The degree to which the local multi-agency Safeguarding Adults Policy and procedure has been embedded across the statutory, independent, and voluntary sectors across Bristol.**
- **The degree to which awareness of self-neglect has been raised across health and social care agencies in Bristol.**

7.19 Police
Finding: 53

7.19.1 As stated above – 7.8.6 – the Police officers who attended Daniel's address during late December 2020 correctly completed the appropriate risk assessment and made a referral to the Lighthouse Safeguarding Unit.

7.19.2 The Lighthouse Safeguarding Unit concluded that no further action was necessary as the BRAG Risk Assessment's outcome was a rating of "Green" and so no safeguarding concern was raised with ASC and no referral on to or contact with any other agency made in accordance with standard practice.

7.19.3 When the Police were called again to [redacted], the "Treat as Urgent" marker was not triggered as it was not against Daniel's flat rather than the property as whole. This meant that an opportunity to review the outcome of the referral to the Lighthouse Safeguarding Unit was missed but was in accordance with standard practice for properties of multiple occupancy.

Issues to be Addressed:

- **The appropriateness of the thresholds for the Lighthouse Safeguarding Unit to refer on to ASC.**
- **The appropriateness of the marker system for properties of multiple occupancy.**

7.20 Good Practice
Findings: 12, 13, 16, 22, 24, 32, 35, 37, 38, 39, 41, 42, 43, 46, 48, 50, 51, 54 and 57

7.20.1 As can be seen from the number of findings – 19 out of a total of 71 findings – there were many examples of good practice identified in this review. However, of those 19 findings only 4 were not linked to causes for concern, highlighting the fact that good practice often occurred despite rather than because of procedures and systems.

7.20.2 The staff directly involved with Daniel demonstrated a commitment to him that enabled him to feel able to be open with them about his concerns.

7.20.3 There were the following examples of good practice:

- Recovery Team staff developing a Wellness Recovery Action Plan with Daniel's active participation.
- Second Step staff reviewing of his housing needs and options with Daniel.
- His GP reviewing Daniel's medication and identify the need for a Treatment Escalation Plan.
- Recovery Team staff liaising with services in Manchester to ensure the coordination of support to Daniel.
- Adult Social Care staff encouraging Daniel's autonomy by closing his support package when it was no longer needed.
- The Recovery Team advising the Health Centre when they closed their involvement with Daniel.
- Second Step staff agreeing a Personal Recovery and Development Plan and a Staff Risk Management Plan, the latter being regularly reviewed.
- Second Step staff advising Daniel of the impact the Pandemic would have on his support and ensuring he knew how to contact staff if necessary.
- Second Step staff and his GP responding to missed calls from Daniel and calling back if he was out when visiting him.
- Second Step staff supporting Daniel to have a balanced diet.
- Second Step staff respecting Daniel's wishes to not involve the Police.
- The Ambulance crew taking Daniel to the Emergency Department where he was appropriately assessed and discharged.
- Both Health Centres contacting Daniel to advise him of the need to make various medical appointments.
- Police officers recognising the need for a BRAG risk assessment and referring him to the Lighthouse Safeguarding Unit.
- The quality and appropriateness of the medical care provided to Daniel in hospital at the end of his life.

8.0 Conclusions and Recommendations

8.1 The postmortem report provided to the Coroner's Court found that Daniel's death was not a direct result of the burns he received prior to his admission to hospital nor a result of the care he received in hospital which was of a high quality and appropriate.

8.2 "The burns were assessed as superficial .. and .. in normal circumstances … would heal … over time with little or no intervention required. However, the deceased was showing signs of sepsis, was malnourished, imaciated (sic) and suffered from HIV, cancer and mental health issues for which he took medication. In all, the deceased was extremely frail and in general poor health."

8.3 "It was suspected that he might have a perforated viscus (stomach or bowel). On assessment for surgery, it was felt that his general state of health was far too poor to justify drastic treatment, with 80% mortality for any major abdominal operation. He was therefore placed on end-of-life care with the agreement of his family, and he declined and died" in June.

8.4 The above accords with the information provided to this review with two exceptions: the referral for a Safeguarding Adult Review referred to Daniel having pressure sores which are not referenced in the post mortem report, and there is no reference to Daniel's family being identified and involved in decisions as to his care in hospital, but these have little bearing on the findings and recommendations contained in this report. The issues to be addressed identified in Section 7 above should be responded to in the completion of the recommendations.

8.5 As has been said above, there were many examples of good practice identified in this review and of practitioners demonstrating personal commitment to Daniel. What has also been identified has been a lack of oversight and coordination of the multi-agency response to identifying and meeting his health and social care needs. Key to this should have been the CPA process.

8.6. Indicative of the issues with the implementation of the CPA process has been the lack of clarity as to when Daniel first entered the process and if/when he was discharged from it. It is clear that his health and social care needs were being managed under it, but there are no regular, only occasional, reviews held under the process, which don't appear to be formally recorded and with very limited attendance or dissemination of their outcomes. In my experience, the CPA process is normally instigated and managed by the adult's consultant psychiatrist – there is no reference to a consultant psychiatrist at any stage of the review period.

8.7 The CPA process should've ensured good communication between those agencies supporting Daniel and provided a forum to review and address his changing care and support needs. While all agencies supporting Daniel had a responsibility to participate in the CPA process and to escalate concerns that it wasn't being implemented properly, prime responsibility for establishing and implementing the CPA process and its successor, the Community Mental Health Framework (CMHF), lies with the Bristol, North Somerset, and South Gloucestershire Integrated Care Board (ICB) – via the AWP - and ASC.

Recommendation 1:
That the Keeping Bristol Safe Partnership seek assurance from the AWP and ASC that they have reviewed and revised their Joint Care Programme Approach (CPA) Policy and Procedures.

Recommendation 2:
That the Keeping Bristol Safe Partnership seek assurance from the AWP and ASC that they have reviewed and revised their Community Mental Health Framework Policy and Procedures.

Recommendation 3:
That the Keeping Bristol Safe Partnership seek assurance from the AWP and ASC that Policies and Procedures in Recommendations 1 and 2 have been promoted across their joint workforces and their implementation supported by a multi-agency programme of staff development opportunities.

8.8 The CPA process should have required an assessment of Daniel's social care and support needs under the then current legislation; this assessment should've

been reviewed at least annually. There is no evidence that a formal assessment under s9 of the Care Act 2014 was completed until February 2018 or of any subsequent formal review.

8.9 Daniel was in receipt of a support package agreed by ASC, but no evidence was seen by this review of the Resource Allocation Process by which this was agreed.

8.10 There were discrepancies in the recording of the closure of Daniel's case to active involvement and its transfer to the status of "Awaiting Review".

8.11 The above issues should have been identified by the line managers responsible for the operational staff supporting Daniel through professional supervision and case work management.

Recommendation 4:
That the Keeping Bristol Safe Partnership seek assurance from ASC that they have reviewed their current assessment process to ensure this is strengthened in line with the Care Act (2014) requirements.

8.12 The CPA process requires good communication between practitioners and agencies; the inability to leave a message for an unavailable member of AWP staff, albeit on only one occasion that is recorded, is therefore of concern.

8.13 There was some inconsistency in the assessment of the level of support Daniel required and the services he was referred to by his Care Coordinator, as well a lack of multi-agency decision making. These issues should have been identified by the line managers responsible for the operational staff supporting Daniel through professional supervision and case work management.

Recommendation 5:
That the Keeping Bristol Safe Partnership seek assurance from AWP that they have revised their Supervision and Case Work Management Policy and Procedures to include backoffice support systems which support staff when they are out of the office.

8.14 There appeared to be a disconnect between Second Step's operational staff and their managers in the assessment of Daniel's housing and social care needs; this manifested itself in him being referred to services that were inappropriate to his level of need and to Service Reviews being completed without reference to him.

8.15 Second Step initiated its Abandonment Policy in a manner which could appear to be insensitive to Daniel's situation after he alleged assault by a fellow tenant and fled to Manchester. However, it is recognised that the Policy was initiated before Second Step were aware of the alleged assault. Second Step's tenants are, by the nature of their care and support needs, likely to live volatile and potentially chaotic lives. Second Step's Policies and Procedures need to reflect this while remaining compliant with Housing Law and other statutory and regulatory requirements.

Recommendation 6:

That the Keeping Bristol Safe Partnership seek assurance from Second Step that it has reviewed and revised its Recording, Supervision and Case Work Management Policies and Procedures.

8.16 The Salvation Army had no direct contact with Daniel once he left [redacted] in December 2019. They did however conduct Service Reviews on services where Daniel had tenancies and participate in the process by which tenancies were considered for him. The former did not consider Daniel's situation on any occasion despite there being grounds for doing so; the latter did propose possible tenancies that were not appropriate for Daniel's care and support needs.

Recommendation 7:
That the Keeping Bristol Safe Partnership seek assurance from the Salvation Army that has reviewed and revised as appropriate its referral, information sharing and monitoring systems and processes.

8.17 There are several Issues to be addressed identified in the analysis above that apply to one or more health providers. If these issues apply to the providers involved in this review, it seems reasonable to assume they may be common to other providers too and therefore to address these to the ICB, who are responsible for service commissioning and monitoring, for resolution.

8.18 The issues to be addressed can be grouped as follows: the sharing of information re medication prescribed to a shared patient; the sharing information re patients who are difficult to engage with; the sharing of information re hospital and paramedic attendance; the robustness of Did Not Attend Policies and Procedures; the robustness and accuracy of Recording Policies and Procedures; the compatibility of providers' internal Safeguarding Adults Policies and Procedures with the multi-agency Safeguarding Adults Policy and Procedures and other internal Policies and Procedures and that the above are supported by appropriate staff development opportunities.

Recommendation 8:
ICB to review and share best practice guidance in relation to DNA / Was Not Brought to ensure that it includes:

- **Guidance for coding of recorded vulnerabilities and appropriate responses to these**
- **Reasonable adjustments required in relation to communication needs**
- **ICB to provide assurance that DNA / WNB guidance has been effectively embedded within primary care.**

Recommendation 9:
The ICB to review guidance to ensure that primary care is clear on how to record medication prescribed by specialist health providers (Brecon Unit).

Recommendation 10:
The ICB to provide training to primary care in relation to best practice when working with patients where self-neglect may be indicated.

Recommendation 11:
The ICB (Named professional for Safeguarding – Primary Care) to review the health centre's safeguarding policy and procedures are up to date and in line with local safeguarding arrangements.

Recommendation 12:
The ICB to share learning from the review in relation to accurate record keeping and the use of codes when referrals are shared or received.

8.19 The local multi-agency Safeguarding Adults Procedures were only initiated once prior to his death; on that occasion, a s42 Enquiry was commenced due to an allegation of possible financial abuse. This Review saw only the Closure Report from the Enquiry which didn't demonstrate the process by which the Enquiry had been carried out or how it met the principles of Making Safeguarding Personal.

8.20 Of particular concern is the fact that the Closure Report contains Daniel's death date, which postdates the closure by more than eighteen months. This is also true of the Care Act Assessment completed in February 2018. This means that records can be amended after their initial completion.

8.21 The lack of detailed recording of the triage process of the other safeguarding concerns that were raised with ASC make it impossible to determine whether or not they were managed in accordance with the principles of Making Safeguarding Personal.

8.22 Daniel's death was due to a combination of factors, including his poor physical condition, exacerbated by self-neglect. Despite the concerns expressed by his GP when they visited him at home in September 2020, by the Police in December 2020 and being seen regularly by support staff from Second Step, no safeguarding concern was raised on the basis of possible self-neglect.

Recommendation 13:
That the Keeping Bristol Safe Partnership seek assurance from ASC that they have reviewed and revised as necessary the Procedures under which s42 Enquiries are completed.

8.23 The Police had little direct contact with Daniel, in the sense that most of their contact with him related to other tenants in the shared property. Officers who attended had raised a safeguarding concern with the Lighthouse Safeguarding Unit, the Police's internal specialist unit, but this did not trigger a safeguarding concern being raised with ASC.

8.24. As a "Treat as Urgent" marker had been put not against Daniel's but a fellow tenant's address, this failed to be triggered by attendance at the same property but to a different tenant.

Recommendation 14:
That the Keeping Bristol Safe Partnership seek assurance from the Avon & Somerset Lighthouse Safeguarding Unit for Bristol to provide assurance that

they have reviewed their triage processes in line with ASC thresholds and they create a marker on their system to highlight properties of multiple occupancy.

8.25 Underpinning much of the interaction of health and social care services with Daniel was the assumption that he had capacity to make decisions about his welfare and finances. This is a legal requirement under the Mental Capacity Act 2005, unless there are grounds to question that assumption.

8.26 Current case law (The Supreme Court in a Local Authority v JB 2021) established that any capacity assessment should begin with the Second Stage of the Two Stage Test of Capacity, namely, can the person understand the relevant information, retain and process it, and then make and communicate the decision? If the answer to any of those questions is "No", then the First Stage of the Two Stage Test of capacity, does the person have an impairment in the functioning of their mind or brain should be considered. The fact that Daniel had had two strokes - a stroke being a medical condition in which poor blood flow causes the death of brain cells – would not, in itself, mean that he had an impairment of the functioning of his brain. However, combined with his regular making of unwise decisions, this should have led, under para 2.11, the Code of Practice that supports the Mental Capacity Act 2005, to a questioning of his capacity and a formal assessment of his capacity, particularly in relation to his self-neglect and lack of response to messages from the two Health Centres.

Recommendation 15:
That the Keeping Bristol Safe Partnership seek assurance from member agencies that they, and the services they commission, are ensuring that staff are acting in accordance with the Mental Capacity Act 2005 and its supporting Code of Practice, particularly in cases of actual or potential self-neglect.

8.27 Despite the large numbers of recommendations contained in this report, there were a large number of examples of good practice recognised in the review.

Recommendation 16:
That the Keeping Bristol Safe Partnership should acknowledge the examples of Good Practice identified in 7.20 above and seek assurance from the relevant agencies that this has been brought to the attention of the relevant staff and their managers.

8.28 While much of the review period falls during the Pandemic and the resulting Lockdowns, there is no evidence that this played a part in the events that led up to Daniel's death. Support continued to be provided to him and the processes in place to coordinate that support continued to be able to function, even if virtually rather than face-to-face.

8.29 Daniel's death was the result of a sad accident, exacerbated by his poor physical health and general physical condition. It is therefore unlikely that it could have been predicted or prevented; what could have happened was that agencies could have acted in a better coordinated manner if existing processes had been followed. This might have resulted in Daniel having a better quality of life during the

review period, although this would have required his cooperation and engagement with services, something that was not always evident.

9.0 Recommendations

Recommendation 1:

That the Keeping Bristol Safe Partnership seek assurance from the AWP and ASC that they have reviewed and revised their Joint Care Programme Approach (CPA) Policy and Procedures.

Recommendation 2:

That the Keeping Bristol Safe Partnership seek assurance from the AWP and ASC that they have reviewed and revised their Community Mental Health Framework Policy and Procedures.

Recommendation 3:

That the Keeping Bristol Safe Partnership seek assurance from the AWP and ASC that Policies and Procedures in Recommendations 1 and 2 have been promoted across their joint workforces and their implementation supported by a multi-agency programme of staff development opportunities.

Recommendation 4:

That the Keeping Bristol Safe Partnership seek assurance from ASC that they have reviewed their current assessment process to ensure this is strengthened in line with Care Act (2014) requirements.

Recommendation 5:

That the Keeping Bristol Safe Partnership seek assurance from AWP that they have revised their Supervision and Case Work Management Policy and Procedures to include backoffice support systems which support staff when they are out of the office.

Recommendation 6:

That the Keeping Bristol Safe Partnership seek assurance from Second Step that it has reviewed and revised its Recording, Supervision and Case Work Management Policies and Procedures.

Recommendation 7:
That the Keeping Bristol Safe Partnership seek assurance from the Salvation Army that has reviewed and revised as appropriate its referral, information sharing and monitoring systems and processes.

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Recommendation 11:

The ICB (Named professional for Safeguarding – Primary Care) to review the health centre's safeguarding policy and procedures are up to date and in line with local safeguarding arrangements.

Recommendation 12:

ICB to share learning from the review in relation to accurate record keeping and the use of codes when referrals are shared or received.
Recommendation 9:

Recommendation 13:

That the Keeping Bristol Safe Partnership seek assurance from ASC that they have reviewed and revised as necessary the Procedures under which s42 Enquiries are completed.

Recommendation 14:

That the Keeping Bristol Safe Partnership seek assurance from the Avon & Somerset Lighthouse Safeguarding Unit for Bristol to provide assurance that they have reviewed their triage processes in line with ASC thresholds and they create a marker on their system to highlight properties of multiple occupancy.

Recommendation 15:

That the Keeping Bristol Safe Partnership seek assurance from member agencies that they, and the services they commission, are ensuring that staff are acting in accordance with the Mental Capacity Act 2005 and its supporting Code of Practice, particularly in cases of actual or potential self-neglect.

Recommendation 16:
That the Keeping Bristol Safe Partnership should acknowledge the examples of Good Practice identified in 7.20 above and seek assurance from the relevant agencies that this has been brought to the attention of the relevant staff and their managers.

Appendix A

Safeguarding Adult Review Terms of Reference

Daniel

Bristol SAR

1. Introduction

This Safeguarding Adults Review (SAR) is commissioned under Section 44 (1) of the Care Act 2014. The purpose of a Safeguarding Adults Review (SAR) is neither to investigate nor to apportion blame. The SAR requires outcomes that:

- Establish what lessons can be learnt from the particular circumstances of a case in which professionals and agencies work together to safeguard adults.
- Identify what those lessons are, how they should be acted upon and what is expected to change as a result.
- Review the effectiveness of procedures both of individual organisations and multi-agency arrangements.
- Improve practice by acting on the findings and developing best practice across organisations.
- Identify areas of good practice in this case.
- Improve inter-agency working to better safeguard adults.
- Make a difference for adults at risk of abuse and neglect.
- Hear the voice of the adult from professionals, family members and others who knew Daniel.

2. Background to the case

A Safeguarding Adults Review referral dated 18th June 2021 was submitted by Avon and Somerset Constabulary and considered by the SAR/DHR Sub-group on 9th July 2021. The sub-group recommended that a SAR be commissioned, a recommendation that was ratified by The Keeping Bristol Safe Partnership Executive on 18th August 2021. The subgroup established a Safeguarding Adults Review Panel to oversee the completion of this SAR for Daniel.

3. Terms of Reference for the Safeguarding Adults Review Panel (the Panel)

The Panel will comprise:

- Avon and Somerset Police
- Avon and Wiltshire Mental Health NHS Partnership
- Bristol City Council Adult Social Care
- Bristol City Council Housing and Landlord Services/ Housing Options
- BNSSG Integrated Care Board on behalf of GPs
- North Bristol NHS Trust
- University Hospital Bristol and Weston NHS Trust
- Second Step
- Salvation Army

Substitutes are acceptable, provided they are of equivalent seniority and briefed by the substantive member.

The Panel is responsible for:

a) Ensuring the review is completed within the agreed timescales.

b) Finalising the Terms of Reference of the Review.

c) Ensuring that relevant agencies are informed of the requirement to complete an Individual Management Report (IMR) and Chronology.

d) Quality assuring the IMRs and Chronologies and identifying any need to commission further IMRs or obtain expert legal advice.

e) Ensuring that each organisation is aware of its own responsibility to implement single agency lessons to be learned, in accordance with their internal quality assurance and governance arrangements, to ensure vulnerable adults are safeguarded.

f) The Panel will make recommendations to the SAR subgroup for a multi-agency Action Plan, ensuring that there is no delay in the implementation of actions which will safeguard vulnerable adults.

g) The Panel Chair will ensure that the Overview Author has all the completed documents.

h) The Panel will make decisions on if/how to involve any wider family in the review.

4. Details of the case

Daniel was living in supported accommodation for adults with complex needs. Another resident allegedly threw boiling water from a kettle on him (no criminal charge). Due to frailty caused by health conditions, Daniel's injuries were difficult to recover from, and he sadly died from his injuries.

5. Period to be covered by the Review

The review will cover the proposed period: 01.08.2019 to June 2021. This is from the date of the first Section 42 Enquiry regarding Daniel under the Care Act 2014 to the date of Daniel's death.

6. Methodology

Agencies will be asked for an IMR supported by a chronology of their contact and involvement with Daniel during the review period; in addition, they should provide relevant information relating to Daniel outside of the review period if pertinent to the review.
The Chronologies will be collated into a single multi-agency Chronology, which will be shared with all the agencies contributing to the SAR, as will the individual IMRs.
The Independent Author will seek any necessary clarifications from each agency prior to drafting an Overview Report that will be shared with the SAR Panel for comments on factual accuracy.
A Practitioners' Event will also be held to focus specifically upon the processes in place at the time, to identify any barriers to good practice and any subsequent changes to improve practice.
The views and perceptions of Daniel's family and significant others will be sought through meetings with the Independent Author.

7. Participating Agencies

The following agencies, as a minimum, will be asked to contribute to the case review by responding to an IMR, Chronology and Timeline as above:

Avon and Somerset Police
Avon and Wiltshire Mental Health NHS Partnership
Bristol City Council Adult Social Care
Bristol City Council Housing and Landlord Services/ Housing Options
BNSSG Integrated Care Board on behalf of GPs
North Bristol NHS Trust
University Hospital Bristol and Weston NHS Trust
Second Step
Salvation Army

The Panel reserves the right to request supplementary information from any agency where the information is pertinent to the review.

The Panel also requests agencies who have conducted any form of internal investigation in relation to the case to submit a copy to KBSP as supplementary evidence.

8. Governance

KBSP has appointed Pete Morgan to act as Independent Author and Chair to lead the review and to write an Overview Report and Executive Summary.
Upon completion of the final draft, the Overview Report, Executive Summary and Action Plan will be presented to the KBSP SAR/DHR Sub-group for quality assurance. The report/s will then be presented to the KBSP Keeping Adults Delivery Group for ratification.
The Keeping Adults Safe Delivery Group will consider any lessons learnt by each agency in conjunction with the findings of SAR Case Daniel to develop a single inter-agency action plan for implementation. Responsibility for driving through any required process improvements will sit with the chair of the Keeping Adult Safe Delivery Group.
It is anticipated that the Overview Report will be published. Consideration will also be given to the publication of an Executive Summary.

9. Key Issues

The Panel has identified a number of issues to be specifically addressed in the SAR. Some of these questions will not be relevant to all agencies, and, where that is the case, they should make that clear in their responses. The Panel identified the following issues:

a. Impact of covid-19 and lockdowns on practice
b. The review should also explore these general themes where relevant:

- Good practice; and
- Wider learning.

10. Family Involvement

The KBSP Business Unit will contact Daniel's family to inform them that the review is taking place (outlining the purpose of the review and its limitations), and secondly, to ask how they would like to be involved in the review, if at all. Should family members wish to be involved, the KBSP Business Unit will arrange for the Independent Author to discuss the review with the family.
The draft Overview Report/Executive Summary will only be shared via a face-to-face meeting with the family member(s) if they wish to see it. Only once the report(s) are made public will the report be shared electronically.

11. Timescale for Completing the Review

The target for completing this review is a year from the initial SAR Panel Meeting to set the TOR.
The final reports will be tabled for approval at KBSP SAR/DHR subgroup in June 2024, before submission to the Keeping Adult Safe Delivery Group for sign-off in July 2024.

Terms of Reference for IMR authors

The following agencies have been requested to submit an IMR. Each IMR will include a chronology of the agency's involvement and brief synopsis of any relevant involvement prior to the Review period:

- Avon and Somerset Police
- Avon and Wiltshire Mental Health NHS Partnership
- Bristol City Council Adult Social Care
- Bristol City Council Housing and Landlord Services/ Housing Options
- BNSSG Integrated Care Board on behalf of GPs
- North Bristol NHS Trust
- University Hospital Bristol and Weston NHS Trust
- Second Step
- Salvation Army

IMRs must be completed by an individual who has had no direct, or line management involvement with this case.
Guidance will be provided to IMR writers as required.
IMR writers will be asked to focus on the following:

a) Consider the events that occurred, the decisions made, and the actions taken or not taken. Assess practice against guidance and relevant legislation and accepted best practise that was in place at that time.
b) Describe any relevant contextual information from your agency at the time and the impact this had on the work undertaken with Daniel. For example, staffing levels, reorganisations or arrangements for supervision or management oversight.
c) Highlight any instances of good practice.
d) Comment on changes to guidance or working practice that has changed which may have affected the outcome.

Scope
The IMRs will cover the following period: August 2019 to June 2021 with a brief synopsis of any relevant prior involvement.
Timetable
IMR writers will observe the following deadlines for the production of:

a) Chronologies *See above*
b) IMRs *See above*

All chronologies and IMRs are to be submitted electronically to the KBSP Business Unit via secure email [redacted] by the deadline dates.

Terms of Reference for Overview Author

The Overview Author will be asked to focus on the following:

a. What were the lessons learnt by each agency?

b. Consider the effectiveness of the work of the various agencies involved with the individual.

c. Consider the role and purpose of each agency's involvement and how well the agencies shared information.

d. Consider the quality of the work of different agencies and the quality of their management of the case.

e. Establish how well Mental Capacity was understood by the various agencies at each point of contact and whether a Best Interests decision was considered at any point.

f. Establish the extent to which the involved agencies adhered to local policies and procedures relevant to this case.

g. Explore the quality of risk assessments and how these were undertaken.

Scope

The overview report will cover the following period: August 2019 to June 2021.

Timetable

The Overview Report Author will observe the following deadlines:

- Submission of first draft *See above*
- Submission of final draft *See above*

The Overview Report is to be submitted electronically to the KBSP Business Unit via SharePoint by the deadline date.

Appendix B

Glossary

ART	Access and Response Team
AMHP	Approved Mental Health Professional (AMHP) position was established in 2007, replacing the role of the Approved Social Worker (ASW). Unlike the ASW, the AMHP role is not exclusive to social workers. Other professionals, including registered mental health or learning disability nurses, occupational therapists, and chartered psychologists, can also become AMHPs. To qualify, professionals must complete appropriate post-qualifying master's level training at Level 7 NQF and receive approval from a local authority for up to five years, subject to re-warranting.
CC	Care Coordinator
CPA	The Care Programme Approach (CPA) was introduced in England in 1991 to coordinate the assessment and management in the community of adults' mental and physical health needs and their social care and support needs. It is now being succeeded by the Community Mental Health Framework.
FNT	First North team
HSC	Health and Safety Check
HCA	Health Care Assistant
IMRs	An Independent Management Review is a process which produces a report detailing, analysing and reflecting on the actions, decisions, missed opportunities and areas of good practice within the individual organisation.
MHA	Mental Health Act
MCAA	The Mental Capacity Act 2005 sets out a 2-stage test of capacity**:** 1) Does the person have an impairment of their mind or brain**,** whether as a result of an illness, or external

	factors such as alcohol or drug use? 2) Does the impairment mean the person is unable to make a specific decision when they need to?
National Local Safeguarding Adult Board Chair's	National Local Safeguarding Adult Board Chair's Network is a community of practice that aims to support and strengthen the effectiveness of Safeguarding Adults Boards across England, Wales, Northern Ireland, the Channel Islands, and the Isle of Man.
Nearest Relative	The Mental Health Act 1983 specifies a strict order for determining your nearest relative: 1. Husband, wife, or civil partner (including cohabitee for more than 6 months). 2. Son or daughter. 3. Father or mother (an unmarried father must have parental responsibility to be the nearest relative). 4. Brother or sister. 5. Grandparent. 6. Grandchild. 7. Uncle or aunt. 8. Nephew or niece. When there are two people from the same group, the elder person takes precedence (e.g., if you have two siblings, the elder one becomes your nearest relative).
OMG	Operational Managers Group for the Housing Pathway
Personal Budget	A personal budget is the amount of money allocated by a local authority to support an adults eligible assessed social care needs.
PRDP	Personal Recovery and Development Plan
S2 and S3 Mental Health Act	Compulsory admissions under these sections of the Mental Health Act 1983 re for up to 28 days for assessment or 6

	months for treatment respectively. The latter can be renewed, initially for a further 6 months and then for a year.
S9 assessment Care Act 2014	An assessment but the local authority of an adults social care needs - see Personal Budget above – but is separate to an assessment of eligibility to financial support from the local authority.
S117 Aftercare	Section 117 aftercare is a legal duty that is placed on health and social services to provide after care services for individuals who have been detained under Section 3, Section 37, Section 47, Section 48, and Section 45A. It is the duty that comes in effect once the person has been discharged from the hospital. Services provided under s117 are free to the individual.
SAT	Safeguarding Adult Team
Safeguarding Concerns	A safeguarding concern is raised with the local authority is advised that an adult in its area may have been subject to abuse or neglect an order that the local authority may decide whether or not to initiate a safeguarding enquiry – see below.
Safeguarding Enquiry	A safeguarding enquiry is a formal investigation under s42 of the Care Act 2014 into an allegation that an adult withy care and support needs has been subject to abuse or neglect to enable the local authority to decide if any action is necessary to safeguard them.
SA	Salvation Army
SS	Second Step
SP	Senior Practitioner
SPW	Senior Project Worker
SRMP	Staff Risk Management Plan
SA	Support Assistant
SUW	Support Worker
SRT	Swift Response Team
SSTM	Team Manager
WRAP	Wellness Recovery Action Plan