Safeguarding Adult Review
Overview Report

Review into the death of Bakar, who died in October 2022 in Bristol.

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Contents

1. Background

1.1 This Safeguarding Adults Review (SAR) relates to Bakar, who was 54 when they died in October 2022. The SAR was commissioned to consider key learning for agencies in the Keeping Bristol Safe Partnership. The review is particularly concerned with the period 2018-2022.

1.2 Bakar was originally from Somalia and had migrated to the UK in approximately 2005. Their only family in the UK was their brother who also lived in Bristol. Bakar's brother told us "Everyone liked Bakar" and professionals agreed Bakar was a pleasure to work with, friendly, respectful, and pleasant, "a really nice person". When well, Bakar had enjoyed volunteering and socialising at the local mosque and going to cafes in the area where they lived.

1.3 Bakar died following a period of significant mental ill-health, increased alcohol use and not taking medications for their mental health or physical health conditions. This took place against a background of significant social and contextual pressures, including concerns about transphobic and homophobic discrimination, eight accommodation moves, a lack of basic facilities (such as cooking or refrigeration) and significant social isolation. Bakar had frequent contact with multiple agencies across the statutory and voluntary sector. It is important to foreground their regular contact with probation services due to a forensic mental health history and significant period in prison from 2009-2018. Bakar was also well known to mental health services and their GP due to their diagnosis of paranoid psychosis, delusional beliefs/paranoid schizophrenia and Type 2 diabetes.

1.4. Bakar identified as transgender and gay. There is discrepancy in the records as to when they first disclosed this to a professional, but those involved at the time of Bakar's death reported they were first made aware of this in July 2021. In subsequent discussion, Bakar requested to use they/them pronouns. We note that not all agencies had been requested to use these pronouns and in discussion with Bakar's brother, we were informed he was unaware of this; he used he/him pronouns in our discussion to refer to Bakar. However, in keeping with the stated wishes that Bakar had made on their health and social care records, we have adopted they/them pronouns throughout this report.

2. Introduction

2.1. The Keeping Bristol Safe Partnership (KBSP), as the Bristol Safeguarding Adults Board (SAB) has a statutory duty[1] to arrange a Safeguarding Adults Review (SAR) where an adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and there is reasonable cause for concern about how the SAB, its members or others worked together to safeguard the adult. SAB partners must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future[2]. The purpose of a SAR is to learn lessons and effect positive change, not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves due to those needs[3].

[1] Sections 44(1)-(3), Care Act 2014
[2] Section 44(5), Care Act 2014
[3] SCIE (2022) *SAR Quality Markers*, Leeds: SCIE

2.2. A referral to KBSP for a SAR was made by SARI (Stand Against Racism and Inequality) on 05/01/2023. SARI had supported Bakar and considered that the circumstances of their death met the criteria for a SAR, stating that Bakar's death might have been avoided if they had been offered better housing and mental health intervention and that Bakar had not experienced discriminatory abuse. Requests for information regarding agency involvement with Bakar were sent out to partners who had worked with them. Responses were collated and reviewed by the SAR/DHR[4] panel on 25/01/2023 to decide if this case would progress to a SAR. Upon reviewing these responses, the panel agreed the case met the Care Act Section 44 criteria for a mandatory SAR and made the decision to appoint independent consultants to support the SAR process and author the SAR report.

2.3 Dr Adi Cooper and Karl Mason were appointed as independent consultants to lead the SAR process, co-chair the SAR panel and co-author the SAR report. As independent consultants, holding a range of safeguarding roles and responsibilities, they have considerable knowledge, experience and understanding of SARs and related processes, including the area of discriminatory abuse. An initial meeting was held on 23/05/2023 to agree the process and Terms of Reference[5].

2.4 A SAR Panel was established for this review with members from the following agencies[6]:

- Avon and Somerset Police (Police)
- Avon and Wiltshire Mental Health Trust (AWP)
- Bristol City Council – Adult Social Care (ASC)
- Bristol City Council - Housing and Landlord Services (Housing)
- BNSSG Integrated Care Board - on behalf of GPs
- Probation Service (Probation)
- SARI - Stand Against Racism and Inequality (SARI)

2.5 The governance for this SAR process was delivered through a SAR panel, which met to support and monitor the SAR process 3 times. In summary, these meetings discussed the progress to date, agreed terms of reference, additional questions, specific information requests, and reviewed the draft report. The Panel met on 06/07/2023; 08/08/2023 and 17/10/2023.

2.6 Family involvement – Contact was made with Bakar's brother and there was a telephone call between him and one of the reviewers. His views have been described in section 5 below. In keeping with his wishes, this review has used Bakar's first name throughout the report[7].

2.6 Coroner's Report – An inquest was opened on 16/11/2022 and a hearing was held on 06/04/2023. The inquest noted Bakar's poor mental health, including paranoid schizophrenia. No medical cause for death was established and the conclusion of the coroner was 'open'.

2.7 Previous KBSP SARs – Upon review of previous SARs in Bristol, the SAR about Kamil and Mr X (2018)[8] stood out as some themes and recommendations apply similarly to Bakar's situation. In summary, Kamil was a Kurdish asylum seeker who was murdered in 2016 by Mr X, a white British male who was discharged, with inadequate communication and planning, from an independent

[4] DHR denotes a Domestic Homicide Review – Bakar's case is a SAR not a DHR.
[5] See footnote 3 – SAR Quality Marker 6, 7 and 9 were explicitly covered at this meeting in order to clarify roles, panel membership, methodology and data collection approaches, timelines and any sensitivities for the independent reviewers to be aware of
[6] Note that throughout this SAR report, the acronyms or shortened names in brackets will be used to refer to the agencies below
[7] See footnote 3 – SAR Quality Marker 11 informs the involvement of family members in SAR processes.
[8] kamil-ahmad-and-mr-x-sar-report-final-for-publication.pdf (bristolsafeguarding.org)

sector mental health bed, to live in the same supported living accommodation. The cross-over with Bakar's case is particularly significant in the following areas:

- Kamil had insecure immigration status;
- Kamil had experienced racially motivated hate crime;
- A safeguarding referral was prematurely closed by ASC before risk was adequately assessed;
- A lack of professional understanding of the dynamics of hate crime;
- A shortage of mental health beds;
- Inadequate discharge planning from an independent sector admission; and
- Limited practitioner knowledge and use of alcohol pathways.

Relevant recommendation from the Kamil and Mr X SAR include:

- KBSP should implement multi-agency training to raise awareness of hate crime and guidance should be produced on how unconscious bias might impact on the assessment of need;
- AWP should review procedures and develop a protocol for information sharing and decision making when patients are transferred from commissioned independent providers;
- AWP should develop standards for discharge planning meetings and arrangements; and
- AWP should make revisions to their bed availability policy.

We will draw on this SAR in formulating our own analysis and recommendations (sections 8 and 9).

3. Overview of terms of reference and key lines of enquiry

3.1 Questions for this SAR were developed over time as information was shared about agency involvement in Bakar's life. There were several generic objectives (3.2 below) and several key lines of enquiry (3.3) as well as specific questions addressed in other communications (see 4 below)[9].

3.2 The overall purpose of the SAR included the following objectives:

a) establish lessons that can be learnt re: how professionals and agencies worked together;
b) understand how effective the safeguarding procedures were in responding;
c) highlighting good practice issues;
d) establish how local inter-agency practice can be improved; and
e) recommend service development needs for one or more service or agency.

3.3 Key Lines of Enquiry (KLOEs) for this SAR were agreed at panel meetings on the following themes: 1. Safeguarding/ safety issues and working together, 2. Discriminatory abuse/ hate crime, 3. Social history, 4. Covid. 5. Mental capacity. The questions raised were:

- How was safety/safeguarding addressed by the agencies working with Bakar? How did agencies communicate their concerns about safeguarding risks and work together to support Bakar regarding them?
- What was the practice around discriminatory abuse, literacy regarding discrimination and hate crime, and the understanding amongst agencies / practitioners? How were any gender identity or sexuality issues identified, understood and responded to in working with Bakar?
- Who was Bakar? How were any learning and communication difficulties of needs identified, understood and responded to in working with Bakar?
- What was the impact of Covid and lockdowns on practice and working with Bakar?

[9] See footnote 3 – SAR Quality Marker 9 outlines the process for developing methodological decisions.

- How was the interface between mental health, mental capacity and safeguarding risks understood and recognised?

4. Methodology

4.1 Chronologies of agency involvement with Bakar were requested from Sirona Care and Health, University Hospital Bristol and Weston NHS Trust and Southwestern Ambulance Service NHS Foundation Trust, as well as the 7 agencies represented on the panel (see 2.3 above) for submission by the end of July 2023. These included information about contact, care and support that was provided to Bakar between the period from 2018 up to their death. Additional questions were developed for specific partners to understand their work with Bakar and communication with each other, to understand the circumstances leading to Bakar's death, identify areas of good practice, and to help to identify learning across the agencies that were involved in their care. The chronologies provided by these partner agencies were integrated into a single narrative of over 100 pages. This has been summarised in section 6 below.

4.2 A key element of the SAR process was a half-day practitioner event[10], held on 18/09/2023, using a multi-agency reflective workshop methodology. The purpose of this event is for agencies involved with the person to meet and share their perspectives as part of the self-assessment of multi-agency safeguarding arrangements and practice and to help identify possible improvements.

4.2 The workshop aimed to provide an opportunity for practitioner contribution to the SAR. The objectives were to: reflect on the summary chronology from 2018-22 and identify any gaps; address practice questions concerning inter-agency work to support Bakar; identify improvements made since Bakar's death; and draw out learning from this to inform the recommendations from the SAR.

4.3 The practitioners' workshop was structured into 4 conversations covering: review and discussion of the summary chronology; practice issues in engagement with Bakar and supporting them with their needs; agency updates on learning and improvement since Bakar's death; considering 'what could have been different?' and contributing to the SAR's recommendations.

4.4 Practitioner workshop attendees were from the following agencies:

- Probation
- Police
- City Council Homelessness service
- City Council Housing service
- City Council AMHP service
- SARI
- City Council ASC front door team
- Housing Association

4.5 In addition to the integrated chronology and practitioner event, the consultants had conversations with four key partners to follow up specific queries: ASC, AWP, SARI and Housing.

[10] See footnote 3 – SAR Quality Marker 10 informs the integration of practitioner contributions and the importance of an open learning environment.

4.6 The SAR report utilises the four domains frequently used in SARs[11] to structure the findings: direct work with the person; team around the person; organisations around the team; governance and strategic leadership in section 8. The analysis is also informed by relevant evidence from research, which has been summarised in section 7[12].

5. Views of Family Members

5.1 Bakar's brother was the main point of support for Bakar from 2018-2022 and his input was noted by professionals as supportive and important. The SAR panel agreed that he should be involved, and we established contact to discuss Bakar's family support, his perspective on where things became difficult for Bakar and what helped or was more problematic from his perspective. Face to face discussion was offered but Bakar's brother preferred to speak via a telephone call. Four phone calls took place during the SAR period. The SAR process was explained at the outset and Bakar's brother expressed a strong preference for Bakar's name to be included in the report – anonymisation was offered but he felt it was important for Bakar to be named. Bakar's brother was pleased that recommendations would be made for KBSP to follow up and commented that the finalised SAR captured the issues that Bakar faced well. He consented to publication.

5.2 Bakar's brother explained he is Bakar's half-brother (but Bakar referred to him as brother, so we have adopted this term). After Bakar's father died, their mother re-married Bakar's paternal uncle and these were Bakar's brother's parents. Although they had siblings, all were now dead, but nieces and nephews live in Somalia, who Bakar was in touch with and worried about, given the political upheaval there. Bakar initially lived in London following migration to the UK. Bakar married in London but then lived separately when the marriage broke down and a family member of Bakar's wife had moved in – it is this person whom Bakar assaulted leading to their imprisonment. After leaving prison, Bakar had no further contact with their ex-wife and moved to Bristol.

5.3 He described Bakar as a friendly person who everybody enjoyed spending time with, but that in the final year Bakar's mental health had deteriorated significantly and they had been troubled and distressed, experiencing paranoia. He acknowledged the professional support that Bakar received but said that essentially in their final weeks, Bakar was alone, drinking, smoking weed, sleeping rough. He was particularly concerned at Bakar's swift hospital discharge without appropriate support. He described calling various services and acknowledged the support that was in place but said that in the last three months this was not enough because Bakar was alone much of the time and went back to drinking and smoking weed as soon as they were discharged from hospital. He said Bakar needed more help and specifically needed to be in hospital for longer or until a more supported environment was in place as Bakar was left to their own devices – daily visits aside. He reported telling the hospital not to release Bakar. He acknowledged that professionals did arrange a new house, but that Bakar just wasn't ready and did not have enough support. As a result, he said, two months after discharge from hospital, Bakar was dead.

5.4 In terms of what was going wrong, their brother stated that Bakar thought Somali people were trying to kill them but that this represented "big paranoia, Bakar was scared of people and would not go out, would just stay in flat" and he could not see any evidence to support that Bakar was being targeted. He said that Bakar thought people were following them, but never able to say who: "you

[11] See Michael Preston-Shoot et al (2020) Analysis of Safeguarding Adults Reviews, 2017-2019 https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019

[12] See footnote 3 – SAR Quality Marker 12 informs the integration of relevant research to inform analysis.

don't know them, they are from London". Bakar thought their ex-wife was sending people from London to kill them and would say "she is my enemy" according to his brother.

5.5 Bakar's brother was asked about any other reason why Bakar may have felt targeted and upon discussion, he reported that he was not aware of Bakar's sexuality or gender identity and said, respectfully, that these were things that he was unable to comment on.

6. Summary Chronology

6.1 – Pre-2019

6.1.1 Bakar was originally from Somalia and travelled to the UK around 2005 via the Netherlands. Bakar settled in London where they married under Islamic law for 3 years. Bakar's parents were both dead and they had no surviving siblings other than their brother in Bristol. Bakar had nieces and nephews in Somalia who they worried about due to political upheaval. Bakar worked as a street cleaner in London (but had been a tailor in Somalia) and rented a flat after their marriage ended. Substantial khat use triggered a mental health crisis in 2019.

6.2 – 2009-2018 Prison Sentencing and Release

6.2.1 On 10/07/2009, Bakar was convicted of Wounding with Intent to do Grievous Bodily Harm and given an indeterminate sentence after stabbing another adult 20 times as they slept at their shared address. This person was a relation of Bakar's ex-wife and was transitioning at the time, according to probation records. Whilst in prison, Bakar attempted suicide in December 2009 and was sectioned to a secure mental health hospital. On return to prison in March 2011, Bakar's mental health was stable for the remainder of their sentence.

6.2.2 A clinical psychology assessment was undertaken whilst Bakar was in prison, finding that they presented with cognitive abilities within the 'extremely low' range. As Bakar was raised in Somalia, spoke English as a second language and had a history of mental health needs, we understand the psychologist stated these results must represent a significant underestimate of Bakar's true level of intellectual functioning and therefore does not support a finding of global learning disabilities.

6.2.3 In January 2018, a hearing date was fixed to plan Bakar's release and AWP and Bakar's brother were involved. A primary concern was to avoid release to an area with prevalent khat use and Bakar was referred to approved premises (no further concerns about khat use in the chronology). Bakar did not have indefinite leave to remain in the UK and needed to re-apply within six months.

6.3 – 2018-2021 - Release from Prison and Housing moves

6.3.1 Bakar was released on 31/10/2018 to approved premises (Address 1). Weekly probation visits offered Bakar support with immigration, GP registration and employment. Bakar's brother provided significant support and Bakar attended mosque on Fridays, enjoying contact with the Somali community. They attended a drop-in centre and received £10 weekly subsistence from Red Cross.

6.3.2 Bakar first engaged with their GP on 03/12/2018. The GP offered regular diabetic review during this period and contact increased when Bakar's blood sugars were raised, resulting in medication changes – on several occasions the GP queried compliance due to Bakar running out of medication or various test results. On each occasion, follow-ups showed improvements. Bakar's diet was frequently discussed, and their diabetic-related eye issues were attended to at Bristol eye

hospital. No concerns were raised about any alcohol use. Bakar's mental state remained stable with no acute issues. On 24/07/2019, the GP noted that Bakar was experiencing worsening paranoia and possible depression. The GP commented that Bakar thought people were saying negative things about them and it was difficult to establish if this was worsening paranoia or a social concern, but there were no signs of an acute psychotic episode. Their medication dosage was increased.

6.3.3 In early January 2019, the approved premises served notice that Bakar must move by the end of the month (later extending this to March 2019), causing Bakar distress. Housing services accepted Bakar as homeless and provided 'emergency accommodation' for them from 01/03/2019 for 5 months (Address 2). In February 2019, Bakar received a UK residence permit for six months. Probation and charities continued to support them with homelessness, immigration, access to food, subsistence, health appointments and welfare applications. Probation agreed that Bakar's brother could collect Bakar's belongings from their ex-wife in London (including documentation to assist their immigration appeal). Housing benefit was established, and Bakar was enrolled on a cleaning training course and attended a job interview. In June 2020, probation noted Bakar had been struggling with sleep.

6.3.4 The lack of settlement regarding immigration led housing to advise Bakar they must leave their accommodation. At the end of August, Bakar moved to high support accommodation (Address 3) but was more independent than expected and transferred to low support accommodation (Address 4) on 21/10/2019. Bakar reported feeling settled with a productive routine, good support and was pleased their visa application was approved on 02/10/2019. Bakar volunteered at the mosque and reported feeling part of the community. Ahead of the Covid lockdown in April 2020, Bakar was asked to consider independent accommodation rather than a multi-occupancy environment (as diabetes place them at high risk regarding Covid). Bakar was worried about lockdown and loss of positive community relationships at the mosque. In April 2020, probation reduced the risk level from high to medium as part of a review when transferring casework from the London office to Bristol given relative stable situation and contact was reduced to 2-4 weekly, often via telephone due to Covid lockdowns. During lockdowns, Bakar reported prioritising fitness and staying on top of medication.

6.3.5 In September 2020, eye appointments were missed due to address changes: the GP rectified this. In December 2020, the GP noted Bakar's blood sugars were raised. Bakar reported adding sugar to meals but also had difficulty reporting their medication regime. Bakar saw their GP due to problems with sleep on 27/12/2021 and their night-time risperidone dose was reduced. They attended a podiatry appointment due to a diabetic foot issue in early January 2021.

6.3.6 On 17/12/2020, Bakar's 2nd application for a 'move on scheme' was accepted. Bakar moved to a new flat (Address 5) on 21/02/2021 with floating support input. Bakar received help with welfare and immigration issues and met their brother daily for walks. In March 2021, Bakar was told their right to remain would expire in 2.5 years. Probation continued to liaise with Bakar's solicitor and at the time of Bakar's death their leave to remain was due to expire the following year.

6.4 – July 2021 - Mental health relapse and recovery

6.4.1 On 13/07/2021, Bakar phoned their probation worker reporting to be scared, holding a knife and hearing voices. Bakar stated they had been living a lie and was transgender. The police attended and contacted the mental health triage services but were informed to make a GP appointment. Given the seriousness of the concerns, police were not satisfied to await a GP phone call. Bakar could not be placed under Section 136 as they were in a private dwelling, so police placed

them under arrest for breach of the peace. Once outside their residence, police de-arrested Bakar and placed them under Section 136 of the Mental Health Act and conveyed them to a 'place of safety'. Mental health liaison notes stated that Bakar highlighted issues around their sexuality and reported that they had been called discriminatory names. Bakar reported they would kill themselves or someone else if discharged. Bakar reported not taking any medication for 2 years.

6.4.2 A Psychiatric Intensive Care Unit (PICU) admission was recommended; as none was available, 'out of area' beds were sought. A Mental Capacity assessment was undertaken on 14/07/2021, finding that Bakar did not have capacity regarding treatment and Bakar was placed in an 'out of area' bed. On 26/07/2021, Bakar was placed on a Section 2, Mental Health Act. Discharge planning started, recommending 'step down' due to Bakar's beliefs about targeting in the community. Simultaneously, probation management considered recall to prison, given the parallel behaviour to Bakar's index offence, but ultimately decided to manage risk through the hospital stay. Probation asked the hospital to fully involve them in discharge plan, alerting the hospital to Bakar's community restrictions. On 26/07/2021, Bakar called probation from hospital to indicate they had phoned probation when in crisis because of a promise to ask for help if not coping.

6.4.3 Bakar was discharged home on 18/08/2021. Probation was not invited to a discharge meeting or informed about this until Bakar was at home. The care coordinator (CCO) says 'little or no discharge planning' occurred as the hospital was 'out of area'. Probation met Bakar and their brother on 19/08/2021. Bakar's brother was visiting regularly, bringing food and advocated for more support. On 07/09/2021, the CCO discussed Bakar's beliefs about being targeted and Bakar said paranoia was possible as they presented as male in the community and others were unlikely to be aware of their transgender identity. Bakar set themselves goals to improve literacy and access LGBTQ+ support. A CPA meeting occurred on 08/10/2021 involving probation and there was a change of care coordinator. For the rest of 2021, the probation worker and CCO visited regularly, noting no significant risk issues. Bakar reported seeing their brother regularly and friends visited from Cardiff. Floating support ended in November 2021.

6.4.4 On 15/12/2021, the GP noted raised cholesterol and queried Bakar's medication compliance. In January 2022, the GP noted Bakar had not ordered medications for diabetes or mental health since October. Bakar reported taking their medication but would have run out of medication by that time. Follow up by GP on 07/02/2022 found better compliance and blood results had improved.

6.5 – Jan-Mar 2022 - ASC referral and ongoing alleged harassment

6.5.1 On 10/01/2022, the CCO supported Bakar with benefits and food vouchers. Bakar told their CCO they were being targeted by members of the Somali community when walking but felt safe at home and planned to visit friends in Cardiff. The CCO was planning to discharge Bakar, but Bakar felt they still needed help, so a referral was made to ASC. On 02/02/2022, Bakar met their probation worker and discussed how LGBTQ+ people were treated within the Somali community. Bakar stated they felt isolated and was concerned about discharge from AWP. ASC phoned Bakar on 03/02/2022, who passed the phone to a friend, reporting communication difficulties. No care and support needs were identified other than rats in the flat. ASC closed the case and passed a referral to the housing department. Bakar later told their CCO they thought this was a call from Housing.

6.5.2 In late February 2022, Bakar reported 'struggling with the community' to their CCO and, on 07/03/2022, discussed anxieties about people coming into their flat, especially as they had female items of clothing. On 09/03/2022, Bakar also reported to the housing team they were experiencing

transgender / homophobic hate crime within the Somali community. Bakar was supported to complete a referral to hate crime charity, SARI. Housing promptly changed the locks when asked.

6.6 – March 2022 - Suicide attempt

6.6.1 Bakar attended A&E on 13/03/2022 regarding their blurred vision. On 16/03/2022, Bakar reported kidney pain, headache, falling and dizziness for 2 weeks to their GP. On 17/03/2022, Bakar's friend called probation reporting Bakar 'could be suicidal'. Bakar confirmed to probation they felt suicidal and was scared to leave flat. CCO had several missed calls from Bakar reporting to be vomiting after overdosing on diabetic medication and eye drops. In A&E, a Psychiatric Liaison Assessment was undertaken and suggested no symptoms of psychosis and found that Bakar had 'capacity', pointing to the social context rather than a mental health crisis and they were discharged.

6.6.2 Bakar immediately presented to homelessness services. An emergency hostel was provided (Address 6) until 27/03/2022 and housing sent a safeguarding referral to ASC on 18/03/2022. A few days later, the CCO visited Bakar who reported drinking alcohol due to sleep problems. On 19/03/2022, Bakar called their CCO and probation reporting harassment from another tenant who was Somalian.

6.7 – March-July 2022 - Engagement with SARI and other agencies

6.7.1 On 24/03/2022, Bakar met with SARI, identifying themselves as female and using they / them pronouns. They reported homophobic and transphobic targeting by members of the Somali community (e.g. being called nasty things in a café). Bakar declined to make a police report as they would not be believed. The CCO told SARI that Bakar's mental health was stable so they would be discharged once support was in place. The CCO said that Bakar's reports that people have entered their room were hard to gauge, due to their paranoia, and said they were unaware of any concrete hate incident. Bakar moved to emergency temporary accommodation (Address 7) on 28/03/2022.

6.7.2 ASC undertook a 'support conversation' on 31/03/2022, with support from Bakar's CCO. This suggested Bakar would be ineligible for care and support from ASC. Although there had been community safety concerns, the assessment concluded that Bakar felt safe and was able to access the community. Information and advice were provided regarding social isolation and the case was closed. As a result, the CCO planned to locate support via the voluntary sector instead.

6.7.3 On 13/04/2022, probation found that Bakar appeared unkempt, shaking, and not finishing their train of thought. Bakar saw their brother less often due to distance and family commitments during Ramadan (Bakar was not fasting for health reasons). The CCO visited on 14/04/2023 and Bakar requested an increase in their medication. They were able to identify their paranoid thoughts and acknowledged alcohol use due to sleep problems and the CCO advised alcohol could increase their paranoia. The CCO discussed Bakar's presentation with their Senior Practitioner and concluded their increased symptoms were due to social stressors. Bakar was informed about a wellbeing café on 05/05/2022 and a discharge CPA meeting on 17/05/2022 noted social support was in place. Bakar was advised to contact their GP for medication and mental health support.

6.7.4 On 08/06/2022, Bakar reported ongoing safety fears to probation and SARI and stated a Somalian housemate had spiked their drink and someone was entering their room. On 26/06/2022, Bakar attended A&E stating housemates were spiking their food, laughing at him and they now had sore eyes. SARI tried to involve other voluntary sector services to support with mental wellbeing.

6.7.5 On 30/06/2022, Bakar contacted their GP about high blood pressure. Bloods were taken and ramipril was prescribed. In June and July 2022, the GP reviewed Bakar – their blood glucose levels

were still high but improved. Bakar was eager to avoid new medications and wanted to increase their gliclazide dose. The statin prescription was increased, and no recent hypos were noted.

6.7.6 On 30/06/2022, Bakar was accepted as homeless with a plan for supported housing. On 12/07/2022, Bakar met probation and stated their landlord was accessing their room and stealing items. Bakar was scared to leave their room and would not cook in the kitchen so was only eating bread and drinking milk. A mentoring referral was declined, and concerns were passed to housing.

6.7.7 On 12/07/2022, SARI called Bakar who reported having gone to London for a "holiday" but was sleeping rough and said they would not stay in their accommodation due to safety issues. Probation called Bakar on 13/07/2022 who reported to be back in Bristol. Bakar was moved to emergency accommodation that day for four days (7th Change of address). SARI chaired a multi-agency meeting on 19/07/2022 leading to a safeguarding referral to ASC. Housing was unavailable to attend.

6.8 – July 2022 - Mental health deterioration

6.8.1 On 20/07/2022, Bakar met probation and reported not sleeping or taking medication. Bakar refused to see their GP saying doctors had hurt them by putting lasers in their eye. Bakar reported other residents were spraying chemicals, so they slept in the garden. Bakar stated they did not have a life anymore and 'didn't want to be here'. Probation sent a safeguarding referral to ASC and asked the GP to re-refer Bakar to AWP. AWP picked this referral up the next day but on 26/07/2022, the crisis team ascertained that Bakar had moved address and transferred them to another crisis team. Bakar met probation on 27/07/2022. They repeated their safety concerns and reported receiving a text from housing, but it was a mental health appointment for the next week.

6.8.2 On 22/07/2022, ASC logged a safeguarding referral about Bakar's concerns regarding neighbours breaking in, concerns for their mental health and medication compliance. On 25/07/2022, the housing association referred Bakar to two supported housing providers. This resulted in confusion as Bakar was a single person and referred to as 'they' in terms of multiple occupation. On 09/08/2022, Bakar was offered a flat (8th address).

6.8.3 On 01/08/2022, an AMHP review identified relapse indicators, refusal of medication and persecutory delusions. A joint visit was done with the police on 02/08/2022 and the mental health team began looking for an inpatient bed. On 03/08/2022, Bakar told the mental health crisis team about their difficulties with cooking and food drop locations were provided. No local bed was available. On 04/08/2022, probation noted an increase in alcohol use, though Bakar denied this. On 05/08/2022, Bakar admitted hearing voices which made them feel unsafe. The Mental Health Act assessment occurred on 10/08/2022 and the outcome was to admit Bakar. An acute bed under section 2 was again sought on 10/08/2022 rather than PICU, but this decision was later overturned by the bed manager who believed Bakar's history of weapon use required PICU. On 12/08/2022, a bed was identified but hospital transport broke down, so Bakar was contacted and agreed to remain at home. On 13/08/2022, Bakar was not at home and was reported missing. Police attended the address on 14/08/2022 and found Bakar at home safe and well. Mental Health and EDT reported no capacity to find a bed at that stage. Bakar remained at home, awaiting a bed to be found.

6.8.4 On 15/08/2022, Bakar was admitted to PICU under Section 2 Mental Health Act and their medication was restarted also their blood sugars were high. Ward staff call Bakar's brother who 'declined carers support'. Bakar was stepped down from PICU to a ward on 22/08/2022. Concerns arose regarding self-care with insulin injections. A Mental Capacity assessment found that Bakar lacked capacity to consent to treatment. During this admission, ASC closed the safeguarding referral as Bakar was an inpatient and safe. The GP was informed about the medication change to insulin

and arranged nursing follow up. A new tenancy was agreed on 30/08/2022 (8th change of address). The Housing Association and Estates agreed to help with white goods and moving belongings as Bakar felt unsafe to return. On 13/09/2022, Bakar attended a Nurse Practitioner appointment to discuss insulin injection and demonstrated they understood how to do this.

6.9 – September 2022 - Discharge from Hospital

6.9.1 Bakar was discharged to new accommodation on 14/09/2022 under the mental health crisis team for six weeks. The accommodation had no cooker, fridge or curtains. This was unresolved for several weeks and the crisis team provided Bakar with ongoing food vouchers. Probation noted the address was in an area with a large Somali population. On 21/09/2022, probation could not contact Bakar but spoke to the housing keyworker who said Bakar was feeling overwhelmed in the flat. On the same day, a nurse practitioner reviewed Bakar's diabetes and insulin use with no concerns.

6.9.2 Both mental health and probation undertook five visits between 27/09/2022 and 02/10/2022. Bakar appeared unkempt, their room was untidy with beer cans and tablets on the floor, and they were drinking. They repeated concerns about Somali people entering their flat or spiking their food or drink. On 30/09/2022 and 03/10/2022, Bakar's brother contacted the CCO advocating hospital admission. Bakar reported the volume of professional visits was overwhelming and declined several contacts between 03/10/2022 and 10/10/2022. On 06/10/2022, Bakar called their female probation worker 'sir' during a supervision appointment, leading to discussion about pronouns. Bakar reported being unsure, saying she/her and then they/them. Bakar said they felt "different" from an early age but could not explore this due to upbringing and religion. Probation asked about Bakar's index offence and if the "victim's" transitioning played a role, however Bakar denied this.

6.9.3 SARI and Second Step reported difficulties contacting Bakar in mid-October and both discussed closing Bakar's case. Probation contacted SARI and Housing as Bakar was paying rent on two properties. Bakar was unwilling to return to their old flat to collect their belongings. By late October 2022, Bakar still had no fridge and continued to need food vouchers. On 19/10/2022, Second Step undertook an assessment and contacted the CCO about Bakar's deteriorating mental state.

6.10 – October 2022 - Safeguarding referral / pre-Care Act assessment

6.10.1 On 20/10/2022, Second Step sent a safeguarding referral to ASC. Second Step stated Bakar was unsuitable for their service due to risk levels. This referral recorded concerns about deteriorating mental health, discriminatory abuse, self-neglect and overall safety. Second Step stated they were unsure if Bakar had capacity as they were unable to fully engage in conversation. The referral also stated that Bakar was unable to keep themselves safe and was disengaging with services. ASC decided on 22/10/2022 that there was 'no abuse or neglect' and therefore would not proceed with a safeguarding enquiry but would offer a Care Act assessment.

6.10.2 On 26/10/2022, Bakar cancelled a probation appointment. Both the CCO and probation worker had difficulty getting through. On 26/10/2022, the CCO spoke to Bakar by phone. Bakar had no money or food, so the CCO offered a food voucher, but Bakar declined this.

6.10.3 On 26/10/2022, ASC's Swift Response Team undertook a 'support conversation' by telephone covering the full range of Care Act outcomes. They noted their history and stated 'Bakar appeared to demonstrate understanding and capacity'. They noted Bakar sounded quite low in mood and did not fully engage, only giving very short answers. As an outcome they requested a full Care Act assessment and suggested the possibility of getting a cooker from a local charity.

6.11 – October 2022 – Reported Missing

6.11.1 Bakar was last seen on the night of 26/10/2022 when they spoke to a neighbour, appearing intoxicated and distracted. On 27/10/2022, Bakar's brother reported they were missing after no contact for several days. He found Bakar's flat open and their phone in the front garden. He informed the mental health team and probation worker. The probation manager suggested the risk could not be managed in the community and that a secure mental health placement would be preferable to recalling to custody. The police searched Bakar's property, finding several unopened medication boxes. Very sadly, on 29/10/2022, Bakar was found deceased in the River Avon. Suspicious circumstances were ruled out.

7. Relevant Research informing the Safeguarding Adult Review

7.1 *Discriminatory Abuse* – This SAR was commissioned with reference to discriminatory abuse, given Bakar's protected characteristics and their concerns about discrimination in the community, regarding their gender identity and sexuality. Discriminatory abuse is a category of abuse in the Care and Support Statutory Guidance[13] relating to harassment, slurs and similar treatment based on one's protected characteristics. Discriminatory abuse is not frequently reported, with approximately 1% of safeguarding enquiries occurring in this category[14]. In Bakar's case, the term was first used in the SAR referral and was not evident in contemporaneous records. All adults who are subject to safeguarding enquiries have protected characteristics given that care and support needs align with age or disability but abuse that fits this category is often captured under more recognisable categories such as physical abuse or emotional abuse. Consequently, dynamics of discrimination may be under-explored in case work and the impacts that discrimination can have may not be addressed through the safeguarding process[15] (e.g. section 6.10.1 where ASC acknowledge targeting but view it as entailing 'no abuse or neglect'). Discriminatory abuse can be difficult to identify due to professional ignorance or unconscious bias. Given the interface with protected characteristics, people who experience this may feel ashamed or worry about stigma or not being taken seriously[16] (e.g. section 6.7.1 where Bakar worried they would not be believed). Discriminatory abuse is often correlated with extreme marginalisation, poverty and other structural factors such as homelessness, depleted community environments or insecure migration status, which can leave people more isolated and open to 'othering'[17] (e.g. sections 6.3.1, 6.9.3 highlight Bakar's social deprivation). The category of discriminatory abuse has potential to enable rights-based practice. Several open-access

[13] DHSC (2023) *Care and Support Statutory Guidance*, London: DHSC

[14] NHS Digital collect statistics and publish these annually: https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/adult-social-care-data-hub/dashboards/safeguarding-adults-collection

[15] Mason, K. et al (2022) "Discriminatory abuse: time to revive a forgotten form of abuse?", *The Journal of Adult Protection*, 24(2): 115-125

[16] Carr, S. et al (2019), "'Keeping control': a user-led exploratory study of mental health service user experiences of targeted violence and abuse in the context of adult safeguarding in England", *Health and Social Care in the Community*, 27(5): e781-e792

[17] Forbat, L. (2004), "The care and abuse of minoritized ethnic groups: the role of statutory services", *Critical Social Policy,* Vol. 24, No. 3, pp. 312-331; Iparraguirre, J. (2014), "Hate crime against older people in England and Wales – an econometric enquiry", *The Journal of Adult Protection*, 16(3): 152-165.

resources are available to support workforce development and organisational self-assessment[18] in this area.

7.2 *Safeguarding and Protected Characteristics (LGBTQ+, Race, Religion)* – There are known health and social care workforce deficiencies relating to confidence and competence regarding working with people who identify as trans. This can include misgendering or a lack of recognition in relation to how a person identifies, which runs against the grain of person-centred practice[19] (e.g. section 6.8.2 acknowledges professional uncertainty about pronoun use). Stigma associated with LGBTQ+ identities can conceal experiences of discrimination and create cultures of silence[20] or ambivalence amongst LGBTQ+ social care users in relation to their expectations of professional inclusivity. This can be exacerbated in institutional, formal care settings or supported housing schemes[21] (e.g. section 6.5.2 where Bakar worried about other residents in supported accommodation spotting they had female clothing in their room). Unfortunately, the gap in research widens even further regarding intersectional identities across race, religion and LGBTQ+ status[22]. SARs rarely make reference to any of these characteristics[23] [24]. One previous SAR[25] emphasises the Black Lives Matters movement and reminds us that SARs relating to racially minoritised individuals have a political element if professional or institutional biases contributed to the circumstances of a death. Qualitative evidence suggests that transgender Muslims may have challenging 'coming out' processes but religion and wider cultural resources may also offer relief[26] (e.g. Bakar's brother was unaware of their gender and sexual identity and Bakar came out to professionals during a mental health crisis where they were sectioned). Racially minoritised groups may experience stereotypical assumptions from professionals that families will provide care as a cultural obligation[27] (e.g. section 6.8.4 is the only time that Bakar's brother was offered carers support). Unconscious bias can result in gaps in

[18] Local Government Association (2022) *Discriminatory Abuse: A Briefing for Practitioners*, London: LGA, Available online: https://www.local.gov.uk/publications/discriminatory-abuse-briefing-practitioners; Research in Practice (2023) Discriminatory Abuse: Developing Practice Responses (podcast), Dartington: RiP, Available Online: https://soundcloud.com/rip-ripfa/discriminatory-abuse-developing-practice-responses; Biswas Sasidharan, A. (2023) Discriminatory abuse self-assessment tool: safeguarding adults, London: LGA, Available online: https://www.local.gov.uk/our-support/partners-care-and-health/safeguarding-resources/discriminatory-abuse-self-assessment-tool-safeguarding-adults

[19] Siverskog, A. (2014) "They Just Don't Have a Clue": Transgender Aging and Implications for Social Work, *Journal of Gerontological Social Work*, Vol. 57: No. 2-4, pp.386-406; Inch, E. (2016). Are you ready? Qualifying social work students' perception of their preparedness to work competently with service users from sexual and gender minority communities, *Social Work Education*, Vol. 36, No. 5, pp. 557-574; Stevens, O. (2022) Trans voices in social work research: what are the recommendations for anti-oppressive practice that includes trans people?, *Critical and Radical Social Work*, Vol. 10, No. 3, pp 422-437.

[20] Cooper, A. (2020), *The Independent Safeguarding Review: Lessons Learnt from Events in the Parishes of Stowe and Maids Moreton, 2012-2019*, Diocese of Oxford, Oxford.

[21] Willis, P. et al (2023). 'There isn't anybody else like me around here': the insider-outsider status of LGBT residents in housing with care schemes for older people. *Frontiers in Sociology*, 8, pp.1-15; Willis, P. et al (2020). 'I'm going to live my life for me': trans ageing, care and older trans and gender non-conforming adults' expectations of and concerns for later life. *Ageing and Society*, Vol. 41 No. 12, pp. 1-22.

[22] Westwood, S. (2018), "Abuse and older lesbian, gay bisexual, and trans (LGBT) people: a commentary and research agenda", *Journal of Elder Abuse & Neglect*, Vol. 31 No. 2, pp. 97-114.

[23] This point is made in the National SAR Analysis 2017-2019 – see footnote 6 above

[24] Mason, K. (2023) Harassment and slurs or epistemic injustice? Interrogating discriminatory abuse through safeguarding adult review analysis, *The Journal of Adult Protection*, https://doi.org/10.1108/JAP-01-2023-0003

[25] https://nationalnetwork.org.uk/2021/SAR%20Olia%20and%20Baby%20W%20Final%20Report%20REDACTED.pdf

[26] Etengoff, C., & Rodriguez, E. (2022). "At its core, Islam is about standing with the oppressed": Exploring transgender Muslims' religious resilience, *Psychology of Religion and Spirituality*, 14(4), 480–492.

[27] Forbat, L. (2004) – see footnote 12 for full reference

care for racially minoritised people (e.g. sections 6.3.1, 6.4.1 and 6.7.3 identify that Bakar volunteered and socialised at mosque and offered explanations around not fasting in Ramadan, but professionals noted that Bakar did not speak about their race or religion). Related to this, Bakar's name was spelled in at least four different ways across agencies resulting in duplicate records in police, mental health and hospital care, fragmenting risk assessment and causing confusion – a risk disproportionately faced by racially minoritised individuals. It is likely that Bakar experienced multiple, intersectional forms of minority stress regarding their protected characteristics.

7.3 *Safeguarding, Mental Health and Suicide* – Michael Preston-Shoot[28] has outlined key learning in this area based on a review of SARs. Key issues include: complexity of referral pathways into mental health services, failures to identify and refer safeguarding issues that coincide with severe mental distress, 'case bouncing' or 'revolving door' activity across fractured professional silos and deficiencies in the availability of secondary mental health services for those not in immediate crisis. His analysis comments on the absence of trauma-informed approaches and notes that the intersections with alcohol or substance misuse and multiple exclusion homelessness were often poorly coordinated or understood. Other key issues concern the importance of recognising issues of stigma and discrimination and the fractures that can occur at the interface between statutory mental health services and adult safeguarding[29]. This interface is sometimes (but not always) managed through Section 75 (National Health Service Act, 2006) arrangements for pooled resources, rather than parallel services providing different aspects, often with poor co-ordination. This is against a backdrop where there is a national shortage of mental health beds and where parity of esteem between physical and mental health is a continuing problem. Linking back to the previous section, significant racial disparities are consistently reported in relation to mental health with more adversarial care pathways (e.g. accessing mental health services via police services and higher rates of compulsory admission). Qualitative findings from conversations with Black men indicate de-personalised mental health services and poor aftercare[30]. All of these findings closely relate to Bakar's experiences.

7.4 *Safeguarding and Multiple Exclusion Homelessness* (MEH) – MEH pushes beyond the absence of a home and looks at the intersection between homelessness and a range of overlapping social exclusions, including mental ill-health, substance misuse, physical ill-health, offending and histories including institutional care (hospital, army, prison or child in care system)[31] (e.g. Bakar had overlapping physical and mental ill-health alongside their alcohol, khat and weed use and likely displacement and trauma in the context of asylum seeking, prison and suicide attempts). Homelessness is subject to strong discourses of individual responsibility ("lifestyle choice"), including from professionals. The concept of MEH offers an alternative lens that focuses on aspects of unmet need, marginalisation and exclusion[32]. These overlapping, diverse forms of need mean that often a range of services are invoked to respond to this complexity, but critical research asks whether it is the person's needs that are complex or whether people who experience MEH are left to navigate

[28] Preston-Shoot, M. (2023) Learning from Safeguarding Adult Reviews: Mental Health, Presentation for Partners in Care and Health, 25/9/2023 https://www.local.gov.uk/events/past-event-presentations/learning-safeguarding-adult-reviews-27-september-2023

[29] Carr et al (2019) – see footnote 16 for full reference

[30] Keating, F. (2021) Black men's conversations about mental health through photos, *Qualitative Social Work*, 20(3): 755-772; Cabinet Office (2017) *Race Disparity Audit*, London: Cabinet Office.

[31] Fitzpatrick, S. et al (2011) Multiple Exclusion Homelessness in the UK: Key patterns and intersections, *Social Policy and Society*, 10(4): 501-512.

[32] Mason, K. et al (2018) Multiple Exclusion Homelessness and adult social care in England: Exploring the challenges through a researcher-practitioner partnership, *Research, Policy and Planning*, 33(1): 3-14

complex and fragmented service frameworks[33] (e.g. section 6.9.2 where Bakar became disengaged from multiple professionals and noted their involvement was becoming overwhelming). Practitioners in ASC often struggle to accommodate homelessness (and the alternative forms of need that MEH is associated with) within their usual ways of seeing their roles even when the Care Act, 2014 outcomes appear to have been met[34]. Increasingly, SARs have been commissioned to look at deaths of people who have experienced homelessness. The findings of SARs in this area highlight professional failure to recognise care needs and self-neglect and provide evidence that professionals did not engage with people effectively[35] (e.g. sections 6.5.1, 6.7.2 and 6.10.1 where ASC deemed Bakar ineligible despite their long term use of secondary mental health and substance misuse as care and support needs and the possibility of discriminatory abuse or self-neglect). A briefing on positive practice[36] in this area may be useful for practitioners.

7.5 *Safeguarding and Self-Neglect* – Self-neglect comprises an array of presentations, including being unable or unwilling to provide oneself with adequate care in areas such as nutrition, medication, living environment and decisions around safety[37]. It is a complex phenomenon and may not adequately describe when a lack of support causes a person to be unable to care for themselves[38] as in the case of Bakar. The Care Act, 2014 initially inserted self-neglect into its statutory guidance as a safeguarding category, but subsequently amended this so that it requires a safeguarding approach in instances where a person is unable to control their self-neglect behaviours. In the context of severe mental distress, this applies, as in Bakar's case. SAR analysis provides insight into key themes in complex cases and highlight a range of practice and organisational issues to learn from[39]. These include seeing referrals in isolation rather than patterned phenomena, grappling with tensions between self-determination and safeguarding from harm, inadequate mental capacity assessments and a need for more professional curiosity (for example, respectful challenge or persisting with difficult conversations) (see sections 6.5.2, 6.8.4 for examples where this applies to Bakar). Voluntary sector organisations have reflected that when their referrals are rigidly gatekept by ASC, the use of the term 'self-neglect' has constituted a 'way in' to ASC for people who experience MEH or are otherwise on the edge of care as their presentations can usually be justified and this terminology captures the attention of those gatekeeping who are unfamiliar the needs of people who experience MEH[40], but although Bakar displayed signs of self-neglect, agencies did not always adopt this lens.

[33] Balda, M.M. (2016) Complex Needs or Simplistic Approaches? Homelessness Services and People with Complex Needs in Edinburgh, *Social Inclusion*, 4(4): 28-38; Cornes, M. et al (2018) Increasing access to Care Act 2014 assessments and personal budgets among people with experiences of homelessness and multiple exclusion: a theoretically informed case study*, Housing, Care and Support*, 21(1): 1-12

[34] See Mason et al (2018) – full reference in footnote 32

[35] Martineau, S., and Manthorpe, J. (2020) Safeguarding Adults Reviews and homelessness: making the connections, *The Journal of Adult Protection*, 22(4): 181-197.

[36] https://www.local.gov.uk/publications/adult-safeguarding-and-homelessness-briefing-positive-practice

[37] Dong X. (2017) Elder self-neglect: Research and Practice, *Clinical Interventions in Aging*, 12: 949–54

[38] Mason, K. and Evans, T. (2020) Social Work, Inter-Disciplinary Cooperation and Self-Neglect: Exploring Logics of Appropriateness. *British Journal of Social Work*, 50(3): 664–681

[39] Preston-Shoot, M. (2018) Learning from safeguarding adult reviews on self-neglect: addressing the challenge of change, The Journal of Adult Protection, 20(2): 78-92

[40] Mason, K. et al (2018) – see footnote 32 for full reference.

8. Findings and Key Learning

In this section we adopt the domains framework from Preston-Shoot et al's work[41]. To avoid repetition we have used judgement as to where any cross-cutting themes can be grouped under one domain and when they should be presented across the range of domains.

8.1 – Domain 1 – Direct Practice

8.1.1 – Good Practice

Many of Bakar's relationships with professionals were person-centred and relationship-based. The same probation practitioner saw Bakar for four years and was a key figure in coordinating support. They had a similarly consistent relationship with their AWP CCO while the case was open. Housing services were involved episodically but were swift to re-house or change locks upon request. Probation, Housing support, SARI and Second Step were strong advocates for Bakar in their escalation statutory services. When well, Bakar valued the professional support they received, expressing disappointment when AWP or floating support were closing their case or phoning their probation worker from hospital to say they called when in crisis due to a promise made to ask for help. Most practitioners reported that they had been able to maintain responsive and effective practice during the Covid pandemic and lockdowns, utilising regular telephone contact when face to face contact was restricted, for example.

8.1.2 – Analysis of Areas for Development

(a) Practice regarding discriminatory abuse, intersectional identities and unconscious bias - The term 'discriminatory abuse' does not appear in contemporaneous records. Bakar disclosed being targeted within the Somali community due to their gender and sexual identity several times and although services arranged for support and/or alternative accommodation, not every disclosure resulted in a safeguarding referral, even though at times Bakar was sleeping rough due to their concerns. One referral mentioned break-ins, medication compliance, mental health and another mentioned correspondence support needs without any reference to discriminatory abuse. This reflects research evidence regarding limited awareness of discriminatory abuse referenced in sections 7.1 and 7.5. Bakar's concerns about targeting may have been a product of paranoid thoughts, given their persistence across different addresses. However, there seems to have set up a binary position between actual discrimination and paranoid thoughts (for example, section 7.4.4 or 7.7.1), whereas– both are simultaneously possible. Bakar disclosed having female clothing at home (section 7.5.2), prompting concerns about co-tenants who may not be accepting of this, which is reasonable. Professionals commented that evidence was not always forthcoming, but Bakar remained uncertain about aspects of their identity, and it is unclear how their earlier assault on a person who was transitioning may have given rise to internalised shame (section 7.9.2). This reflects research evidence regarding unconscious bias and low reporting rates due to stigma and shame (see sections 7.1 and 7.2.). Although the first disclosure to most professionals about Bakar's gender and sexual identity occurred in 2021, AWP have informed us that there was a letter in November 2018 from another mental health trust stating that Bakar commented that a niece (though this may have referred to the person Bakar assaulted) was 'also' transgender. We have been unable to establish who was aware of this information, but it suggests that some parts of the professional system, who were no longer involved, were aware of this. Earlier awareness of this could have therefore been

[41] See Footnote 11

preventative and there is a strong suggestion that had Bakar been asked about aspects of their identity, they would have disclosed this.

Recommendation 1 - KBSP should ensure that practitioners across agencies have a better awareness of the unique dynamics of discriminatory abuse (including the discussion of protected characteristics as part of person-centred care and the role of professional unconscious bias or assumptions) and should monitor and audit practice in this area.

Specifically, this should consider how discriminatory abuse links to safeguarding criteria, how professional unconscious bias may require reflection and challenge and how early, affirmative discussion of and curiosity about identity and intersectionality is at the heart of person-centred practice. The recommendations for monitoring and audit are made in view of a similar recommendation from an earlier Bristol SAR (see section 2.7) to ensure unconscious bias and the dynamics of hate crime were understood across all services.

(b) Practice with substance use - Upon release from prison, a major concern was to avoid Bakar's resumption of khat use. Consequently, Bakar was released to Approved Premises, rather than to the home of a neighbour of their brother (which was never explored later) because he lived in an area with a large Somali population. While Bakar was accommodated in several residences that were located in areas with significant Somali populations, khat use was only mentioned once in the chronology where Bakar confirmed no further khat usage since their release. Whilst this decision was informed by risk assessment, the consequences regarding informal and cultural or religious support for Bakar as a Muslim and Somali adult were not explored. Given their later eight moves in a multi-ethnic city, this appears to adopt a risk elimination discourse rather than a contextual, culturally-affirmative and intersectional approach.

Bakar initially abstained from alcohol. It is unclear exactly when they started drinking alcohol regularly. In the final year of their life, Bakar was drinking heavily, and this interacted with their diabetes and mental health symptoms, which appears not to have been recognised or understood by practitioners working with them. No referral to substance misuse services was initiated and discussions about avoiding alcohol appear to have been ineffective. Bakar noted that their brother had limited his support because of their drinking and the significance of this could have been explored further. Alcohol pathways should have been discussed, including considerations of mental capacity. Discussions about the cultural (and potentially religious) understanding of Bakar's alcohol use could have been beneficial, including offering joint meetings with their brother. Bakar's brother also noted that Bakar had been smoking large quantities of 'weed' since leaving prison, which no services appeared to be aware of or did not comment upon. The large network of services seem to have been working with partial information and ineffective strategies regarding Bakar's substance misuse, and so not engaging with alcohol-specific service pathways for them.

9.2 Recommendation 2 – KBSP should ask agencies to assure the board that alcohol pathways are being used correctly and monitor practice in this area. Given that this issue was raised in a previous Bristol SAR (see section 2.7), this should be assured through a multi-agency audit of practice.

(c) Difficulties accessing secondary mental health services – In early 2022, AWP spent significant effort establishing community supports for Bakar so that they could step back from and close the case on the basis that the mental health situation had stablised. There was significant momentum towards this end. Although Bakar continued to experience paranoid symptoms and suicidal ideation (including an attendance at A&E following an overdose), AWP continued to move towards this discharge plan (see sections 6.5.1 through to 6.7.3.) This plan moved ahead despite concerns from

Bakar. Within weeks of support ending, Bakar was expressing suicidality "nothing left to live for" and experiencing mental health crisis, suggesting some degree of a tunnel vision 'decision trap'. Probation services attempted to re-involve mental health services but were advised to refer to the GP. Six days later a GP referral was made to mental health service prompting crisis team involvement, but due to a change of address, the wrong crisis team initially attended and had to refer Bakar on to the correct crisis team. Bakar was referred to an AMHP for mental health review, but no bed was available. There were disputes about whether PICU or a non-acute bed were more appropriate. Twenty-three days after the probation officer attempted to involve mental health services, Bakar was admitted.

In the final two months of Bakar's life, the mental health crisis team were meeting Bakar daily, and noted that Bakar was drinking regularly and self-neglecting, with medication scattered on their floor and their brother reported they were regularly smoking weed. After the police searched their home when Bakar went missing, they found three boxes of unopened medication. AWP have said that the crisis team do not observe medication intake but would be watching out for symptoms that might suggest re-admission might be indicated. It is not clear what decision-making and risk assessment processes were followed or what the tipping point would have been to justify re-considering re-admission, particularly considering the brother's concerns that Bakar was not safe in the community. Bakar avoided several contacts with mental health services in the last weeks of their life or was unavailable to speak via telephone. Overall, there are several instances in the chronology supporting concerns about the accessibility of secondary mental health services and the support available through this service and all fitting with research findings from section 7.3.

Recommendation 3 – AWP should develop guidance for closing cases where there is significant multi-agency involvement and consider their referral or re-referral pathways.

(d) Mental Capacity Assessments - Two mental capacity assessments were undertaken according to agency records (sections 6.4.2 and 6.8.4). We were surprised not to see further use of the Mental Capacity Act, 2005, particularly during the last month of Bakar's life when they were not taking their medication, drinking alcohol and sleeping in their garden, and experiencing increased paranoia. The chronology included references to issues about Bakar's language and cognition skills and there was reference to a learning disability. Professionals who knew Bakar well commented that they did not have concerns that they were unable to take part in discussions or did not understand risks, certainly while they were well. The information about their learning disability was originally posited by a psychologist who saw Bakar in prison, though this comment was qualified, given Bakar's circumstances as not providing evidence of global learning disabilities (section 6.2.2). Nonetheless, Bakar's significant distress, substance use and paranoia in the later part of their life suggests that mental capacity should not have been assumed. The absence of mental capacity assessments in the last two months of Bakar's life is notable in this context, given their decisions to sleep outdoors, disengage with essential health and social care input, discontinue medications (essentially self-neglecting). This links with research findings in Sections 7.3 and 7.5. Whilst practitioners have said that Bakar appeared to understand the issues they spoke with them about, their executive mental capacity or fluctuating mental capacity was not considered.

Recommendation 4 – KBSP should satisfy itself that Mental Capacity assessments are being done by partner agencies for people experiencing severe mental ill-health, substance misuse or medication non-compliance and that practitioners understand how executive and fluctuating mental capacity needs careful assessment. Regular audits of practice would provide assurance that Mental Capacity assessments are being undertaken appropriately.

(e) Immigration issues - Probation colleagues were supporting Bakar with their immigration issues, alongside support from their brother and solicitor. Initially this caused a lot of distress, housing and financial problems and they were referred to voluntary sector and housing support (sections 6.3.1, 6.3.4). It is important to note that at the time of their death, Bakar's leave to remain was due to lapse within a year. The impact of this ongoing precarity on Bakar's mental health is not fully apparent from the agency notes that we have reviewed and the extent to which this was on Bakar's mind in the months leading up to their death is not known. Probation had remained in contact with Bakar's solicitor but there are no other comments and AWP and ASC did not make special reference to it in their notes. Had Bakar stabilised, it seems possible that this insecurity could have caused further distress later and may have caused the need for further accommodation moves. This aligns with comments in a previous Bristol SAR (see section 2.7) where a recommendation was made to ensure that ASC practitioners were aware of the specific needs of asylum seekers. A recommendation is made under the inter-linked next theme (f) regarding meeting basic needs.

(f) Basic needs – Setting aside the resolved No Recourse to Public Funds issues after prison release, Bakar spent the last two months of their life living in extremely deprived conditions after discharge from hospital to an address without access to basic amenities such as a fridge, a cooker, or a washing machine. The discharge was based on an assumption that the housing association was managing the delivery of white goods (section 7.9.1), but timescales were not known, and these basic facilities were still not available by the time of Bakar's death. Bakar was provided with food vouchers, but they were very unwell and drinking heavily so did not always take these offers up. Problems accessing food were particularly important given Bakar's diabetes diagnosis. When ASC assessed Bakar (section 7.10.3), they suggested a charity could help purchase white goods resulting in cyclical attempts to purchase, since goods had already been bought and just required delivery.

Recommendation 5 – KBSP partners should work with voluntary sector services to create pathways for working with people who have severe unmet basic needs or destitution and develop an escalation protocol for unblocking problems. This should include specific challenges in working with people with insecure immigration status but should also be generic enough to support broader case work.

8.2 – Domain 2 – Inter-Organisational Working

8.2.1 – Good Practice

Strong working relationships are observed between probation, housing association and SARI colleagues, as they advocated to statutory housing, mental health and ASC services. SARI called for a multi-disciplinary professionals meeting when concerns about Bakar increased. Housing responded swiftly to requests for emergency accommodation and for locks to be changed in response to Bakar's fears. ASC consulted SARI when screening Bakar, acknowledging the presence of hate crime.

8.2.2 – Areas for Development

(a) Joint working between AWP and Police - Problems emerged in communication pathways between the police and AWP on two occasions. Police requested advice and support during a mental health crisis but were advised to contact the GP for an appointment, which police colleagues believed was inappropriate. This resulted in police arresting Bakar and de-arresting them once outside their home in order to detain them under Section 136 (see 6.4.1 above). Police have reflected that this was not a correct process and believe a more helpful response could have been forthcoming from AWP (police pathways will be discussed in section 8.4.2). On another occasion (section 6.8.2), police had been asked by mental health to undertake a welfare check as Bakar was due to be admitted but hospital transport had broken down. Police colleagues have stated that

AWP also commented that no beds or transport would be available if police did believe that Bakar needed to be detained, leaving police in a potentially difficult position. The research evidence in section 7.3 points to systemic issues in this area. The relevant recommendation is made under Domain 4 (see section 9.14)

(b) *Care Act pathways and Safeguarding Thresholds* – Four referrals were sent to ASC for reasons as diverse as appointment and correspondence management, medication mismanagement, deteriorating mental health, break-ins and being targeted in the community (sections 6.5.1, 6.6.2, 6.8.1, 6.10.1). The first referral was initially closed as Bakar said they had no support needs as they thought they were speaking to housing. It was re-opened, and Bakar was found to be ineligible, despite being under secondary mental health services and alleging targeting in the community. One safeguarding referral was sent by Housing but never received by ASC, which is a governance issue (Domain 4). Another safeguarding was closed as Bakar was an inpatient and assumed to be safe. A Care Act assessment was pending when Bakar died. Services in the community did not understand Care Act eligibility criteria and how to refer relating to adult social care's statutory remit. Whilst Bakar was very independent at certain points, they would have been eligible at other points when they were less well, and if more targeted referrals had been made. This highlights training needs, and organisational responsibilities, so a recommendation is made under Domain 3. The research base (see 7.3 and 7.4) highlights the poor understanding of how mental health and MEH interfaces with safeguarding criteria and Care Act pathways. Mental health practitioners were seeing Bakar regularly, apart from a short period when his case was closed (March-July 2022, paras 7.7.3 & 7.8.1). They were monitoring his mental health, so were aware of his deterioration and self-neglect, medication non-compliance and nutritional unmet needs, and fears of discrimination. However there seems to have been no awareness that these might constitute safeguarding concerns and multi-agency protection planning might be an appropriate approach to risk management either under s41(1) or s42(2). We were informed that AWP was working to improve practitioner awareness of self-neglect and referral of safeguarding concerns to ASC. This will be picked up in Domain 3.

Recommendation 6 – KBSP should assure itself that the referral pathway to ASC is functioning. This serious governance issue needs audit, testing and safeguards such as a checking system while the system is being examined and reviewed.

Recommendation 7 – Safeguarding teams should review closure decision making if a person is in hospital. Practitioners should remember that a hospital stay is not a permanent safety measure and hospital discharge can be a time where fractures in the system can place people at further risk.

(c) Hospital Discharge – Bakar was admitted to hospital twice during the review period and both discharges created challenges. On the first occasion Bakar was discharged without probation being informed, despite their requests to involve them. On the second occasion Bakar was discharged home without basic facilities. AWP have commented that they have an 'out of area' bed manager, whose role is to maintain daily contact with all 'out of area' wards and ensure a smooth transition back to the locality. This professional did have contact with the ward and was also in contact with the probation service during the inpatient stay. Probation have noted that on speaking to a new CCO, they had commented that 'little or no discharge planning had occurred because the bed was 'out of area'. It is also important that the primary concern raised by Bakar's brother relates to readiness for hospital discharge. Bakar's brother felt he was being ignored by mental health services and was told 'they do not admit people for alcohol use'. Whilst this is undoubtedly correct, Bakar's brother felt that no other arrangements were made to step up the support on the basis of his concerns. Families may not always have the correct ways of phrasing concerns or may ask for interventions that are not possible, but this does not mean that teams should not think about how

support might be garnered. AWP commented that this particular discharge was not a good discharge and acknowledged that more could have been done in relation to communication across the professional network. A previous Bristol SAR (section 2.7) made a recommendation regarding discharges from independent sector mental health beds.

Recommendation 8 – KBSP should audit out of area mental health hospital discharge arrangements. This audit is important given an earlier recommendation in a previous Bristol SAR

(d) Professional and MDT meetings - A range of multi-agency panels and meetings exist for partners in Bristol to work together to support people with complex needs, e.g. MAPPA. There is also an internal forum in ASC for safeguarding case discussions. Late in the chronology, SARI and colleagues called an ad hoc meeting to discuss how to support Bakar in July 2022 (7.7.7.) in the absence of a formal mechanism to bring people together who were working with Bakar. Discussion at the practitioners meeting illustrated that there needs to be more clarity on what panels exist, who can refer to them and where the gaps are; the panels need to be accessible to all partners. The internal ASC meetings could be opened to practitioners from partner agencies. Further, clarity is required regarding who can call a multi-agency safeguarding meeting, particularly for people on the edge of care and support, and not deemed to meet the criteria for a safeguarding enquiry (s.24(2)). This is important when cases are closed and partners struggle with outstanding risk and their capacity to support the person to live with those risks. This links with research findings in section 7.3 and 7.5.

Recommendation 9 – KBSP should review the range of panels and pathways and ensure that all partners are informed of what exists, how to refer, and any gaps are identified. Proposals to meet identified gaps should be presented to the SAB, including protocols for any partner initiating a multi-agency meeting about someone with complex needs, where there are safeguarding concerns.

8.3 – Domain 3 – Organisational Environment

8.3.1 – Good Practice

SARI and housing have already begun to liaise about training regarding transgender people's needs and this may be transformative in relation to how both organisations can work together in future.

8.3.2 – Areas for Development

(a) Care Act 'thresholds and criteria' - Following on from comments under Domain 2 (see 8.2.2(b) above), Bakar was told that they were ineligible for care and support or safeguarding support to manage the risks in their life (see above 7.7.2, 7.10.1 and 7.10.3). Interpretation and assessment of Bakar's needs for care and support and safeguarding did not fully acknowledge his mental ill-health, self-neglect/medication non-compliance, lack of access to appropriate nutrition, substance misuse, or fears regarding discriminatory abuse. This is an issue for individual practice and multiagency working (as per Domain 2) and it also requires addressing at an organisational level. Multi agency policies and procedures need to clarify that substance misuse and mental ill health, lack of access to appropriate nutrition can constitute care and support needs; medication noncompliance and can be self-neglect; and fear of hate crime can constitute a risk of discriminatory abuse.

Recommendation 10 – KBSP should review multi-agency policies and procedures to ensure that these aspects of safeguarding practice are clarified: mental ill-health and substance misuse do constitute care and support needs; self-neglect can include medication non-compliance; lack of access to appropriate nutrition is a care and support need; fear of hate crime can constitute a risk of discriminatory abuse.

(b) Pathways between AWP and ASC safeguarding services - Bakar's experiences raise questions about whether mental health practitioners are raising safeguarding concerns appropriately (see also Domain 2). In the absence of a formal mechanism (e.g. section 75 agreement) for clarifying roles and responsibilities, AWP needs to demonstrate that staff understand their safeguarding role and responsibilities in terms of awareness and referral of safeguarding risks and concerns. When someone is deemed ineligible for a safeguarding enquiry, there should be effective monitoring and prevention activity in place. In Bristol, all safeguarding concerns are sent to ASC who triage and decide what is the appropriate response i.e. information and advice/ Care Act assessment and/or safeguarding enquiry. The various responses to requests to ASC for help for Bakar suggest that the internal pathways and interfaces could be improved to avoid people being 'bounced' from one part of the service to another. It is sad that a Care Act assessment was arranged after Bakar's death.

Recommendation 11 – KBSP should ask AWP and ASC to monitor and report back to KBSP on the interface between their services relating to self-neglect referrals. ASC should also report on the effectiveness of their internal arrangements in addressing safeguarding needs of people with mental illness, substance misuse and self-neglect.

(c) Interface between SAB work and suicide prevention - Bakar's experience should inform local suicide prevention strategy and priorities in Bristol. We were not informed of any interface between these two policy areas and there is learning for the whole system from this SAR. This links to research findings in section 7.3.

Recommendation 12 – KBSP should review the interface between safeguarding adults strategic plan, particularly in relationship to understanding and responding to self-neglect, and relevant aspects of the suicide prevention strategy and action plans, to establish whether there is a shared priority for improvement.

d) Training and Workforce Development – As commented under Domain 1, practitioners said that there was uneven understanding of protected characteristics, particularly transgender identities. Others acknowledged uncertainty in working with trans people including confusion around pronoun use. A positive outcome was that the housing service had made proactive contact with SARI for training in this area. All KBSP partners could benefit from this and it has the potential to be transformative, laying the groundwork for a shared reference point if difficult conversations are later required. Secondary benefits are also likely to arise, for example, SARI have commented that they do not receive referrals for their hate crime service from ASC in Bristol, but in another local authority area, where they supply training to ASC, this has led to more recognition of discriminatory abuse and hate crime and a number of ASC referrals have been generated as a result. Training should be wider than transgender issues and should relate to the spectrum of protected characteristics. This links to research under 7.1 and 7.2 regarding practitioner confidence and training needs in working with discriminatory abuse and intersectional needs and echoes a previous Bristol SAR (section 2.7).

Recommendation 13 – KBSP should ensure that all partners are offered training on discriminatory abuse and should monitor and review take up. We have suggested monitoring because multi-agency hate crime training was suggested in a previous Bristol SAR.

8.4 – Domain 4 – SAB governance and leadership

8.4.1 – Good Practice

The SAR was supported effectively by a statutory review officer, partnership co-ordinator and a panel of agency leads. The panel were honest where there were barriers and proactive in identifying improvements ahead of the SAR recommendations.

8.4.2 – Areas for Development

a) *Police and mental health services - people in crisis* - Further to related comments under Domain 2, the police responded promptly and effectively when Bakar was unwell, using their powers to take Bakar to a place of safety (see 7.4.1.). The introduction of 'Right Care, Right Person' across police forces in England has triggered concerns that police involvement in supporting people experiencing mental health crises may be reduced in future. The SAR authors have been informed that local discussions about this national policy have begun. In this context, KBSP needs to seek assurance that people in such situations are safeguarded and risks managed properly by relevant statutory services.

Recommendation 14 – KBSP should seek assurance from relevant Board partners that the forthcoming implementation of the policy 'Right Care, Right Person' maintains effective protection for people experiencing mental health crises and AWP should report on the use of police welfare checks in the context of bed unavailability.

(b) Scarcity of supported housing and mental health Inpatient beds - Participants at the practitioners' event cited the lack of access to and supply of supported housing as a key factor that meant that Bakar was unable to get the support that they needed to live independently, manage their tenancy and achieve basic needs like a functioning kitchen. They said that there were many people in inappropriate and inadequate temporary accommodation. These structural challenges, due to central government policy and reductions in public funding, have impacted on the choices available for officers to offer to Bakar. Bakar's brother also thought that there was a lack of support when Bakar moved into their own flat, which contributed to their deterioration. The scarcity of inpatient placements for people with mental illness in crisis caused delays in Bakar receiving appropriate support during July 2021 and August 2022 (paras 7.4.2. & 7.8.3). When their mental health was deteriorating in October 2022 Bakar's probation officer was advocating for them to be admitted (7.11.1). The police also experienced difficulties in accessing a 'place of safety' and exercising their powers appropriately. The scarcity of appropriate resources appears to have influenced how and when their needs were met. Whilst this was aggravated at times by the impact of the Covid pandemic, demand for mental health services has continued to escalate adding pressures on services. There is a national challenge for all mental health services in terms of availability of specialist resources, following years of austerity and cuts to public services as per research presented in section 7.3. In the Kamil and Mr X SAR (see Section 2.7) a recommendation had been made to refresh the bed availability policy, which AWP have reported is kept under review.

Recommendation 15 – KBSP should consider escalation of the issues of scarcity of supported housing, scarcity of mental health inpatient beds and places of safety at a national level.

(c) Community Safety Partnership and Discriminatory Abuse - Discriminatory abuse and Hate Crime are often used synonymously and may involve multi-agency working but can be challenging for practitioners – see Domain 1 and 2. Training has been recommended but strategic oversight would be beneficial given a previous Bristol SAR (section 2.7) raised similar issues five years earlier.

Recommendation 16 – KBSP to engage the Community Safety Partnership function of the partnership in relation to discriminatory abuse in view of the two SARs that Bristol has commissioned on this theme, to consider actions for improvement in understanding across the whole system.

9. Summary of Recommendations

Recommendation 1 - KBSP should ensure that practitioners across agencies have a better awareness of the unique dynamics of discriminatory abuse (including the discussion of protected characteristics as part of person-centred care and the role of professional unconscious bias or assumptions) and should monitor and audit practice in this area.

9.2 Recommendation 2 – KBSP should ask agencies to assure the board that alcohol pathways are being used correctly and monitor practice in this area**.** Given that this issue was raised in a previous Bristol SAR (see section 2.7), this should be assured through a multi-agency audit of practice.

9.3 Recommendation 3 – AWP should develop guidance for closing cases where there is significant multi-agency involvement and consider their referral or re-referral pathways.

9.4 Recommendation 4 – KBSP should satisfy itself that Mental Capacity assessments are being done by partner agencies for people experiencing severe mental ill-health, substance misuse or medication non-compliance and that practitioners understand how executive and fluctuating mental capacity needs careful assessment. Regular audits of practice would provide assurance that Mental Capacity assessments are being undertaken appropriately.

9.5 Recommendation 5 – KBSP should liaise with voluntary sector services to create pathways for working with people who have severe unmet basic needs in their area, including training and escalation policies. This should integrate specific problems in working with people with insecure immigration status but should also be generic enough to support broader case work.

9.6 Recommendation 6 – KBSP should assure itself that the referral technology to ASC is functioning. This serious governance issue needs audit, testing and safeguards such as a checking system while the system is being examined and reviewed.

9.7 Recommendation 7 – ASC should review closure decision making when a person is in hospital. Practitioners should remember that a hospital stay is not a permanent safety measure and hospital discharge can be a time where fractures in the system can place people at further risk.

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9.9 Recommendation 9 – KBSP should review the range of panels and pathways and ensure that all partners are informed of what exists, how to refer, and any gaps are identified. Proposals to meet identified gaps should be presented to the SAB, including protocols for any partner initiating a multi-agency meeting about someone with complex needs, where there are safeguarding concerns.

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9.14 Recommendation 14 – KBSP should seek assurance from relevant Board partners that the forthcoming implementation of the policy 'Right Care, Right Person' maintains effective protection for people experiencing mental health crises and AWP should report on the use of police welfare checks in the context of bed unavailability.

9.15 Recommendation 15 – KBSP should consider escalation pf the issues of scarcity of supported housing, scarcity of mental health inpatient beds and places of safety at a national level.

9.16 Recommendation 16 – KBSP to engage the Community Safety Partnership function of the partnership in relation to discriminatory abuse in view of the two SARs that Bristol has commissioned on this theme to consider actions for improvement in understanding across the whole system.