Bristol Safeguarding Adults Board Briefing

Information about Briefings

This is produced by BSAB to help practitioners reflect and continuously improve their practice.

Thank you for taking the time to read this Information.

There are three areas of learning:

- What you must know
- What you should know
- What is good to know

At the end is a feedback form to help us assess how you and your organisation has implemented the changes

SAR Briefing: BSAB Lessons Learnt

What Is A SCR/SAR?

A Serious Case Review (SCR) is the old name for a Safeguarding Adult Review. The Care Act 2014 states that Bristol Safeguarding Adults Board (BSAB) must commission a review when:

- an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more or effectively to protect the adult
- an adult in its area has not died, but the Board knows or suspects that the adult has experienced significant abuse or neglect.

BSABs can arrange for a SAR in any other situations involving an adult in its area with needs for care and support but will only do so when learning can be gained which can be used to prevent future harm or death to others within the city and / or wider.

The purpose of a SAR is to determine what relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again.

About the individual

On September 9th 2014 Mr Robert Crane died aged 61 in a fire at his flat in Bristol. There were no other casualties. His flat was in a Bristol City Council owned tower block. Various agencies had been involved with Mr Crane including Avon and Wiltshire Partnership Mental Health NHS Trust (AWP), Avon Fire and Rescue, Avon and Somerset Police, Bristol City Council Housing delivery and Adult Social Care.

Mr Crane was well known to secondary mental health services. Between 1997-2011 he had eight admissions to psychiatric in-patient services. Deterioration in his mental state was characterised by certain behaviours symptomatic of a bi-polar disorder that occurred and re-occurred during this period. He also continued to use recreational drugs which seemed to exacerbate his condition. At the time of his death there had been significant concerns around his self-neglect,

What can you do?

Read the full report on the BSAB website

Read and follow the Self Neglect Policy and Use the Clutter Tool to assess levels of hoarding

Ensure your organisations policies and procedures

What must you know:

- Mr Crane was known to be articulate and resistant to receiving help. As a result assumptions were made about his capacity based on his verbal reassurances of his ability to cope. **Never assume capacity—ensure that MCA assessments are appropriately targeted and consider any implications of the outcome of your assessment.**

- Agencies working with Mr Crane only seemed to work together during crisis periods. As a result there was no overall analysis or planning to inform a shared strategic approach and agencies had no clear idea of what input was being provided. **When working with individuals who self-neglect multi-agency working is essential.** It provides an opportunity for increased collaboration, shared decision making and provides a more innovative approach to engaging with the individual.

- Mr Crane's circumstances in terms of his self-neglect were seen as a life-style choice with insufficient consideration to the threat his behaviours posed to others. **The impact on others needs to be considered** – it is the one of the key parts of assessing the appropriate response to a presenting situation.

What can you do?

Take some time to think about what these key messages mean for your practice.

Ask yourself:

- Can I make changes to my own practice?
- Do I need to seek further support, supervision or training?

What should you know:

- Mr Crane had a complex and long mental health history. Professionals involved with his care often failed to take this into consideration when making decisions about his care. It is essential that if you are working with an individual who is difficult to engage you consider any current or historic mental health or substance misuse history in all decision making.
- Always consider lack of engagement to be a risk.

What would be good to know:

- None of the professionals working with Mr Crane registered the pivotal nature of his son's role in his care and therefore when his son withdrew from his care the 'gap' was not filled. **Always consider the important role that family may play, their expertise and knowledge about the individual and consider carefully the significance of any withdrawal of family support.**
- When making a referral to another agency it is important to follow-up of the referral if you are not made aware of the outcome. If you disagree with another agencies decision not to provide a service, you should challenge this and escalate if required following consultation with your line manager. BSAB Escalation Policy

What can you do?

Please fill out this page and send it back to BSAB

Please complete any reflections that you have had from reading this briefing and any practice changes considered:

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