BRISTOL SAFEGUARDING ADULTS BOARD BRIEFING

DATE: 28TH SEPTEMBER 2017

ABOUT BRIEFINGS

This is produced by the 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 have implemented the changes.

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SERIOUS CASE REVIEW BRIEFING - 'MELISSA'

WHAT IS A SCR or 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.

'MELISSA' SERIOUS CASE REVIEW

The Bristol Safeguarding Adults Board today published a Serious Case Review concerning the murder of Melissa, an 18 year old woman who was killed in a Bristol-based independent Care Home in October 2014 by another resident, a 19 year old male.

Both young adults were placed in the Care Home by commissioners from different local authorities a significant distance from Bristol. Neither Bristol's Safeguarding Adults Team nor the Clinical Commissioning Group were informed of them being moved into Bristol despite their complex and multiple needs.

The case has raised significant learning particularly in regards to the commissioning of out-of-area placement, risk assessment, risk management, and transition planning between providers, NHS trusts and commissioners. The review found Melissa's death could have been prevented had better processes been in place.

The full report can be found on the BSAB website https://bristolsafeguarding.org/adults/safeguarding-adult-reviews/bristol-sars/ alongside the Board's Response and a public statement from Melissa's father.

WHAT CAN YOU DO?

Read the full report on the BSAB website.

Check the local Adult Safeguarding policies on the BSAB website.

Ensure your organisation's policies and procedures are up to date.

Review the compatibility assessment process for introducing a new adult into a group living environment.

Update your General Data Protection Regulations.

Deliver staff briefing sessions to discuss the case.

WHAT WE KNOW ABOUT THE ADULTS INVOLVED

Melissa lived at home with her parents and sibling for most of her childhood years. At the age of ten she was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and later diagnosed with Autism Spectrum Disorder (ASD).

In July 2013 Melissa was admitted to the first of two CAMHS Adolescent Units for a period of in-patient assessment. Subsequently Melissa's home authority children's services, supported by the Adolescent Unit, decided that a residential placement should be sought for her. This view was not supported by her family who expressed concern about her ability to relate to other adults in a residential placement because of her immaturity.

Aged 18 Melissa was placed in the Care Home 2 months before her death. During this time she exhibited significant distress and received support from mental health crisis services.

The young man who was convicted of murdering Melissa had been in care since the age of seven. He had lived in multiple placements including foster care and residential schools. The review identified a chronology of sexually motivated violent behaviour to women throughout his adolescence.

A forensic assessment conducted in the year before his move to the Care Home identified his significant ongoing risk and recommended a high level of supervision and risk management strategies. These were set out in a report shared with the professionals supporting him at the time.

The young man struggled to distinguish between fact and fiction. He enjoyed science fiction films and books such as Marvel Comics and Star Wars and liked time role=playing in these characters.

OUR FOCUS IN THIS ISSUE: MANAGING RISK

It was evident through the review that the young man should not have been placed in the same provision as Melissa because of his risk profile. It is vital that providers undertake a compatibility assessment should be undertaken considering the combination of needs of all adults in any group living situation whenever a new adult is placed there. Commissioning authorities should ensure this is completed as standard.

WHAT WE LEARNT/NEED TO DO DIFFERENTLY:

- Bristol City Council's Safeguarding Adults Team and the Bristol Clinical Commissioning Group should be informed when adults with complex needs and who pose a significant risk to themselves or others are placed within Bristol.

- Any professional involved in commissioning services out-of-area placements for high risk or complex adults must also ensure they notify local Safeguarding Adult Teams and Clinical Commissioning Groups. Providers should seek assurance that this has been completed on accepting a new placement.

- Commissioners and providers must ensure that their understanding of agreed staffing levels are explicit throughout a twenty-four period including at night.

- Assessments undertaken when an adult is moving into a provision must include assessments of compatibility with other residents as well as robust risk assessment. This includes ensuring that placing authorities provide information in a timely and accurate way.

- Risk management assessments and strategies should be reviewed regularly and ALWAYS reviewed if there is a change in behaviour or new information about risk becomes available.

- All documentation and assessments concerning an adults risk must be provided to providers in a timely manner and their findings must influence placement decisions and the development of robust risk management plans.

- Referrals and professionals undertaking assessments should mitigate against the rule of optimism when conveying and assessing potential risk. The desire to place an individual or ensure they are not stigmatised should not be barriers to effectively sharing information about potentially risk behaviour. These should be conveyed explicitly and factually, reflecting potential groups who may be more at risk if relevant.

WHAT IS GOOD PRACTICE IN THESE CASES:

- Potentially Dangerous Persons is a term used by the police to describe individuals where there is 'present likelihood' of them committing an offence or offences that will cause serious harm. A 'present likelihood' reflects imminence and that the potential event is more likely than not to happen. These individuals fall outside of the criteria for MAPPA normally because they have not been convicted of an offence. In these cases an individual should be referred to the police so that a risk management place can be established.
- Ensure that recording is accurate, factual and completed in a timely way. Recording should be reviewed to consider whether there is pattern of behavior being demonstrated.
- GPs should be informed of any risks posed by an adult moving into their area. It is best practice for Care Homes to have a relationship with their local GP so that the GPs are aware of the kinds of needs their residents have and can establish good working relationships.

IDEAS/WAYS TO REDUCE RISK IN THE FUTURE:

- Adults with care and support have a right to an independent advocate to be involved in decision making. Advocates should be engaged at the earliest opportunity.
- Providers should review their General Data Protection Regulations to ensure they include information sharing arrangements for when they accept or managing high risk residents.
- The BSAB Escalation Policy should be used to manage professional disagreements.
- The BSAB will be holding an event on 30th November to hear about best practice options for managing risk. This will be advertised in the next few weeks so keep it free in your diary to attend.

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FEEDBACK, SUGGESTIONS AND IDEAS:

Tell the BSAB how you have used this briefing in your team by:

Email: bsab@bristol.gov.uk

Website: https://bristolsafeguarding.org/adults/contact/contact-the-bsab/

Twitter: @BristolLSAB

Please also let us know if you identify work that could be completed by the BSAB which would support multi-agency professionals to implement the report's findings.

